Re-visioning Stuckness in Psychotherapy

by

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ABSTRACT

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This research explored the meaning therapists ascribe to stuckness and the internal and external responses they have when encountering it. The Research Problem asked: “When in the face of stuckness, what tendencies can be seen in therapists’ thought process in their choice making between active, change-seeking interventions and passive, encouraging and accepting interventions?” The hypothesis stated: “When faced with stuckness, some therapists tend to want to do ‘something’ even when they do not know what to do. Their discomfort prompts them to choose active, change-seeking interventions against their intuition or deeper knowing.” Taoist theory was used as the theory in practice when examining the research findings.

The literature review explores the roots of change theory in western psychology and philosophy, and the dichotomy between process and substance metaphysics. It looks at the role of the therapist in the change process and at cultural biases towards active interventions. It covers other terms used to describe the lack of change, such as resistance and impasse. Finally, it explores modalities that accept stuckness in the therapy process. Although stuckness was identified since the early days of modern psychology, and there are sources suggesting how to fix it, there are limited sources that look at therapists’ reaction to stuckness. There is a shortage of literature that recognizes the healing and
developmental role of stuckness. Some exceptions can be found in Buddhist psychology and in Gestalt.

The research data was collected using Imaginal Inquiry and Phenomenological interviewing. The data analysis used Thematic Content Analysis. 10 professional therapists were interviewed after a short therapy session where the researcher role-played a stuck client. Additionally, 84 professional therapists responded to a request to define stuckness in psychotherapy. Thematic analysis was used to glean common themes from these responses in preparation for data collection and to substantiate the Research Problem focus.

The Cumulative Learning suggests that therapists might respond to stuckness by disconnecting from their intuition. The first learning suggests that therapists’ desire to help leads them to respond to stuckness with dread and shame. The second learning suggests that responses to stuckness lead to disconnection from the client. The third learning suggests that therapists frequently expect the client to know and name their therapy goals. The fourth learning suggests that therapists are often ambivalent about their wishes to slow the therapy process. The fifth learning suggests that therapists often treat the therapy as a riddle and tend to offer shortcut solutions.

Deepening therapists’ awareness of stuckness and considering its place in the process of therapy can reduce their dread and shame and the pressure on the client to change. As a result, Stuckness might be loosened and new paths to internal and external change can be revealed. The story of Odysseus in Ogygia illustrates stuckness as part of the therapeutic process.
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CHAPTER 1

INTRODUCTION

Stuckness shouldn't be avoided. It's the psychic predecessor of all real understanding. An egoless acceptance of stuckness is a key to an understanding of all Quality, in mechanical work as in other endeavors. It's this understanding of Quality as revealed by stuckness which so often makes self-taught mechanics so superior to institute-trained men who have learned how to handle everything except a new situation.

—Robert M. Pirsig, *Zen and the Art of Motorcycle Maintenance*

Research Topic

Psychotherapy is a process. As such, it involves intentional actions towards a predefined or wished for goal. The driving force behind the process of psychotherapy is a desire for change coming from the client or from people in the client’s life who encourage or force the client into therapy.

Clients seek psychotherapy expecting some change in their external or internal lives. When the therapy process is perceived as successful, some change must have happened; either externally in the client’s circumstances or abilities, or in the way the client perceives their life and its overall meaning. The therapist is expected to be a change agent in that process, helping the client move from an undesirable situation or condition into a more desirable or at least an acceptable one.

Psychological theories and modalities vary in their recommendations for the therapist’s style and procedures of involvement in the process of change.¹ Some tend towards a detached position, for example, classical Psychoanalysis.² Other theories view
the therapist as an integral part of the system, for example, Client Centered Therapy.\textsuperscript{3}

Most psychological theories and therapeutic modalities including psychodynamic, behavioral, humanistic, strategic, solution oriented, to name a few, provide some compendium of tools and concepts that help or facilitate the change process. Usually, psychological theories also provide tools and concepts for diagnosing and assessing the client’s condition and some instruments for measuring progress.

When the therapy is successful, at least as measured subjectively by the client, the therapist or the people closest to the client, the process usually ends with feeling of satisfaction. However, when not immediately successful, the process can stop or slow down to a point of discomfort for some of the parties involved. In these circumstances, it is often said that the therapy is stuck.

Although references to \textit{stuckness} can sometime be found in professional therapy books, I could not find it in any professional psychology dictionary. For the purpose of this research \textit{stuckness} can be defined as the frustrated subjective perception of the therapist, the client or both, that the therapy process is not proceeding fast enough towards the desired change. Sometimes that perception is in the eyes of the client’s family and friends, as it happened with the sisters of Psyche in the story about her marriage to Cupid.\textsuperscript{4} Other definitions focus on the lack of movement. For example, Marie-Nathalie Beaudoin says: “Stuckness can be defined as an absence of movement or as movement towards an unhelpful direction. For therapists it is experienced as an inability to foster change.” \textsuperscript{5}
The main questions that guided the research were:

Can stuckness have a positive and even a necessary role in the overall development of the psyche?

Can it have value in the process of therapy?

In what ways do our respective cultures affect our choice of therapeutic interventions?

Are there different types of stuckness in therapy?

What conditions or causes lead to stuckness in therapy?

According to Robert Whitaker, the mental health economy that prefers brief therapy and is to a large extent controlled by the pharmaceutical and insurance industries does not easily make room for long gestations and incubation periods in therapy as they expect quick and efficient results. Yet, every change of direction requires at least a temporary stop and rest as explained by Susanne Cook-Greuter. Any developmental model includes periods of dismantling structures and related confusion. As suggested by Tara Brack, in order to change or heal, clients need to accept their situation, accept themselves, and gradually own their innate powers and abilities. Often that implies a change in their self-image or identity. The Tao-Te-Ching has similar suggestions about accepting and embracing experience.

A larger encompassing topic for this study was the questioning of the mainstream model of therapy that is often based on behaviorism and is rooted in early 20th century scientific views. James Hillman’s and Michael Ventura question the current trends of the profession and its place in the culture. Inviting a reconsideration of stuckness and non-change as valuable, as this research suggests, brings the question about the need for therapy altogether, which can be threatening to those who have a stake in the profession.
There is plenty of research showing that psychotherapy basically works, for example, the work of Scott Miller and his colleagues.\textsuperscript{11} That group of researchers conducted a large-scale (over 30,000 cases) meta-research trying to find out what works in therapy. Their clear conclusion is that overall psychotherapy works. On the other hand, as Whitaker has suggested, in 21\textsuperscript{st} century US, there are social, technological and economical changes that put into question the general therapy model of the last 100 years.\textsuperscript{12} That model includes regular one-on-one meetings with a trained professional. Modern communication devices and the fast pace of life, especially in urban America, increase the demand for remote and faster interactions. The pharmaceutical industry pushes towards replacement of that model with drugs. Newer modalities are frequently invented and often market themselves as faster and better replacement for the old and more expensive model.

Questioning some very basic tenets of psychotherapy, such as the superiority of the therapist, the medical model, the diagnostics manual and the traditional psychological theories, can attract objections from the establishments of the profession. Going against the professional mainstream might associate this research with the anti-psychology movement and with great teachers like James Hillman, Thomas Szasz and R.D. Laing.\textsuperscript{13} That association is likely to invite opposition and criticism.

Suggesting that in some cases waiting and non-action is preferable to immediate action might expose a therapist to litigation as had happened to some of the psychologists mentioned above.\textsuperscript{14} A common understanding of the Hippocratic Oath that Medical Doctors take, is that when they see suffering, they try to do something about it. It is
harder to explain that the principle of do-no-harm might imply in some cases waiting patiently and promoting non-change.

Existential psychology and Gestalt therapy often state the need to stay present with whatever is presented by the client. James Bugental points out how often that need is ignored in therapy.\textsuperscript{15} Kenneth Bradford similarly suggests that by intervening too early, with pharmaceuticals or with action-oriented-therapy; the client is blocked from a necessary developmental stage. Bradford says that clients often describe their problem as “I lost it.”\textsuperscript{16} According to him, the therapist needs to stay with the notion of “losing it” before arriving at “it can be found.”

\textbf{Relationship to the Topic}

I regularly consult interns that are struggling with the question: “What should I do?” They often seem to be under great pressure to perform, to show results and to “do something.” I often suggest to them: “If you don’t know what to do, please don’t do it.” Occasionally, I ask a supervisee to avoid all interventions for a few months except for active listening. Sometimes we explore the possibility of allowing and even encouraging the client to stay exactly where they are, while slowly and clearly naming the stuck situation.

Being born and raised in Israel and having the experience of living in Europe for many years gives me another perspective on the current day American culture. My years of spiritual practice add more awareness and another dimension to the cultural lens.

Consequently, I wanted to help therapists in training develop the sensitivities and the wisdom to choose between active interventions and accepting or allowing interventions that promote rest, gestation and incubation.
When therapists referred to *resistant clients* or to *stuck therapy*, I could not avoid thinking that they were blaming the client for their own shortcoming of not being able to connect, see deeper into the client’s pain and stay with it. I wanted to explore ways of being in therapy that do not evoke the client’s so-called resistance but melt it or go around it. I wanted to consider the possibility that what is labeled *stuck or resistant* was both a significant step in the therapy process, and a necessary stage in the personal and psychological development of the client.

Margarita Tartakovsky interviewed many experienced therapists and asked them what can be done when therapy is stuck. All these therapists offered their different approaches, yet none of them considered the possibility that the *stuckness* itself might be exactly what was needed for the client at that time. I wondered if the fear of *stuckness* comes from deeper layers in the therapist’s individual psyche and possibility from the collective unconscious.

Robert Sapolsky claims that contemporary western culture tends towards over-activation of the sympathetic nervous system. Many of the common current day ailments can be related to this imbalance: ADHD, addictions, tension and anxiety. If therapists had greater awareness of this cultural tendency, would it bring some positive change to therapy? Although used by many authors and researchers, the construct ‘contemporary western culture’ is not clearly defined. It is used in this research, to refer broadly to the 21st century American culture and its mutual influence with other western cultures.

A supervisee shared with me how she does not like one of her clients who were 76 years old, selfish, racist and presented with some psychotic hallucinations. She and her
client were stuck. When I asked how old the client really was, the supervisee thought for a moment and said: “Eight.” We explored the hallucinations as if they were a meaningful dream and a story. After that conversation, the relationship with her client started to make more sense in light of the client’s early childhood trauma. The supervisee left the supervision session with a lighter feeling and with a renewed curiosity. She was looking forward to the next session with the client.

The combination of Imaginal Inquiry with Phenomenological Interviewing as the research methodology corresponds with my experience as a therapist. In my conversation with clients I am always aware of the practical and pragmatic goals: the client wants to get better or resolve a problem or an issue. In that respect I am a student of Ericksonian psychology where Utilization is a primary principal aimed at translating the client’s expertise into practical results. Building on Archetypal Psychology I am often interested in deep meaning and in mythological connections. From the Humanistic Psychology, above all from Victor Frankl, I inherited the primary interested in the meaning the client can make of actions and of the experiences in their life. I am also deeply aware of the influence of every therapeutic relationship on my own life and on my soul.

**Theory-In-Practice**

_Taoist Psychology_ theory has its roots in the 2500-year-old _Tao-Te-Ching_. Taoist theory is especially suited for this research as it holds a worldview of non-intervention and a fundamental trust in the natural way things are. In that sense, the _Tao-Te-Ching_ is very aware of eternal change and holds it in a very different way from traditional and modern western views. In the western philosophical tradition, there is a
fundamental dichotomy between process metaphysics and substance metaphysics, as explained by Nicholas Rescher. The first recognizes change as fundamental, yet having difficulty analyzing fixed situations into their building blocks. The second has essential difficulties explaining change. Thus, Taoist theory is helpful in the context of this research, as it offers an alternative view to the questions around change, one that does not lead to contradictions.

There are several concepts from this body of knowledge that are significant here. The Tao, the way or the path, is the primary topic of the original text whose name is often translated as the book of the way (Tao) and of virtue (Te). The concept of the Tao suggests that there is a natural way to be followed. Stuckness might be understood as losing the natural path or going against it. The Tao-Te-Ching is comprised of 81 short poems. Many of them can be seen as an advice to the good ruler and can also be applied to a teacher or to anyone in a leadership role. In the context of this research, the Tao is used as guidance to the therapist.

According to Taoist psychology, the basic dynamic of any process or action in the world is seen as based on three forces: The Yin (feminine) the Yang (masculine) and the Tao: the way. The Yin and Yang principals have to be balanced for right action to take place. The Yang/masculine looks for forceful or active approaches for change while the Yin/feminine can support slow periods of waiting, incubation and gestation.

The way a good leader is recommended to be and to act in the world, is using Wu-Wei - Non-doing or doing without doing. It is a rather active approach based on awareness and on stepping back. According to Greg Johanson and Ron Kurtz, an effective way of dealing with stuckness might involve a deeper understanding of this
concept and finding new approaches that follow it within the therapy. This might involve patience and acceptance that allow the client to gradually accept themselves. In the right moment, the therapist points to a new path and that might be enough to initiate change.

In addition to Taoist theory, this research also refers to concepts from Archetypal and Imaginal psychology: The Dark Night of the Soul or the Hero phase of going into the Belly of the Whale. Stuckness might be seen from that perspective as depression, which can have a meaningful role in psychological development. It can also be understood as a step in the Hero’s Journey. The Hero needs to go down, sometime all the way into the underworld, to find the secret, the magic potion or the instructions needed for the next step of the journey.

The Gurdjieffian Metaphysical Laws are used as another theoretical anchor. The Literature Review (Chapter 2) includes an extensive presentation of these laws and explains their relevance to the research topic. These laws have a perspective on change and stuckness in processes that is different from traditional western views. The Gurdjieffian view includes both a static analysis that looks for three forces that define every process, and a dynamic model of the step-by-step progression of any process. The use of both views goes around the western philosophical conflict between process and substance metaphysics that is elaborated upon in the Literature Review.

Research Problem and Hypothesis

The Research Problem that motivated and guided this research asked: “When in the face of stuckness, what tendencies can be seen in therapists’ thought process in their
choice making between active, change-seeking interventions and passive, encouraging and accepting interventions?"

In the professional literature one can find many suggestions how to get the client or the therapeutic process unstuck, however, there is a shortage in the literature and in research that explored therapists’ responses, both external and internal, to therapy situations that were perceived as stuck. Notable exception is the work of Judith Hartley that examined the responses of therapists to stuckness (referred to as impasse in her research), using a relatively limited scope by including only four therapists in her research and inquiring only about cases that ended due to what she named as impasse.30

Buddhist and Taoist psychology writing relate sometime to the stuckness as an integral part of therapy.31 However, a mainstream traditional western framework in which stuckness itself was seen and named as an essential part of the therapy is hard to find. An exception is the work of Kim Bella, who researched art therapy for stuckness.32 She asked: “Is feeling stuck a crisis to recover from or is it an opportunity for growth and change?” In that question, Bella demonstrated more openness to stuckness as part of the process. However, her work was focused on the client in the stuck situation and not on the therapist.

The research hypothesis stated: “When faced with stuckness, some therapists tend to want to do ‘something’ even when they do not know what to do. Their discomfort prompts them to choose active, change-seeking interventions against their intuition or deeper knowing.”
Methodology and Research Design

Some theorists consider that research in the social sciences has suffered from a tendency to be modeled after research concepts that were borrowed from the hard sciences. These include counting and measuring samples and using statistics to validate theories. Such approaches create new knowledge that the practice of psychotherapy can sometime use. They also run the risk of confusing correlations with causation, and of losing sight of the specifics of an individual client by holding too tightly to a general principal or formula.\(^{33}\)

John Creswell has suggested that the overall paradigm of qualitative research methods is based on generating knowledge from human interaction, going deeper into human processes through contact with the individual participant, and focus on the meaning the participants ascribe to the questions being researched.\(^{34}\)

While quantitative research uses statistical methods that are pointed at a specific inquiry, and can answer “what,” “where” and “when” questions, qualitative research attempts to look more holistically at the problems being explored. In part, a more holistic approach always includes the context in which the problem is presented, thus such research can go deeper and attempt to answer “why” and “how” questions.\(^{35}\)

The Research Problem of this dissertation asked: “When in the face of stuckness, what tendencies can be seen in therapists' thought process in their choice making between active, change-seeking interventions and passive, encouraging and accepting interventions?” This was an open-ended question and the range of the possible answers or results could not be known in advance. Thus, it was a good fit for a qualitative research method.
*Imaginal inquiry* is a form of qualitative research-design that evokes the experience being studied. This is a method practiced as part of the Transformative Learning curriculum as taught at Meridian University. In this research the evoked experience was the reaction of the therapist to an interaction with a stuck client in (role-play) therapy. Further, this qualitative method includes the expression of the participants to the evocative material. Going through an experience as a full participant, is a key ingredient in *transformative learning.* Being a full participant in the research applies also to the researcher. This was a significant aspect of this research, as the researcher also played the role of a stuck client in every interview.

This research looked for better understanding of the terms *stuck or stuckness* as used in the context of therapy. A simple questionnaire was helpful towards clarifying how professional therapists use these terms. This questionnaire was sent to a relatively large number (several hundreds) of professionals using email lists the researcher is a member of. The complete list of responses to the questionnaire is included in appendix 9.

The methodology used to collect and interpret data for this dissertation is inspired by *Imaginal Inquiry,* as taught at Meridian University. It was also influenced by *Phenomenology.* Creswell describes this type of research as looking for “…the common meaning for several individuals of their lived experience of a concept or a phenomenon.”

The overall interpretive approach was pragmatic as well as phenomenological. That means that as I looked for the meaning that participants ascribed to *stuckness* and to stuck situations, I also held in mind what learnings and insights can be helpful for therapists and clients as they find themselves in stuck situations. The co-researcher and I
did a basic thematic analysis of the questionnaire answers and of the transcripts from the interviews. We did this independently, before we integrated our separate observations and merged the common themes we discovered. The goal was to get to the meaning professional therapists ascribe to the term stuckness and to their experiences in therapy that are related to stuckness.

Phenomenological research is rooted in the philosophies of Edmund Husserl, Martin Heidegger, Jean-Paul Sartre and Maurice Merleau-Ponty. Some of the basic ideas behind Phenomenology are linked to realizing the limits of science in the late 19th and early 20th centuries. These include returning to the roots of Greek philosophy in search for wisdom, letting go of any assumptions, awareness of the connection between the object being researched and the consciousness looking at it and the awareness of the subject-object relationship, i.e. the researcher being impacted by the research.

Learnings

The Cumulative Learning: Return to the Common Source connected the five learnings that emerged from the study through the theoretical foundation of the Tao-Te-Ching and opened a path towards revisioning stuckness. All the five learnings demonstrated that behind stuckness there is some form of disconnection from the source. The disconnection can be somatic, spiritual or on the soul level. Often it is the client who disconnected from their life-giving and meaning-making resources. The therapist might also be disconnected from the source, by putting theory before and above awareness of and responsiveness to the present moment.

Learning One: Of the Terrible Doubt: Am I Doing My Job? Am I Helping? suggested that when faced with stuckness, therapists often feel dread and shame, feelings
that arise from the therapists’ need to know that their work was meaningful and that they were ‘doing something’ to bring change and help the client. Responding to stuckness with dread, as this learning found, was a surprising answer to the Research Problem; yet it supported the hypothesis that anticipated therapists’ discomfort with stuckness.

Learning Two: Connecting in the Heart of Stuckness suggested that client’s experience of connection to the therapist could have been lost when the therapist was not willing or not able to stay present with stuckness. This learning expanded on the nature of the impact of stuckness on the therapeutic relationship and added another answer to the Research Problem. Although not directly supporting the hypothesis, this learning clarified how the break in the interpersonal bridge as a reaction to stuckness was adding to the discomfort of the therapist, who was often looking for reassurance from the client that they were doing ‘good therapy.’

Learning Three: If You Don’t Know What You Want, I Cannot Help You! suggested that therapists may, mistakenly and without realizing, pass on to their client the responsibility for knowing what the client’s wants and needs are. This was the most unexpected finding of the research. Although not directly supporting the hypothesis, I contend that the tendency to pass responsibility to the client comes out of the same discomfort with stuckness and the same need to ‘do something’ rather than staying with the clients and with the lack of change, as the hypothesis suggested.

The findings from the last two learnings directly supported the hypothesis. These learnings demonstrated the related tendencies to choose active, change-seeking interventions and avoid slow or permissive therapy interventions that might be the call of the heart or the hint from the intuition.
Learning Four: Who Would Allow You to Slow Down? suggested that at times, the therapist would wish to proceed with a slower pace of therapy yet is conflicted about that. Learning Five: If I Know the Answer, I Will Give It to You suggested that when confronted with a stuck client, therapists might respond by relating to the therapy as an investigation or a puzzle to be solved. When they could figure out what was going on, they were inclined to tell the client what to do to ‘fix’ the situation. Thus, preventing the client from accessing a deeper learning experience that can be owned and that might persist much longer.

**Significance and Implications of the Study**

The intended audience for this dissertation is mental health professionals. From conversations I had with colleagues before and during the early stages of this research, I have found that most of them have encountered stuck situations in their work. I also found that they are often frustrated when feeling stuck and not knowing how to proceed. The awareness of the parallel process with stuckness is a good start, yet it might be insufficient. Personally, I seek consultation when I feel stuck with a case. Sometimes the consultation leads to a new viewpoint or a new approach that releases the stuckness. When a stuck case is shared in supervision groups, there is often a wealth of suggestions for interventions. The variety of viewpoints can be refreshing and helpful. What is usually missing is a viewpoint that reframes the stuckness as a natural step in a process of healing or growth. Questioning who is stuck, the client, the therapist, the relationship or the process of therapy as a whole, is also not something I have frequently encountered in professional circles.
Working on this research helped me as a therapist to widen my view of stuck situations and helped me to go slower in the therapy process, be more patient, and wonder deeper into root causes of clients’ suffering that are often well hidden.

I was touched by the feedback I received from several participants, who reported following our enacted session and our interview and conversation, some similar changes in their own work.

I hope that this research can invite mental health professional to approach *stuckness* from a different and new dimension, exploring how *stuckness* in therapy can be a necessary step for any change or progress. Just by taking that standpoint, the pressure on the client to change might be reduced and the *stuckness* might be somewhat loosened.

The main focus of the research and possibly the first contribution to the profession might be a new awareness of *stuckness*, and an invitation to re-examine the use and meaning of the various constructs commonly used to describe stuck situations such as *resistance* and *impasse*, that most if not all therapists are familiar with. As suggested by Steven Frankel, the existing differing terms are not only outdated, but also often misleading. The discussion of these various constructs in comparison to *stuckness* is largely expanded in the Literature Review (Chapter 2).

The research included here is preliminary and can open the door to further investigations, specifically comparing attitudes about stuckness between therapists from different cultures, and from different modalities and therapeutic approaches. Further research can also explore various types of stuckness and lead to deeper understandings and awareness for therapists when faced with *stuckness*. 
CHAPTER 2

LITERATURE REVIEW

We shall not cease from exploration, and the end of all our exploring will be to arrive where we started and know the place for the first time.

—T.S. Elliott, *Four Quartets*

Introduction and Overview

The purpose of this literature review is to place the Research Problem, as well as the secondary research questions into the context of existing literature of both philosophical and psychological origins. The Research Problem that motivated and guided this research asked: “When in the face of stuckness, what tendencies can be seen in therapists’ thought process in their choice making between active, change-seeking interventions and passive, encouraging and accepting interventions?”

The literature review comprises of five sections: Theories of change; The role of the therapist; The nature of non-change, Cultural biases towards action and goals; and Willingness to be with stuckness.

Although the term stuckness can often be found in professional psychology writing, a formal definition for it could not be found in any Psychology dictionary. For this research, stuckness can be defined as the frustrated subjective perception, of the therapist, the client or both, that the therapy is not proceeding fast enough towards the desired change. One keyword in this definition is ‘change.’ It is assumed that the responses to stuckness are primarily about the perceived lack of change. Thus, the first
section of the Literature review is dedicated to literature about change, while the third section explores stuckness and lack of change.

The first section of the Literature review is dedicated to literature on the nature of change in general and then, specifically about psychological change. The exploration of the literature starts with Greek philosophy that struggled 2500 years ago with questions about the nature of change and its very possibility. The section continues to discuss various psychological modalities and their understanding of the change that takes place in psychotherapy. The exploration of the nature of change continues with a review of the cosmological laws of the universe as presented by Gurdjieff and continues into the ways that the Tao-Te-Ching and Taoist psychology views change. Both these philosophical systems present a different approach from a western philosophical tradition that is rooted in ancient Greece.¹ The first section also includes a summary of the Law of Three as presented by Gurdjieff and his students. This theory attempts to explain all processes of change on any level and thus it is relevant to understanding change and lack of change. Although Gurdjieff’s theory does not discuss specific aspects of psychotherapy, other authors including Peter Ouspensky and Rodney Collin, have expanded it to show its relevance. Specifically, my master’s thesis at John F. Kennedy University was dedicated to the exploration of the Law of Three in Psychotherapy. The Literature review section below draws upon that work.²

The Research Question asks about therapists’ responses to stuckness. The exploration of that question requires a better understanding of how the role of the therapist is perceived. The second section of the Literature review explores the role of the therapist. That role is an important aspect of the therapeutic relationship and the therapy
process. The implicit or explicit understanding that the various psychological theories
have about change and stuckness, affect the way they influence and mold that role.
Accordingly, they each suggest different expectations and promote different positions,
interventions and actions. When various theories are examined, for example,
psychoanalysis and Taoist psychology, their recommendations, explicit or implicit, can
appear to oppose each other. Some encourage the therapist to be an active and involved
force while others suggest roles of an observer or a coach. The section includes an
exploration of the role of the therapist through Taoist and Zen approaches and in various
western psychologies.

The third section of the Literature review explores the nature of stuckness and
specifically the lack of change stuckness implies. This section addresses even more
directly the Research Problem, as well as the main hypothesis that states: “When faced
with stuckness, some therapists tend to want to do ‘something’ even when they do not
know what to do. Their discomfort prompts them to choose active, change-seeking
interventions against their intuition or deeper knowing.” This section contains a survey of
literature about the dark night of the soul, a period where nothing seems to happen, yet it
is a necessary phase in the Hero’s journey.

Professional writing about Stuckness traditionally used other more common terms
such as resistance, impasse, depression or freeze response. What seems as common to all
these terms is the lack of movement or lack of change, as the definition above suggests.
The third section of the Literature review also explores the various and sometimes
contradictory and confusing ways these traditional terms have been used.
A secondary question behind this research asks about the impact that contemporary western culture has on therapists’ attitudes towards change. An assumption held in this dissertation is that in a dominant, North Atlantic or Judeo-Christian culture, the bias is towards active and short-term approaches and away from slow and accepting approaches that recognize the need for incubation and gestation periods. Although some psychodynamic modalities such as psychoanalysis and Gestalt are not inclined towards brief approaches, the overall culture that is driven by the medical insurance forces is biased that way.3 The fourth section of the Literature review explores such cultural biases. It also investigates the ways these biases might affect the therapist, the client and their positioning within the therapy process.

Another secondary research question asks about the possible value of stuckness. The last section of the Literature review looks at sources that present with more openness towards stuckness, often by seeing it as a period of gestation or incubation. In some cases, they even include stuckness as part of the process of therapy. These alternative views come mainly from eastern traditions, Gestalt and from Imaginal psychology.

In each of the five sections of the Literature review there are references to Taoist Psychology theory and to its roots in the 2500-year-old Tao-Te-Ching. Several sections connect Imaginal Psychology and its roots in Carl G. Jung and Hillman to the specific focus of the section. When relevant, the Literature review section explores the main branches of western psychological theories: psychodynamic, behavioral, humanistic and transpersonal, and their approaches to the topic of the section. In each section, the Literature review covers the understandings and recommendations of each of these theories in relation to the issues related to stuckness, change and the role of the therapist.
All the reviewed sources are linked through common concepts and principals that are essential for this research. From Taoist Psychology there are several concepts that are relevant here:

*Tao* - The way or the path. Suggesting there is a natural way to be followed. *Stuckness* might be seen as losing the natural path or going against it.\(^4\) Alan Watts suggests that the principal of Tao reconciles some of the dichotomies of western thinking such as order and spontaneity, unity and diversity.\(^5\)

*Wu-Wei* - Non-doing or doing without doing. Although this concept is often misunderstood as passivity, it is a rather an active approach based on awareness and stepping back, while allowing the natural progress of things to take place. Effective way of dealing with *stuckness* might involve a deeper understanding of this concept and finding ways to follow it in the therapy practice.\(^6\)

*Yin and Yang* – These are the feminine and masculine principals that are present in every person and in every process and need to be balanced. The Yang/masculine tends towards forceful or active approaches for change that can occasionally verge on violence, while the Yin/feminine can support slow periods of waiting, incubation and gestation.\(^7\) Watts suggests that this principal is at the very roots of Chinese thinking and feeling and advises to not confuse this principal with conflict or opposition.\(^8\) He suggests viewing this principal in the context of cyclical metaphysics, in contrast with Judeo-Christian metaphysics that is linear and emphasizes progress.\(^9\)

From Archetypal and Imaginal psychology come the concepts of the *Dark Night of the Soul* or the Hero phase of going into the *Belly of the Whale*.\(^10\) *Stuckness* might be understood from that perspective as depression with a meaningful role in psychological
development or as a step in the *Hero’s Journey* as described by Joseph Campbell.\(^{11}\) The Hero needs to go down, sometime all the way into the underworld to find the secret or the magic potion. Heraclitus says that the way down and the way up are the same way.\(^{12}\)

**Theories of Change - how does change happen in psychotherapy**

This section reviews the various perspectives on the process of change within psychotherapy and anchors the literature in philosophical writings that explore how change happens in general. The literature shows that change is an essential aspect of psychotherapy. This section includes a review of the philosophical roots of change as well as the various explanation of therapeutic change in different psychological modalities. The section is organized around the dichotomy between process metaphysics and substance metaphysics. Also introduced are the metaphysical laws of Gurdjieff and the way that his approach attempts to resolve the conflict between these two types of metaphysics. The section proceeds to look at a variety of psychological theories and how they are influenced by this very basic philosophical conflict.

There are many definitions for the term *psychotherapy* and some of them, such as the Concise Dictionary of Psychology or the one used by the American Psychological Association, are circular, i.e. referring to psychology and to psychologists in the definition.\(^{13}\) Several sources including Stanley Messer and Alan Gurman, quote a definition by Julian Meltzoff and Melvin Kornreich: \(^{14}\)
Psychotherapy is taken to mean the informed and planful application of techniques derived from established psychological principles, by persons qualified through training and experience to understand these principles and to apply these techniques with the intention of assisting individuals to modify such personal characteristics as feelings, values, attitudes, and behaviors which are judged by the therapist to be maladaptive or maladjustive.\textsuperscript{15}

The emphasis in the definition above underlines the importance of change in the process and the role of the therapist as a powerful expert.

Other definitions, such as H.P. Hildebrand’s, limit psychotherapy to non-medical interventions.\textsuperscript{16} The Dictionary of Philosophy and Psychology and the American Psychiatric Association refer specifically to psychotherapy as treating mental disease and name the preferred treatments.\textsuperscript{17} For the purpose of this research, the broader definition such as the one from Meltzoff above is sufficient. The key points are that a designated professional is trying to help another person(s) overcome a stated personal problem and some change is expected.

As Meltzoff’s definition above states, psychotherapy revolves around helping a person change something about a problem or a situation that troubles them. The most essential questions about life and death, about free will, and about the meaning of human existence are tied to the nature of change, as presented by Rescher and by Richard Tarnas.\textsuperscript{18} Change was also a subject of deep inquiry already for the earliest philosophers.\textsuperscript{19} To deepen an understanding of change in the context of psychotherapy it is useful to review the broader historical inquiry into change.

**Philosophical Background**

This sub-section examines the philosophical reflections on the topic that directly and indirectly affected psychological theories. It reviews some of the early Greek
philosophers and proceeds through the ages, following the basic difference between philosophies that look for essentially static and substance-oriented reality, and those that try to understand reality as based on process.

One of the earliest philosophers that investigated change related issues was Heraclitus of Ephesus. Heraclitus was active in the late 6th century BCE. He is best known for saying that the very essence of the universe is change. The phrase *Panta Rhei* or everything flows, expresses this most basic aspect of existence. Many philosophers at that time were searching for the basic substance of the world, for example, Thales of Miletus who claimed that the basic substance is water. Heraclitus did say that the basic element is fire, however he meant it more metaphorically, insisting that the essence of the universe is a process of change.

One can associate this notion of an ongoing change with Buddhist philosophies that argue against any notion of permanence.

At about the same time of Heraclitus, the philosophers of Elea argued against the possibility of change. Parmenides who founded that school, and later Zeno who expressed its philosophy through the famous set of paradoxes about movement, claimed that nothing changes. Nothing appears, and nothing disappears; what seems to be changing is actually an illusion. This school of thought is known mainly from Plato’s dialogue *Parmenides*, where Socrates argued with Parmenides and proved that change is actually possible. Plato himself tried to resolve the conflict by creating the world of ideas. He acknowledged that according to human perceptions there is change in the world but since reason requires stability and reason is the higher principle according to Plato, there must be another world where nothing changes.
According to Tarnas’ understanding of Emanuel Kant and Thomas Aquinas, recognizing or accepting the possibility of change and restricting the reign of strict determinism, are necessary for allowing human free will. Later in the 4th century BCE, Aristotle, tried to reconcile the two conflicting positions, by arguing that apparent change is an actualization of a potential that was already there from the start. When the acorn becomes an oak, it is revealed that the potential to be that oak always existed.

The late 18th century English philosopher David Hume concluded through his inquiry into perception, that there was no permanent identity and all that can be observed or known is distinct experiences. Like Heraclitus, Hume’s approach suggests that change occurs all the time. Hume’s views influenced modern philosophy especially through Kant. Philosophical views that see change as essential are sometime grouped under the title of Process Philosophy.

Rescher makes a clear distinction between philosophical views that are process oriented and those that are substance oriented. Process philosophy describes the basics of the universe through the lens of process; something that flows and changes. Rescher says that: “The salient idea of process philosophy is that the world consists of-and must, in consequence, be understood in terms of changes rather than fixed stabilities.”

Substance philosophy on the other hand looks for the basic ontology in things that can endure. One of the basic conflicts between these views is around change. In process philosophy change is inherent. Heraclitus who made change or fire the central and most basic element, is a prime representative of process philosophy. Process philosophy has difficulties explaining permanence. Rescher anchors that conflict back in Plato’s writing that claims that sensual perception is essentially processual, but reason requires stability.
and permanence. According to Rescher, that conflict was the driver for Plato’s creation of the word of ideas, where permanence can allow the work of reason. Rescher also notes that the famous paradoxes of Zeno mentioned above, are an example of the difficulties of substance philosophy to explain change and movement. One implication of process metaphysics for psychology, is related to the nature of mind and self. Philosophies based on substance tend to reduce mind to matter and psychological processes to chemical brain activities. On the other hand, psychologies based in process philosophy, see the self as a process and not as a thing. That means that the self is not permanent but is constantly changing.

This basic dichotomy in western metaphysics and philosophy affects many disciplines including psychology. The following sub-section presents the idea of metaphysical thinking from more eastern origins. Eastern philosophy seems to bridge the gap between process and substance focus and thus it deals more fluently with both change and non-change.

**The Law of Three and the Six Processes**

Gurdjieff tried to include in his metaphysics both these approaches, looking at substance and process at the same time. According to him, the *Law of Three* is one of the two basic metaphysical laws of the universe. It states that everything in the world, from subatomic particles to galaxies, from art to great empires, is a manifestation of three forces coming together. These three forces have different levels of energy or vibrations. These energy levels are named active, passive and neutralizing. When three forces meet, some process takes place. When they do not meet, nothing happens. When ‘something happens,’ there is progress according to another basic law: The Law of Seven
or the Law of Octaves. The symbol of the enneagram shows these two laws working
together and thus it represents a complete world or cosmos.37 These two laws together
lead to and explain all possible manifestations: The Ten Thousand Things of the Tao.38
Using these two laws together, makes it possible to see things simultaneously as both a
process and as substance. According to Tarnas, this kind of simultaneous perspective is
similar to ideas in modern physics that includes both relativity and quantum mechanics
theories, which together allow for seeing things as energy and as substances at the same
time.39

The coming together of three forces is called a triad. The use of the term level in
relation to the forces, is abstract and does not suggest any quality or moral value.
Ouspensky talks about rate of vibrations, implying that blue light is on a higher level than
red light, or atom of Hydrogen is on a higher level than an atom of Lead.40 It is also
possible to use awareness or knowledge as a gauge for the level of the forces.41
The Active Force is on the highest level. It is the most vibrant and it dominates the triad.
The Passive Force on the lowest level is the most inert or resistant. The neutralizing force
on the middle level allows the other two to meet. It can appear as the medium, the middle
ground, the catalyst or the environment in which the other forces meet.

The nature of the triad is further determined by the order in which the three forces
appear. The First Force initiates, the Second Force responds or resists, the Third Force
makes the interaction possible or gives it a certain flavor or meaning. Any one of the
forces can be in any of the three positions, creating thus six possible combinations.42
Ouspensky explains the importance of this idea: “The Law of Three explains many things that cannot be explained in the ordinary way, because we usually think about only one force. Very seldom do we take the Second Force, resistance, into consideration, never the Third Force. Yet, in calculation of actions it is necessary to take three forces into account.”

Normally, the tendency is to see only one or two forces in activities. People think either: “I can do it,” “It is being done to me” or “This is what should be done and that is the resistance.” Classical physics includes the idea of force and counterforce. The Law of Three suggests that next to every pair of forces there is an additional element, a relationship or an overview, which is called the Third Force. The Third Force is more mysterious or elusive and often comes from another dimension as suggested in the famous quote by Einstein: “Problems cannot be solved at the same level of awareness that created them.”

Each of the six different triads or processes has certain characteristics and leads to a different kind of process or activity and thus to different outcomes.

Triads in which the Third Force is on a higher level than the First Force are ascending. They consume or absorb energy to increase order and potentials. Physics calls
such processes endothermic. When the Third Force in a process is on a lower level than the First, the process is descending. Such processes release energy and increase disorder. Physics calls these exothermic.\textsuperscript{46}

The idea of three forces behind the working of any process opens the possibilities for new inquiries and helps to fill in what is identified in this Literature Review as a gap in the literature. For example, one can ask which force is lacking or blocked when something is stuck. More specifically one can always ask if a triad is ascending or descending. Does it release or consume energy? Does it increase or decrease order? In any situation that seems stuck, one can look for a missing Third Force, or for absence of contact between the forces. It is a useful tool for looking at failed communication and for trying to discover where something in the process went wrong. An example of communication problem that happens frequently is confusion of levels or scales. One person talks about a small event and the other person understands it as referring to general principals or to universal truths, i.e. they are referring to different triads.\textsuperscript{47}

Linking these ideas to the Research Problem, one can ask how the various reactions of therapists to stuck situations map into a specific process and into specific forces. For example, when the therapist assumes the role of an active first force and experiences the client as resisting (second force), it implies a triad of destruction. Such a triad might lead to letting go of old habits or thought patterns, but it cannot bring healing. The research hypothesis can also be re-formulated in terms of the Law of Three by asking which force the therapist is enacting and in which triad, when they are responding to stuckness by choosing certain interventions.
There are other psychological theories that explore the various forces involved in the therapy process. According to Messer and Gurman, psychological approaches that build on systems theory such as brief therapy and strategic therapy, often takes a step in this direction by looking at larger contexts or at the various relationships within the system, rather than isolating an ‘identified patient.’ They describe Systems-Theory as an approach that suggests that what is seen from one point of view as a problem, is actually in fact a resultant of many forces and relationships within the system.

Influenced by systems theory and by Ericksonian psychology, Paul Watzlawick et al. make a distinction between first order change and second order change. The first order implies changes to elements within a system while the system itself remains unchanged. The second order implies change to the system that must happen in a larger context. Watzlawick calls this change of change and claims that it is a type of change that Aristotle refused to recognize.

As was explored by Messer and Gurman, many theorists of modern psychology use the notion of force and counterforce. They continue to suggest that the idea of defense mechanism in itself includes two forces: the pressure of the world on the various ego structures and the unconscious response of the ego to protect its integrity.

Other theorists such as Watzlawick noticed the need for all three forces. Watzlawick suggest that an element from another level must be introduced to create a second order change, a change in the system.

Watzlawick continues to suggest that when the therapist truly understands the principle of force and counterforce, they are likely to already be searching for a second-order change (Third Force). Understanding that applying more force leads to greater
resistance and thus to no change, invites an inquiry on a different dimension or a larger systemic context. Such inquiry might bring clues to the underlying causes and can initiate a transition from the current stuckness.

Depth Oriented Brief Therapy also looks at various forces. Bruce Ecker and Laurel Hulley suggest that the conscious undesirable presenting symptom is at the same time a desired unconscious solution to another problem. The non-judgmental presentation of these two forces next to each other already allows a Third Force to enter in the form of awareness.

The three forces that create the various processes in psychotherapy can be thought about in various ways. The Third Force comes through awareness. The therapist and the client provide two forces. The awareness that can come through a theory or through mindful, present-moment experience, mindful experience of the present-moment is often the Third Force that can enable change.

Another possible triad occurs between the conscious and unconscious minds of the client. The therapist’s awareness and knowledge provide the Third Force, by allowing the other two forces: the conscious and unconscious minds to meet.

The examples above follow different perspectives of the mysterious Third Force. In one, the Third Force is determining the struggle between First and Second Forces by supporting one of them. The other example sees the Third Force as what allows the other two forces to meet and produce an action. In this second example the Third Force is seen as medium, as a catalyst, an enabling environment or even as a result or purpose.
Traditional Western Psychologies

This sub-section reviews some of the most popular western psychological theories from the perspective of their understanding of psychological change.

Messer and Gurman created a model for describing and comparing various psychological approaches. According to them, every psychological theory includes some similar basic elements. Messer and Gurman claim that every psychological modality has a presentation or a model of the psyche; each has a vocabulary and a system to describe psychopathology, or what can go wrong psychologically. Every psychological modality describes what leads a client to seek therapy, a major cause being pathology as the specific theory sees it. Finally, according to Messer and Gurman, every psychological theory attempts to explain how the process of therapy works to bring change and what the therapist should do to make change happen or at least how the therapist is meant to support change.

In psychoanalytic approaches, the principal of change is primarily in new insight and in the relationship to the therapist. According to Sigmund Freud’s this change is created through interpretation of the transference. In the Freudian classical tradition, change happens to the client by deepening or widening the scope of their insight.

The object-relation theorists from the British school, such as Ronald Fairburn, Wilfred Bion, Melanie Klein and Donald Winnicot, all part of the psychoanalytical tradition, put the emphasis more on the relationship as the medium for change. According to Klein, the therapy promotes an externalization of inner objects and images and displacing them into the outer world. The desired change is still based on insight, however, that insight is more specific to a widening range of experiences of self and other
as practiced in the context of therapeutic relationship. According to Winnicott, the healing aspect of therapy is done not by the therapist, but by the client, in the context of the therapy relationship.\footnote{While earlier psychodynamic theorists looked for insight into past events, the object-relations theorists looked for insight into emotions and into relationships. According to that school of thought, inter-psychic change is related to intra-psychic change that goes beyond personal insight.} Behavioral theorists took a very different approach to change in therapy. Based on new research into learning theories at the time (1950s), they believed that change is the result of alteration in environmental contingencies.\footnote{In traditional behavioral approaches as taught by B. F. Skinner in the early 1950s, change is based on classical conditioning mechanisms or on extinction of previous conditioning.} In Cognitive-Behavioral approaches, the focal point of change is in altering thought patterns and schema, i.e. the underlying principles of thought and belief formation. These lead in turn to changes in behavior. Albert Ellis taught that change comes through changing our beliefs. He said: “…it takes you only a few minutes to change your unhealthy, self-sabotaging negative feelings to healthy, self-helping ones.”\footnote{Although Ellis referred to his Rational-Emotive approach as Humanistic therapy, his teaching was a forerunner of Cognitive Behavioral approach. In Humanistic Psychology, as posited by Messer and Gurman, an important mechanism of change is in the client’s capacity for productive and creative self-organization and growth. Processes that lead to change rely on creativity and not on a prescribed formula or the therapist’s expertise. Messer and Gurman use an analogy from quantum mechanics, describing how in a disorganized system, particles jump to a whole new level thus}
creating a new order of organization. Person-Centered therapists such as Carl Rogers, believe that a similar process happens in therapy. This ‘jumping’ is an example of the difficulties of substance philosophies to explain or accept the process of change.

In Person-Centered Psychology change is in the self-concept of the client according to Dave Mearns. He says that self-concept is the attitude of the person towards themselves, and that has three components: cognitive, affective and behavioral. These three components are working together to oppose change. Through the process of person-centered therapy, the therapist introduces dissonance between these elements and destabilizes their harmony, thus leading to a new self-concept that is more conducive to healing. Rogers emphasized self-acceptance as a change mechanism. He said: “The curious paradox is that when I accept myself just as I am, then I can change.”

Coming from a similar humanistic tradition and exploring intimate and non-intimate interactions in therapy, Kathy Weingarten says: “Therapy is the art of contact and change through conversation” She criticizes the psychodynamic model that tries to keep the therapy relationship distant and the therapist neutral and uninvolved. She contends that only through intimate relationship that leads to intimate conversation, change can come for both, client and therapist.

Change requires courage according to Rollo May. He contends that we live in between ages, the old one is dying and the new one did not start yet. Thus, change is a sign of the time. May enumerates several types of courage: physical, moral, social and creative. May describes how courage contains a contradiction between absolute commitment and awareness of not knowing the results or the possibility of being wrong. He also suggests that the change in artistic creation is the prototype of any change and
any knowledge creation.\textsuperscript{72} That kind of change comes out of the imagination, using form to create order and meaning out of chaos.

In an analysis of Jean Piaget’s theory of learning, Gianpiero Petriglieri describes how that theory specifies two types of change: assimilation and accommodation.\textsuperscript{73} Assimilation is a fitting of new data into existing organizing principles. Accommodation is needed when new material from the environment does not fit into existing schema. Petriglieri claims that deeper change is associated with accommodation. However, for accommodation to occur there is often a need to take time and regroup. He associates \textit{stuckness}, a term he literally uses, with such waiting and regrouping.

From the perspective of the \textit{Law of Three}, assimilation is the process of growth, a descending process, whereas accommodation is closer to the process of healing or invention, which is an ascending process.

Similar views about Piaget’s theory are expressed by Knud Illeris. He says that during accommodation it is the organism itself that needs to change.\textsuperscript{74} Illeris also looks at situations where learning does not occur, and quotes Peter Jarvis, who divides non-learning into three subcategories. These are \textit{presumption}, where the learner assumes that they already know, \textit{non-consideration}, where the learner does not relate to the learning opportunity, and \textit{rejection}, where on a more conscious level the learner does not want to engage in learning.\textsuperscript{75} These connections between change and the developmental and learning theories of Piaget, are especially relevant considering Meridian University’s focus on transformative learning. Transformative Learning catalyzes experiences, which are transformative and integrative.\textsuperscript{76} This emphasis is related more to Piaget’s accommodation whereas knowledge-based learning is more related to assimilation.
This sub-section reviewed how traditional western psychologies understand change. These psychologies span a wide variety of approaches, including psychoanalytic, behavioral, cognitive and humanistic. Some of these relate to change from process-oriented perspective and others from substance orientation. Yet the overall tendency in this tradition, with some notable exceptions such as Rogers and his followers, is towards specific, concrete and observable results, a tendency that is more aligned with metaphysics of substance.

**Eastern, Imaginal and other Less Traditional Approaches**

This sub-section explores theories and approaches that are more aligned with process philosophy, meaning, they recognize change as a basic principle or reality. The roots of *Zen Buddhism* are in the teachings of the Buddha and of Lao-Dze. Both were active in the 6th century BCE.\(^77\)

The similarities between psychotherapy and Zen practice were explored by Robert Rosenbaum.\(^78\) The basic views of Zen are in many ways similar to the views of Heraclitus and to those of process philosophy, asserting that the only permanent thing is change. Rosenbaum says; “Life is not a thing that has the quality of being transient: Life is transience flowing.”\(^79\) He suggests that since change is always happening there is absolutely no need to encourage it. Zazen means seated meditation in Japanese and is a central practice in Zen. The practice of Zazen, and similarly of psychotherapy is about learning to flow with the changes of life and being aware of these changes.\(^80\)

According to Jean Shinoda Bolen, knowing the mythological gods is a tool for self-knowledge and integration. For Bolen, change is based on shifting the internal emphasis from one God to another God or archetype; a common thread in Jungian
inspired approaches. Bolen says: “Through knowing the gods as archetypes, you can see yourself and others more clearly.” Bolen implies that searching within through the use of mythology, is a way for *re-membering* the inner parts of the psyche into a meaningful whole.

Another approach that emphasizes the unconscious mind, although in a different way comes from Milton Erickson and Ernest Rossi. They argue that any real change must happen in the unconscious mind. Like earlier theorists, Erickson and Rossi distinguish between the conscious and the unconscious mind. However, unlike Freud and other psychodynamic theorists, Erickson views the unconscious as a positive source, and a force for healing and change.

The change in the field of psychology itself was written about by Hillman. He claimed that the roots of all modern psychology were in the protestant movement and religion. The change to psychology would come from going back to the polytheistic view of Greek mythology and back into the world of images embedded in mythology and in the catholic saints’ imagery. Similarly, he suggested that personal change comes from soul making using the imagination and allowing integration of unconscious forces that tend to appear in what other psychologies might see as pathology.

According to Patricia Berry, change in the actual life of the client can come through working with dreams. Similar to other Jungian theorists, she argues that dreams are the royal path into the unconscious. Discussing the role and faith of mother, personified by Demeter, Berry explains that in the effort of the mother to create an actual and concrete world in the *Upper-world*, the connection to the daughter Persephone who is in the Underworld, is lost. There is a split between the two worlds that is the cause of
great suffering. Change comes from slowly healing that split through the lessons of mythology and connecting them to the actual life of the client. According to Berry, the essence and meaning and our sense of what matters, resides in the Underworld, thus any change must include healing the split between the two worlds.

A comprehensive theory that includes both permanence and change was proposed by Watzlawick and his colleagues at the MRI (Mental Research Institute). Starting from the mathematical theories of groups and of logical types, they suggested that change could occur within a system, while the system as a whole remains unchanged. Another way to think of this is that change is an attribute of a process while the elements of the process remain unchanged. They introduced the concepts of first order and second order change. Looking at a system or a group, first order change is in the elements of the group. Second order change is in the rules that govern combinations and processes within the group. The authors claimed that real change must be a second order change. Watzlawick guides the reader through applications of these abstract mathematical concepts into actual life and into psychotherapy. The authors described how second order change comes through creativity and thinking out of the box. They quoted Albert Einstein, who said that “We cannot solve our problems with the same level of thinking that created them.”

This section of the Literature Review shows that there is a gap in the literature regarding the inclusion of non-change as part of the therapy process. Throughout the history of psychology, all the way to its historical roots in philosophy, questions about the possibility and the nature of change reappear in every theory. Each psychological theory attempts to describe a pathology or an undesirable situation and charts the path of change towards a resolution or at least an improvement. The fundamental philosophical
The dichotomy between process and substance metaphysics is echoed in psychology. The roots of modern western psychology are in early twentieth century positivist science that tends towards substance metaphysics and analysis that takes the parts out of the context of the whole. Thus, it has inherent difficulties explaining change or the lack of it: stuckness. These sources also tend towards evidence-based results and are lacking in the inclusion of non-change.

On the other hand, psychologies that are influenced by eastern philosophy and religion, tend towards process metaphysics that see change all the time and everywhere. The Gurdjieffian metaphysics holds both sides of the dichotomy between process metaphysics and substance metaphysics, by integrating the Law of Three and Law of Octaves through the symbol of the enneagram.

This section of the Literature Review provides the basis and background for the following sub-section: the role the therapist is expected to play in the change process and in a later section, the possible cultural biases towards change.

**The Role of the Therapist in the Process of Change**

This section of the Literature review focuses on the therapist’s role in general and specifically, their position in the process of change that is expected to occur in therapy. The Research Problem asked about therapists’ attitudes towards and responses to stuck situations. Thus, reviewed in this section of the literature are ideas offered through the major approaches to psychotherapy regarding the position the therapist should take in the process of change. These comments and suggestions are looked at in the major approaches in psychotherapy. The section also reviews some therapy training manuals written by Irvin Yalom and James Bugental. Their writing, aimed at teaching younger
practitioners, explain in more detail the stance of therapist. The *Tao-Te-Ching* also has a lot to say about the position and actions of the good leader or teacher. Some conclusions about the role of the therapist can be inferred from that as well.

According to Messer and Gurman who quote Anna Freud, Psychoanalytic approaches suggest or even require that the therapist be neutral.\(^8^9\) Anna Freud describes neutrality as equidistance between ego, id and superego.\(^9^0\) Sigmund Freud maintains that change occurs through the interpretation of the client’s projections (transference) and the interpretation of the client’s resistance as childhood fixations and replacing it with more conscious awareness.\(^9^1\) In this approach the rational for the required neutrality is to make room for the client to freely project on the therapist the contents of their unconscious.\(^9^2\) They go on to say that the therapeutic relationship is the container in which transference can occur and transference and its interpretation is the mechanism that brings change. Thus, there is a great emphasis on insight. Through the transference, the unconscious forces are seen, interpreted by the therapist and become gradually more conscious. The therapist role is thus to be a neutral mirror that can reflect the client’s unconscious material. To that end, the therapist needs to clear their own unconscious reactions to the client material known as countertransference. The therapist holds the knowledge and the power and is ultimately the primary cause of change.

According to Alan Jacobs the emphasis on transference in psychodynamic modalities such as object-relations, led to the concept of *re-parenting*.\(^9^3\) He goes on to say that the therapist role is to act as a good parent that the client did not have and take the client through a corrective experience that leads to healing. Jacobs suggests that the potential for misuse and abuse of power is too great in such approach. This is due to the
symbiotic transference and thought reform that according Jacobs are involved often in re-parenting.

According to Messer and Gurman, in Behavioral and Cognitive Behavioral approaches, the risk of abuse is similar to those mentioned by Jacobs above, as the therapist is also in a power difference position. However, in these approaches, the power difference is not based on emotions or relationship but rather on the knowledge therapists holds and, in their skills, and procedures. These can lead to change in the client’s cognitions and through them change their behavior. The therapeutic relationship is viewed as unimportant or irrelevant, at least in the classical Behavioral presentations. According to Messer and Gurman, the therapist’s role in these approaches is more of a coach or a trainer, able to change the client’s understanding or interpretation of the environment. Since the emphasis is on the behavior and the procedures, the role of the therapist is insignificant, a machine could potentially replace the therapist as P.J Lang suggested: “An apparatus designed to administer systematic desensitization automatically was as effective as a live therapist in reducing phobic behavior, suggesting that effective desensitization is not dependent on a concurrent interpersonal interaction”.

In the last 20 years, some behavioral and especially CBT theorists, try to adopt mindfulness approaches. They go on to suggest that inevitably such emphasis changes the role of the therapist and adds more significance to the human nature of the specific relationship between the therapist and the client.

On the other hand, in Person-Centered therapy as developed by Rogers and in various experiential approaches, the therapeutic relationship is considered the most important factor. The locus of change is in the relationship between therapist and
client. The role of the therapist is to provide *unconditional positive regard* which models for the client the possibility for self-acceptance. Rogers encourages the therapist to be outgoing with the expression of positive feelings and avoid evaluations. For change to happen in the relationship, the therapist needs to be present and genuine. Strupp and Hadley found that untrained college professors who were sensitive and emphatic were on average as therapeutic as trained professions. The emphatic understanding is founded on intimacy, i.e. the ability to see into the client’s inner world and model for a client the safety of such intimacy.

Mearns acknowledges that the therapy process can get stuck and suggests that the role of the therapist is to raise awareness for both client and therapist. He lists a series of questions to trouble-shoot apparent *stuckness* and understand more specifically its nature. The questions are: “Are we indeed stuck, or am I misperceiving the process through my own impatience, or perhaps because I expect the client to move in different direction from what is happening just now? How does my client perceive the process at this time? If we are stuck, what is the source of our ‘stuckness?’” These questions bring light to the situations, create more awareness of the process and possibly open the door for change.

In humanistic psychology, according to Messer and Gurman, the therapist is more of a coach, who trains and encourages the client’s own creative forces. Similarly, Yalom suggests that the role of the therapist is to remove obstacles. He says: “What I had to do was to identify and remove obstacles. The rest would follow automatically, fueled by the self-actualizing forces within the patient.”
Like Weingarten and other humanistic writers, Jean Houston views the therapeutic relationship and its aspect of intimacy as most important for the therapy process.\textsuperscript{106} This is relevant when considering the Research Problem that asks about therapists’ responses to \textit{stuckness}. Using metaphors from the story of the Odyssey, she suggests that the role of the therapist in the person of Calypso, is to help the hero go beyond his current experience through the intimacy of the relationship. Houston notes that Calypso is related to Hera, the goddess of family and orderly human society. That dual aspect makes Calypso suitable companion to the change process. Houston notes that although Odysseus seemingly completed the aspect of dying to his old self, he still needs to go through a long period of being hidden from the world, like the god Osiris, who must be hidden after his death and dismemberment, before he can be resurrected. Houston points out that Calypso’s role as a therapist, include a balance of forces. On the one hand being a lover and companion and providing a womb-like island to hide in. On the other hand, encouraging Odysseus to look deeper into his psyche. And finally, Calypso lets him go when he is ready. Through the emphasis on the relationships between the Hero, Odysseus and the various Goddesses, the author invites another approach to therapy that allows waiting and gestation. Houston’s approach acknowledges the time required to go through stuckness.

A different approach of relating to others and thus a different suggestion for the role of the therapist is taught by Thick Nhat Hanh.\textsuperscript{107} In his course, designed specifically for therapists, he suggests that therapy is a work of love and must include compassion. Hahn emphasizes the literal meaning of com-passion: willingness to suffer with the other and says that it is a required part of therapy, as well as seeing the other as separate and
Hahn lists four main characteristic of true love and links them to Buddhist principals. These are loving-kindness, the ability to care and support the other; compassion, the willingness to suffer with the other or be with the other who is suffering; joy, or the positive regard towards the mutual relationship and seeing it in a positive light; and equanimity, or the ability to see the other as a separate and independent being. Hahn directs the reader back to themselves and invites self-love that includes all these four aspects of love, as a necessary condition for loving others. Hahn seems to invite the therapist to be the facilitator of love that can flow with no specific agenda.

Coming from the Zen tradition, Hahn is aware of more than force and counterforce in any therapy situation. In that he echoes the approach of the Law of Three that was discussed above. In the language of the Law of Three, Hahn’s approach can be described as trying to be a Third force, instead of being caught in the first-second force stuckness.

The Law of Three does not recommend a specific role for the therapist. The six processes describe 18 different positions (three in each of the six processes). I.e. in each of the six processes the therapist can be the first, second or third force. Similarly, the client can be in either of the two remaining positions. Some of these combinations are not likely to occur in therapy situations, especially as it might be assumed that most often the therapist is on a higher level (of awareness or understanding) than the client.

The Tao suggests that the leader puts themselves below the people: “If you want to govern the people, you must place yourself below them. If you want to lead the people, you must learn how to follow them.” Johanson and Kurtz suggest that confrontation in therapy can take the form of encouragement and that leading or educating the client
can happen by letting things follow their natural course. This is following the Taoist principle of Wu-Wei.

This section reviewed how various approaches to psychotherapy envision the role of the therapist. Most traditional western psychologies, and specifically behavioral and cognitive, often cast the role of the therapist as an expert and an active agent of change. Some theories, and especially Person-Centered Therapy emphasize the relationship and the supportive and teaching role of the therapist. Eastern psychologies that are influenced by the traditions of Zen and the Tao tend to see the therapist more as a facilitator that allows change to emerge.

Although every theory has some ideas and suggestions about the role of the therapist and the therapeutic relationship with the client, there is no comprehensive system to study this relationship. The Law of Three could provide such system, yet, there is no literature based on that theory that is specifically about psychotherapy. Rather than pointing to a specific gap, this section helps to provide background and better understanding of the Research Problem that asked about therapists’ attitudes towards and responses to stuck situations.

The Nature of Non-Change

Lack of change or lack of flow is one of the main characteristics of stuckness as was defined above. The distinction between change and flow is a subtle one and might require more exploration, beyond the scope of this research. Now, after aspects of change were reviewed in the first section, the review of the literature next discusses its counter-part, or non-change. This section explores literature that refers to the lack of change by different names such as resistance and impasse. The different theories
explored in this section use a variety of explanations for the underlying causes for non-change or the arrest of flow in the therapy process. The term *Stuckness* is looked at both from the experiential lens, i.e. how do people describe being stuck and also from the theoretical lens, explaining what leads to *stuckness* and distinguishing different types or flavors of *stuckness*. Regardless of the terminology, the wish for change and the experience of lack of it, appears to be an integral part of the psychotherapy experience.

**Resistance, Impasse and other Traditional Views of Stuckness**

This sub-section reviews the traditional terms used in psychology to describe *stuckness*. These include resistance and impasse as well as some suggestions for additional or alternative constructs.

According to the Concise Dictionary of Psychology the psychological term *resistance* was first coined in the context of psychoanalysis: “Resistance is the term that describes both the reluctance of material submerged by REPRESSION in the UNCONSCIOUS to surface into CONSCIOUSNESS and the reluctance of the ANALYSAND, or patient, to allow the ANALYST’S probing to uncover areas of unconscious conflict.” ¹¹⁵

In the context of the medical model that Freud’s thinking emerged from, the viewpoint of the practitioner often sees the client as not cooperating and actively or passively produces a counter force to the therapeutic initiatives of the therapist. The result is often a lack of movement. Freud said: “When we undertake to cure a patient, to free him from the symptoms of his malady, he confronts us with a vigorous, tenacious resistance that lasts during the whole time of the treatment.” ¹¹⁶ According to Messer and Gurman, in psychoanalytic tradition, both therapist and client think of this situation as
something bad to be overcome.\textsuperscript{117} According to Freud, the interpretation of the resistance, and of the transference it led to, has a major role in the therapeutic process as it leads to new insight of the instinctual drives and the basic defenses of the psyche. He said: “The decisive part of the cure is accomplished by means of the relationship to the physician, the transference, by means of which new editions of the old conflict are created.” \textsuperscript{118} For Freud, the therapist’s role is essential and his approach to the “cure” appears to place the therapist in the role of expert and the client in the role of passive recipient that often resists the work of the therapist.

\textit{Resistance} as describe by Freud is equated by Daniel Stern with the concept of repression. He expands resistance into several kinds or types, one of which is repetition compulsion.\textsuperscript{119} Stern suggests that awareness of implicit memory and implicit knowing, changes the focus of therapy away from bringing awareness to unconscious or repressed material. He says that therapeutic change can come from changes to the implicit knowing.

Another psychodynamic perspective is presented by Stanley Messer who defined Resistance thus:

…resistance refers to the customary and automatic ways in which clients both reveal and keep hidden aspects of themselves from the other, especially as these occur in their relationship with the therapist. It is a way of avoiding and yet expressing unacceptable drives, feelings, fantasies, and behavior patterns. However, it is also how clients assert their healthy human need to be autonomous and separate from others, or to protect their sense of self in an adaptive fashion.\textsuperscript{120}

This definition is consistent with the earlier definition by Freud.\textsuperscript{121}

The negative connotations of the term resistance are acknowledged by Messer, especially as they reflect on the oppositional attitude of the client. In his article on resistance Messer invites therapists to a change of attitude where the therapist welcomes
the resistance as a friend. Messer acknowledges that the very nature of the term resistance leads to oppositional thinking, pitting therapist against client. He suggests thinking about it differently, as the very material the therapist must work with.

Messer proceeds to distinguish five different types of resistance. The first is resistance of awareness. The client resists recognizing their feelings and motives. The second is resistance of the therapy relationship or transference, specifically resistance to reveling the feeling towards the therapist. This type includes resistance to anger towards the therapist. The third type of resistance is expressed by testing the therapist in relation to manifesting autonomously. The fourth kind of resistance is in behavior. The client does not change their behavior (presumably undesired behavior) outside the context of therapy. The last type or resistance that Messer lists is a reaction to failure of empathy from the therapist.

Messer acknowledges the therapist’s reactions to resistance and uses the term *countertransference* to name these reactions. Messer notes that therapists might respond to clients based on their issues and not see the issues of the client. He lists feeling of anger, wanting to get rid of the client, anxiety and need to nurture and protect. He invites therapists to be aware of their own reaction and consider the possibility that their feelings are an unconscious attempt by the client to communicate the client’s feelings.

The older psychodynamic theory that gives primacy to the sex and aggression drives was criticized and revolutionize by Fritz Perls, by focusing on the power of hunger. Perls suggests that the physical hunger of the infant develops in later years into mental and emotional hunger. Perls criticizes Freud for linking the idea of resistance to anal resistance only, thus neglecting oral and genital resistance. According to Perls,
oral resistance would manifest as spitting the food or as hunger strike. He links oral resistance to the feeling of disgust and in more general, not accepting something that comes into the body.\textsuperscript{126} Perls continues to describe another type of resistance: resistance against resistance, which he associates with suppressing disgust.\textsuperscript{127}

Perls criticized the Freudian notion of “analyzing the resistance” and says that by pointing out resistances the client feels guilt and shame and sometimes these evoke the therapist’s guilt.\textsuperscript{128} He argues that in order to deal with resistance, the analyst must appreciate the patient’s position on the resistance. He adds that such a position makes the analyst an ally of the forbidden impulse and thus alienated from the client.

Another criticism of the way Freud conceptualized resistance and the struggle between therapist and client it implies comes from Donald Nathanson. He argues that any attempt to interfere with natural affects evokes shame and guilt. He suggests that regardless if the intervention is chemical or psychological, the body responds by stiffening and defending against the evoked shame.\textsuperscript{129} Nathanson emphasizes that the shame response is rooted in biology and adds that it is firmly linked to the sense of identity. Nathanson quotes the Talmud that suggests that public shaming is as hurtful as shedding blood. He points out that revealing personal stories in therapy inevitably leads to shame and contends that the skillful therapist is able to stay connected with the client in such moments and provide the healing power of love next to the experience of shame.\textsuperscript{130}

Another psychological construct sometime used by clinicians and theorists to describe the lack of movement or change in the therapy process is \textit{impasse}. For example, Gary Yontef describes \textit{impasse} as a situation that does not move as a result of two
opposing forces, in this case impulse (or desire or life force) and resistance. ¹³¹ He says that “An impasse is a situation in which external support is not forthcoming and the person believes he cannot support himself. The latter is due in large part to the person's strength being divided between impulse and resistance. The most frequent method of coping with this is to manipulate others.” ¹³²

Another perspective on the lack of change in the therapy process comes from Gestalt therapists Erving and Miriam Polster who claim that everyone manages their energy by making good contact with the environment or resisting it. They describe significant parts of Gestalt theory as based on resistance. ¹³³ They distinguish five types of resistance. Introjection refers to limited interactions with the environment, taking what is easy to take and limiting the investment. Projection is putting energy out, being wrong a lot of the time and experiencing powerlessness. Retroflection is disengagement from the environment, feeling disconnected and restricting flow of energy between self and environment. Deflection is an engagement with the environment of hit-and-miss. Sometime gaining something sometime loosing something. Confluence is going along with the environment with little as possible investment. The Polsters describe in great length each of these types of resistance and often use them as attributes of a person, i.e. the projector, the deflector, etc. and describe their typical behavior.

The Polsters complete their description of types of resistance with the recommendation to learn to recognize and state one’s own needs, thus becoming an independent agent, and not needing to resist the environment. ¹³⁴

In a case study, the Polsters describe Impasse as an event in the therapy process, although they do not include a definition. Following a quote from the case they describe:
“At this point Bernard reaches the impasse (stage 5). His sense of limpness has gained enough power to confront his sense of urgent demand and the result is a stand-off.” 135

They suggest resolving the impasse by impelling the client to move beyond their old contradictions. They describe making a closer contact with the client through physical movement behind them. In describing the actual resolution of this impasse case, they suggest that the client loosened the impasse by discovering that they can behave in ways that were previously unconsciously forbidden, and that this option brings satisfaction.

A different use of the term Impasse comes from Bella, who reserves the use of it to describe problems in the therapeutic process itself. She uses the term stuckness to explore the feelings of the client.136 Based on her research into artistic interventions, she suggests that such interventions can help therapists understand Impasse and possibly resolve it.

Yet another definition of impasse that is congruent with the definition of stuckness used in this dissertation was suggested by Marli Frances Weiner. He proposes that impasse is “An acute or chronic failure of treatment in which the patients’ presenting problems and overall level of coping with themselves are not ameliorated or significantly worsen in spite of the active efforts of the therapist and the patient working together.” 137 Weimer’s definition emphasizes the lack of change, as the working definition of stuckness of this research does.

Weiner points out that therapists have much at stake when faced with an impasse and that an impasse is seen as failure of the therapist: “They have pitted their expertise, effort, narcissism and omnipotent strivings against the patient’s maladaptive psychological state. They have more than a rational mature involvement in helping
patients change for the better; they also have an irrational involvement tied to their self-esteem and personal needs.”  

Hartley determined that the impasse is seen as representing evidence of therapeutic failure and such failures threatens the therapist’s sense of competence and self-efficacy. Quoting several sources, Hartley points out that the perception of impasse or its detection is subjective. What is seen as impasse in one theory can be seen as part and parcel of the therapeutic work in another theory. Hartley suggests that impasses can often be traced to errors in diagnosis and quotes Rob Leiper, who contends that therapists are often reluctant to engage in proper diagnosis. Another cause for impasses is failure to form a clear therapy contract.

Throughout her dissertation Hartley quotes various opinions on the value of therapy and concludes that while some theorists contend that therapists should not be allowed to rationalize the negative effect of impasses, other encourage staying in the impasse and values the oppositional stance. Hartley quotes a research into therapists’ reaction to stuckness that found that therapists had several negative feelings responding to impasse: anxiety and confusion about the therapy process; anger and frustration towards the client; and negative thoughts and feelings in relation to their own self-efficacy.

The dissertation and research of Hartley’s are similar to this dissertation in being focused on therapists’ responses to impasse. However, the scope of her work as well as several other aspects are far more limited as discussed below. Her research questions were also somewhat similar to the questions guiding my work: “How do therapists recognize an impasse? What is the therapist’s emotional experience of an impasse?
How do they conceptualize the impasse and its causes?

How do they respond to an impasse?”

Hartley describes her motivation for the research: “The beliefs with which I embarked on the study were that therapists find impasse very disturbing in relation to themselves as therapists and are likely to attribute the impasse to the client, especially given the context in which they work where it is the client who is presenting as the one experiencing difficulties.”

Hartley found that all her participants (four therapists in total) shared the feelings of being useless and had a sense of failure. In addition, the majority of the participants felt guilty and felt anger towards the client. Most participants also felt frustration in relation to lack of progress in the therapy process. Hartley reports that two of the participants became aware during the impasse, that their method or approach is not working and changed their approach. A few of the participants reported the sense of mutual avoidance with the client.

In her conclusions, Hartley says that the most significant characteristic of impasse is the lack of progress. All her participants reported the tendency to work harder during impasse. Hartley’s research is similar in many ways to this current research in both questions and findings. Yet, it is different than this research in scope, depth and focus. Her research used only four therapists and explored only cases that were already terminated due to impasse. Her research does not look at stuckness as an ongoing therapy situation and does not explore stuckness as an integral part of the therapy process.

The linking of Impasse to the slowing of the flow was also mentioned by Nathanson. He recommended learning more about that slowing down, as deep work
happens slowly. He says that “Superficial change occurs rapidly, and deep change occurs slowly. We know this as an abstract concept, but often both patient and therapist forget it. Either partner may complain that therapy is at an impasse simply out of ignorance of the depth of the problem being treated.”

Using the theory of Piaget, James Byrnes describes how frustrating the lack of change can be for teachers:

…Piaget argued that assimilation and accommodation work in opposition to each other. The central tendency for assimilation is to keep the existing knowledge structure the same and find a place for new information in this structure. The central tendency for accommodation, in contrast, is to change the existing knowledge structure. It is not possible to keep things the same and change them at the same time. Thus, only one or the other—assimilation or accommodation—‘wins out’ in a given situation. This ‘battle’ between these processes means that change in children’s misconceptions can be frustratingly slow for teachers.

In his discussion of person-centered therapy, Mearns uses the actual term stuckness. He distinguishes between client’s stuckness that arises from interpsychic sources such as denial or fear of change and relationship stuckness, where the therapeutic alliance is not working for a variety of reasons. Mearns also mentions that therapist’s agenda and values that are not in line with the client’s values and timing can lead to stuckness. Mearns acknowledges that the therapy process does not proceed in straight lines and it is natural for it to slow down at times. He suggests a series of questions to trouble-shoot apparent stuckness. These are mainly aimed at raising awareness of the process in both client and therapist.

As in Messer’s discussion of resistance, Steven Frankel also questions the validity of the various traditional terms and states the need for a new construct that refers to slowing down or disruptions to the therapy process. He describes the implications of the traditional terms:
The problem with relying on the conventional explanations, such as resistance, splitting, and dissociation, for explaining obstruction in the flow of therapy or analysis is that each taken alone tends to emphasize pathology, most particularly the patient’s pathology, as opposed to incongruence between states within the patient or between the patient and the therapist, or even the patient and society (Frank, 1999; Levenson, 1998; Safran & Muran, 2000). They tend to support the fiction that the therapist is consistently clear seeing and authoritative, and they reduce the patient’s vitally needed authority and perspicacity. They also make the therapy field seem too simple, removing its bidirectionality.

Following this, Frankel coined the construct of Disjunction, defined as: “Disjunction refers strictly to the restricted capacity of the analyst and patient to work together therapeutically.”

Frankel claims that the advantage of the new term is that it is descriptive and does not carry a theoretical baggage. He proceeds to describe a variety of therapy situations that fit the new term. Frankel distinguishes between internal disjunctions that come from the intra-psychic sources of either client or therapist. Resistance in the traditional psychodynamic sense would fall into this category. Then he lists external disjunctions that relate to various misalignments between the client and the therapist. These can relate to attunement, to the therapy environment or to cognitive and temperamental differences.

Acknowledging the difficulty of introducing a new term, Frankel proceeds to explain that his new term gives the therapist freedom from theoretical or personal biases. He claims that using the old terms such as resistance, dissociation and splitting, inevitably leads to focus on pathology, most likely the client’s pathology.

The central importance of resistance in psychotherapy is also acknowledged by Johanson and Kurtz. They claim that it can be concealed in various forms and describe how in traditional therapy resistance is met with confrontation, and that even when that takes the form of encouragement it is still a contradictory force. Johanson and Kurtz describe the western impulse to do something that is explained as done for the good of
the client. They say that “in therapy, effortful work is a warning sign of disharmony with what is organic.”

This subsection reviewed the more traditional terms that describe *stuckness* or lack of change. It can be seen that terms like resistance and impasse, for the most part, focus on the client, and that these terms suggest a certain fault of the client and in some cases blame the therapist or the therapeutic relationship. Most specifically, Frankel claims that the traditional terms emphasize the client pathology and recommends looking for new terms that are free from these connotations. His position supports the need for simple construct like *stuckness* that is understood by most people as describing neutrally an undesired lack of movement.

**Stuckness and Depression**

Another area that explores the lack of change and dissatisfaction is in the dynamic of depression. Of the eight diagnostic criteria of depression in the DSM5, four mention reduced activity, slowing down and dissatisfaction. The phrase *The Dark Night of the Soul* is often used to describe depression more poetically. The phrase comes from St. John of the Cross, a 16th century Spanish mystic and an important figure in the Catholic counter-reformation movement who wrote a mystical book with that name. The author says: “Into this dark night souls begin to enter when God draws them forth from the state of beginners…” Beyond the religious connotation, this quote seems to suggest that this stuck state is also developmental and marks progress rather than failure or regression.

James S. Gordon also connects non-change or lack of movement with depression. He suggests an alternative view of depression and a method for getting out of it. Gordon challenges the prevailing medical model of using drugs and instead suggests
seven steps, including meditation, physical exercise, good nutrition and spiritual approach. Gordon includes a chapter on the Dark Night of the Soul, and similarly to St. John of the Cross—, he sees it as a call for change and emphasizes the need for awareness about the spiritual and developmental meaning of that state.160

Procrastination is another common manifestation of non-change that is often viewed as pathology and linked to depression. Fuschia Sirois and Timothy Pychyl argue that procrastination is a form of short-term mood repair and emotional regulation.161 They contend that a disconnection between past and future selves is both leading to procrastination and the result of it. The goal that is avoided belongs to a future self, while the one avoiding it is a past or present self. According to them, procrastination can lead to physical and psychological negative consequences such as depression.

In the Red Book, Jung talks about the going into the desert and about the descent into hell.162 Later, Jung viewed that period of his life, which according to some theorists would qualify as psychotic, as an important developmental stage that led him to his deepest understanding. Jung’ views of that stuck period, are closely related to one of the secondary research questions of this research, asking if and how stuckness could be a useful developmental period. Yet Jung does not provide any clear directions that can help another person travel safely through experiences similar to his. There is no guidance to a therapist how to help a client who is stuck in similar ways.

In her discussion of stuckness, Bella mentions that some therapists would suggest that such artistic work as Jung did through painting and writing is a good therapeutic avenue for stuckness and specifically for depression.163 Bella points out the similarities between stuckness and depression, mentioning the themes of frustration, anger, isolation,
energy, fear of change, not knowing, and rejection of experience. However, in her research she found that the participants made a distinction between depression and stuckness. Bella concludes that stuckness has mainly psychological causes, while OCD and depression have proven biological roots in addition to psychological connotations.

The Law of Octaves

As this section of the Literature review already demonstrated, non-change is recognized and named by many systems of thinking. Often the lack of change is seen with negative connotations. The Gurdjieffian metaphysics offers another viewpoint that tries to understand non-change as an integral part of any process. In addition to its Law of Three that was reviewed above, this system describes the Law of Octaves, which helps reframing stuckness as a natural occurrence in every process and not as an accident or abnormality that needs fixing.

This law states that within every process, progression follows a specific pattern that resembles the structure of the musical major scale. Every western musical scale has seven steps that lead to the next octave (half or double the vibration of the initial tone.) These steps can be big or small (whole tones and half tones). In the major scale, the two smaller intervals are the third and the seventh steps. In musical terms, these are the notes Mi-Fa and Si-Do. When the process is descending, these slower intervals appear in the reverse order, i.e. the first and the fifth steps down.

The Law of Octave claims that at these intervals, the process changes from its initial direction. Going through these two intervals require different approaches. In ascending processes, during the Mi-Fa interval, there is a need to reconnect with or re-
assert the initial intention or goal. During the Si-Do interval there is a need for vision and imagination that lead to the final note. Hafiz expressed this idea in the following poem:

How should
Those who know of God
Meet and part?
The way
An old musician
Greets his beloved Instrument
And will take special care,
As a great artist always does,
To enhance the final note
Of each Performance.169

The formulation of the Law of Octaves suggests an association of stuckness with intervals. From the perspective of the Law of Three that was discussed above, the lack of change comes from First and Second force that balance each other, or from a lack of Third force.170

A related view of stuckness is explored by Ecker and Hulley. They suggest that the conscious undesirable position is a response or a solution (Second Force in the Law of Three terminology). It is responding to an unconscious initiating force (First Force.)171 According to them, stuckness is due to lack of awareness. The two forces balance each other and there is no real incentive to change. The awareness of the unconscious motives is in itself a Third Force for change. Ecker and Hulley continue to say: “Symptom deprivation is used to discover the unwelcome or dreaded consequences that would result from living without the symptom.” 172

They continue to claim that by reducing the Second Force, at least in the exercise of imagination, the balance of forces that leads to stagnation is broken and the unconscious First Force can become more conscious. Approaches or techniques that are similar to Depth Oriented Brief Therapy 173 are used according to Messer and Gurman in
Narrative Therapy’s search for exceptions, in Solution Focused and in various strategic approaches.174

**Neuroscience Based Approaches**

This sub-section reviews a few current researchers in neuroscience that can introduce different perspectives on questions regarding the nature of change and non-change. It is possible that the bodily explorations of movement and lack thereof, and specifically the flight-fight-freeze mechanisms, might have some connections with psychological *stuckness*.

The evolutionary roots of the fight-flight-freeze mechanisms in mammals and their specific operations through the different branches of the vagus nerve were researched by Stephen Porges.175 The freeze state can be relevant to the inquiry into non-change. In the introduction to Porges theory, Bessel van-der Kolk says “…Porges’s polyvagal theory gave us a powerful means of understanding how both bodily states and mental constructs dynamically interact.” 176 Van del Kolk continues to point out how the polyvagal theory opens new psychological understanding regarding the ability to influence bodily states through voice and facial expressions. A further research into the possible connections between the freeze response and psychological *stuckness* might open up new ideas for therapy.

In his work that focuses on healing that has its foundation in modern neuroscience research, Norman Doidge reports on the work of Moshe Feldenkrais. Feldenkrais had often worked with a healthy part of the body to teach an unhealthy or a wounded part that could move how to find movement and health.177 For example, if the left leg was stuck, Feldenkrais would study the movement of the right leg evoking mindful
awareness. After a period of working in that way, the left leg would learn a new way of moving. Elizabeth Towill explained that the practitioner supports the resistance. She describes how a man that could not move his neck, was encouraged by Feldenkrais to move the body on a swivel chair and leave the head unmoved and in the same place. After some time of exercising that way the head could freely move. Feldenkrais saw the nature of stuckness in holding too tight. He recommended making more space and practicing where movement is possible. Doidge contends that Feldenkrais’ insights from the mid-20th century, are reaffirmed by recent neuroscience research.

Another brain-based theory for dealing with stuckness was suggested by Maria Kharitonova, Sarina Chien, Eliana Colunga, and Yuko Munakata. In a series of experiments, the authors observe that ‘switchers’ types who have more flexible thinking patterns, store their behavioral ‘rules’ more in the prefrontal cortex. In contrast, ‘preservers’ who are more prone to getting stuck, store their rules more in other brain areas. Flexible thinkers were more able to generalize meta-rules and apply them more abstractly. Their research provides another perspective on therapy situations that do not change.

The most central issues that contribute to the stuckness aspect of obsessive-compulsive disorder are explained by Jeffrey Schwartz as based in brain dysfunction. According to Schwartz the part of the brain called caudae nucleaus has a similar function to the automatic gearshift in a car. This part allows thoughts to flow from one subject to the next, including noticing mistakes or wrong paths and correcting them. Unless as occurs in OCD, this part is not functioning well, and it leads to brain lock. Schwartz’s approach to bringing change is largely cognitive and mindful and comprises four steps:
Relabel: Recognize that the intrusive obsessive thoughts and urges are the result of stuckness.

Reattribute: Realize that the intensity and intrusiveness of the thought or urge is caused by stuckness; it is probably related to a biochemical imbalance or damage in the brain.

Refocus: Work around the stuckness (thoughts and feeling) by focusing your attention on something else, at least for five to 10 minutes: do another behavior.

Revalue: Do not take the stuckness thought at face value. It is not significant in itself.

According to Schwartz, these steps retrain the brain to do something different by acknowledging that the problem is not what it initially seems to be. This is analogous to learning to shift gears manually.\(^{183}\) Schwartz’s discoveries and healing approach are relevant to this research in their recognition that the lack of change is not due to the context it is attributed to. The compulsive hand washing is not about dirty hands. Yet there is a problem and it is the very fact that one is stuck.

In an extensive review of the left and right brains, Iain McGilchrist suggests that stuckness can be related to the differences between the right and left hemispheres.\(^{184}\) He describes an attribute of the left hemisphere he calls stickiness. That is the tendency of the left-brain to stay with the object of perception it focused on and have difficulties shifting. Quoting the brain researcher V.S. Ramachandran, McGilchrist claims that the left-brain does not like to take responsibility, it tends to use denial of sensory input as it relies on the already existing knowledge or conceptual structures. Often the left-brain will look for someone to blame for the discrepancies between theory and apparent reality. The left brain
hemisphere is conformist and does not adjust easily to change. Denial often goes along with conformism.\textsuperscript{185}

Adding these brain-related perspectives to this dissertation provide another dimension for understanding \textit{stuckness} and might open possibilities for additional research. Therapists that are more aware of neuro-science perspectives might be more accepting of therapy that is not leading to immediate change.

\textbf{Eastern, Imaginal and other Less Traditional Approaches to Non-Change}

The 12\textsuperscript{th} pictogram of the I-Ching is called \textit{stuckness} or stagnation.\textsuperscript{186} The I Ching suggests that one needs to put distance between the self and the situation. There is a warning to not throw everything away to get unstuck. Another suggestion is that by changing one small thing such as the mental approach, the entire situation can be changed. \textit{Stuckness} is resulting from past mistakes. If these are not corrected the situation will repeat. And it might be better to stay stuck than let others lead you into a quagmire. The situation is larger than it seems, and others are stuck with you.

According to Tsung Hwa Jou, an essential principal of Chinese medicine is flow.\textsuperscript{187} The practitioner looks for blockages and tries to release them and open the flow, which equals health. In Chinese medicine there are three forces or elements, similar to the \textit{Law of Three} described above. These are the feminine principal Yin, the masculine principal Yang and the life energy Xi (pronounced Chi).

As a master teacher of eastern martial arts, Fito Schreiber resonated with the ideas in this research, and the essential role \textit{stuckness} has in guiding the therapy in the context of Chinese medicine.\textsuperscript{188} He described various kinds of \textit{stuckness} he is aware of that can arise from imbalances of Yin and Yang. These forms of \textit{stuckness} are important
components in diagnosis and provide at least a starting point for the therapy. Schreiber said that lack of movement is the natural state of the whole. To get movement you need to separate the Yin and The Yang. Intention, when focused and present, can be sufficient to initiate a change.

Schreiber gave examples using external movements. He said that when trying to move to the right, just moving makes it a forced movement. Instead, starting with allowing the movement to the left naturally gets also the other movement, so both the right and the left motions are in balance and are not forced.

In a similar way to the analysis from the Law of Three above, Schreiber suggests that stuckness can be two different forces in locked balance. This would be a different kind of stuckness from the one where movement is forced. He said “Stuckness is always the balance of Yin and Yang with none being able to take over.” 189

Schreiber suggests the value of stuckness by saying that it is necessary to be stuck before change can happen. Taking into account the different elements in Chinese medicine, he suggests that seeing things from the perspective of lack rather than looking for balance can be seen as a transition. Schreiber suggests asking for example: is it Yang diminishing or Yin rising, or is it the other way around? Schreiber associates the permission of lack and the acceptance of stuckness to the practice of Tai Chi, where sometime there is a need for the teacher to stop the student in order to prevent injury. At the same time, he says that encouraging stuckness per-se is a very advanced work.190

Another acupuncture practitioner, Amaluna says:

Sometimes feeling stuck means there isn’t space for what needs to move through to move. Creating space for our feelings is a transformative process. Most of us spend an incredible amount of time and energy consciously and unconsciously
trying to avoid uncomfortable feelings. This is natural! We don’t want to suffer. But it isn’t the best way.\(^\text{191}\)

Also influenced by Eastern ideas, Ethan Nichtern, describes aspects of the Buddhist path including the meaning of *stuckness*.\(^\text{192}\) He claims that in Buddhist tradition, *stuckness* or frozen moments are viewed as the source of all psychological problems or in his words: defensive Karmic strategies. Nichtern quotes Chögyam Trungpa, who likens *stuckness* to being in a cocoon. According to Nichtern, the issue is partly linguistic, and related to the term “ego.” The Buddhist claims that ego is an illusion and that there is nothing that is non-changing. Trungpa with his analogy of the cocoon, offers a way for coexisting changing reality alongside with a fixed ego that like a cocoon, cushions the experiences of reality with silken threads. Nichtern quotes Trungpa who says: “The way of cowardice is to embed ourselves in a cocoon, in which we perpetuate our habitual patterns. When we are constantly recreating our basic patterns of habits and thought, we never have to leap into fresh air or onto fresh ground” \(^\text{193}\)

Nichtern further connects the basic assumption behind Judeo-Christian thought of humans being essentially evil, or born in sin, to *stuckness* in ego states.\(^\text{194}\) That comes from the unconscious avoidance of looking inside, as what is found there is assumed to be bad or flawed. Quoting Trungpa and Chodron, Nichtern suggest instead, that the very awareness of being flawed, already implies that we are not flawed but rather aware. That awareness introduces movement away from *stuckness*.\(^\text{195}\)

Another Buddhist teacher, Pema Chodron, teaches that the core of *stuckness* is in the inability to stay present to what is in the moment. She uses the Tibetan term *Shenpa* to name and describe this inability.\(^\text{196}\) According to the Buddhist teaching she follows and teaches, (Trungpa Rinpoche tradition) the ongoing work of mindfulness meditation
that returns to the present moment and to the breath, slowly releases Shenpa. Shenpa is related to what is often referred to in Buddhist teaching as attachments. According to Buddhist philosophy it is the attachments that keep the endless cycle of reincarnations and releasing those frees one to evolve further.\textsuperscript{197} The concept of Karma is also related to attachments, that holds the soul in its place throughout the cycles of incarnations. Chodron prefers the original term Shenpa, claiming that the term attachments, is not an accurate translation and does not capture the sticky emotional aspect of the phenomena. She describes how one can focus in meditation on the inner process of the psyche moment by moment. Shenpa is the force that takes one back from process to content: thoughts that arise from past incomplete business and from desires related to the future.

The teaching of Ouspensky and Gurdjieff includes the term Identification that is in many ways similar to Shenpa.\textsuperscript{198} Their term could well be derived from similar roots in Buddhist teaching, as Gurdjieff spent many years collecting eastern teachings before he started to teach his system in Russia, early in the 20\textsuperscript{th} century. It is worth noting that the translation of concepts from different systems and different languages always affects meaning. In the teaching of Gurdjieff, the focus is on the personal identity derived from internal and external objects, activities and titles. The person loses themselves in the thought or the feeling and experience reality through that object. In a similar way to the Buddhist description there is stuckness in the object and releasing it through awareness leads to freedom and to greater presence. It is the freedom to flow with what is in every moment and be aware of changing reality without forcing it by fixed preconceptions.

In addition to eastern ideas about non-change and stuckness, ideas and images from Greek mythology are used by Patricia Berry to explore stuckness and movement.\textsuperscript{199}
Following various stories, Berry goes deep into the imagery by stopping the story at specific moments. She claims that the myth about myth is that it is static in time and does not change. Berry confronts that idea by picking a moment, a snapshot in the story and invites our imagination to hear the rustle of the wings of Pegasus against the stony Medusa. Seeing the source of movement in stopping, Berry comes close to Taoist ideas that see movement and change emerging from sticking or lack of movement. In the words of the Tao: “A good traveler has no fixed plans and is not intent upon arriving.”

Another archetypal-psychology writer Bolen uses the period of mid-life crisis that often leads to meaninglessness and despair as an example of sticking. She prescribes the work on the inner Gods as a path towards integration and individuation that can lead to change. Her description of the myth of the Judgment-of-Paris is another example of sticking. According to her analysis, the trouble came from permanent preference to one goddess. Her solution is to keep choosing the right God again and again, according to the needs of the present moment. In that suggestion, Bolen follows Hillman’s general preference for polytheism as the primary psychological view that allows for more movement and is less likely to get stuck. This is in contrast to monotheistic psychology that Hillman sees as the tyranny of the ego or of the single opinion.

Linking brain research and Eastern Ideas, Daniel Siegel bases his theory of trauma on the understanding of implicit memories. These memories are not connected to narrative memory and thus lack connection and meaning. In his model, the therapy helps the client reorganize the traumatic memories in several dimensions. In the time dimension the client is able to say something like: “This happened in the past but now I can deal with it.” In the narrative dimension the client is able to include the traumatic
memory into the overall scheme of meaning making. Both Stern and Siegel maintain that trying to bring awareness directly into the *stuckness* aspects of trauma is not therapeutically useful.

The idea that *stuckness* might represent an arrested process stuck in time is suggested by Alison Holman and Roxane Cohen Silver. They define *temporal perspective* as the overall span of cognitive involvement across past, present and future life domains. Their research compared the levels of temporal integration of trauma sufferers; both war veterans and survivors of wildfires and concluded that trauma symptoms are related to temporal disintegrations. They claim that people with more future orientation were less affected by the traumatic events. They suggest further exploration of the relationship between trauma and temporal orientation and integration and the various methods that can lead to temporal integration.

The individuals experience *stuckness* and how this experience changed when touched or participated in art therapy was explored by Bella. Her research explored the feeling of *stuckness* from the psychological, spiritual and creative dimensions. Bella uses both verbal methods and creative art techniques. Bella suggested that *stuckness* is a complex phenomenon that often includes fear of change. She recommended to practitioners to include an alternative form of expression such as art or movement. Bella pointed out that *stuckness* is generally viewed in a negative way and asked if there are also aspects of *stuckness* that represent an opportunity for growth and change.

Bella also reviewed *stuckness* in the psychological contexts of depression and OCD as well as in the therapeutic process itself. She pointed out the danger to the therapy relationships from experience of *stuckness*. She also reviews *stuckness* in the creative
process. She suggested *stuckness* could result from both, lack of ideas or creative initiative, or too many ideas and energy. She quoted Graham Wallas who claimed that *stuckness* is a necessary step to allow inspiration to occur.207

In a philosophical treatise about the process of thinking and where it can get stuck, Wallas suggested that thought could be divided into four stages: preparation, incubation, illumination and verification.208 He claims that mental relaxation is required during the stage of incubation.209 He describes his students reporting during the incubation, which precedes any new thought, there is “a slight feeling of discomfort arising from a sense of separation from one’s accustomed self.” 210 Wallas points out that the preparation and verification stages (first and last) are more conscious, whereas the middle stages are largely unconscious. He warns against trying to make conscious or mechanical these stages, which leads to loss of spontaneity and intuition.211 Wallas contends that the balance between the conscious and the unconscious stages of thoughts is especially crucial. Writing in the 1920s he claims that in America there is imbalance towards the conscious stages and that students there do not learn how to maintain a thought process.212 As Bella suggested in the quote above, *stuckness* might be related to the second stage in Wallas’ thought theory.

A developmentally based approach to *stuckness* was suggested by Stanislav Grof. He associated the feeling of *stuckness* with the prenatal experience.213 Grof based his developmental theory on the four stages of prenatal experience. The transition from stage three- “The death-rebirth struggle” into stage four- “The death-rebirth experience” includes feeling of impending annihilation and desire to stop the process.214 Grof argues that every baby feels stuck in the birth canal. Grof claimed that life experiences that
invoke strong conflicts or contradictions and cannot be processed consciously can invoke the feeling imprinted during that prenatal struggle.\textsuperscript{215}

Another view of non-change that connects it with the relationship of the conscious and the unconscious mind was suggested by Erickson and Rossi. They argued that psychological problems are fixated by the conscious mind.\textsuperscript{216} Many of Erickson’s methods are aimed at releasing the grip of the conscious mind, mainly via altered states of consciousness created during trance. Such altered states allow the unconscious mind to follow its innate tendency towards health and solution finding. Erickson argues that often it is the conscious mind or the conscious behavior that keeps the current undesirable situation and prevents the unconscious mind from expressing itself creatively thus leading to new paths towards change.\textsuperscript{217} Erickson recommends fostering not knowing that reduces thinking. This recommendation is reminiscent of the Tao that advises: “Stop thinking and end your problems.”\textsuperscript{218} Erickson sees the therapeutic relationship as more important than any specific intervention.

In a similar way to Erickson, yet using a different vocabulary, Eugene Gendlin’s method is aware of non-change and facilitates change through awareness of body processes. The core practice of \textit{Focusing} is based on paying attention to the \textit{felt sense}.\textsuperscript{219} That approach implies allowing the unconscious mind to come forward by slowing down conscious mind activity. \textit{Felt-sense} points to the vague and indefinable constellation of sensations in the body that includes feelings and thoughts. Like Erickson, Gendlin claims that by releasing the fixation of the logical mind, one allows the \textit{felt sense} to shift, leading to changes in emotions and attitudes, which is the reason one was seeking therapy in the first place. Gendlin’s innovation is in integrating the body processes into the
psychological process of change. He said: “Thinking in the usual way can be objectively true and powerful. But, when put in touch with what the body already knows and lives, it becomes vastly more powerful.”

Gendlin also points out the discomfort of non-change and the tendency of the therapist to turn away from stuck situations. He says:

One is usually turned away from such feelings [of being confused and pained, thrown off stride, put in a spot without a good way out,] and in the habit of ignoring them. I have gradually learned to turn toward any such sense of embarrassment, stuckness, puzzledness or insincerity that I may feel. By ‘turn toward it, I mean that I don’t let it simply be the way I feel, but I make it into something I am looking at, from which I can get information about this moment.

The theories and methods of both Erickson and Gendlin are relevant to the research hypothesis that points to the discomfort therapists feel when faces with stuckness and to their tendency to choose change-seeking interventions. Both Erickson and Gendlin are more comfortable with non-change and encourage accepting it as is. They trust that real change will emerge naturally from within the psyche.

This section of the Literature review looked at the nature of non-change and explored the various constructs used in western psychology such as resistance and impasse to negatively describe unchanging situations. The section connected non-change with depression and OCD and explored several views from Neuroscience research that attempt to explain lack of movement. The section also covered some eastern views as well as some archetypal psychology views that include periods of non-change as integral parts of a process. With the exception of the Gurdjieffian metaphysical laws, it appears that there is no overarching view that integrates change and non-change in the process of therapy. Lack of change is sometime viewed in negative terms, leading to various
suggestions on removing it, for example, the quote above from Weiner, who suggested that therapists view lack of change as their own failure. The limited numbers of suggestions or approaches that include non-change as part of the process represent a gap in the literature.

The following section explores the biases in western philosophy and psychology that value progress and change above non-change, thus leading to the preference of more active approaches.

**Cultural Biases Towards Action and Goals**

This section explores research and theories showing the bias in western culture and specifically in the American culture, towards active change, setting goals and getting forward as well as negative biases towards stability and non-change. Some of the sources in this section explore the impact of these biases on the profession of psychotherapy, showing that psychological theory and psychotherapy practice are impacted by these biases.

Petriglieri suggests that the social context of stuckness is a result of the cultural bias toward change. He says:

> We live in times that glorify change and denigrate stability. Contemporary cultures, especially in the West, have wholeheartedly embraced (and perhaps corrupted) the humanistic values of improvement, betterment, growth, progress, and so on. We constantly hear that the world is changing fast, and we had better change with it.\(^{223}\)

Tartakovsky lists a variety of responses by other professional therapists who were asked the question: “What to do when a client is stuck?”\(^ {224}\) A clinical psychologist she interviewed suggests going back to theory to find out why the client is stuck. He suggests that the *stuckness* is in the therapeutic relationship that needs to be strengthen. Another
therapist interviewed in her article claimed to rely on Jung saying that the client cannot move beyond the place where the therapist already explored. Thus, he recommends new explorations from new angles. Another therapist Tartakovsky interviewed who is working with a Post-Partum case suggests discussing with the client the feeling of stuckness in the therapy. A few more therapists from other modalities who were interviewed in Tartakovsky’s work looked for the cause in the relationship. The article ends with the conclusion: “When a client stops making progress or takes a few steps back, clinicians contemplate their role in the stagnation. They have an honest conversation with their clients to pinpoint the problem. And they work on getting unstuck together.”

In a more recent article, Tartakovsky suggests that one cause of stuckness is mental clutter. She lists a variety of inner judgments and disempowering beliefs that keep the client stuck. Tartakovsky quotes Natalia van Rikxoort who suggests a five-step process to getting unstuck: question your beliefs, identify the first step, shift the shoulds by changing should to want and reconnecting with your own values. The focus is on a prescribed list of actions that leads to change.

Another action-focused approach uses goals as suggested by Trevor Eddolls. He claims that one cause of stuckness is limiting beliefs that tell the person they cannot do something. He suggests replacing these beliefs with empowering beliefs. Another suggestion is to imagine the solution and move towards it. He describes his work with clients where he helps them imagine the not-stuck situation. Eddolls also focuses on inner judgments that can lead to stuckness and confronts them.
Quoting anthropological sources, Yalom divides cultures according to their value-orientation into *being, being in becoming* and *doing* cultures. Yalom claims that contemporary American culture is an extreme example of a *doing culture*, meaning that most people get value from their actions and external achievements and define themselves accordingly. That clearly does not leave room for inward looking or for being stuck extended periods without apparent achievements. Yalom asserts that getting ahead is an embedded value of contemporary western culture. He described a visit to a Caribbean resort where he compared himself to one of the workers who could spend extended time just looking at the sea and doing nothing. Yalom described how he felt smug in comparison to that person, since he was doing something. Yalom says that the value of getting ahead breaks down when one starts to inquire about the end goal. He suggests that the incessant drive to get ahead is a defense mechanism against the awareness of death.

Yalom connects the issues of a *doing culture* with the way people defend against death, a central topic for existential psychology. He quotes the economist John Maynard Keynes who describes how the ‘purposeful’ man tries to secure an elusive immortality. Yalom describes how Tolstoy’s novels, Anna Karenina and Ivan Illich, deal with the contradiction embedded in a life spiral of purposeful and external achievements that collapse with the realization of an inevitable death. Yalom also refers to Maslow, saying that the very pursuit of external achievement is exactly what prevents people from achieving their highest possibilities.

The relationship between strategies that lead to change and action and the cultures in which they are practiced were explored by Brene Brown. She says that while
strategy is “what we want to achieve,” culture is about “who we are.” She lists 10 questions that help explore the unconscious aspects of a culture that can block action. Some of these questions are very pertinent to the question of stuckness. For example:

“What behaviors are rewarded? Punished?” “Do people feel safe and supported talking about how they feel and what they need?” “What happens when someone fails, disappoints, or makes a mistake?” “What’s the collective tolerance for discomfort?”

Brown proceeds to discuss the gap between our aspirational values and our practical values. She theorizes that if that gap is too large, we tend to disengage, which she claims is at the root of many major problems. Brown claims that one aspect of contemporary western culture is “never enough” which invites disengagement, as no one can match that impossible value.

The contrast between the Greek philosophical base in archetypal thinking, expressed in the writing of Plato, and the postmodern scientific and rational thinking coming from Descartes, Kant and Darwin that alienate modern western man from spirit is pointed out by Tarnas. The rational thinking pointed out echoes the ideas of Brene Brown about “never enough” that stem from ongoing comparisons. When there is no acceptance of things as they are, it is not possible to accept non-change.

Tarnas further likens this situation to the psychological concept of double bind as suggested by Gregory Bateson: “The impossibly problematic situation in which mutually contradictory demands eventually lead a person to become schizophrenic.” Bateson describes four premises leading to a double bind, using the mother-child relationship: the relationship is vital to the child, the child receives contradictory information, the child does not have an opportunity to ask questions and the child is not allowed to leave the
situation. Tarnas suggests replacing in Bateson formulation of these four premises, *mother* with *world* and *child* with *man*. This replacement shows that as Bateson’s double bind leads to schizophrenia, the current human alienated condition leads to all the ailments of modern society. However, he suggests that the analogy is not complete and western man’s Promethean tendency is the gate of hope. Tarnas says: “Modern human being has not been simply a helpless child but has actively engaged the world and pursued a specific strategy and mode of activity – a Promethean project of freeing itself from and controlling nature.”

A connection between cultural values and brain research is made by McGilchrist, who claims that the left hemisphere of the brain dominates contemporary western culture. He acknowledges that the questions of distinctions between the two hemispheres became less popular after brain research showed that both hemispheres are involved in almost every brain activity. He points out that the basic difference between the hemispheres is the way they work with attention. The left-brain uses focused attention that can take a detail out of context and study it carefully. The right brain uses spread attention that is always in context. According to McGilchrist, the right hemisphere is the natural master since it is the one that can create meaning. However, as he points out, during the development of contemporary western culture, the left hemisphere usurped the prime position and it largely governs both individuals and the culture at large. The hemispherical differences McGilchrist describes echoes the distinction made above between process philosophy and substance philosophy. The focus of substance philosophy on distinct objects is similar to the workings of the left hemisphere and reminds of Plato’s need for unchanging world for the purpose of reason.
McGilchrist also goes back to Heraclitus as the best proponent of right hemisphere primacy. He suggests that while the left-brain philosophies are stuck in re-presentation, explaining phenomena by what is already known, the right brain option is to go deeper into phenomena and find deeper and yet unknown meaning.\textsuperscript{242}

McGilchrist’s research has deep implications for the subject of \textit{stuckness}. If as he claims the culture and individuals within it, are dominated by left-brain tendencies, then at least some stuck situations can be explained by the left-brain tendency to stick to what it focuses on. Similarly, the therapist’s tendency to reapply prescribed responses would also be explained and maintained by a dominating left hemisphere.

The negative bias in the culture towards non-change can be seen in the many courses that offer to teach therapists how to deal with or manage resistant clients who are not changing. Joshua Watson explains the various types of resistance, acknowledges its traditionally negative connotations, and invites therapists to take a new approach that sees resistance as part of the process. Yet, after several suggestions about education, support and empathy he demonstrates an action-oriented bias by saying: “Gently persisting when a client either is unable or unwilling to proceed.”\textsuperscript{243} 

In another such course, titled “Effective Techniques for Managing Highly Resistant Clients” Clifton Mitchell says: “I do not like the word ‘resistance.’ It conjures up precisely the image that I wish to eliminate.”\textsuperscript{244} Mitchell also provides a comprehensive review of the history and analysis of resistance and promotes a changed approach towards it. As a summary of his ideas, Mitchell quotes David Burns who stated that you can never help your client until the problem is defined around a specific person,
place, and time. Although this course and the corresponding book has a wealth of suggestions and techniques, it still reflects a cultural bias towards achieving goals.

Bella reflected this cultural bias when discussing that during her research she often felt the pressure to ‘fix’ the participants and relieve their suffering. She connects this with the cultural pressure to perform and with the image of the therapist as an expert.

The following few paragraphs reviews two theorists that represent an exception to the cultural tendencies described above that promote the professional role of the therapist as a change agent. Both Raphael-Lopez Pedraza and Diana Voller invite a mercurial approach to therapy that allows for the unknown and for lack of change. In their writing the overall active and change oriented tendencies in the culture can be seen from the opposite side.

The concept of Negative Capability that was coined by the English Romantic poet John Keats, was explored by Voller. She defined the term as “the advanced ability of a person to tolerate uncertainty.” Voller points out that unlike other medical professions, the therapist’s special capacity is being with the uncertain and the unknown. Such Negative Capability stands in contrast to the view of the therapist as an expert and professional. Voller pointed out the contradiction between being a seasoned expert in the field and thus having to ‘know,’ while at the same time being open to uncertainty and ‘not knowing.’

Voller underscored the difficulties of professionally defining this capability or training for it. She tried to distinguish the ability of the seasoned therapist to be with uncertainty from the uncertainty of the trainee, who is just learning to become a therapist. Voller also pointed out that the profession attended well to the anxieties around not
knowing, by attending seminars, reading books and participating in professional training that lead to certifications. At the same time there is no attention given to the required Negative-Capacity, which in her words is mercurial and ephemeral.\textsuperscript{248}

The god Mercury/Hermes is described by Pedraza as the guardian of psychotherapy.\textsuperscript{249} Pedraza points to another role of the therapist as a messenger and a connector of heaven and earth, following the spirit of the God Hermes. The suggestion is that heaven does not change, and earth does not change, yet the connection between them can lead to change. Pedrazza refers to change using the term \textit{psychic movement} and connects it with the Hermes’ freedom of movement between heaven and earth. Pedraza also points out that Hermes has many undignified things about him compared to his brother Apollo or the Goddess Athena. Pedraza says: “Only the undignified Hermes in the analyst can constellate a communication with the undignified side of life and can evaluate hermetically what has been reported as undignified.”\textsuperscript{250} Pedraza continues to point out that contemporary western culture is largely apollonian and does not look favorably on the undignified sides of Hermes that are required for the kind of therapy he recommends.

A strong cultural influence and avoidance of \textit{stuckness} in the field of psychotherapy has been forwarded by the American Psychological Association when it adopted in 2005 new standards for Evidence Based Psychotherapy.\textsuperscript{251} The APA recommends to its members to follow the practices of evidence-based psychotherapy and adds that these need to be done in collaboration with the patient. The standard stresses the central place of research and science in defining EBP. Timothy Thomason predicts that as a result of these new policies and standards, psychologists would soon stop doing any
Thomason tells how a past president of the APA insisted that these standards are what distinguished psychologists from counselors and Gypsies. He contends that the pressure for EBP pushes psychotherapy further into the medical model and leaves little room for actual therapy.

This section has looked at the biases of the western and American culture through historical, philosophical, psychological, archetypal and brain-based lenses. Through all these viewpoints, the culture appears to be action and results oriented, favors structure and prescriptions to intuition. Contemporary western culture appears to be impatient with attempts to slow down and expand the therapeutic perspective. The following section reviews some other approaches that favor some alternatives, giving priority to the right brain, intuition, and the slower rhythms of the soul.

Willingness to Be with Stuckness

The Master does his job and then stops. He understands that the universe is forever out of control, and that trying to dominate events goes against the current of the Tao.

—Lao Tzu, Tao Te Ching, Ch. 30

This section looks at theories and practices of psychology that do not follow the contemporary mainstream western cultural norms. For the purpose of this dissertation, these theories have in common an acceptance and sometime even valuing of stuckness or what might be called resistance. Further, some look for meaning in such situations. From another viewpoint, what is common to these approaches is that they base their meaning making not on doing and external achievements but rather on internal processes.

Milton Erickson and his followers share trust in the unconscious mind’s tendency towards healing and creativity and they look for solutions that emerge from the
unconscious mind. They say: “Patients have problems because their conscious programming has too severely limited their capacities. The solution is to help them break through the limitations of their conscious attitudes to free their unconscious potential for problem solving” 253

Similarly, Imaginal Psychology and other Jungian based approaches, look for meaning in the transpersonal and view psychological situations from a larger archetypal perspective. Stuckness has to be resolved between the Gods or the archetypes. The distinctions between external myth and stories and the inner life of the psyche are blurred.

In Taoist psychology there is a basic awareness that every force evokes its opposite, thus there is an impetus to follow the Tao and practice Wu-Wei or action-less doing. Talking about comparisons and change the Tao Te Ching says: “Therefore the master acts without doing anything and teaches without saying anything.” 254

Approaches Using Archetypes and Myth

The use of story and myth to penetrate the unconscious is demonstrated by Robert Bly, who also gives several examples of reframing failure as success.255 As in Ericksonian approaches, Bly uses reframing to suggest a different view of a situation and how to interpret it more productively. This allows the psyche to move towards its own solution. The golden boy in Bly’s story, who is stuck in his failed tests, finds out that he actually passed the overall bigger test. Bly tells how Iron John gave the boy a different horse on each of the three days of tests. Bly uses this sequence uses this sequence of red, white and black horses to demonstrate the growing awareness of the hero.256 The red represents blood and war and strong emotions. The white represents the innocence and
nativity of a youth that puts ideology and rules above reality. Bly says that a man who is in the black gave up blame. He explains how that takes long time and includes deep and dark shadow work and self-acceptance. Bly points out how teachers and ministers try to make people skip certain steps, yet according to him, to be fully developed one needs to go through the whole sequence.

Thomas Moore reclaims the literal meaning of the term *psychotherapy* as “Care of the Soul.”²⁵⁷ As other primarily Jungian writers, Moore looks for change in staying with the image and letting the Gods/Archetypes do their work. He reminds the reader to return to a soul connection between therapist and client and bypass complex theory in favor of trust in the soul’s inner power to heal.

Moore also reframes depression as a healing journey.²⁵⁸ Following the inspiration of Saint John of the Cross-, Moore invites new understanding of long periods of depression as necessary descents into the underworld and the depth of the psyche. In his book *Care of the Soul* Moore described depression as the God Saturn coming to visit and suggested that the host would treat Saturn respectfully and ask what he came to teach.²⁵⁹ This image supports one of the research questions regarding the possible benefits or usefulness of *stuckness*.

Exploring the place of intuition and the willingness to take time for it, Claudio Naranjo says: “Knowledge of unity can only be tested in multiplicity, and unity is all the greater by apparent diversity.”²⁶⁰ The author uses eight children books to explore the similarities and differences of the *Hero* and the *Divine Child* archetypes. This distinction of archetypes and styles of meaning making is significant in exploring approaches to *stuckness*. On the one hand confronting *stuckness* using external action, and on the other
hand reinterpreting its meaning. Naranjo suggests that the *Hero* moves from present to future and is always future oriented. The *Hero* exists for the test, the battle, the adventure and the prize. Their life’s meaning is embedded in the trophies or in telling stories about past heroic deeds. Odysseus is either scheming the next heroic act or weaving stories about their past exploits. Once the journey is completed there is nowhere else to go and there is often a loss of meaning. The *Divine Child* on the other hand, lives in the eternal present. Meaning is derived from within. Life, whatever it brings is meaningful, because I am.

A similar view that looks for healing and change in the anti-hero is shared by Filippomaria Pontani, who argues for seeing the character of Calypso in Homer’s *Odyssey* as a therapist. She points out that ancient scholars used Calypso’s speech as an example of excellent rhetoric. She claims that both Homer, and later Virgil, who modeled his character of Dido after Calypso, exaggerated the dramatic and romantic aspects of the character and neglected to see her healing influence on the hero. Pontani, using etymology and linguistic analysis, claims that Calypso, as a goddess of death takes the hero through a transformation. She focuses on the main aspect of Odysseus’s suffering that is the inactivity in her island. Pontani points out the tension between revealing and concealing and the willingness to stay in non-action for as long as needed. Calypso is seen as a therapist of a different kind that helps the hero change and move on from his past trauma.

Another writer who uses Greek Mythology sources to look at heroes with a new perspective is Jeanette Winterson. She re-told the Greek myth of Atlas and Heracles and explored Atlas’s *stuckness* holding up the sky. Throughout the story Atlas considers
the weight of the task given him and cannot imagine the possibility of just dropping it.

Once Atlas realizes that nothing much is going to happen, he lets go. According to Winterson, *stuckness* is clearly related to imaginary conflict, internal and external. Once the *stuckness* is resolved internally the problem simply melts away.

**Milton Erickson and Other Therapists who are Willing to Stay with Stuckness**

Telling stories often create a state of trance in which change is possible. This was demonstrated by Erickson throughout his work. Sidney Rosen tells that towards the end of his life, Erickson claimed that he could help both students and clients much more effectively, by telling stories.\(^{264}\) Erickson claimed that in his teaching seminars, the students’ unconscious mind is affected deeply through the stories, and in turn they change the way they work with their clients.\(^{265}\) In this story about stories, Erickson demonstrates his indirect approach to change and his deep trust in the inner tendency of the psyche to heal itself, when the conscious mind is encouraged to stay out of the way.

A prominent student of Erickson, Stephen Gilligan, suggests befriending the presenting symptom, treat it with respect and find its role in relation to the person as a whole.\(^{266}\) Gilligan explores behind the symptom the part that is trying to awaken or evolve. Telling about a famous case of Erickson, Gilligan says:

Instead of reducing her to some diagnostic label or metaphorical description, he approached her as a unique person with many distinct values and interests. He demonstrated that while persons stuck in problems typically restrict their attention to a single frame; therapists searching for solutions must widen their lens to include many other aspects of the person as well.\(^{267}\)

Such an approach is following a key principal of Erickson’s teaching called *utilization*.\(^{268}\) That principal implies that the therapist looks for whatever the experience in moment brings and especially any expertise of the client that can be used practically or
metaphorically to address the issue at hand. This means that therapy does not follow a predefined script but is rather recreated for each client. The research of Miller et al. came to similar conclusions.

In their meta-research about the effectiveness of therapy, Scott Miller, Mark Hubble and Barry Duncan concluded that highly effective therapists are attuned to their clients’ needs, regardless of training, modality, degree or years in practice. Their very large meta-research explored what works in therapy and what are the factors that affect successful therapy. Their finding supports indirectly the hypothesis of this research regarding interventions. Their research concluded that it is not the right choice of interventions or a specific modality that brings change in therapy. According to them, the majority of factors contributing to change are general to all therapies or not directly related to the therapeutic relationship. The minority of factors that depends on the therapist, are mainly in the area of the therapeutic relationship and requires the therapist to pay special attention to the needs of the individual client and tailor the therapy work individually.

Siegel defines the mind as a system that monitors and control energy and information. Starting from that definition, Siegel advises therapists how to work mindfully, by taking into account the interactions between brain, mind and relationships. Siegel brings together his experience as a child therapist, a brain researcher and attachment expert and his experience in meditation and mindfulness practices. He emphasizes that while the brain can affect the mind, the mind can also affect the brain. Siegel contends that as a complex system, the brain tends towards integration that signifies health. Stuckness in his view would result from lack of
integration. Integration in turn is based on differentiation and linkage of different parts. Siegel details nine different types of integration and guides the therapist how to encourage each one of them. One of the dimensions of integration is temporal, connecting past, present and future and developing an awareness of the flowing presence in the context of passing time from past to future. This aspect of Siegel’s work can be linked to the Holman and Silver research mentioned above, that viewed stuckness, specifically as related to trauma, in the lack of temporal integration. By Siegel’s admission, his system, called “Mindsight” is similar to many eastern traditions and requires years of practice and personal development from the practitioner.

The creator of Internal Family Systems Richard Schwartz explains in his review of therapy obstacles, how new therapists feel pressure to provide the perfect interpretation and find it hard to trust the client’s resources. He claims that all the inner parts need to be heard and when the therapist follow their own agenda, some parts could feel rejected. Schwartz suggests that when the therapist is not aware of their countertransference and cannot hold to their own Self, therapy gets stuck. He suggests the therapist would admit to the client that they got lost or dissociated and reestablish a deeper connection.

**Taoist Psychology**

The Tao-Te-Ching recognizes that non-change is as valuable as change. Thus, therapist coming from this tradition brings a more integrative approach to stuckness. For example, Bella suggests that stuckness can be seen in the context of an organic process: “A natural cycle of inhalation and exhalation that can be a fluid and illuminating experience if mental and emotional distance can be cultivated to the extent that one is
able to refrain from getting caught up in thoughts and feelings about being stuck.”

Her suggestions resonate with Chinese medicine recommendations quoted above, regarding making space to allow flow.

Johanson and Kurtz contend that the Tao-Te-Ching can be used as a manual for a new style of therapy. Above all they emphasize the balance of Yin and Yang and the principal of Wu-Wei or doing without doing.

The Tao explains that every force evokes its counter force, thus confrontation generates an endless cycle of violence. Instead, the Tao, and Johanson and Kurtz following its teaching, recommend supporting the defenses. They liken the process of supporting resistance to non-doing through encouraging whatever is already arising. Paradoxically, they claim, this allows the process to move forward as it makes the resistant no longer necessary.

Several poems in the Tao-Te-Ching describe how force and counterforce are locked and suggest finding the balance and a third force in the larger Tao. For example: “If you want to shrink something, you must first allow it to expand”

Johanson and Kurtz encourage therapists to follow naturally and effortlessly what arises and add nothing new. They say that avoiding confrontation creates a sense of safety that allows the client to relax. By not requiring anything to change the process is allowed to unfold and change by itself.

This sub-section reviewed several approaches that are more willing to allow stuckness, or non-change in the therapy process and in some cases look for ways to interpret it as an integral part of the process. This was mainly to present a counterexample to literature reviewed in previous sub-sections that in general looks to confront and
change stuck situations. There is no underlying theoretical connection between all the sources presented in this sub-section, yet, all of them recognize in some way that looking at therapy situation through the lens of force and counterforce is limited. In that sense they share the spirit of the Tao-Te-Ching that always look for a third option through the Tao.

**Conclusion**

This Literature Review explored the Research Problem in the context of change. The Research Problem asked: “When in the face of stuckness, what tendencies can be seen in therapists’ thought process in their choice making between active, change-seeking interventions and passive, encouraging and accepting interventions?”

The first section, Theories of Change, discussed a variety of approaches to the very question of change from both philosophical and psychological viewpoint. It is clear that from the dawn of philosophy, people wondered about the nature of change and its possibility. The conflict between process philosophy and substance philosophies was carried into psychology and is still unresolved. The Literature review has shown that holding to a substance philosophy and its focus on things, including specific diagnosis and evidence-based treatment, inevitably leads to the paradoxes of Zeno, i.e. denying the possibility of real change. During my internship, one of my supervisors, a psychiatrist, often said that therapists are just tweaking around, but real change for patients is not possible.

Most of the literature dealing with stuckness uses other names for it, such as resistance and impasse. These sources are mostly focused on bringing resolutions to the stuck situation that is perceived negatively. Only a few of the sources reviewed here such
as Gendlin and Hartley look at the response of the therapist to the stuck situation. And it appears in the literature reviewed that therapists primarily respond negatively to *stuckness* or try to avoid the stuck situation and the feelings it evokes in them.

Although *stuckness* was always recognized in the process of therapy, the inconsistent and often vague use of terms leads to confusion and as Frankel observed, can be misleading and can negatively impact the therapy process. There is clearly a need to clarify these terms and relate them to actual therapy situations by bringing awareness of therapists to the predictable reactions to *stuckness* in both client and therapists.

This review also showed that the tendency and bias in several western psychotherapies is towards goals, action and short-term solutions. This is especially apparent in the most popular and institutionally accepted approaches in the US, those of Behavioral and Cognitive-Behavioral theories and their related therapeutic modalities. The influence of the culture at large, and especially the economic pressure of the insurance companies and the pharmaceutical industry, further shift the dial towards action oriented and *Evidence Based* approaches.

Several alternative approaches were reviewed that demonstrated interest in *stuckness*, even when calling it *resistance*, and ascribed meaning to periods of therapy when not much is happening externally. Taoist and Zen based approaches are the closest to promoting action-less therapy.

Although several theories including Gestalt, point to the important part of impasse and resistance, this research focuses on *stuckness* as relating specifically to the non-change in therapy and cannot be identified with similar terms such as resistance and impasse. Only a few therapists and theorists have found a way to integrate *stuckness* into
the very process of therapy and guide therapists how to not only accept, but also promote and encourage *stuckness* as an integral step in the therapeutic process. Paradoxical approaches in the tradition of Erickson come close to such position, although most often they view the allowing of *stuckness* as a strategic intervention. Critics of Ericksonian therapy sometime see this approach as a trick and miss its basic philosophical stance in allowing the psyche to find its own natural reorganization towards healing.

Hartley’s research asked similar questions to this current research; however, her scope was very limited. She interviewed only four therapists and only in relation to therapies that ended prematurely due to what she calls impasse. She did not look into stuck situations in an ongoing therapy relationship. Thus, there is a need for further research into the reactions that therapists have towards *stuckness*, including the way they recognize it, the language they use to describe it and the possible responses they have towards it. There is also a need to expand the vision of therapists, both theoretically and practically regarding the possibly positive place of *stuckness* in the therapy process.
CHAPTER 3

METHODOLOGY

Introduction and Overview

For many years, research in social sciences was modeled after research paradigms of the hard sciences. These included counting and measuring samples and using statistics to validate theories. Such an approach creates new knowledge that can be used in therapy practice. It also runs the risk of confusing correlations with causation.¹

In general, qualitative research methods intend to generate knowledge based on human contact and attempt to go deeper into human processes. This is done through conversation with the individual participant and by discovering the meaning they ascribe to the questions being researched.²

While quantitative research is usually focused on a specific question and can answer “what,” “where” and “when” questions using statistical methods, qualitative research attempts to look at problems in context and more holistically, and thus able to go an additional step and attempt to answer “why” and “how” questions.³

Qualitative research uses open-ended questions that can yield unexpected results. That is another reason that these results are harder to quantify.

I used the Tao-Te-Ching and Taoist Psychology as the conceptual and theoretical framework that guided this research. In poem 27 Lao Tzu says:

A good traveler has no fixed plans
and is not intent upon arriving.
A good artist lets his intuition
lead him wherever it wants.
A good scientist has freed himself of concepts
and keeps his mind open to what is.
Accordingly, the research was guided by curiosity more than by assumptions or
hypotheses.

Research Problem, Hypothesis, and Design

The Research Problem that guided this work asked: “When in the face of
stuckness, what tendencies can be seen in therapists’ thought process in their choice
making between active, change-seeking interventions and passive, encouraging and
accepting interventions?” In the literature there are several suggestions how to get the
client or the therapeutic process unstuck. There are several psychological traditions
including psychodynamic and Gestalt that emphasize the work with resistance or
impasse, which as explained above are old terms that often lead to negative view of the
stuck situation. I did not find a traditional western framework in which the stuckness
itself: the lack of change in therapy, is clearly seen and named as an essential part of the
therapy process.4

The Research Problem stated above led to questions about attitudes that therapists
hold and behaviors they manifest when they encounter a therapy situation they perceive
as stuck. These are open-ended questions and the range of possible answers or results is
not known in advance. Thus, a qualitative research method presented a good fit for these
questions.

Secondary questions that were explored in the research were:

In what ways our respective cultures, and our professional psychology education,
affect our choice of therapeutic interventions?
Can *stuckness* have a positive and even a necessary role in the overall development of the psyche? Can it have value in the process of therapy?

Are there different types of *stuckness* in therapy?

What conditions or causes lead to *stuckness* in therapy?

The research hypothesis suggested: “When faced with *stuckness*, some therapists tend to want to do ‘something’ even when they do not know what to do. Their discomfort prompts them to choose active, change-seeking interventions against their intuition or deeper knowing.”

The scope of the research could not include significant comparisons between western and non-western therapists, yet the learnings emerging from the research did reveal some common attitudes of western therapists representing a bias towards action.

*Imaginal inquiry* is a form of qualitative research designed to evoke the very experience being studied. In this case it is the reaction of the therapist to a therapy situation that is perceived as stuck. Further, this qualitative method includes the expression of the participants to the evocative material. Going through an experience is a key ingredient in transformative learning. Aftab Omer and his colleagues developed *imaginal inquiry* as a research method at Meridian University. Being rooted in Transformative Learning theory and emphasizing the importance of experience, it is situated well within the tradition of participatory research, where the research process affects both researcher and participants.

The primary methodology used to collect and interpret data for this dissertation was a form of *Imaginal Inquiry*. It was combined in this research with In-Depth phenomenological Interviewing.
The overall interpretive approach was pragmatic, holding in mind the goal of being useful for therapists in exploring new approaches to what might be perceived, consciously or unconsciously, as stuckness. Creswell describes qualitative research based on pragmatism as “focus on outcomes of the research – the actions, situations and consequences of inquiry.”

At the same time, this research can be seen in the framework of a Phenomenological Study. Creswell describes this type of research as looking for “…the common meaning for several individuals of their lived experience of a concept or a phenomenon.”

Phenomenological research is rooted in the philosophies of Edmund Husserl, Martin Heidegger, Jean-Paul Sartre and Maurice Merleau-Ponty. Some of the basic ideas behind Phenomenology are related to the realization in the late 19th and early 20th centuries of the limits and limitations of science. These ideas included returning to the roots of Greek philosophy in search for wisdom, letting go of any assumptions, awareness of the connection between the object being researched and the consciousness looking at it and the awareness of the subject-object relationship. This awareness includes the realization that the researcher is being impacted by the research. The impact of the researcher on the subject being studied came into the more popular consciousness with the discovery of the uncertainty principal in modern physics.

The combination of Imaginal Inquiry with Pragmatic Phenomenological Interviewing was a natural choice based on my experience and interests as a therapist. In my conversation with clients, I am aware of the practical and pragmatic goals; the client always wants to get better or resolve a problem or an issue. In that respect I am a student
of Ericksonian psychology where *Utilization* is a primary principal aimed at translating the expertise of the client into practical results. Ericksonian therapists work primarily with the unconscious mind and assume its innate tendency towards healing. By inviting the client to exercise any expertise they have and can acknowledge, the tendency of the unconscious mind’s towards healing is recruited. The focus of the research was on the practical experience of participating therapists and the meaning they give to their intervention choices. That combination of methodologies was thus well suited to generate the research data in an interview environment that resembled a therapy session.

*Archetypal psychology* is another theory and practice that informs this inquiry as it works primarily with the unconscious. Using archetypal ideas and methods I am always interested in deep meaning and in mythological connections. From the Humanistic Psychology, above all Victor Frankl, I inherited the deep interest in the meaning the client is able to make of actions and experiences in their life. I am also deeply aware of the impact of the therapeutic relationship on my life and soul.

Part of this research included better understanding of the use of the term *stuck* or *stuckness* in the context of therapy. A simple questionnaire (Appendix 8) was employed as a tool for understanding how professional therapists use this term. This questionnaire was sent to a relatively large number (several hundreds) of professionals using email lists I am a member of. Further, I used snowball method that implies asking the already recruited participants to invite additional participants. Both me and the co-researcher did a basic textual analysis of the answers independently, found repeated themes and tried to get an overall sense of the meaning professional therapists ascribe to the construct “stuck.” From the consistent themes that were found, I created a working definition of
stuckness. One of the most common themes that emerged was describing lack of movement or change in the therapy. Thus, stuckness can be defined for the purpose of this dissertation as the slowing down or stopping altogether of the therapy process, as perceived by the therapist, the client or both.

The most significant data-collection part of the research was based on interviews with 10 professional therapists. These interviews were conducted following a 20 to 30 minutes of role-play where the researcher enacts a stuck client with the interviewee as therapist.

Co-Researchers

I used one of my Meridian University classmates as a co-researcher. Her role included going over the data collected in the interviews and doing an independent textual analysis. Adding a co-researcher established greater validity of the analysis by having another independent perspective. We worked together to find and establish the themes to be used in the analysis of the data.

Limitations and Delimitations

A few of the research questions as well as the Research Problem touch on cultural aspects that might contribute to western therapists’ biases towards more active approaches. The scope of this research, by time, sample size and methodology, did not allow exploring in a comprehensive way, the differences between therapists of different cultures. To explore differences in attitudes and actions towards stuckness between therapists from a variety of cultural backgrounds would have required a much larger sample and possibly travel to other countries. Possibly, these other cultures would have to
be explored first to understand better the possible cultural interactions to the observed reactions to *stuckness*. The researcher is an immigrant from Israel and a lifelong student of spiritual traditions. This is potentially another bias that could have affected both the choice of participants and the interpretation of the results.

Another limitation was the lack of clear definition of the term *stuckness*. Although there are references in the literature to *stuckness* in therapy, there is no commonly agreed upon definition. The pre-research questionnaire was an attempt to mitigate this limitation and discover some common understanding of the term amongst professionals. This part of the research uncovered a few different meanings embedded in the term *stuckness* as used professionally.

Choosing participants from my direct and indirect contact list was another scope limitation. Most of the participants came from the San Francisco Bay Area or from other parts of Northern California. Although I attempted to recruit participants with a variety of convictions and modalities, many of them came from transpersonal or humanistic schools, just by virtue of our connection. At the same time, there was some representation of different modalities, including EFT, psychodynamic, Gestalt, somatic and CBT. Choosing a more randomized sample was beyond the scope of this research.

The interpretive methods chosen were oriented to the verbal and visual. Both the pre-research questionnaire and the data from the interviews were studied using phenomenological textual analysis. The primary evocation was an enactment of a session with stuck client. This delimited the research from accessing more somatic forms of data. Similarly, interviewing the participants after the enactment about their reactions and in general about their professional experience, delimited access to more unconscious forms
of data that can be found through expressive art or through movement. I trusted that the unconscious mind would as always, find its proper expression and that such expression can be uncovered to some extent using textual analysis.

Research Procedures

The email inviting participants to reply to the questionnaire stated that the research was a part of a PhD dissertation on stuckness in psychotherapy.

When I contacted interview candidates, I gave the same explanation, and added that the goal of the research was to explore therapists’ relationship to and attitudes towards stuckness.

Questionnaire respondents were screened only by the distribution lists the invitation was sent to. I assumed that all members in these lists were mental health professionals. The interview participants were screened by their interest in the topic, their ability to relate to the experience of stuckness and by balancing the sample to include a variety of modalities, years of experience and gender.

In my initial contact with prospective interview participants I asked if they experienced stuckness or stuck situation in their work as therapists. Then I proceeded to find out if they were willing to spend the time required for the main meeting (about 90 minutes) and the additional 15-minute phone or online meeting. Originally, I planned on two 15-minute meeting, however, it turned out after the first few interviews, that the original contact was very short, just enough to explain the scope and schedule time. Consequently, only one follow up meeting, in person or by phone was needed.

Interview participants were contacted initially by phone or email, depending on our previous connection. Once they agreed to participate, I emailed them a brief
description of the research process and we attempted to schedule time in their office for the main interview and for the initial phone or online brief meeting. The purpose of that meeting was to go over the research procedures in more detail and answer any questions they might have. As explained above, it turned out that a clarifying brief email or phone call was sufficient, and in many cases not even needed. There was an email reminder a week before the interview.

A few weeks after the interviews I sent to each interviewee a request for follow-up, checking if they learned or realized anything new from our interaction and if there was any impact on their therapy work. In a few cases we followed with a phone conversation. In other cases, I received a detailed email with their later reflections.

After the initial writing of the Learnings I shared a summary of learnings with the participants that expressed interest.

Description of Meetings Activity

The first 10 minutes included greeting and connection. Following that we reviewed and signed the informed consent form and reviewed biographical data. That data included age, professional education, years of experience, academic degree, professional license and favorite modalities or approaches to therapy.

The next 20 to 30 minutes were dedicated to role-playing a stuck therapy situation. The researcher enacted a stuck client and the participant was invited to role-play the therapist. A vignette describing the case was sent to the participant at least a week before the meeting (Appendix 6).

Following the role-play there was a 10-minute reflection time. The participants were invited to reflect and journal about the experience of role-playing.
The next 20 to 30 minutes were an unstructured interview. I asked the participants open-ended questions about their experience and was open to any associations, feelings, reactions and thoughts they might have had. The intention was to follow the participant’s stream of consciousness and discover their specific interests, sensitivities and wisdom. I asked participants to identify key moments in the role-play. I also asked them if they have found connections or associations between the role-play we enacted and their own work as therapists.

The next 20-minute section was a more structured interview including the following topics or questions:

- Do you recall a case where you regretted intervening actively and decisively?
- Do you recall a case where you regretted NOT intervening decisively?
- Do you recall a case where your active intervention was successful?
- Do you recall a case where holding back and waiting led to a desired outcome?

The last 10-minute section was an exploration of participant’s understanding of *stuckness* using the following questions:

- What is your understanding of *stuckness* in therapy?
- What leads to it?
- How does it resolve?
- Did you see expression or signs of stuckness in the role-play or the vignette?
- Where?
- How *stuckness* does relate to resistance?
- How it relates to Impasse?
Finally, the last five to 10 minutes were for closure and integration: meditation, attending to unresolved feelings or questions, procedural review of our follow-up meeting and a closing bell.

The total time of the meeting was planned for 90 minutes. Naturally, sometimes it took slightly longer, thus we always reserved two hours. Participants were informed of the time requirements in our initial contact.

The questionnaire data was filled anonymously and was recorded by the hosting application (typeform.com).

All the interviews were recorded on video. The recordings were copied from the video camera and kept on my private and secure computer. All the data was backed up to another secure computer. All the data was encrypted, and password protected.

After each interview, the video was converted to audio-only for transcription. I did the transcription of three interviews and a paid transcriber did the rest. The transcriber received only the audio and the initials of the participant. That helped with keeping participants’ confidentiality. Naturally, the transcriber could hear if I addressed the participant by their name during the interview.

A research for computer-based transcription yielded poor results. All the transcription software I found was based on “training” the program to recognize a specific voice. Since each interview was with a different person, no software application proved useful. The transcripts were kept in computer files, encrypted and password protected. Participants’ biographical data was recorded in computer files, also kept on my computer, encrypted and password protected. Participants’ full names were not recorded, only their initials.
Three to six weeks after each interview I scheduled a 15-minute individual online or phone meeting with the participant. The purpose of that meeting was to find emerging new understanding for the participant. It was also intended for integrating any unresolved experiences from the previous meeting or any unanswered questions. In that later meeting I asked the participants the following questions:

Are there any thoughts or feelings about our last conversation?
Did you notice any impact on your therapy work?
Was there anything in your work since we met that you saw in a new light?
Do you have any new understanding of stuckness?
Anything you would like to tell me or suggest for the research?

Participants

All the participants were professional therapists at various stages of their career. That includes psychologists, Marriage and Family Therapists and Social Workers. The only requirement was that they were licensed and were currently practicing some form of individual psychologically oriented work as therapists. I tried to include somatic therapists as long as they perceive their work as psychological and include in it some conversational element. At least two of the interview participants fit that description and described themselves as somatic therapists.

I planned to include 14 participants, assuming up to four dropouts. Indeed, I managed to recruit and complete the interview with 10 participants. The participants were recruited through my direct professional connections and through the initial questionnaire that had a wider distribution. One participant contacted me following the request sent with anonymous questionnaire invitation. The intention was to have representation of
therapists using different modalities, of different ages and experience and as much as possible of different cultural background. I tried to balance the number of female and male therapists.

I approached participants personally through phone and email. Larger groups were approached through various professional email lists and internal communication in professional organizations of which I am a member. The recipients of the communication were invited to participate in a PhD research on stuckness. They were given a general sense of the required commitment. For the questionnaire participants this was five to 10 minutes. For the interview participants I asked initially for a total of three to four hours in three separate meetings. After the first two interviews, I learned that less time was needed and informed the participants accordingly. These two different parts of the data-collection were independent, i.e. participants could respond to the questionnaire, take part in the interviews or participate in both.

Participants in the pre-research questionnaire were asked only to define stuckness in up to 40 words. The questionnaire was filled anonymously online using the online survey service Typeform. In addition to the definition, participants were asked to provide minimal demographic data including age, gender, highest degree, professional license and main modalities used in their work.

Participants were selected for the interview phase based on their willingness to take on the time commitment. They were screened towards balancing the participants’ sample according to the various categories explained above. These participants were asked to sign an informed consent form (Appendix 4). That included their agreement to publish the data from their interview in the dissertation. Participants’ names and
identifying data are not being included in the dissertation, however, demographic data such as academic degree, professional license and experience is sometimes mentioned, and a summary is included in Appendix 9. Since the interviews were done on an individual basis there was no need for a confidentiality agreement that protects other participants. Participants were also informed that the preliminary learning would be shared with them after the interview, if they expressed interest. Before the interview they received a brief explanation of the methodology and of the intention to form a research team together, i.e. their role as participants was not passive. Rather, they were invited to discover new knowledge with the researcher.

The 10 interviews I conducted were spread over the course of six months. Nine of them were conducted in the participant’s therapy office, helping them to be in their usual environment. One interview was conducted in my Berkeley office. Before I started the interview series, I conducted one pilot interview with a friend therapist. That helped me to adjust the timing, get used to the recording equipment and to the transition from role-playing a client to acting as an interviewer.

Initial Meeting

After the initial screening and the participant’s verbal consent, I emailed the participant the consent form, the demographic questions and the interview vignette (Appendix 6). In the initial phone meeting, which lasted five to 10 minutes, I verified their demographic data, briefly explained the timeline of the research and went over their definition of stuckness. This meeting also included basic introduction to the concepts of imaginal inquiry and the specific topic of this research. It was an opportunity to form a
connection with the participants and invite them to be part of a research team. That meeting usually occurred one to two weeks before the interview.

**Four Phases of Imaginal Inquiry**

**Evoking Experience**

In this part the research, the participants were instructed to be their usual therapist selves, in a role-play with the researcher enacting a stuck client based on a detailed vignette (Appendix 6). The vignette described the client and the history and lack of progress in the therapy over the course of about a year. The vignette was sent to each participant before to the meeting, giving them a chance to get to know the “client.” In response to the initial learning from the questionnaire and from the pilot interview, the role-play vignette was slightly adjusted to focus more clearly on the research question.

There was only a short introduction before the role-play to minimize expectations that can skew results. The aim was to encourage the participants to conduct themselves as close as possible to their normal therapist’s demeanors, attitudes and behaviors.

After the role-play, 20 to 30 minutes altogether, the participants were invited to reflect in silence for a few moments and then come back into the present moment.

The research design of the interview process assigned the researcher two different roles that presented some challenges. On the one hand I played the role of a stuck client according to the prescribed vignette and tried to fully embody that role. On the other hand, I had to remain the objective interviewer and researcher, trying to observe and record unbiased data. I used the participant’s reflection and journaling time, to switch my role, using short meditation, some stretching and to take some notes. Role-playing the
stuck client was always evocative for me and generated many internal observations as well as sharpened the observations about my role-playing therapist: the current participant.

**Expressing Experience**

Moving forward from the brief meditation, I invited the participant to reflect in writing on their experience. Journaling privately about the experience was intended to help the participant have at least part of the expression not impacted by the later interview process. After five minutes of journaling I conducted an in-depth interview guided by phenomenological approaches. This was aimed at discovering the roots and sources of the participant’s experience. The main focus of the interview was on the meaning the participant made of what they had experienced and observed in the role-play.

Each interview had two sections: the first was an unstructured part, open for any material or response to emerge. The intention was to follow the participant’s stream of consciousness and discover their specific interests, sensitivities and wisdom, using open-ended questions such as:

- How were you affected by the role-play and the vignette?
- What attracted your attention?
- What were some of the more significant moments you noticed?
- Anything you noticed about your own reaction?
- Any sense how you would have worked with such clients?

This was followed by a more formal and structured interview focused around aspects of *stuckness*. I was especially curious to link the role-play to the therapist’s own
experience of dealing with *stuckness* in their therapy work. I was looking for any ideas they held or even formulated about the causes of *stuckness* and the possible therapeutic responses to it. The formal interview included clarification of the meaning of *stuckness* for the participant. I asked if the role-play reminded them of cases they worked with. I then asked the participants if they viewed the role-play client or any of their clients as stuck. Did they ever intervene in stuck cases in a way that led to movement and change? Did they ever intervene in such a case and later regretted their action? Did they ever choose to not intervene in such a case and regretted their choice? In their experience, was there ever a situation where holding back and not intervening was successful? I was also interested to find out how their attitudes and understanding of *stuckness* might be related to their professional education and training.

Finally, I inquired about their theory, explicitly or implicitly regarding *stuckness*, its causes and its possible resolution. I also asked them about their familiarity with the constructs of *resistance* and *impasse* and how these might be related to *stuckness*.

This two-part interview was recorded on video and audio for later transcription and review. The camera was set at the beginning of the interview and remains focused on the participant throughout the interview. The camera was remotely controlled from my cell phone, so I was able to handle the entire recording without any help and without moving around and interrupting the flow of the role-play or the interview.

**Interpreting Experience**

Imaginal Inquiry Interpretation phase includes the following steps: identifying key moments, responding to key moments, exploring parallels and differences and contextualizing using mythology and theory. Going back to the participant’s earlier
journal, I asked participants during the interview, to identify the key moments in the role-play and make sense of them according to their own theory and modality. I also invited them to link the experience to any myth or theory they know or find meaningful. I assumed that as the professional backgrounds of the participants was varied, only some of them would relate to the question about mythology. Indeed, only a few were interested to explore myth related questions.

Later, when I worked with the transcripts, I repeated a very similar interpretive process using mythologies that are part of my own meaning-making toolkit. These came primarily from Greek mythology, Bible stories, and when relevant, myths from other cultures. The co-researcher worked with the transcripts in a similar fashion, using her store of myths and other meaning making sources.

In later stages of the interpretation I kept in mind Taoist theory and therapy, especially as presented by Johanson and Kurtz. I also looked for Ericksonian interpretations based on my own experience and on stories told in the book My Voice Will go With You. I added to the original design also the interpretive lens of the Gurdjieffian theory of the Law of Three, as described in the Literature Review chapter.

The interviews were transcribed, and the text analyzed for significant statements that were grouped into themes. Those were in turn analyzed for common meaning and compared with their impact on the researcher. Initially I explored the usage of several computer based thematic analysis tools such as MaxOda, Envivo, Compendium and QDA. However, after initial evaluation and comparison I decided to forgo the use of any software-based tool. The amount of data did not justify the complexities and additional training involved in using software. The co-researcher joined me during this latter part of
the interpretation. We choose the main themes together and compared our conclusions regarding the meaning found in the transcripts.

Catherine Kohler Riessman explains the basics of thematic analysis and describes various modes of working with the interview transcripts. She describes how in thematic analysis the emphasis is on contents. Combined with the phenomenological approach the analysis of the content is focused on meaning making and the essence of the participants’ experience. Creswell summarizes the phenomenological data analysis thus: “Analyzing data for significant statements, meaning, units, textual and structural description, and description of the ‘Essence.’”

Both the co-researcher and I reviewed carefully all the questionnaire responses and marked the phrases that seemed especially meaningful. Independently we developed a list of emerging themes. Then we reviewed these together and distilled the list into the most essential themes. For the questionnaire, I marked each reply with the themes it included and followed with some statistical analysis.

That work prepared us for analyzing the data from the interviews, which comprised of over 100 pages of transcripts. Initially we repeated the process of independently reviewing the transcripts and marked the significant phrases. That was followed by distilling the significant themes and comparing these to the themes that emerged from the questionnaire. The co-researcher and I discussed areas where we had different impressions and came to some consensus. For the most part we had similar impression and chose similar themes. In several places, the co-researcher comments about the feeling of the role-playing client were closely matched with what I experienced.
While studying the transcripts, I occasionally went back to the corresponding video recording to clarify the meanings the participants expressed, using somatic data, facial expressions and tone of voice. The video recording was also useful for recollecting my own experience as the role-playing client since that part of the interview was not transcribed.

Once I defined the major Learnings, I consulted with the co-researcher and together we finalized the Learnings list and the exact wording for their propositional statements.

**Integrating Experience**

At the end of each interview there were five to 10 minutes of closure that allowed participants to summarize and integrate their experience. I invited each participant to further reflect on the experience. I thanked each participant for their participation and reminded them of the follow up conversation a few weeks after the interview. I also reminded them of the participatory model where they were co-researchers that contribute new knowledge to the research.

Between two and four weeks after the main interview, there was a 15-minute follow-up interview by phone. In a few cases the follow-up was done completely by email. The purpose of this exchange was to help the participant integrate their experience and find out whether there were aspects of the initial interview, the role-play and our following conversation that led them to emerging new ideas or understanding. I also asked about any changes they noticed in their therapy practice. During that last conversation I was interested to find out additional meaning that came up for the participants during their later reflection and in their own integration process.
I invited the participants to make any suggestions for the research process and to contact me later with any new understanding that arose for them.

**Preliminary Learnings**

I expected that the research process and the meetings and conversations we had together would impact the participants. Throughout the interactions with the participants I was curious about that possible impact and invited the participants to also be curious about that and share their observations with me at any stage of the research. When I noticed an emerging pattern or theme, I shared that with the participant during the follow-up process and checked if that made sense to them.

At the end of our interaction, I informed participants, that if they were interested, I would share with them when ready, the summary of my finding and invite them to respond and comment at that time.
CHAPTER 4

LEARNINGS

Introduction and Overview

The title of the dissertation: “Revisioning Stuckness in Psychotherapy” suggested an opportunity to conduct research into the common ways in which therapists respond to stuckness, and a possible new vision that can enable therapists to respond differently and possibly more productively. The Research Problem asked: “When in the face of stuckness, what tendencies can be seen in therapists' thought process in their choice making between active, change-seeking interventions and passive, encouraging and accepting interventions?” All the following five learnings that emerged from the research respond to this question from different perspectives.

Learning One: Of the Terrible Doubt: Am I Doing My Job? Am I Helping? suggests that when faced with stuckness, therapists often feel dread and shame; feelings that arise from the therapist’s need to know that their work was meaningful and that they were ‘doing something’ to bring change and help the client.

Learning Two: Connecting in the Heart of Stuckness suggests that client’s experience of connection to the therapist can be lost when the therapist was not willing or not able to stay present with stuckness.
Learning Three: If You Don’t Know What You Want, I Cannot Help You!
suggests that therapists may, mistakenly and without realizing, pass on to their client the responsibility for knowing what the client’s wants and needs are.

Learning Four: Who Would Allow You to Slow Down? suggests that at times, the therapist would wish to proceed with a slower pace of therapy yet is conflicted about that.

Learning Five: If I Know the Answer, I Will Give It to You suggests that when confronted with a stuck client, therapists might respond by relating to the therapy as an investigation or a puzzle to be solved. When they could figure out what was going on, they were inclined to tell the client what to do to ‘fix’ the situation.

These five learnings support the Research Hypothesis that stated: Therapists can often be noted as not comfortable with stuckness, tending to want to do ‘something’ even when they do not know what to do. This prompts them to choose active, change-seeking interventions even when their intuition might suggest otherwise.

The Cumulative Learning: Return to the Common Source connects all these learning through the theoretical foundation of the Tao and opens a path towards Revisioning stuckness.

The interview participants are referred to below as P1-P10, in order to protect their confidentiality.

**Cumulative Learning: Return to the Common Source**

Watch the turmoil of beings,
but contemplate their return.
Each separate being in the universe
returns to the common source.
Returning to the source is serenity.
If you don’t realize the source,
you stumble in confusion and sorrow.
—Lao Tzu, Tao Te Ching, Ch. 16

Stuckness is an unpleasant state of affairs that leads to unpleasant feelings for both client and therapist. The various learnings explored the different responses to stuckness reported by participants and the different ways they attempted to avoid the experience of stuckness. Responding to stuckness with dread (Learning One) and demanding that the client know their goal (Learning Three) where surprising findings.

When they did not “realize the source” as the poem above describes, therapists were uncomfortable, blamed the client or demanded that the client will define their goals. They took actions that were unnecessary, premature or even harmful, and avoided simply staying with the stuckness. That can be done for example, by recognizing that it is a natural manifestation of the dark mystery of the Tao or the source mentioned in the poem quoted above.

Returning to the source might be related to reconnecting with the body, as opposed to staying with theory or empty words. The research shows that the participants often reported somatically the unpleasant feelings related to stuckness, which included guilt, shame and blame. They reported physical discomfort, need to move, difficulty to stay still or “butterflies in stomach.”

Returning to the source is simply accepting what is. The serenity prayer asks: “God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.”¹ The dread feeling shown in Learning One, does not allow for serenity. The disconnection from the client in Learning Two, does happen when there is acceptance. Demanding the client knows their needs and
goals as Learning Three describes, does not demonstrate the wisdom of discernment between the courage to change and deep acceptance. In psychodynamic language, returning to the source is taking back projections. When the therapist can sense their own body and dread feeling and return to the source by being aware of their various reactions, internal and external, there is no longer a need to distance the client or demand that they know what is still unconscious. As the Tao says in chapter 45:

The Master arrives without leaving, sees the light without looking, achieves without doing a thing.

The Tao is suggesting that returning to the source requires no action. The few participants-therapists who could tolerate the unpleasant feelings that emerged when faced with stuckness, were able to recognize the potential value of stuckness. In a few instances, they hinted that stuckness could be a necessary crossroad in the process of healing, as implied by these less-known lines of the Serenity Prayer: “…enjoying one moment at a time; accepting hardship as a pathway to peace.”

Other participants reported in the follow-up, about six weeks after our interview, some changes in their understanding of stuckness. P6 reported awareness of her tendency to over-prepare and feeling more comfortable sitting with silence and letting the client find the path. P5 reported being proud of more somatic interventions. P10 said: “I've been trying to cultivate more self-compassion and respecting more the timing and pacing of my clients.”

Learning One: Of the Terrible Doubt: Am I Doing My Job? Am I Helping?

Therefore the Master acts without doing anything and teaches without saying anything.
Things arise and she lets them come; 
things disappear and she lets them go. 
She has but doesn't possess, 
acts but doesn't expect. 
When her work is done, she forgets it. 
That is why it lasts forever. 
—Lao Tzu, Tao Te Ching, Ch. 2

Learning One suggests that when faced with stuckness, therapists often feel dread and shame. These feelings arise from the therapist’s need to know that their work was meaningful and that they were ‘doing something’ to bring change and help the client. In a stuck situation it is hard or even impossible to get feedback that confirms these. Participants reported feeling shame when their inner voices expressed criticism or doubt about their professional abilities or skills. These inner voices got even louder when faced with stuckness. The participants tried to avoid the feelings of dread and shame by taking decisive and goal-oriented actions in their therapeutic interventions.

**What Happened**

After each role-play, I asked the participant to take some time to reflect silently, and then we explored what was evoked for them by the experience. P6 said “I guess a premature feeling of tiredness and exhaustion. Burdensome. Am I going to, in time, think ‘Oh God, I’ve got Rulik this morning.’” P2 responded: “The most powerful feeling I had was dread, anticipating stuckness.” Her voice dropped when she said this, she looked down and spoke slowly. Then she added: “It had to do with me feeling stuck with him, and not with him.” P5 was concerned about being effective: “The big thing that came up for me is I was, I felt myself chasing around trying to come at all angles. I was not very effective at just sitting in the stuckness.” P1 admitted: “You see how I am triggered even from a 30-minute role-play.”
It turned out that just reading the vignette already evoked the feeling of dread, as happened for P2 and P7. P2 said: “The proposal of coming into a session where we will do 20 minutes with a client who is stuck, definitely brings up dread.” P7 said: “When I read the vignette, I was nervous because the vignette really blocked off a lot of dead ends. Right? ...so, it felt very limited. I feel like what stands out for me is I may have been less inclined to explore and be patient if I had truly been seeing you for a year.” She was quiet and introspective and a few minutes later added: “When I start to feel stuck in real life with my clients I think it’s more my fear or impatience that feels I want to hurry things along or have something show up.”

When describing a stuck case, P4 said “its teeth pulling, and I am pulling teeth. I am a dentist; we don’t know which tooth it is. So, we got to pull them all. But I don’t want to pull them all, it is very painful.” This was one of the more extroverted participants, and she spoke forcefully and decisively. Later in the interview she said: “I have clients actually that are doing this, because they are paying, I cannot hear their pain… and I feel very guilty about that.” She went on describing a client who cannot connect, in her words: “…not giving anything of themselves” and she concluded: “…but if they can’t, I don’t know what I can do.” Then she turned to me and asked what I would do in such a case.

Other participants repeated the same theme. P8 said: “What stands out the most was the challenge of stuckness. Like, ‘Oh...That’s like pulling teeth.’” and P6: “How hard it would be, I’m pulling. I’m gonna be pulling for a long time… but I guess for me there’s some element of anger or challenge in it. And I don’t find anger or challenge useful in a room.”
Exploring the nature of stuckness, P4 said: “Stuckness is a form of despair.” Her facial expression reflected her own despair.

P3 described her doubt: “But there’s kind of a constant doubting of it. I think because of the culture, not just the larger culture, but the psychotherapy culture here. The progress oriented…” P8 shared his doubt: “I can notice some layers of fear, ‘Oh, am I going to be good enough? I’m not going to be effective.’” Talking about his feeling towards the client in the role-play he said: “Do I have the willingness and capacity to go and stay with the depth of where he’s at?” and later in the interview: “…it feels awful at the end of the session feeling like I didn’t do anything. The client didn’t get any value out of it. It feels yea, like wet noodle therapy.” I never managed to unpack the meaning of that image, but it surely did not feel good to him.

In the questionnaire responses, 31% of the answers indicated that stuckness is the responsibility of the therapist. Over 10% of respondents offered active solutions to the stuckness, although that was not asked for. Over 50% indicated some notion of blame towards the therapist, the client or both.

How I Was Affected

When the word dread was first mentioned in the second interview, I was surprised. As that word or allusion to its meaning repeated in almost every interview, I was no longer surprised and gradually felt more disappointed. I was especially sad to hear of specific client relationships that were weighing so heavily on the therapist. Clearly such a therapeutic relationship was in itself stuck, adding to whatever stuckness the client brought to the therapy in the first place.
In two interviews I retreated deeper into my own stuckness during the role-play, when I experienced the therapist’s frustration, fear or anger. That felt safer than facing a therapist who dreaded the connection with me. The therapist’s dread felt as an unconscious request to be taken care of. Being in the client position that evoked in me anger and sadness.

Throughout the interviews I got to know the work of each of the participants, and my appreciation for their work grew. Thus, it was painful to witness the various ways these seasoned good professionals avoided dealing with stuckness and in the process, lost the connection with the client.

**Interpretation**

Learning One suggests that when faced with stuckness, therapists often feel dread and shame. These feelings arise from the therapist’s need to know that their work was meaningful and that they were ‘doing something’ to bring change and help the client. This is a direct response to the question asked in the Research Problem: what tendencies can be seen in therapists’ thought process in choosing interventions when faced with stuckness? Several participants indicated that when the therapy was stuck, it was hard for them to feel effective and fulfilled in their work. It was hard for the therapist to know that they were doing good work. As P2 said: “Because I have my own feeling of being stuck. I have to do a lot of internal self-soothing just to be with a person wherever they are stuck.” Patience is a necessary professional skill. Without it, the therapist’s unconscious need for approval prompts active interventions, attempting to get the stuck client to move. As P1 said: “I would like to find ways to move things. Something has to change. I am a change junky…I will find myself in a super active modality.”
From the questionnaire results mentioned above, it appeared that therapists feel responsible for the stuckness, often respond with blame or guilt, and are often inclined to take an action to confront or oppose it.

By many accounts, shame was identified as the hardest emotion to experience as according to Nathanson, it attacks the very sense of self and its integrity. People are often reluctant to admit shame and use other words such as self-conscious, embarrassment or guilt to describe their feeling. Several participants used dread and shame related words interchangeably or in the same phrase. Shame is a very powerful motivation and most people would do anything to avoid it. The participants have reported inner voices saying things like: “You are not good enough,” “You are being paid to do this” and “You should have figured this out.” Such voices are implying directly or indirectly that the therapist is not up to the real or imagined expectation of the profession and thus not good enough. My interpretation is that such voices are the driving force behind choosing to take an action even when none is called for.

**Imaginal Structures in Use**

The caretaker was often evoked for me in response to the dread expressed by the participants, wanting to care for the difficult feelings they had. During the role-play, the therapist’s apparent need for approval appeared to me as role-reversal and led to my feeling of anger or resentment. During the interview, the imaginal structure of the caretaker led to the inner teacher wanting to share and educate. I was generally aware enough to avoid that, however, in a few interviews, the participants actually asked me how I as a therapist, deal with stuckness and what would my approach be in the cases we explored.
The social justice fighter also came up to protect the neglected clients who faced the dread of the therapist. That part in me could not bear the injustice of the vulnerable stuck client facing the anger and fear of the therapist. These negative feelings of the therapist were often camouflaged as an all-knowing professional advising on or directing the right course of action.

When Odysseus went down to the underworld, the house of the dead, he was faced with the spirits that dwell there. They were all thirsty for the blood he prepared for the sacrifice on the altar. Circe instructed him to stand with his sword and prevent the spirits from drinking the blood until Tiresias, the blind seer came to instruct him about his future journey. This is the imaginal structure of waiting in stillness while facing the possibly dreadful unknown.

The title of this learning is a quote from a poem by Walt Whitman. There I find the imaginal structure of doubt in external manifestation that can lead to deep inner search, where one can let that doubt be present and fully felt. Whitman’s answer is in embracing the doubt and the not knowing and finding solace in deep human connection: “He ahold of my hand has completely satisfied me.”

Theoretical Concepts

The second poem of the Tao-Te-Ching quoted after the learning title above, is a clear description of the Taoist principal of Wu-Wei that is sometimes translated as doing without doing. Acting without doing and teaching without saying anything is a great mastery that requires first being at peace with not knowing. That means not focusing on diagnosis or treatment plan, not assuming what is good for the client and being open to a myriad of optional paths. The Tao states: “Things arise and she lets them come; things
disappear and she lets them go.” As McGilchrist has suggested, this requires allowing the right brain to participate in the process. The left-brain (and contemporary western cultural bias) is focused on separate, out of context details. It is also goal oriented and values efficiency. The right brain can see the whole and looks at all things in context, connecting separate details into larger meaning.

Several participants shared the connection between their feeling of dread and their sense of responsibility for the therapy outcome. The master in the poem “has but doesn't possess, acts but doesn't expect.” This is not a detached or a passive stance. It is involved and active, yet aware of a larger context within which therapy is happening. That allows for “forgetting the work when it is done” and not feeling blame and shame that negatively affect the therapy.

Johanson and Kurtz emphasize the need to relinquish control: “To do this requires the ability to give up not only personal agendas but also therapeutic agendas.” Research participants often linked the dread feeling to their need to follow therapeutic agenda as prescribed by their modality or professional education and training.

Yalom says that therapists are faced in their daily work with idealization and devaluation, both projected by the clients. He suggests that without awareness, these lead to both self-aggrandizement and self-doubt and create states of instability in the therapist’s self-confidence. He links these inner states to the isolating nature of the therapy work and recommends going back to therapy, consultation or support groups. His suggestions were echoed in P6’s words: “We live in such an isolated world as clinicians we don’t, we’re not good about sharing our work. That’s one of the reasons I was, you
know, I was anxious actually to participate in this. I don’t think that we’re very generous and I wish we were more generous about sharing.”

Some of the literature referring to dread in countertransference, links it with erotic feeling, as suggested by Jody Messler Davies. Yalom suggests that learning to see the therapist’s feeling as a possible projective identification is a basic therapeutic consideration, i.e. asking oneself: “Is it my feeling or the client’s feeling?” This learning suggests that it might be more productive to see the dread felt and expressed by the participating therapists as actually the feeling of the stuck client.

The Law of Three perspective on this learning suggests that the therapist who feels dread is unable to progress any further using the processes most familiar to them, i.e. growth and destruction. Moving forward requires a change of triad or process. The therapist needs to move away from the active-first force position (as the case is in growth and destruction triads) and explore other triads that can bring change to the therapist-client relationship and to the therapy process as a whole. The therapist can remain the expert on the higher level of the triad yet allow the client to initiate by asking questions and expressing needs. That can lead to a triad of refinement or digestion. A further option is to initiate the process from below, learning to focus on the higher possibilities of the yet unseen and unexpressed life force in the client. That stance of a passive-first force requires great humility and patience on the part of the therapist and possibly enables a process of healing. The very nature of this process requires trust in unknown outcomes. It requires ongoing presence and curiosity that asks: “Let’s see what gift the next moment brings or what is being called for.”
Validity Considerations

Long before this research and throughout my supervision work, I was aware of therapists, especially beginners, being preoccupied with results. So not knowing what to do and wanting to do something was part of the expected results of this research. However, I had no expectation of the repeated expression of dread by the participants. Thus, the unexpected nature adds to the validity of this learning, even when taking into consideration the small sample. The co-researcher independently noted the same prevalent expression of dread and shame.

General validity considerations that apply to all the learnings are the limitations of the sample. There were 10 interviews, mostly with experienced therapists recruited through my professional network. The sample covered as wide as possible range of modalities, ages, gender and licenses. Yet, all participants were from Northern California and mostly from the Bay-Area. This is a specific professional sub-culture and is not likely to represent the profession as a whole. The demographic details of the participants are in the Summary of the Data (Appendix 10).

Another general validity consideration is the dual role of the researcher being also a client in the role-play. On the one hand, being a client provided much more direct data, on the other hand it represented a dual relationship with the participants leading to the typical complexities of dual relationships. This issue is discussed in more details in the following learnings where it is more relevant.

The questionnaire, which I used to prepare for the actual data collection, included 84 responses and covered a much wider demographic variety. The sample was significantly larger than the suggested minimum of 50. There was a wide variety in
degrees, education, and years of experience, age, gender, modalities and locations, including some respondents from other countries. Most of the respondents live and work in the San Francisco Bay-Area. Most of them have some training in mindfulness-based modalities. Details of the questionnaire participants’ demography are in the Questionnaire Responses (Appendix 9). It is possible that a random sample, spanning more states and countries would yield different results.

The researcher and the co-researcher did the thematic analysis of the questionnaire independently. The fact that both came to very close definitions of themes and to similar analysis of the responses, adds to the validity.

**Learning Two: Connecting in the Heart of Stuckness**

It doesn't interest me if there is one God
Or many gods.
I want to know if you belong -- or feel abandoned;
If you know despair
Or can see it in others.

—David Whyte, *Fire in the Earth*

Learning Two suggests that client’s experience of connection to the therapist can be lost when the therapist was not willing or not able to stay present with stuckness. When the therapist who was faced with stuckness, went their own way by trying to generate change and action, or tried to protect themselves by avoiding the feelings around stuckness, the client felt abandoned or left alone. Even their stuckness was not accepted or acknowledged by the therapist to whom the client came for help. Participants often indicated that they were feeling sadness and loneliness and were looking for connection with the client, at least in part to serve their own need. Some participants were not clearly aware whether these were their feeling or the client’s. Several of the participants noted as
significant, the moment when they finally were able to make eye contact with the client. Often that came after numerous attempts, and the therapists were feeling relieved as a result.

**What Happened**

In only two of the 10 role-plays was the therapist able to stay present with the stuck client and with the feelings that *stuckness* evoked. These two therapists remained interested and connected and conveyed a sense of acceptance. In all the other eight cases, the therapist disconnected from the client in one of two primary ways. Some were busy trying to do something that would get the client unstuck, others were trying to get eye contact or reassure themselves that they were doing their job by getting some feedback from the client.

Responding to my questions about types of interventions, P1 said: “People are stuck in relationships; I move them one way or another. I am more of the ‘shit or get of the potty’ kind.”

When asked about the nature of *stuckness* she said: “For me, stuckness must be a temporary phase. It must be something to recognize, diagnose and break through. Even if it means cutting it, cutting it, cutting it.” The co-researcher commented on this response: “I feel the threat that she will violate (me) through her zeal, however well-intentioned it may be.”

P2 was doing the other kind of disconnection mentioned above, by taking care of herself: “I was mostly looking for the connection. I have to do a lot of internal self-soothing just to be with a person wherever they are stuck.” Later she said: “I would be gasping for breath because I could feel the stuckness” at this point she actually gulped for
air and continued: “It felt like he was just wasn’t breathing, he wasn’t taking anything in.”

When we explored various interventions in therapy and specifically in the role-play, P2 indicated her awareness of her tendency to make unconscious responses: “So that intervention came from outside of the room, and nothing to do with what was happening in the moment for me and him. It had to do with me feeling stuck with him, and not with him.”

P6 demonstrated using both styles of disconnecting. First, seeking connection for herself: “The significant moments for me was when I could get an eye contact.” And later, reporting on a successful active intervention: “I really wanted her to leave because I was so tired of her that day. I just really wanted her out of here.”

When asked about her feeling during the role-play P4 said: “It’s a little bit all this resistance, which negates everything. It puts one off.” I wondered how the client feels when the therapist is put-off. The co-researcher commented on this interaction: “The alliance is ruptured when the client is not or cannot be ‘a good client.’”

When we discussed various intervention styles, P5 said: “It was surprising to me in some cases that questions that I did not mean to cause discomfort were causing discomfort.”

P8 also demonstrated both styles of disconnection. Taking care of his own feelings: “It’s a lot for me. I can take sadness or lot things, but anger directed at me…, at other people I’m fine but at me, I’m like, ‘OK…’” His tone of voice indicated the boundary setting. He also demonstrated rejecting the client’s stuckness by requiring deep
conversation: “Oh I’m doing my job. I’m not going to tolerate the superficial conversation.”

P9 also indicated both ways of disconnecting: “I would not work with somebody who wouldn’t do the exercise.” And later: “I will react to passive anger in a way that’s not comfortable for me particularly.” Later in the interview she expressed another perspective, acknowledging the importance of the connection: “If the therapist is not curious, I don’t know how the therapy…, you know, it’s mechanical then.”

When we explored the conflict that arose between therapist and client during the role-play, P10 described his thought process: “Initially I took it wrong: ‘Oh, I did something wrong’ and ‘Oh, like that was a violent act against you.’ then after I think I was able to calm myself down and then I felt, ‘OK I can see this really objectively,’ ‘No, it’s not me, so let’s figure out how that was to you.’ An issue that’s not felt. And so, I think, I didn’t do this consciously, but I felt like I need to repair really quick.”

When asked about the cultural pressure to get unstuck or to make progress, P10 reported about pressure from clients to perform or show results: “Yes. Definitely. ‘What are we doing?’ I mean that’s what they are, sometimes I have to start… It’s like, ‘What are we doing? I don’t get this. I don’t see the progress.’” The co-researcher commented on this cultural pressure: “When I contrast this with a more Buddhist approach, I find it disturbing. If we join in with the compulsion to be ‘doing’ for its own sake, such an important opportunity is lost. There’s too much of import in what ‘is’ to be rushing pell-mell away from it.”

P3 was one of the two therapists that remained open and accepting throughout the role-play. When we explored the feeling of stuckness in the role-play she said: “I felt self-
conscious when I wasn’t matching his energy.” And later: “I get stuck. So, what that means to me is I can’t really access, it’s like I don’t have access to my confidence or my inner knowing or my self-trust. It’s like part of me is like offline and I’m just like in terror and self-judgment and fear.”

P3 clearly demonstrated a high level of reflexivity. It seems that her self-awareness came first, then her self-acceptance, and through that she was able to help the client feel accepted. In the client’s role, I felt the warmth of the connection and held to it as to a lifesaver.

The other session where I, as a client felt fully seen and accepted was with P7 who said: “And often this is a blind spot, getting impatient. What is the outcome I am desiring? Instead, focus on the outcome the clients desiring. Maybe this is me needing connection for the client.” She owned her needs and through that, was able to convey full acceptance of the client.

**How I Was Affected**

My primary response as the interviewer inquiring about participants’ work, was sadness. Every time I sensed the therapist had put their needs first, I felt sorry for the client. Often, the sadness was followed by anger. I felt the abandonment of the client and responded from my own personal experience of attachment wounding; being the angry baby who is not held or not seen.

As the client in the role-play, the sadness was far deeper and far more palpable. I retreated further into the stuck depression, avoided eye contact, even when I sensed that the therapist was seeking it, and turned completely inward, hiding in the loneliness of the
stuckness. Some of the participants had noticed my response and checked what was happening.

There were two general trends in the participants’ attempts to repair the connection. Some were able to convey their empathy and tried to stay connected, focusing the therapy interaction on the client. I then felt seen and was able to come a little out of the shell. It felt like the sun came out for a moment behind the clouds. Other therapists would respond in a more cold and formal way. Many of them reported later during the interview, that they responded from their own countertransference. Often, they used other terms such as self-conscious, dread, discomfort and put-off, to describe their own negative reaction to the stuckness of the client. When I noticed such reactions while role-playing the client, I sometimes felt anger, and in two interviews ended up expressing it. In other cases, I retreated further and further inward to a place with no hope and no feeling. Such dark inner place reminds me of bad migraines or seasickness. These are the closest personal experiences I associate with the “Dark Night of the Soul” the deepest level I know of despair and hopelessness.

In the two interviews where I felt seen and accepted, I did not want to end the role-play. I felt it was a precious therapy session that was healing my own deep sadness about disconnection. While part of me was aware of time and of the interview framework, a younger part wanted to stay connected with the good therapist and just feel seen and held in safety.

**Interpretation**

Learning Two suggests that client’s experience of connection to the therapist can be lost when the therapist was not willing or not able to stay present with stuckness.
Various conflicting forces impact the therapist who is faced with *stuckness*. By their nature and training, they are empathetic and aware of the client’s deep suffering that led into *stuckness*. When that awareness did not include some level of detachment from the client, the therapist could easily fall into projecting their own personal suffering onto the client. As any average person, it is likely that the therapist had their own attachment wounding.

Depending on the therapist’s temperament and level of awareness, they resorted into their favorite (unconscious) defense strategy. Some therapists chose the more active route, trying to tell the client what to do to get out of *stuckness*. Often the client experienced that type of prodding to change, as judgment.

Other therapists chose a passive defense by detaching themselves, at least emotionally from the suffering of the client. These were, in the examples cited above, the cases where the therapist was seeking eye contact or other signs of reassurance from the client, and often giving up the connection. Some participants were able later in the interview, to name their own experience of wounding or their projections. Shame often develops from not being seen and is defined as the “Breaking of the interpersonal bridge.” 15 Thus, this passive detachment by the therapist is equally shaming for the client, who is likely to get the unconscious message that they are not worth staying in touch with, and that their suffering or *stuckness* makes them unlovable or even untouchable.

*Stuckness* often leads to long silences. Sitting with a client in silence is a form of intimacy. It allows the client to feel accepted and seen, possibly for the first time in their life. Following being accepted by the therapist, the client can slowly start to accept
themselves and the negatively charged parts of their life. The silence allows the therapist to connect more deeply with their own feelings, with the client and with their reactions to the client, all excellent source for therapeutic inspiration. Yet many therapists were not comfortable sitting in silence and often said something just to restart a conversation. The breaking of silence often breaks the intimacy between therapist and client and leads to emotional disconnection. The silence can allow the client to go deeper and possibly discover a new path out of stuckness. Thus, breaking the silence perpetuated the stuck situation. Yalom says: “Beginning therapists must learn that there are times to sit in silence, sometimes in silent communion, sometimes simply while waiting for patients’ thoughts to appear in a form that they may be expressed.”

**Imaginal Structures in Use**

I experienced the felt abandonment of the client directly during the role-play and indirectly from the reporting of the participants about cases they worked with. That evoked the imaginal structure of the orphan child, who did not get enough mirroring and was locked in their internal depressed world. This imaginal structure is explored in The Stone Child, a story about a rejected orphan that does not get any warmth from other tribe members. He is chained to a stone that he drags around, as he is mocked and scorned by the other tribe members. Eventually his despair gets so deep and overwhelming that he falls asleep on his stone. The warm tears he sheds during his sleep fall on the stone and crack it. Out of the stone comes a beautiful young girl that becomes his true companion and leads him to freedom. The story demonstrates redemption of the orphan through their utter despair. The work of Miller and Duncan suggests that therapists do not need to rely on such rare exception to the destiny of an orphan as in the story of the Stone Child.
Their research suggests that consistent attunement and responsiveness to the need of the client is in itself healing.

Another orphan child is Andersen’s Little Match Girl. She freezes to death after striking all her matches and seeing her good grandmother in their dim light. The protective image of her grandmother is more powerful and more attractive than the instinctive drive that could have helped her knock on some door and maybe find safety. Good therapy that recognizes this imaginal structure in the client, can help them connect the hope invested in the grandmother image to actual action in real life. To help in that way, the therapist needs to connect with the client in the heart of stuckness and despair.

Righteousness was evoked by the participants who followed their theory or methodology instead of responding to the apparent need of the moment. Bly describes the White Knight who is the pure one and follows the rules to the dot. This contrasts with the more advanced Red and Black Knights who have more awareness and flexibility to respond to the needs of the present with love or with courage. Several participants mentioned the advanced level required for staying with stuckness, or the courage needed to not follow the mainstream. These are attributes of the Black Knight that is aware of his shadow and accepts his own flaws.

**Theoretical Concepts**

If you want to become full, let yourself be empty.

—Lao Tzu, *Tao Te Ching*, Ch. 3

The therapists that respond to stuckness with their emotional needs or with their theory are too full and are not available for connection. Their heart and mind are full of ideas, rules, theoretical biases, self-importance or fears. The client feels that fullness,
often unconsciously and does not try to connect. The Tao recommends emptying.\textsuperscript{21} Johanson and Kurtz suggest that “Becoming mindful has to do with letting go of ambition to control, solve problems or achieve something.” \textsuperscript{22} They also suggest replacing Why questions with simple curiosity about the moment and focus on the body as the container.

The \textit{Law of Three} offers a perspective on both styles of defenses used by the therapists to disconnect from \textit{stuckness}. Those therapists taking care of their own emotional needs using the client are participating in a \textit{triad of growth}, projecting their loneliness on the client and using the client as \textit{matter} to prop-up the therapist by repeating old forms and procedures.

The therapists putting theory first, above presence or love, were involved in a \textit{triad of crime}. Reducing the life force of the client (and their own) to inert \textit{matter}. The inability to be in the present moment with the suffering of the client, leads to reduction of the situation into a diagnosis or other labels. Such reduction might make the interaction more tolerable for the therapist, yet it is devoid of any potential for healing.

Those therapists who were able to stay with the \textit{stuckness} and the pain it evoked, were involved in a \textit{triad of healing}. The client is the \textit{matter} or the lowest level of the triad, the same position as in the \textit{triad of growth}. However, unlike the previous cases, this \textit{triad} starts on the lower level. The client’s needs are what initiate the process. Through the acceptance of the therapist there is an opening to reorganize the \textit{matter} into new \textit{forms} that invites a renewed life force. These new \textit{forms} can appear as new understanding or as new meaning found in the current situation. A complete acceptance and openness to whatever comes, is a necessary pre-condition for a \textit{healing triad} to proceed or even to start.
Validity Considerations

The comments of the co-researcher were based only on the verbatim transcript, and where matching my own responses. In several places the co-researcher expressed feelings that I had as the client during the role-play. In several cases, the co-researcher could get into the client role and feel their own strong emotions such as shame, anger or rejection, in response to the therapist’s comments or overall stance.

The research design that called for the researcher to first play the role of the stuck client and then, conduct the interview, is a double-edged sword. On the one hand, going deeply with every interview into the role described by the vignette, provided me with direct emotional feedback about the different interactions with each therapist. I was very aware of my own feelings that were different in every interview.

On the other hand, this research design implies a greater level of subjectivity, compared to a design where the researcher is only interviewing the participants. I had to trust my therapist’s skills and my consciousness, which helped me raise awareness of my own feelings and the feelings of the other simultaneously, and at the same time, make some more detached or objective observations, thus increasing the scope of emotional data that went into the research.

Specifically, for this learning, the ability of the participating therapist to connect with the role-playing client might have been affected by the fact that I also played the researcher role. The participants varied in their ability to fully engage in the role-play, although all of them demonstrated their style and preferences as if it was a real session. At the same time, I have to assume that the dual role of client and researcher might have affected the participants’ ability to more fully connect with the client.
Learning Three: If You Don’t Know What You Want, I Cannot Help You!

Stand still. The trees ahead and bushes beside you
Are not lost. Wherever you are is called Here,
And you must treat it as a powerful stranger,
Must ask permission to know it and be known.
…
Stand still. The forest knows
Where you are. You must let it find you.

—David Wagoner, Collected Poems

Learning Three suggests that therapists may, mistakenly and without realizing, pass on to their client the responsibility for knowing what the client’s wants and needs are. Several participants stated explicitly that the client must be able to clearly express their wants and needs before therapy can start. Some used strong verbs such as demand and require. When confronted to clarify their understanding of therapist’s responsibilities, most participants declined to plainly say that they would terminate therapy with a client who cannot state their wants or needs, yet, they indicated their preference to avoid situations where the goals were not clear, and they were reluctant to take part in clarifying the client needs or their goals.

Only a few therapists were willing to wait and help the client find, and later articulate their wants and needs. These therapists were looking for the last embers in the fire of life-force and were patient enough to gently blow on them for a long time. As one of the participants stated: “If you sit with people long enough, what comes up is usually what they do want.”

What Happened

Reflecting on stuckness in the role-play case, P4 said: “I have a problem. I don’t meet with a client unless they do define something. They can take 10 years to do that, but
there must be more getting on board to go in some direction.” In her framework, it was the client’s responsibility to set a direction and work towards it.

When we explored intervention styles and setting the direction of therapy P4 said: “So I would raise it as a challenge to him. When you can come up with something that you want to change, I will interact with you on that. Until then, I can’t help you.”

Towards the end of interview, after exploring our different styles of work, P4 seemed to have taken a different approach: “I am amazed that if you sit with people long enough, what comes up is usually what they do want.” Which sounded very patient and permissive. Yet, a few minutes later she added: “We need to get the guy to admit there is something he likes to do.” She was clearly conflicted in that area as only a short time after she referred to both approaches in the same sentence: “Because if therapy is about some kind of change and he does not care to change there is a problem. It is my problem as a therapist not his problem.”

Talking about the shared responsibility in the therapy process and specifically about giving homework and setting the direction of therapy, P1 said: “…and I mandate it. I do my job, you (referring to the client) have to do your job.”

Exploring the causes of stuckness, P6 who was coming from a more cognitive approach, said: “He can’t think. And when we can’t think we’re stuck.” She was saying that the client’s inability to think causes stuckness in the therapy and also affects the therapist.

P5, who was generally patient and tolerant, commented about the role-play: “I tend to work with folks who have more concrete goals or can create more concrete goals earlier in the process…It’s worrying to me that he doesn’t know why he’s here.”
She was conflicted about the client’s choice: “I don’t necessarily feel when I sit with him that he’s making a choice. I don’t feel necessarily that he has chosen boredom. I feel that he has run from fear and ended up in boredom. So, I am OK clinically if he ends up in boredom as long as he is choosing boredom.”

As our exploration of *stuckness* during the interview deepened, she gradually changed her perspective: ”I wonder if I had taken it up level on meta, if I had said: I’m curious about what you’re feeling right now, and I don’t want to push you. Because it feels like this is a tender, fragile moment.”

When we recognized a moment of repair she made during the role-play she became more emotional and involved: “I feel really proud of us that we’ve built a relationship over, oh god I’m tearing…I’m not sure what this person wants and I wish I knew.” She was gradually taking back the responsibility for the therapy.

When talking about roles and responsibilities in therapy, P9 quoted one of her mentors, David Burns: “You know I can listen to this or we can do something about it. Which do you want?” And she followed with her own conviction: “…I was not focused really on treatment but on getting unstuck because …we have to agree that you want to be unstuck and then it’s treatment after that.”

She supported her conviction about the need for goals by stating: “When somebody keeps coming back week after week you have to believe they have a goal.”

However, later in the interview she was more willing to open up to alternative views: “When people look for therapy it’s because they changed already but they don’t know how to show the world. So that’s the question when you can find it.” Suggesting it is not the client’s responsibility. And she stated her discomfort with stepping outside
what she saw as mainstream:”…not being bound by a theoretical orientation especially when it doesn’t work anymore, or it has garbage jargon. You know? But that puts you outside the conventions sometimes.”

During the role-play, P10 took a very similar approach to David Burns. When the client kept changing the topic of conversation out of discomfort with the therapist’s active approach he said: “Is this really what you want to talk about today?!” After he repeated similar interventions a few more times, I (playing the role of the stuck client) said that I did not feel safe. He immediately drew back and tried to repair the relationship. Later he told me that he thought that my response was a scripted planned part of the research. I explained that I was fully embodying the role-play character of the vignette and tried in each interview to respond to the specific session as led by each therapist. He responded: “…I realized how that was triggering. So that stood out as ‘OK there’s some wounding there.’”

I was aware that if this was actual therapy it would be hard to repair and most likely I, as a client, would have looked for another therapist.

Invited to define or describe stuckness, P7 said: “Well, something is getting in the way from the client moving into, towards the goal they have set for themselves. It’s a block to movement.” Describing her overall approach to stuckness she said: “…letting the client tell you, right, how to heal.” As the interviewer and as the role-playing client I felt the spaciousness and permission to move towards healing. Possibly the key to that spaciousness was P7’s attitude: “Because I also realized I’m not necessarily a gauge of what the client needs or is getting or not getting.”
P3 also expressed a different approach to goals, wants and needs: “I think of stuck as, like, when you want something, but you can’t get it? But I have no idea what he wants yet. So, I don’t know.” She was patient and curious and took all the time she needed:

“But it’s nice to just have 20 minutes where I’m just like ‘Ok it’s not my responsibility, I can just be with him.’” That stance allowed her to fully be with the client and even enjoy it: “But I don’t think I wanna do anything differently. I liked how I was with him. I liked being with him.”

P3 was manifesting the teaching of the Tao: “When nothing needs to be done, nothing is left undone.”

How I Was Affected

Hearing in several interviews that the therapist expected the client to set clear goals, was one of the most surprising findings for me. My first reaction was puzzlement and in some cases disbelief. In my work as therapist, I also explore goals, primarily from a solution-oriented perspective. Especially in the early stages of therapy, the client and I try to define what will constitute a successful conclusion to our work. However, I never see goal setting as the responsibility of the client. Rather, I try to invite their unconscious mind, to join in on a discovery journey towards deep needs that were not met. This is my personal bias, yet it is consistent with other modalities, for example, Person-centered counseling as presented by Mearns.

When the direct demand to state goals came from P10 during our role-play I felt frightened and disempowered. I found myself retreating further into my depressed and protected inner world, yet, he kept pushing. Eventually I told him that I felt unsafe. That
restored our emotional connection to some extent, but I felt that I was doing his work for him, and the session never got back to deeper exploration.

When other participants declared the need for the client to define their goals or state their needs, I often felt invaded and angry, imagining how I would feel as their client. In several interviews I wanted to argue about that claim. However, when I remembered that I am conducting a research I took some deep breaths and managed to stay in the more objective interviewer role.

**Interpretation**

Learning Three suggests that therapists may, mistakenly and without realizing, pass on to their client the responsibility for knowing what the client’s wants and needs are. In many theoretical frameworks, the therapist is warned against telling the client what they feel, need or want. That can easily put the therapist in a bind: they have to lead and direct, yet they should avoid setting the goals.

The greatest therapists, regardless of modality, were able to sense the unconscious needs of the client, and patiently, through questions and other indirect methods, help the client come to realize, express and accept their needs and wants. That kind of ownership leads to greater sense of agency. This is clearly an art and not a methodology or technique. Sensitivity and creativity cannot be taught or imitated.

It is thus understandable that some of the participants required the client to state their goals. Otherwise, the therapist is left on the precipice facing the unknown. I was encouraged to find at least two of the research participants that were more comfortable in that edge position. I was even more encouraged that some of the stricter participants, who
started with a clear demand for stated goals, were able to soften through our interview and consider a more open approach.

**Imaginal Structures in Use**

Requiring the client to know their wants and needs evoked the imaginal structure of the magic word or spell. When Ali Baba said *Open Sesame*, he knew his goal and had the instructions to go ahead with it. There are similar scenes of gate opening in *The Lord of The Rings*, in the *Odyssey* and in other myths. However, these myths are *hero journeys* and these moments are from a later stage of the journey: taking the actual path. During the initial refusal of the call, the client/hero knows neither the goal nor the magic words. Gandalf was dependent on Frodo to want to go on the mission and he waited a long time to introduce the goal only at the right moment. Yet the therapist/magician must do plenty of work to help the client/hero get to a place of commitment where the client can start to actually follow the goal. If knowing the goal comes as a demand, the client is likely to retreat, refuse the call more forcefully, which often leads to an aborted mission.

Vasilisa is sent on her journey by threat and fear. When she meets Baba-Yaga the witch, who asks: “Why do you think I will give it (the fire) to you?!” She is met with terror that prompt her into selfhood that expresses itself bravely: “Because I ask!” The witch then tells her that she was lucky to have known the right answer, otherwise she would have been eaten.

The evil stepmother and Baba-Yaga can in a stretch, be seen as therapists who demand that the client would know where they are going to. My preference is to associate the therapist role with the doll in Vasilisa’s apron pocket. Vasilisa got that doll from her real loving mother, and it helped her find the way by suggesting at every junction: “Turn
left” or “Go straight.” The doll does not say “When you know where you want to go, I will show you the way…”

**Theoretical Concepts**

The Tao says: “A good traveler has no fixed plans and is not intent upon arriving.” Requiring a goal for therapy is putting the cart before the horse. Such a demand implies distrust in the healing power of the client’s soul and the therapy process itself. It is a plausible assumption that the client’s more innate life goals were faced with ample opposition, which led to abundant suffering, to the point that even the consideration of these goals is avoided. In other words: these innate goals became unconscious. In the Ericksonian tradition this idea is expressed in the phrase: “The presenting problem is an attempted solution.” I.e. the client that comes to therapy stating: “I want to stop drinking” is not aware that drinking was an attempt to solve a deeper unconscious issue, possibly loneliness or emptiness. Thus, the therapist’s requirement for a goal can only lead back to the presenting problem, which in all likelihood is not the real issue. Therapists that are more comfortable with less control, express their trust in the client’s process and through that, allow deeper layers in the client’s psyche to slowly emerge into the client’s more conscious awareness.

From the perspective of the *Law of Three*, focusing on a goal is a process of growth. Essentially this is a repetition of a known formula or procedure while expecting a known result. It creates more of the same but cannot lead to any essential change. The active therapist is in the expert position (P1 saying: “If I know the answer, I am going to give it!”) and cannot be with the unknown or let the client lead the process from within.
The other alternative, demonstrated by P3 and P7 is to initiate from below by showing willingness to be with the unknown and trust in the client’s process. This is the process of healing or invention, where inert matter reorganizes itself into new forms thus bringing new life energy. These new forms manifest as new understandings, viewpoints or attitudes that the client finds. They could also manifest as newly found acceptance of limitations or of past events, both opening a path for the client to live their life more fully with whatever it brings. Naturally, the therapist needs to feel and express acceptance of the client as they find them before such new forms can be found.

Validity Considerations

As in Learning One, the repeatedly mentioned demand for known goals by the participants, was not an expected finding and took me by surprise. The co-researcher independently noticed this repeated theme. Both the unexpected theme and the confirmation by the co-researcher add validity to this learning.

The dual role I played as both the client in the role-play and as researcher is an ongoing validity consideration that was discussed in previous learnings. Specifically, for this learning it does not pose a problem. The participants that demonstrated the attitudes pointed by this learning did so both in the role-playing session and in the interview. They did it in a variety of ways and styles. In the session, demanding from the client to clearly express their goal or needs and most strongly as P10 did, pressing the client to focus on goals. In the interview, various participants said in so many ways that the client needs to know their goal.

The co-researcher also noticed the variety of expressions pointing to this learning. The variety supports the validity of this learning.
Learning Four: Who Would Allow You to Slow Down?

Start close in,
don't take the second step or the third,
start with the first thing close in,
the step you don't want to take.
—David Whyte, *Fire in the Earth*

Learning Four suggests that at times, the therapist would wish to proceed with a slower pace of therapy yet is conflicted about that. Most participants reported being aware on some level, that slowing down is essential for getting beyond surface anxieties and habitual defenses. Nevertheless, they reported feeling pressure to produce that kept the therapy session on a fast track and on high intensity. That pressure was financial (“I am paid $2 a minute, I cannot just sit there…”) and cultural, as participants reported their sense of needing to perform and produce. The pressure was also related to the imaginal structures of psychotherapy: the healer, the coach and the medical or licensed professional. The conflict about choosing a slower pace was often related to a teacher or a mentor that appears to work more actively, or to a theoretical idea or stance that in the therapist’s understanding was promoting a faster pace.

**What Happened**

Most of the data for this learning came from the section of the interview where I asked participants about the various types and styles of interventions. I invited the participants to recall cases where they intervened actively and felt that the intervention was successful or not. And on the other hand, cases where they chose to hold back or slow down and felt successful or not. In several interviews these questions led to a
conversation about overall therapy style and in several cases, new awareness has emerged for the participants.

Commenting on her very active style P1 said: “I think it leads more to burnout. So, there are two things, one is that I do believe it leads to more wear and tear on me, and possibly on cutting the client resources, that they are not given opportunity.”

Commenting on being a client with a less active therapist she said: “…I would get bored, as a client. But I could see the value, on two levels, I can see the value, because part of me appreciates that piece of me that is missing, which is being more calm, being more a listener, and asking more questions. I miss, I know that there is a part of therapy that I am bypassing…There is something for me to learn! … I just can’t go there. So, as a client I would just be bored.”

Reporting about the overall experience of our interview, P1 said: “It was fun. I think in some way I stopped learning. I am going deeper in a very narrow area. So, this reminded me of going to school.”

Commenting on her tendency to get lost in interventions P2 said: “…so I tell myself to slow down, just be with him where he is.”

Toward the end of the role-play P5 noticed my hands and asked me (the client) to make fists and then tighten them. That invited new emotions, had a deepening effect on the session and brought us closer. Commenting on that intervention during the interview she said: “I wish I’d ended up in the body sooner.” She noticed that the somatic intervention came when she was more comfortable sitting with the stuckness. When I asked how she sits with stuckness P5 described her experience: “There’s a lot more silence… There’s a lot more, ‘Yeah, we don’t know where we’re going. No, we don’t
know what we’re doing.’ Yes, that’s overwhelming…” Later she linked that overwhelming feeling to her relationship to silence: “…the moments where I am pleased that I don’t intervene are moments where I do not interrupt silence.”

P9 clearly expressed her conflict about the pace of therapy: “I was feeling really pushy. And I would, and I doubted, I was uncertain that that was gonna work…For me to back away also is to model slowing, slowing down and thinking about it. Which I would never have done with this guy. Well I might, you know depending… I’m just far away from… Let’s see…”

P3 described her experience of pressure to perform: “This is why I don’t like consultation, cause then I like operating with him from, like what she’s telling me I should do. And then I’m like less, have less access to my own presence” and later: “…suicidal clients bring up a lot of anxiety for me. It’s hard to think clearly. And I really feel like I am supposed to do something. And I’m supposed to do the right thing. And if I don’t…”

P8 also described his conflict about going slowly and not doing enough: “I would feel guilty if someone paid me just for an expensive conversation… there’s part of me that holds that. There’s also part of me that feels that’s my own work.” He described his inner voices that judge his own work as inadequate or not valuable and concluded: “That’s my own healing stuff to do.” Exploring cases where he held back successfully, he said: “…but there’s a sense that they just need me to listen…They just need some space to not be judged and just be.”
When asked about a case where she regretted being withdrawn or held back, P1 said with a sigh: “It is usually the opposite, it is usually ‘I wish I wouldn’t have talked so much. I wish I was less active.’”

P10 clearly expressed the pressure to produce: “…if I’m not tied for, tied to unstucking that person then I’m OK. But if I’m tied towards ‘oh we got to get this person unstuck’ then I think there’s, then I have to make more pushing or having to do.”

At the end of the interview P10 asked about the overall perspective of the research and I explained it to him. He acknowledged his experience of the cultural pressure to be active and efficient: ”Because I think it’s how each therapist is with their own stuckness, and that whole value system… Because I have that pressure in me. So, my own spiritual work is to be more compassionate about my own timing and pacing. You know, I don’t like to be pushed either. And so, if I’m able to really see that in a client then I can really respect their timing and pacing and I can slow down and feel their pace and be like, ‘OK I can be here.’” As this was the last interview, I shared some of my experience as the client in the role-play from previous interviews and he commented: “Oh, the ones that were able to sit with stuckness are more seasoned.”

When we explored the nature of stuckness, P7, who in general was comfortable with the slow pace, commented on the relation between therapeutic alliance and deeper and slower work: “…you’re getting too close to something that’s painful…fear, pain, getting close to something they haven’t wanted to look at…Sometimes, I think, it’s I’m not sure if he trusts me. The alliance isn’t ready for it yet. Too fast is sort of once again what I’m thinking. The speed is too fast, the expectation. It needs to go slower. I don’t
know what, how that fits in … there’s a pacing and a trust that needs to be built more before we go there.”

**How I Was Affected**

In most interviews I felt the conflict of the participant about the speed of intervention and empathized with them. I could relate to their inner struggle from my own experience. I remembered periods where in my therapy work, I would make myself count to five or even 10 before responding to a client or expressing a new thought. During the interviews, I often stopped myself from assuming the supervisor role and telling the participants about my ongoing work towards slowing down.

I was encouraged to confirm that as a client in the role-play, the deeper experiences were with the therapists who were comfortable with silence and with a slow pace, which allowed them to see me as a client and empathize with my pain.

In most interviews I was aware of the parallel process aspect of the interview. I was under time pressure to complete the role-play and the set of interview questions within the promised timeframe. I also tried to slow down and make space for the experience of the participant and their deeper wisdom to slowly emerge and express itself.

**Interpretation**

Learning Four suggests that at times, the therapist would wish to proceed with a slower pace of therapy yet is conflicted about that.

In my work as a supervisor, I tell almost every trainee at some point: “If you don’t know what to do, please don’t do it!” Most therapy schools teach in addition to theory,
some techniques and practices. This is like building a therapy toolbox. It is not common and maybe not possible to teach students what tool to use in which therapeutic situation. Any such attempt to prescribe interventions is rooted deep in the left-brain’s tendency to focus on details and take things out of context. The pressure to do something is increased by the larger culture that is focused on efficiency and short-term results. Additional burden comes from the professional pressure towards Evidence Based Outcomes. Several participants commented on these stressors.

Sitting with a client and their issues and feeling responsible for the client’s wellbeing and for the overall outcome of therapy, is a very lonely experience. Not all therapists are aware that in addition to a client and a therapist, their respective unconscious minds are also present in the room. Both the client’s and the therapist’s unconscious parts can make judgmental comments about what the therapist should and shouldn’t do, and how therapy is proceeding. Unconsciously, the therapist is waiting for permission to slow down from all these internal and external voices, which makes it more difficult to stay present with stuckness and not act. As several participants commented, this is a difficult situation to be in and it can lead to burnout.

The co-researcher observed that when looking for various examples of interventions, numerous participants had to go back in memory to their internships, which in some cases occurred several decades ago. The co-researcher interpretation linked this observation to therapists feeling lonely and unsafe exploring their interventions. This is in contrast with a good internship where the therapist’s experience was held by a bigger container of school, fellow students and supervisors. The co-researcher noticed the need of the therapist for permission to slow down, as this learning suggests. In a good
internship, that permission is granted by the supervisors and by consulting with colleagues, however, as several participants commented, professional therapists are often lonely with their therapeutic decisions and have to look for other sources that can grant such permission.

As their experience grows, most therapists develop their own therapeutic intuition. However, following that intuition with presence moment by moment, requires letting go of the training wheels that theory or technique provides. It requires, using the words of the Tao, “drifting aimlessly in the wind,” 33 which can be a very frightening experience. Slowing down is like closing the toolbox and waiting for intuition or inspiration to guide one. The Tao asks: “Can you remain unmoving till the right action arises by itself?” 34

Many participants commented how difficult that waiting can be. Experiencing lack of movement is one of the frightening aspects of stuckness. Yet, most participants, even when unable to follow their intuition, were aware of the option, if not the need, to slow down and just be with the client, wherever they are, or with whatever the present moment brings.

**Imaginal Structures in Use**

The participants’ conflict about slowing down, evoked the imaginal structure of murky waters. Swimming in such ponds requires trust or faith. There is no standard procedure to clear the water or to get out of it. The Tao asks:

Do you have the patience to wait till your mud settles and the water is clear?
Can you remain unmoving
till the right action arises by itself?
—Lao Tzu, *Tao Te Ching*, Ch. 15

There are many maxims that essentially claim: “Fast is slow, slow is fast.”

When observing a master artisan, one can usually see slow and assured movements that come from long practice of inner confidence. These cannot be prescribed or imitated. For the right action to arise by itself, one needs to be in tune with the present. Ideas are too slow to follow the ever-changing present and usually they introduce some level of violence by forcing external influences of a theory or by imitating an admired teacher or mentor.

The murky water is dangerous and hints at some monster that lives at the bottom of the lake. That monster could be a great teacher or a wild man, as the case is in the story of *Iron John.* Fear of the hidden monster prevents the connection to new knowledge or influence and keeps the stuckness in its place, unchanging.

**Theoretical Concepts**

The Tao-Te-Ching describes the inner conflict several of the participants reported on and identifies thinking as the root of it. In this case thinking refers to psychological ideas acquired by therapists at school and other trainings, that conflict with their intuition. Lao-Dze asks: “Must you value what others value, avoid what others avoid? How ridiculous!” The Tao contrasts thinking with emptiness. The poet states: “I am like an idiot; my mind is so empty.” Yet that emptiness provides the connection to the greatest source: “I am different from ordinary people. I drink from the Great Mother's breasts.”

The ability to wait for an organic or intuitive action to arise by itself is linked to the patience of the therapist. This is exactly what makes therapy an art and not a
prescribed technique. It makes every case and every therapy session a unique experience to be recreated at real-time.

From the *Law of Three* perspective, the inner conflicts described by the participants are related to confusion of *forces* or confusion of *triads*. If the therapist attempts to be a *first force* and a *third force* in the same triad and at the same time, confusion or conflict arises. That is the case when the therapist initiates a goal-oriented intervention (*first force*) while at the same time sees their role as the container of the process or the inspiration/model for the client (*third force*). Trying to maintain safety and trust while pushing the client to do something different than what the client is doing, is a similar conflict of forces.

Confusion of *triads* occurs when the therapist is aware of their own active role in the therapy while linking it to their own personal development or spiritual work, as some participants did. The therapist is one force in relation to the client and another force in relation to their spiritual practice, and they are not aware of the boundary or the distinction between the two triads. This gives another perspective to projections and to Countertransference: when the therapist confuses their own *stuckness* with the client’s *stuckness* it is a confusion of *triads*.

**Validity Considerations**

A significant part of the interview was focused on exploring active and passive interventions, and the therapist’s relationship to these in specific cases. We also explored therapy styles and modalities that lead towards faster or slower interventions. Most of the data for this learning came from that discussion. It is inevitable that the participants
picked up on my own bias towards a more permissive and slow style and were affected by that in their responses.

The inner conflict about the pace of the therapy was clearly expressed by many participants and was also noticed and commented on by the co-researcher.

As in all the learnings, my deep and personal experience of playing the role of a stuck client gave me access to deep experiences of both client and therapist and at the same time, varied with the different dynamic and relationship created with each of the participants.

**Learning Five: If I Know the Answer, I Will Give It to You**

The Tao that can be told
is not the eternal Tao
The name that can be named
is not the eternal Name.
—Lao Tzu, Tao Te Ching, Ch. 1

Learning Five suggests that when confronted with a stuck client, therapists might respond by relating to the therapy as an investigation or a puzzle to be solved. When they could ‘figure out’ what was going on, they were inclined to tell the client what to do to ‘fix’ the situation. They did not have the patience to just sit and wait for an organically emerging solution or for the client to realize what the client already knew unconsciously. Usually they were aware of their tendency to be fast or active and often explained it using their modality or the cultural pressures.

This learning addresses similar findings to those discussed in Learning Four. However, in Learning Four the focus was on therapists avoiding non-action or slower pace, and here the focus is on therapists’ choice of active, coaching or fixing interventions.
What Happened

When exploring various intervention styles P1 said: “‘How do you feel? How do you feel?’ Is not for me. If I know the answer, I am going to give it! And I am not going to spend an hour.” She was aware of the alternative and she chose the active route saying: “Spending an hour helping someone access their inner resources is a good idea, and yet … if I know a shortcut, why not give you a shortcut.” She explained it using her style or temperament: “Something has to change; I am a change junky.” She was aware of the negative sides of an active approach and used a mentor to support her choice: “But also the impatience I had, which I always have, is that I am going to give the answers…Yes. I think it leads more to burnout … it leads to more wear and tear on me, and possibly on cutting the client resources, that they are not given opportunity. They do not develop their own resources because I give them the answers. I provide them the answers …that is one reason I love Sue Johnson’s work… in Emotionally Focused Therapy we are very active. We are orchestrating, in every session we are a producer, and I love it.”

P2 was also aware how she was pulled by the stuckness: “I think when the client is stuck, there is a risk of soliciting my agenda…I guess I want to get him moving.” P7 had a similar observation: “When I start to feel stuck in real life with my clients, I think it’s more my fear or impatience that feels I want to hurry things along or have something show up. And I felt that before with clients and that’s never been useful.”

P5 described in more detail and possibly most clearly what leads her to choose active interventions. When we explored the role-play, she said: “On my side of things I ended up more in a fix-it mode than I wanted to be.” Describing an active interaction that
did not turn out well she said: “… I was so focused on having her take ownership that she felt like I was blaming her for being assaulted.”

When we explored the nature of stuckness, P5 said: “Stuckness for me on the therapeutic side is about unsuccessfully trying to push an agenda that is mine and not the client’s.” and she acknowledged: “Weirdly enough clients are not super interested in coming to therapy and having someone else tell them what to do.” Yet, a few minutes later she said: “I pride myself on keeping folks moving towards whatever the goal they set for themselves is. So, I want to refocus the conversation on moving them toward that goal.” She also expressed another understanding: “And sometimes stuckness will happen because a person just wants an opportunity to rest. Change is tiring, change is exhausting. But then what I want to do is… so in those moments I want to check in with them and see if they want to cool their jets.” Finally, she shared her preference for working without agenda: “…the moment the therapist walks into a room with an agenda that’s the moment therapy stops. That when I come in and say here’s what we’re doing today, that in that moment I am not doing therapy.”

P9 described the pressure to produce: “If they're paying you don’t get to waste their time and I really believe that. I really believe it. You know, two bucks a minute or three bucks a minute? No. You got to be earning your money. So, sitting and listening and not...” In another part of the conversation she was more ambivalent: “I was feeling really pushy…and I doubted, I was uncertain that that was gonna work.”

P8 described the pressure to produce in similar terms: “There’s something about I would feel guilty if someone paid me just for an expensive conversation.”
P3 described an opposite kind of interaction with a consultant. She shared with the consultant her disappointment with the progress of a case, and he said “Not at all…I’m not monitoring your progress. I’m just loving you.”

**How I Was Affected**

As the client in the role-play I had two main responses to being told what to do; resist, mainly by arguing, or retreat further into *stuckness* or a depressed mood. In the 10 interviews I was told to do many things: play the guitar, exercise, change my medications, look for a job, connect with my family, talk to my wife, and change my diet. This not the complete list. As P5 noted, I did not want to be told what to do. On many of these occasions I felt the therapist’s discomfort and occasionally I was moved to help them by being a responsive ‘good client.’ In several cases my observing self was amused: “Am I really hearing what is being said?!?” but I stayed congruent with the client role. With only a few exceptions and as discussed in Learning Two, the contact with the therapist was lost when I was told what to do.

**Interpretation**

Learning Five suggests that when confronted with a stuck client, therapists might respond by relating to the therapy as an investigation or a puzzle to be solved. When they could ‘figure out’ what was going on, they were inclined to tell the client what to do to ‘fix’ the situation. This learning addresses directly the research hypothesis: Therapists can often be noted as not comfortable with *stuckness*, tending to want to do ‘something’ even when they do not know what to do. This prompts them to choose active, change-seeking interventions even when their intuition might suggest otherwise.
As emerges from the interviews, and discussed in Learning Four, the participants were aware of the conflictual choice between active intervention and holding back. Often, they were aware of the benefits of holding back and making room for the client to find their own answer, yet they chose the active route. The therapist’s education and training and above all the cultural pressure are telling the therapist “don’t just sit there, do something!” Their intuition or their heart and maybe their spiritual bias tell them the opposite: “Don’t just do something, sit there!” Marion Woodman describes that conflict well in her poem:

What do we do when everything rational says, Let go! and everything emotional says, I cannot! We can swing back and forth between opposites indefinitely. Better to stand on the stillpoint at the center.\(^{40}\)

In the conflict of the therapist between acting and holding back, the reason and the emotions might take different sides, yet the issue is the same; there are two options that appear contradictory and the therapist is under pressure to choose. It is easier to explain later the choice for action, as P9 said: “I was not sure if it is gonna work” but at least she tried. It is much harder to justify passive or slower therapy choices by saying something like “I just waited for the right moment to arrive.”

Woodman’s poem offers an alternative: the ‘stillpoint at the center.’ That choice takes a masterful balancing act that requires lots of training and experience. The Tao is offering Wu-Wei or doing without doing. The Law of Three offers the option of being a third force. All these alternatives are hard to conceptualize and understand and even
harder to explain or teach. Most therapists are likely to “swing back and forth between
opposites” and in contemporary western culture are expected to choose action. As P10
said: “Oh, the ones that were able to sit with stuckness are more seasoned.”

The professional pressure towards *Evidence Based Therapy* is focused on
results. A lot of psychological research is designed to prove that for condition X
therapy Y has certain efficacy. Many research projects include some placebo
comparison, although that usually complicates the research procedures. It is not
possible to design a research within the scientific paradigm, which will conclude that in
situation X, not doing Y, leads to a desired outcome. The logic does not work for proving
negative causes. Most people are aware that in the initial example, causal conclusion such
as X intervention leads to good outcome in certain percent of the time, is a fallacy of
statistics, yet often that logic is used to explain or justify therapy choices and recommend
modalities. However, in the negative case, the logic is completely false. A certain
intervention was not done, but many other things were equally not done, thus it is
impossible to conclude anything about what was not done.

We might have to let go of science and logic as the only foundations of
psychology, and accept that sometime, good therapy is an art form. As P9 said at the end
of her interview talking about staying out of Procreates’ bed: “…not being bound by a
theoretical orientation especially when it doesn’t work …but that puts you outside the
conventions sometimes.” Staying outside the conventions takes courage.

**Imaginal Structures in Use**

Giving the right answer evoked the imaginal structure of the expert: the one who
knows the answers and can solve riddles. It reminded me of my Marriage and Family
Therapy licensing exams. In these exams, many of the questions describe a therapy situation and the examinee needs to find the right action or most often, the least wrong answer. The licensing board wants to make sure that therapists know what to do in every situation. The expert is the one who can analyze a condition, name it and apply a prescribed solution. With the advances in technology it becomes clearer that expertise of that kind is largely mechanical and can be automated in a phone-app. Indeed, there are more and more such phone based automated ‘therapists’ that can remind you to relax and even link it to your blood pressure or heart rate measurement. Such expertise is completely based in the left-brain: focused on detached details that are taken out of context.\textsuperscript{44} In contrast, the Wizard in the image of Gandalf is not a ‘know it all’ arrogant. The wizard knows also what they do not know and respect the larger powers and contexts.

Another famous riddle solver is Oedipus, who saved Thebes by solving a riddle, but ended up blind, partly as punishment for the cluelessness of his heart. His tragedy is a severe warning for the hubris of trusting the mind above the heart and going against faith.

Solving riddles also reminds me of the famous radio show Car Talk, where the experts can figure out any problem in any car model just by hearing a few details or sounds. They know what should be done to fix the car. Maybe they were wizards?

**Theoretical Concepts**

The therapist that choses to give the answers and make shortcuts, is an active first force in the Law of Three terminology. That combination implies two possible triads: Growth and Destruction. In a triad of Growth, the life force is organizing matter into forms. The therapist is following a known procedure or plan, to replicate a predefined
result. That corresponds well with Evidence Based Therapy. There is no recognition of
the uniqueness of the client or the situation, thus no new understanding or new resolution
of a specific problem can emerge from this triad.

In a process of destruction, life force brakes down forms into basic matter. The
therapist confronts bad habits of the client or helps the client realize that certain behaviors
or ways of thinking are not useful. Of course, such interventions are called for in many
therapy cases, yet this triad cannot by itself lead to a deeper healing, new meaning or to
resolutions.

The very first and possibly the most famous poem of the Tao was quoted at the
top of this learning and stated: “The Tao that can be told is not the eternal Tao, The name
that can be named is not the eternal Name.” Giving the answer or diagnosing the
condition is at best superficial and does not get into the core of a problem. Real change is
an internal process and there are no shortcuts leading to it. The poem concludes with:
“Darkness within darkness, The gateway to all understanding.”

The Tao recommends confusion and not knowing as the deeper paths towards real
knowledge and is opposed to right answers and shortcuts. This poem also underlines the
limitations of talk therapy as far as its reliance on words is concerned. This contrasts
with therapy that is based in experience, which in itself is fleeting and cannot be captured
in fixed forms or in words, at least not in exact scientific words.

Rushing into action, you fail.
Trying to grasp things, you lose them.
Forcing a project to completion,
you ruin what was almost ripe.
—Lao Tzu, Tao Te Ching, Ch. 64
Validity Considerations

Many of the co-researcher comments noted the conflicts the participants shared and their choice of active interventions despite their awareness of alternatives.

As in Learning Four, my own bias towards making room and waiting, was likely to have had an influence on the participants. Their conflicts were apparent as well as their awareness of alternative choice. Yet their willingness to acknowledge the value of a more Taoist approach might have not been expressed with a more action-oriented interviewer.

Conclusion

All the five learnings that emerged from this research, addressed the Research Problem which asks: “What tendencies can be seen in therapists’ thought process in choosing interventions when faced with stuckness” and supported the research hypothesis: “Therapists can often be noted as not comfortable with stuckness, tending to want to do ‘something’ even when they do not know what to do. This prompts them to choose active, change-seeking interventions even when their intuition might suggest otherwise.”

Learning One: Of the Terrible Doubt: Am I Doing My Job? Am I Helping? suggests that when faced with stuckness, therapists often feel dread and shame. These feelings arise from the therapist’s need to know that their work was meaningful and that they were ‘doing something’ to bring change and help the client.

Learning Two: Connecting in the Heart of Stuckness suggests that client’s experience of connection to the therapist can be lost when the therapist was not willing or not able to stay present with stuckness.
Learning Three: If You Don’t Know What You Want, I Cannot Help You!
suggests that therapists may, mistakenly and without realizing, pass on to their client the
responsibility for knowing what the client’s wants and needs are.

Learning Four: Who Would Allow You to Slow Down? suggests that at times, the
therapist would wish to proceed with a slower pace of therapy yet is conflicted about that.

Learning Five: If I Know the Answer, I Will Give It to You suggests that when
confronted with a stuck client, therapists might respond by relating to the therapy as an
investigation or a puzzle to be solved. When they could figure out what was going on,
they were inclined to tell the client what to do to ‘fix’ the situation.

The Cumulative Learning: Return to the Common Source connects all these
learning through the theoretical basis of the Tao and suggests an opening towards
Revisioning stuckness.

This research showed that stuckness in therapy is a common situation that
therapists were familiar with. The Research Problem asked about therapists’ choice of
interventions when faced with stuckness. The five learnings and the examples quoted,
demonstrated that when faced with stuckness, therapists tend towards active interventions
that try to change the situation and avoid feelings of shame that might arise when they
were unable to change the situation. Several examples have demonstrated that as this
research hypothesized, most participants were not comfortable with the negative feelings
stuckness evoked and often tried to avoid them in various ways. The few participants that
were more able to stay present with the stuckness were able to take the therapy to a
deeper level and better connect with their clients. This suggests the positive value of
stuckness as pointing deeper into the unconscious and sometimes being a necessary turning point in the therapy process.

When they lose their sense of awe,
people turn to religion.
When they no longer trust themselves,
they begin to depend upon authority.
Therefore the Master steps back
so that people won't be confused.
He teaches without a teaching,
so that people will have nothing to learn.

—Lao Tzu, Tao Te Ching, Ch. 72
CHAPTER 5

REFLECTIONS

I said to my soul, be still, and wait without hope
For hope would be hope for the wrong thing: wait without love
For love would be love of the wrong thing; there is yet faith
But the faith and the love and the hope are all in the waiting.
Wait without thought, for you are not ready for thought:
So the darkness shall be the light, and the stillness the dancing.

—T.S. Elliott, *Four Quartets*

Introduction

The title of the dissertation: Revisioning Stuckness in Psychotherapy, suggested a research into the ways in which therapists respond to *stuckness*, and a possible new vision towards alternative responses. The excerpt above from T.S. Elliot’s *Four Quartets*, offers therapists a vision of illuminating the darkness by waiting. The poem emphasizes the need for slowing down and reframes waiting as a positive step. The Research Problem asked: “When in the face of *stuckness*, what tendencies can be seen in therapists’ thought processes in their choice making between active, change-seeking interventions and passive, encouraging and accepting interventions?”

The first section of this chapter explores the significance of the five learnings that emerged from the research and discussed in detail in chapter four. This section shows how the learnings lead from the Research Problem to the Research Hypothesis that stated: Therapists can often be noted as not comfortable with *stuckness*, tending to want
to do ‘something’ even when they do not know what to do. This prompts them to choose active, change-seeking interventions even when their intuition suggests otherwise.

The second section reflects on archetypal and mythological connections to stuckness. It explores the story of Odysseus in Ogygia, the island of the nymph Calypso who saved Odysseus after his shipwreck. This story illustrates the necessity of stuckness during that developmental phase and the special role of Calypso’s in the hero’s growth.

The last section looks at possible implications of this research on various levels, from the implications for my own life and work to possible implications for the profession of Psychology as a whole and for the culture at large.

**Significance of the Learnings**

The Cumulative Learning: Return to the Common Source connected the five learnings through the theoretical foundation of the Tao-Te-Ching and opened a path towards revisioning stuckness. All the five learnings demonstrated that behind stuckness there is some form of disconnection from the source. The disconnection can be somatic, spiritual or on the soul level. Often it is the client who disconnected from their life-giving and meaning-creating sources. The therapist can also be disconnected from the source, by putting theory before awareness of the present moment and being responsive to it. I expanded on the nature of the source in chapter four. To briefly recap, returning to the source is simply accepting what is, or in the words of Tara Brack: Radical Acceptance.¹

Learning One: Of the Terrible Doubt: Am I Doing My Job? Am I Helping? suggested that when faced with stuckness, therapists often feel dread and shame, feelings that arise from the therapists’ need to know that their work was meaningful and that they were ‘doing something’ to bring change and help the client. Responding to stuckness with
dread, as this learning found, was a surprising answer to the Research Problem; yet it supports the hypothesis that anticipated therapists’ discomfort with stuckness.

Learning Two: Connecting in the Heart of Stuckness suggested that client’s experience of connection to the therapist could have been lost when the therapist was not willing or not able to stay present with stuckness. This learning expanded on the nature of the impact of stuckness on the therapeutic relationship and added another answer to the Research Problem. Although not directly supporting the hypothesis, this learning clarified how the break in the interpersonal bridge as a reaction to stuckness, and especially to the shame it evokes, is adding to the discomfort of the therapist, who is often looking for reassurance from the client that they were doing ‘good therapy.’

Learning Three: If You Don’t Know What You Want, I Cannot Help You! suggested that therapists may, mistakenly and without realizing, pass on to their client the responsibility for knowing what the client’s wants and needs are. This was the most unexpected finding of the research. Although not directly supporting the hypothesis, I contend that the tendency to pass responsibility to the client comes out of the same discomfort with stuckness and the same need to ‘do something’ and feel productive and useful rather than staying with the lack of change, as the hypothesis suggests.

Learning Four: Who Would Allow You to Slow Down? suggested that at times, the therapist would wish to proceed with a slower pace of therapy yet is conflicted about that. Learning Five: If I Know the Answer, I Will Give It to You suggested that when confronted with a stuck client, therapists might respond by relating to the therapy as an investigation or a puzzle to be solved. When they could figure out what was going on, they were inclined to tell the client what to do to ‘fix’ the situation.
The findings from the last two learnings directly support the hypothesis, demonstrating therapists’ tendency to choose active, change-seeking interventions and avoid slow or permissive therapy that might be the call of the heart or the intuition.

**Mythic and Archetypal Reflections**

**Odysseus in Ogygia**

Many mythological stories describe *stuckness* or refer to it. Sisyphus and Tantalus were both stuck in a repeated action that led nowhere. Prometheus was chained to the rock as a punishment for giving the fire of the Gods to humans. Atlas was stuck holding up the sky. In many traditional mythologies, there are stories of exile that have an aspect of *stuckness*. The Fisher King was stuck in his illness and the whole country suffered with him. Parsifal, the hero of that story, was equally stuck, not knowing the right question that needed to be asked of the Fisher King. When reading such stories, I wonder what the alternatives might have been in order to not be stuck. Could Sisyphus and Tantalus invent some tool or technology to overcome their endless tasks? Could the exiles go back to their city, maybe under changed identity? Could Atlas just let go as Jeanette Winterson suggests, and see what would happen next? ²

Looking for a myth that could capture the essence of this research, I was attracted to the story of Odysseus in Ogygia, Calypso’s island. This story includes not only the Hero/client who is stuck, but also a therapist, represented by the nymph Calypso. Most of the stories mentioned above imply that the stuck situation was a punishment by the gods for some offense or sin. The story of Calypso is more of a stage in a Hero’s Journey; thus, it offers a broader perspective on the question of *stuckness* and on the possibilities of
going beyond an undesirable and unchanging situation. Homer does that by placing the Ogygia story exactly in the middle of the Odyssey as explained below. There is some notion of punishment also for Calypso, who in some stories was exiled to Ogygia in connection with her father’s sins against the Gods. Yet Odysseus is the focal point in the story, and he was not punished but rather saved in Ogygia from the previous ordeal brought by the wrath of Zeus.

The structure and the timeline of the Odyssey can be seen as a spiral. We start in the center and go around in circles, occasionally coming back to seemingly the same point, yet progressing on another dimension. When he recounts his adventures to the Phaeacians, Odysseus himself tells large parts of the story as past events. The reader, who encounters various versions and references, is aware of layers beyond the surface story Odysseus is telling. Other segments are prophecies, given mainly by the blind seer Tiresias and by Circe, the Nymph with the lovely braids. The narrator tells us other sections of the saga in present tense. Some parts of the story are told as linear progression while others move back and forth in time.

Human lives often follow spiral movements in their progression. When clients return to the same point on the spiral, they often perceive their situation as stuck, missing the progress made along the other dimension, the axis of the spiral.

Along the spiral of the Odyssey there are several significant thresholds. They might indicate the completion of one circle of the spiral and arriving to the same point, yet at a higher level. They might correspond to a stage in Campbell’s Hero’s Journey. Once a threshold is crossed, the Hero acquires new abilities, new awareness and new identity; younger parts are left behind, and they become a changed being. Two of these
important thresholds in the Odyssey are the descent to the underworld and the overcoming of the suitors. Odysseus is prepared for both by longer gestation periods with a woman-witch-Goddess character: Circe and Calypso.

Odysseus and his men spent one year with Circe and the story includes many pages and many details about that time. On the other hand, in Ogygia, Odysseus have spent seven years of the 10 years span of the entire story, yet Homer told us about that period only in a few paragraphs and in dearth of detail. I am puzzled by this discrepancy and wonder what is that Homer wanted to convey. Is there a deeper mystery related to the time in Ogygia?

Homer is pointing us to the significance of the feminine role at every threshold of the journey. We are told that Circe the nymph “speaks with a human voice.” No other immortal is described that way. Maybe she is not human yet. Odysseus managed to overcome her magic with his sword and a magic potion, forced her to re-humanize his men-turned-pigs and enjoyed for a whole year the ‘Club-Med’ style feasting, including her company in bed. What lessons did she teach Odysseus that prepared him to go down to the house of the dead? This was a very serious endeavor that only few mythological figures had accomplished.

Descending to the underworld and meeting Tiresias is an ultimate test for Odysseus’s heroic and masculine part, facing the ultimate challenge of death. Only a few months later, after losing his men in shipwreck, he learned with Calypso’s help, to be aware of his feminine side and make it human. The Ogygia period with Calypso is the only one that is not explicitly described in Tiresias’s prophecies and in Circe’s explications of them. Was this a phase that even the powerful seers Tiresias and Circe
could not foretell, or perhaps it was a door into free will? Was there a choice for Odysseus about the unfolding of events that led to Ogygia?

What would have happened if Odysseus did not fall asleep and prevented the crew from slaughtering the cattle of the sun? Would they arrive home safely seven years earlier as predicted by Tiresias? The suitors would not be there to fight with, and Telemachus would still be a young boy. Where would any of us be today, without some life choices that in hindsight appear to be terrible mistakes?

Both Circe and Calypso were welcoming Odysseus to their divine bed and took care of all his earthly and bodily needs. Odysseus was clearly more powerful than Circe and she submitted to him, magical as she was. Did Odysseus’s power over Circe and Calypso’s power over him have anything to do with the sexual relationship he had with both goddesses?

Calypso, whose name is from the same root as ‘eclipse,’ did her work in darkness, in a cave. She first healed Odysseus’s wounds and helped him recover. For seven years Odysseus could not act out his external heroic ego, either because his self-confidence was destroyed or his trust in the Olympic gods was diminished. Working in the shadow, he discovered with Calypso’s guidance a new identity. She was the leader and he followed.

However, Odysseus felt trapped by Calypso’s power. According to other sources they even had children together, but nowhere is it said that he hated her.\(^4\) Neither is it clearly stated what was the power she had over him that prevent his departure. In fact, it seems that he had much more power over her. He was the one being pursued and the one rejecting her as a lover. His ability to turn his back on the loving goddess might have been a new and subtle feminine power, one that served him well when he later studied the
suitors from a very inferior position, preparing to reaffirm his complete mastery as a whole human being.

Calypso, like Circe, is a goddess from a lower and earlier realm. The victory of Zeus and the Olympians over these other gods is an important milestone in western cultural heritage as well as in every individual’s psychological development. This victory celebrates the superiority of the masculine. Calypso’s father Atlas was subjugated and severely punished by Zeus and his brothers. The Olympians victory also signifies the superiority of the ego and the rational mind over the unconscious mind and magical thinking. This story tells us that the victory of the Gods-of-Reason did not eliminate the periodic need for regression or re-exploration of younger developmental stages. 

*Stuckness* can often be related to relying only on reason and neglecting the body, the emotions or the unconscious mind.

Since its inception, the Odyssey was studied and interpreted many times over the millennia. Most commentators see Calypso as a seducer and Odysseus as her victim. The text does not clearly support this interpretation and I find it shallow. The Odyssey tells us that Calypso loved Odysseus, wanted him as a husband and tried to make him forget his home, but there is no explicit indication of seduction. It is not clear what made her more powerful than him other than being an immortal. Odysseus was an accomplished hero when he arrived in Ogygia, with incredible fits of courage and ingenuity under his belt. What stopped him from building a raft earlier during the seven years? Did he really need the woodworking tools that Calypso provided after Zeus’s decree was communicated? Could she have prevented him from appealing to the Olympian gods earlier, and especially to his patron Athena who was always watching over him?
My sense is that even the more psychologically oriented interpreters that view Calypso as a seducer, are focused only on the psychosexual layer of the story and ignore the other facets of spiritual development and shadow work that are implied. The unconscious is deep and layered. Gods often come in pairs that hold multiplicities. To deeply understand the meaning of a myth and of a metaphor we need to allow different and contradictory viewpoints.

Jungian commentators are aware of the multilayered nature of myth and they emphasize the development, growth and acceptance of the anima as the central meaning of the Calypso experience. ⁶ They point out the need for letting go and having to surrender to the feminine both emotionally and sexually, as a necessary developmental step before returning to the mortal wife. Odysseus keeps emphasizing in his storytelling how Calypso never touched the heart inside him, which always longed for home and for his wife. Penelope can be seen as the mature anima that is not projected on a goddess but rather integrated by the mature man who had successfully celebrated the inner marriage.

Tracy Marks underlines Odysseus’s move towards the feminine. ⁷ All the previous stories in the Odyssey are very manly; they involve fights with men, with demi-gods and with nature. In these stories, Odysseus’s masculine fellow comrades always accompany the hero. Odysseus had to be broken down and hit rock bottom to be able to meet his own inner feminine through Calypso’s projection. For instance, Odysseus did not cry in Troy, nor when the Cyclops trapped him, or when Scylla devoured six of his men alive. He told about his horror on that occasion, but he did not cry. In Ogygia he finally breaks down and cries on a daily basis.
This analysis implies some new connection with feeling. Odysseus’s repeated reports about the state of the “heart inside of him” indicate his new emotional awareness. Prior to Ogygia he never surrendered, even when things appeared to be quite desperate. His curious and adventurous sides and his arrogance had always led him to action and confrontation. Calypso completed the violent external destruction that Zeus initiated with her deep and loving breakdown from the inside. I am wondering about the possible connection between stuckness and the lack of surrender. As we have seen in the research, the balance of two opposing forces is a common aspect of stuckness. Surrender changes that balanced stagnation and possibly allows for new movement. Of course, any confusion between surrender and resignation needs to be clarified.

Jean Houston describes the healing, rest and incubation aspects of the Ogygia period. She links this story to the earlier Egyptian myth of Isis collecting and restoring Osiris to life after his brother Seth cut him to pieces, and she points out the archetypal development between Isis and Calypso. Houston emphasizes the change that occurred during periods of routine that can appear as stuck. She points out that growth is also possible for Calypso during this time. Houston suggests that growth might have redeemed her punishment on a remote island after supporting her father in his rebellion against the Gods.

Logically one can assume there is a parallel: a man needs to allow the development of the anima, the inner feminine and a woman needs to allow the space for the animus to grow. However, a man needs to surrender and accept his weakness and the subtle powers of intimacy, vulnerability and connection. A woman, on the other hand, needs to discover the strength of her solitude and her ability to face the world alone. The
Animus is about making decisions, possibly without consultation or reliance on external sources. It is about feeling strength from within and knowing “Here is where I stand.” For many women, this inner development goes through periods of passive aggression or even violence, whether internal or external. For many it implies standing up and confronting repression and abuse.

For a man on the other hand, the process might include learning to be vulnerable and even accepting some level of discomfort, weakness and even abuse without reacting, as Odysseus seems to have done with Calypso and later in Ithaca with the suitors.

It is interesting to note the similarities and differences between the two incidents where Odysseus is naked at sea without a ship. Before Ogygia, Odysseus is holding on to the mast of the broken ship. He clings to the most masculine part of the boat, after the external, feminine container was broken by Zeus’s thunderbolt. After Ogygia, when Poseidon destroyed Odysseus’s shabby raft, Odysseus is completely naked at sea again. He relies only on the strength of his body and the magical scarf that a sea goddess gave him in her pity. He is completely vulnerable, and his protector Athena is nowhere to be seen until Poseidon finally calms down. Reasonable Athena cannot face Poseidon’s unconscious rage, but Odysseus with his new inner transformation finally can.

For men and women alike, the ultimate developmental step is the inner marriage, where both feminine and masculine principals are owned and mastered. Their coexistence no longer appears any more as contradictory or conflictual, and neither of them rules the other. One of the underlying forces behind stuckness might be the lack of this inner imbalance and the yearning for it.
We can see this transformation in Odysseus’s meeting with his wife Penelope later in the story; they meet as two complete and equal beings that need to recognize each other as strangers, find their old connection and intimacy, and develop these to a new and deeper level.

My child, Penelope, well-aware, explained, I’m stunned with wonder, powerless. Cannot speak to him, ask him questions, look him in the eyes … But if he is truly Odysseus, home at last, make no mistake: we two will know each other, even better— we two have secret signs, known to us both but hidden from the world…

They are both transformed and meet from a new strength that changes the quality of love between them. Did the work done in Ogygia contribute to this transformation? Was it the hero stage of going into the belly of the whale as described by Campbell in the following quote? “The idea that the passage of the magical threshold is a transit into a sphere of rebirth is symbolized in the worldwide womb image of the belly of the whale. The hero, instead of conquering or conciliating the power of the threshold, is swallowed into the unknown and would appear to have died.”

This quote from Campbell is yet another lens through which to explore the Ogygia story. Not everyone is prepared to understand and follow the T.S. Elliott poem quoted at the top of this chapter that advises to just wait. In order to guide others through the dark forest, the therapist must recognize the needs of the client and encourage the client to hold some hope for the light on the other end. To paraphrase Campbell, the client needs to be willing to let go of their former self and previously known world and go over the threshold into the unknown.

*Calypso therapy* addresses the human need for gestation and incubation, accepting or even encouraging periods of *stuckness* in therapy when apparently nothing is happening. The unknown and the lack of meaning is a necessary stage between different
orders of meaning and internal organization. During these times, some inner quality is developing in the depths, or some old ideas and attitudes are preparing to be shed like dead skin.

These changes are required for the next step of the Hero’s journey: the return home. Something deeper wants to be born and it is pushing against the old layers. When not seen in this archetypal dimension, the client is often labeled ‘resistant’ and the therapy is perceived as stuck. When a gestation period is forcefully stopped or skipped, a whole developmental phase is missed, like the chrysalis that was taken prematurely out of the cocoon and ended up as a butterfly that could not fly. Biologists have found out that the constant pressure against the cocoon pumps blood into the wings and makes them flight worthy.

The natural impulse, and unfortunately the mainstream psychological education, prompts most therapists into the Athena position, which is taking a decisive action that is expected to cause change. Athena goes to Zeus, the ‘higher power,’ and prompts him to send Hermes to deliver the message that forces the ensuing change; Odysseus must go on to the next step. The story does not explain to us why Athena waited seven years for that intervention. Seven years is a very significant period in many cultures and mythologies; for Odysseus, it can signify a complete developmental phase. Athena, the goddess of war, tactics and intellect could do nothing for him during this long period of gestation.

The Talmud says: “A blessing is found only in what is hidden from the eye, for it is written, The Lord shall command the blessing upon thee in thy hidden things.” This suggests that once something is measured or counted it is no longer hidden and thus contains no blessing. Similarly, the Fox tells the Little Prince: “Here is my secret. It is
very simple: It is only with the heart that one can see rightly; what is essential is invisible to the eye.” 15 The Calypso Therapist must forgo evidence-based strategies that are measurable and wait patiently until the vision of the heart emerges and becomes clear.

As a therapist I want to refine my Athena skills and be able to act with laser-like precision. I want to cut to the chase with words, suggestions and homework assignments and lead my clients to the next stage in their development and growth; but only when they are ready, and the time is ripe for that kind of change. That implies waiting. Therapy schools do not teach that sensitive awareness; indeed, there is no defined procedure to determine that readiness. The therapist must find the balance of courage and intuition while holding in awareness both the vow to do-no-harm and the complete trust in the competence of the client’s soul to know what the right move is. This includes the courage to make mistakes, apologize and retract one’s steps.

…If you don't trust the people, you make them untrustworthy. The Master doesn't talk, he acts. When his work is done, the people say, ”Amazing: we did it, all by ourselves!” 16

Neither contemporary western culture nor psychological education support being a Calypso Therapist. Can I hold and nurture my clients through these long years of waiting and gestation? How can I normalize the waiting and even encourage it? Images, symbols and rituals - some new and some old - are needed to hold this understanding of patience in the space between a therapist and a client. Some plants share their beautiful flowers only once in several years; some fruits take very long time to develop and ripen. The story of Odysseus in Ogygia offers some images that can serve as containers to hold this deeper meaning of waiting and gestation.
Moore reflects on waiting as an important skill for therapists that is not taught in schools. Moore uses Becket’s play “Waiting for Godot” as an example of complete acceptance of waiting as part of the human condition. He suggests that it takes an anti-hero to undertake such a form of waiting, which is harder in a culture that emphasizes heroism.

Extrapolating further on this reflection, I dare to consider the possibility that sometime, the therapist needs to stand in the way of any movement towards change, and help the client see that they are not ready, as the T.S. Elliott poem above suggests. Naturally, that might promote depression just as Calypso did. We are trained to not accept depression as a necessary step and fight it with any tool available. A better option is to ask with Thomas Moore: “What does Saturn, the god of depression come to teach me?”

There are many stories about spiritual teachers, especially in the Zen tradition, that in the crucial moment push the student deeper towards rock bottom and thus usher them through the final barrier to awakening. Often these teachers can appear cruel, violent or abusive. As therapists we do not have the option to even consider such forceful interventions, although some modalities tried that approach of shocking the client; stories about Fritz Pearls or Milton Erickson comes to mind.

Houston also associates Odysseus’s daily weeping on the shore of Ogygia with depression. I am not aware of any formal therapy training that encourages us to stay with the depression and reframe it as gestation. The anti-depression pharmaceutical industry and the medical model used by the culture at large calls depression an epidemic and would relate to Ogygia as a mistake. Such mistakes should be avoided, eliminated
or as most often happens, medicated into oblivion. Medication is precisely what prevents the intensification of longing for home that is necessary for a real lasting change. Crying for the inability to go to the next stage is exactly what pumps the blood into the butterfly wings and makes them able to carry weight.

Only through these seven years of crying, and the ultimate surrender to Poseidon, is Odysseus ready to nakedly face the pure virgin Nausicaä, to be vulnerable with her and to completely trust in her help and in the gods. Clearly, that is the skill he needed for his next challenge, that of facing the suitors, and ultimately, meeting Penelope. She is both the human and the archetypal wife. Through that relationship the hero can meet the challenges of life as an adult and balance the inner male and female parts.

Both therapy and life can be truly stuck. In therapy this often happens when the goals are dictated from outside: by a formal modality, by a family member or by some authority. When the client does not participate willingly in the therapy process, things get surely stuck and no power-tools or evidence-based procedures can change the situation. Similarly, when therapist and client are working against each other, therapy gets stuck, unless someone ends the stalemate. When shared vision is lost, and with it any form of hope, there is nothing to drive the process further.

In contrast, during gestation process, the vision is kept alive. When the chrysalis becomes formless goo, the vision and hope are kept somewhere, whether we call that holding place DNA, morphogenetic field or spirit. It is the responsibility of the therapist to keep the connection to that vision alive and allow the client’s inner life to reorganize and find new meaning around that hope. That is the deepest meaning of healing, and it takes a lot of patience.
When visiting the underworld, Odysseus also receives a prophecy and the final instructions from Tiresias. These might hold the vision and the deeper meaning for the whole epic:

But once you have killed those suitors in your halls— by stealth or in open fight with slashing bronze— go forth once more, you must... carry your well-planed oar until you come to a race of people who know nothing of the sea, whose food is never seasoned with salt, strangers all to ships with their crimson prows and long slim oars, wings that make ships fly. And here is your sign— unmistakable, clear, so clear you can not miss it: When another traveler falls in with you and calls that weight across your shoulder a fan to winnow grains. Then plant your bladed, balanced oar in the earth and sacrifice fine beasts to the lord god of the sea, Poseidon—a ram, a bull, and a ramping wild boar— then journey home and render noble offerings up to the deathless gods who rule the vaulting skies, to all the gods in order. And at last your own death will steal upon you... a gentle, painless death, far from the sea it comes to take you down, borne down with the years in ripe old age with all your people there in blessed peace around you.25

This paragraph is the deepest mystery of the Odyssey. Although fantastic and complete on many levels, it is still incomplete. The human journey is ongoing even after the greatest achievements. Odysseus achieved the Inner-Marriage: he can be with his own nakedness and at the same time, fight and kill the suitors, and reconnect with the fully mature feminine in his earthly wife Penelope. Yet, he needed to go further, to the people who know nothing of the sea of the unconscious. What might have he learned from these people that he did not already know?

My recommendation for waiting and even encouraging the client to stay in the seemingly stuck place can inspire the critic to suggest that therapy is altogether unnecessary. If things work themselves out by the natural process of inner development, why spend all this time and money on therapy?

What would have happened if Odysseus landed on a deserted island- an Ogygia without Calypso? He would have taken longer to recover; but eventually, with his superior hero skills, he would have found food and shelter, made some tools, gotten
comfortable and eventually tried to build a raft. He would have remembered the Gods, especially Athena, prayed to them and received help. He would have returned home six years earlier, sad for his dead comrades, scarred by wars and adventures, yet completely full of his inner sense of identity as a masculine hero. At home he would have found no suitors. Penelope would have less trouble recognizing him, Telemachus would have still been a preteenager ready to admire his hero father. In short, the deep inner transformation would have not been completed.

The Battle of Jericho

The 40 years the Israelites spent in the desert, between their release from slavery in Egypt and arriving in the Promised Land, is another story of stuckness. The 40 years were a punishment for their lack of faith in God, fear of the challenges ahead and wish to return to the comforts of slavery. Seen as a metaphor from the perspective of this study, the story is about a necessarily long gestation period before the final transformation.

Once they enter the land of Israel, they come to the oldest walled-city, Jericho. Its name literally means “his moon.” The wall is a symbol for civilization and for the personal ego. The scouts Joshua had sent ahead of the troops got help from a prostitute they met in the city. She is likewise a symbol of civilization, similar to the story of Gilgamesh. In that story it is also the harlot that initiates Enkidu into civilized living.

When the Israelites arrived in front of the city, they set up a camp. Then, for seven days they marched in a procession around the city, blew their horns, hit their drums and returned to camp. On the seventh day, they repeated the procession and the music and encircled the city seven times, after which they stormed the city, the walls fell down, and Jericho became their first victory.
When working with clients on a stuck situation, I often like to use the story of Jericho. Especially when trying to reframe a core understanding or belief of the client; I suggest looking sideways at this new framework and encircling it a few times. Exploring it from all angles, singing the old song, and not confronting anything directly. After we do these enough times, the walls of old fixed ideas just tumble down.

This approach avoids the notion of resistance and respects the stuckness by acknowledging it from all angles. It also includes waiting for the right moment, not knowing in advance when it might appear.

**Implications of the Study**

**Myself**

The impact of this research on myself and on my therapy-work was gradual and significant. As I was conducting the interviews, analyzing the transcripts and getting feedback from participants, I slowly changed my approaches and attitudes towards stuckness in my clients, in the therapy work and in myself.

Long before I embarked on this work, mentors and colleagues had described my therapy style as very patient. Yet, this research work made me even more tolerant and accepting. This change manifests primarily in being more aware of stuck situations and more often able to name them as such. When I encounter stuckness both in my personal life and in my therapy work, the non-judgmental naming opens the door for further reflection and for more conscious choice in response to the situation at hand. That includes the option to name and accept stuckness as a significant and necessary step on any path. Very often I am aware of P5’s words: “…sometimes stuckness will happen
because a person just wants an opportunity to rest. Change is tiring, change is exhausting… so in those moments I want to check in with them and see if they want to cool their jets.”

I like this expansive viewpoint that allows me to relate more kindly to clients and to myself. A good yoga teacher invites the students to rest after every difficult stretch. Such rest is not just lack of action; it promotes digestion and integration of whatever was experienced and learned in previous steps.

At the same time, letting go of the preoccupation with change and with ‘doing something’ allows me to intervene more directly and sometimes forcefully, when it is clear that the client is ready and the door for change is open.

Participants

I was touched and inspired by the different feedback I received from participants. I learned that some of the participants were affected by our interaction, changed their understanding of stuckness, and with it, the way they approached it in their therapy work. P6 said in her feedback: “Since our role-play, I have also spent some time thinking about the patient's capacity to use such a moment and how that affects the therapy’s stuckness.” She told me about a recent session where she was more willing to sit in silence and realized that the client felt comforted.

P10 said: “I’ve been having a deeper understanding or patience within myself and my clients when they or I feel stuck. I’ve been trying to cultivate more self-compassion and respecting more the timing and pacing of my clients.” He added: “Especially working in San-Francisco amongst techies, there is a bias to always be moving forward and
achieving, so being stuck seems to have a negative bias. Being more ok with stuckness or having more self-compassion during those times can be very healing.”

P2 shared her new understanding that stuckness is a coping mechanism that protects the client from the next step they do not want or are not ready to take.

P7 did not have any specific feedback yet acknowledged the impact of our meeting: “I do appreciate being a part of this and it did have a nice effect of clarifying for me a lot of things I had been feeling about my recent evolution as a therapist in a new environment.”

At the end of our interview P6 said: “It’s not always a problem that requires treating, but it is something I’m always gonna want to give attention to. It’s a natural part of the therapeutic process for so many clients and so many therapists. That because progress isn’t linear it’s not always being pushed forward. In general, my sense of stuckness, personally and professionally, is that it’s a sign that something wants to shift. That either we haven’t evoked enough internal motivation toward whatever the goal we say we’re working on or we don’t have a sense of where we’re going or we don’t actually really care about the thing that we said we were going toward.”

**Profession of Psychology**

One of the unexpected results from this research was the positive feedback from participants that included reporting change in their professional work following our interview. This encourages me to nurture the hope that some new awareness can slowly grow in my supervisees and in my colleagues. Gradually this can lead to a shift in attitudes towards stuckness in the profession as a whole. P10’s comment about his change in relation to stuckness: “I’ve been trying to cultivate more self-compassion and
respecting more the timing and pacing of my clients,” captures the essence of the kind of shift I would hope for.

As discussed in other sections of the dissertation, the pressure of the ‘mental health industry’ for efficiency and evidence-based therapy is a major roadblock for such changes. These pressures increase anxiety in both therapist and client, lead to lower self-esteem and do not allow for a conceptual framework that can see stuckness as a necessary step in healing.

Yet, the kind of change P10 described can slowly penetrate the profession and lead to a tipping point and to new kinds or styles of therapy that might yield better results and possibly affect the culture at large.

A growing awareness that not knowing is the natural state of things and the source of all knowledge, can lead gradually to changed attitudes for therapists. Therapists will need to learn to tolerate the pressure to do something in response to clients’ suffering and the sense of powerlessness when not being able to alleviate the suffering. Therapists might start to develop the habit of questioning before any intervention if the client might benefit from it. With such new awareness the therapist would be more able to slow down and stay in more meaningful human contact with the client, trusting that healing can come from another level.

**Academic Discipline**

A few months after the research I discussed it with a friend who used to teach graduate psychology and she shared a personal insight. She suggested that the sixth step of Twelve Steps programs, which uses the phrase “character flaws,” can instead refer to work on stuckness. Understanding stuckness can help as she suggested, bring a non-
pathologizing approach. Siegel also suggests a non-pathologizing approach, saying that all DSM diagnostics can be reduced to rigidity and chaos. Both are aspects of stuckness.

I can see in some not so far future, an elective course about stuckness as part of the academic curriculum of professional psychology. In such a course, the students will learn to recognize stuckness as a natural part of every process, including therapy. They will develop the ability to be with it and avoid shaming the client and feeling shame themselves. They will be able to associate the feeling of stuckness with mythological images that help seeing it as a natural process as opposed to a static pathology to be diagnosed and eliminated.

**Imaginal Psychology**

More than other psychological modalities or theories, Imaginal Psychology recognizes the power of the image and extensively builds on it. As homage to James Hillman, the title of this dissertation includes the idea of re-visioning Stuckness. Hillman argues that psychology must include personification, which leads to image. He equates depersonalization with loss of soul. Stuckness can be seen as an aspect or even a result of loss of soul. Trauma or other forms of contradictory inner or outer forces lead to paralysis. Any attempt for movement or change is met with a counter force or an inner discouraging voice.

Imaginal Psychology can contribute by including images of stuckness that will help clients to re-vision and re-personalize their stuckness. Odysseus in Ogygia, Israelites in the desert or the battle of Jericho can become part of the more familiar image collection that feeds the transpersonal unconscious. Such enrichment of the imaginal
language facilitates both conversation and actual therapy that is more relevant to situations of *stuckness* in psychotherapy.

In an upcoming book, Moore included a chapter about *stuckness*. He quotes Patricia Berry, who sees the birth of Pegasus as a gift of the gorgon’s curse of *stuckness*.

He continues:

This myth would have us consider that within our immobility is a pregnancy and possibility for unusual creativity, a close connection to the Muses and to the deep, earthy kind of inspiration, the kind that bubbles up from the depths and offers certainty and confidence. And so the waiting may be a gestating, carrying to term that asks for near impossible patience.

**Contemporary Culture**

Stuckness in psychotherapy is not separate from the values and issues of the culture at large. Several participants pointed out that connection. A culture that values efficiency, change and immediate results above soul values such as inner growth and deepening would have no patience for gestation and incubation and would continue to see *stuckness* as a problem to be opposed or eradicated. The most frequent presenting issue in psychotherapy in recent years is anxiety. Some people try to cope with anxiety by hyperactivity and others by *stuckness*. For still others it ends up manifesting as bodily illness. Recent research demonstrates these connections and the overall implication on contemporary western culture. The personal and cultural conflicts between living a meaningful life and being busy with goal-oriented action can be seen through the lens of left- and right-brain dichotomies.
Ideas for Further Research

This research was limited to the common tendencies and responses that therapists exhibit in response to stuckness. It would be interesting to deepen the insight into various types of stuckness and the ways they show up in therapy from the perspectives of both therapist and client. The Law of Three can provide insight into some general types of non-change: lack of first force, too much second force and lack of third force. Each would manifest differently, although on the surface there will be an apparent lack of movement and non-change.

It will be interesting to research how long it takes for the therapist and the client to realize that therapy is stuck. What happens when that realization is shared in therapy by either therapist or client? Would the naming of stuckness be perceived as failure or as a new insight? It would also be interesting to research clients who already realized that they were stuck when they came to therapy, and what expectation for change they hold.

Conclusion

The fear of stuckness is needless because the longer you stay the more you see the quality-reality that gets you unstuck every time. What's really been getting you stuck is the running from the stuckness through the cars of your train of knowledge looking for a solution that is out in front of the train. Stuckness shouldn't be avoided. It's the psychic predecessor of all real understanding.

—Robert M. Pirsig, Zen and the Art of Motorcycle Maintenance

On the path to real change, as good therapy entails, our separate parts need to be known, accepted and then brought together, towards an integrated new meaning and new life. When I reach a blockage in my work with clients, it is often shame that is baring the door to change. The client’s shame or my own shame, equally leads to stuckness. My training with Healing Shame opened for me some deep realizations and new paths for
working with clients.\textsuperscript{36} Knowing and accepting the different parts is a major aspect of melting shame, rebuilding human connections and accepting one’s own humanity. \textit{Stuckness} is often the precursor to such changes.

Many psychological modalities and theories recognize the importance of \textit{stuckness} by whatever term they use to refer to it. Some of them recognize that the \textit{stuckness} might be an expression of the deeper part of the psyche. However, most are looking for a solution that is expressed behaviorally: going back to work, finding relationship or ending some form of suffering. In that sense, these approaches are following substance metaphysics that looks for meaning in detached objects or events. Calypso Therapies are more process oriented and can relate to \textit{stuckness} in the fuller context of a whole life span and create larger meaning from that perspective. Such approaches look for results in the fuller expression of a growing soul.

\textit{Stuckness} and the inability to move or change can be reframed in terms of the serenity prayer: “God grant me the serenity to accept the things I cannot change; courage to change the things I can; and wisdom to know the difference.” \textsuperscript{37} The wisdom mentioned is about the freedom to choose in every situation, between acceptance of things as they are and the courage to change. I hope that the learnings and the reflections that emerged from this research will contribute to that wisdom, specifically in the context of therapy.

Iain McGilchrist quotes Gendlin who says: “We think more than we can say. We feel more than we can think. We live more than we can feel. And there is much else besides.” McGilchrist adds: “Perhaps the soul is what we mean when we reflect on that ‘much else besides.’” \textsuperscript{38} Many psychological theories and approaches focus on the
thinking and some on the feeling. It is harder to talk about the ‘much else besides.’ I hope that this work can spark an interest in stuckness as a facet of the movement and rest of the soul. As such it deserves more respect than is usually given to it. With such respect we might look in a new way at the quote above from Pirsig, who considers stuckness as the real source of all understanding.
APPENDIX
APPENDIX 1

ETHICS APPLICATION

Participant Population and Recruitment

All the participants in this research are mental health professionals. This includes psychologists, Marriage and Family Therapists and Social Workers. Included in all these subcategories both licensed and interns. All participants have active experience of conducting psychotherapy for at least one year.

The research includes two distinct parts: a pre-research questionnaire and an interview. These parts are independent. Each participant can participate in both parts of the research or in only one of the parts.

I hope to get 50 to 100 responses for the questionnaire. The participants will be recruited through emails sent to various professional organizations and professional lists I am a member of. Closer professional acquaintances will be recruited via direct phone contact. I will also use snowball recruiting to increase the initial circulation. The total membership in these lists is well over a 1000 so that five to 10% response rate will satisfy the research need.

There will be initially 14 participants in the interview. The participants will be recruited through my direct professional connections and through an invitation embedded in the initial questionnaire, which will have a wider distribution. The intention is to have representation of therapists using different modalities, of different ages and experience.
and as much as possible of different cultural background. I will try to balance the number of female and male therapists.

**Research Procedures**

**How the Study is Described**

The email inviting participants to reply to the questionnaire will state that the research is part of a PhD dissertation on stuckness in psychotherapy.

When I will contact interview candidates, I will state the same, and will add that the goal is to explore therapists’ relationship to and attitudes towards stuckness.

**Participants Screening Process**

Questionnaire respondents are screened only by the distribution lists the invitation is sent to. I am assuming all members in these lists are mental health professionals. The interview participants are screened by their interest in the topic, their ability to relate to the experience of stuckness and by balancing the sample to include a variety of modalities, years of experience and gender.

In my initial contact with interview prospective participants I will ask if they experienced stuckness or stuck situation in their work as therapists. Then I will find out if they are willing to spend the time required for the main meeting (about 90 minutes) and the additional two 15-minute phone or online meetings.
Phone Contact – When and How

Interview participants will be contacted initially by phone or email, depending on our previous relationship. Once they agree to participate, I will email them a brief description of the research process and we’ll attempt to schedule time in my office for the main interview and for the initial phone or online brief meeting. The purpose of that meeting is to go over the research procedures in more detail and answer any questions they might have. There will be an email reminder a week before the interview.

After the interviews and the initial data analysis, I will send by email the initial-learning summary to participant who expressed interest.

Script of Meeting

There are no specific scripts. The main interview is described below. The first initial meeting includes description of the process, clarifications and answering procedural questions. The follow-up meeting’s purpose is to find additional emerging understanding and resolve unfinished issues or questions.

Description of Meetings Activity

The first 10 minutes include greeting and connection. Then we’ll review and sign the informed consent for and review biographical data. That includes age, professional education, years of experience, academic degree, professional license and favorite modalities or approaches to therapy.

The next 20 minutes are dedicated to a role-play that present a stuck therapy situation. The researcher will enact a stuck client with the participant enacting themselves
as a therapist. A vignette detailing the client and the case history is sent to participants before the meeting.

Following the role-play there will be a 10-minute reflection time including meditation and journaling about the experience of participating in the role-play.

The next 20 minutes are an unstructured interview. I will ask clients open-ended questions about their experience and be open to any associations, feelings, reactions and thoughts they might have. The intention is to follow the participant’s stream of consciousness and discover their specific interests, sensitivities and wisdom. I will ask participants to identify key moments in the role-play. I will also ask them if they find connections or associations between the role-play and their own therapy work.

The next 20 minutes section will be a semi-structured interview including the following topics or questions:

- Do you recall a case where you regretted intervening actively and decisively?
- Do you recall a case where you regretted NOT intervening decisively?
- Do you recall a case where your active intervention was successful?
- Do you recall a case where holding back and waiting led to a desired outcome?

The last 10-minute section is an exploration of participants understanding of “stuckness”:

- What is your understanding of stuckness in therapy?
- What leads to it?
- How does it resolve?
- Did you see expression or signs of stuckness in the role-play or the vignette? Where?
Finally, the last five minutes are for closure: meditation, unresolved feelings or questions, procedural review of our follow-up meeting and closing bell.

The total time of the meeting is planned for 90 minutes. Naturally, it can take slightly longer. Participants will be informed of the time requirements in our initial contact.

**Actual procedures for data collection**

The questionnaire data is filled anonymously and recorded by the hosting application (Survey Monkey or similar application).

All the interviews are audio and video recorded. The recordings will be kept on my computer and backed up to another computer. Both are encrypted and password protected. Later, the interviews will be transcribed. The transcripts will be kept in computer files, encrypted and password protected. Participants’ biographical data is recorded in computer files, also kept on my computer, encrypted and password protected.

**Follow-Up meeting**

About two weeks after the interview I will arrange a 15-minute individual online or phone meeting with each participant. The purpose of that meeting is to find emerging new understanding for the participant. It is also for integrating any unresolved experiences from the previous meeting or any unanswered questions. I will ask the participants:

- Are there any thoughts or feelings about our last conversation?
- Did you notice any impact on your therapy work?
- Was there anything in your work since we met that you saw in a new light?
- Anything you would like to tell me or suggest for the research?

Consent Process

The transcriber will sign confidentiality agreement before receiving any material related to this research.

The participant will sign the informed consent form in the beginning of the interview meeting, before participating in the role-play or starting to collect any research data. All these forms are included below.

Risks

Watching the therapy session excerpts is likely to evoke some emotions. Similarly, discussing one’s therapy work and history can also evoke emotions such as shame, guilt, sadness and regret. As all the participants are professional mental health workers and have some training in emotional management, I estimate that the risks of the interviewing process are minimal.

The questionnaire respondents are asked only to provide a definition of stuckness and are doing so in the safety and privacy of their own home or office. Thus, I cannot see risks there.

Safeguards

The interviews are conducted with one person at a time. The interviewee will have my full attention and in case there is any sign of emotional dysregulation I will check with the person, give them time to process and if needed stop the interview. I am a licensed and practicing Marriage and Family Therapist with over 16 years of experience.
working with situations of emotional dysregulation, always emphasizing safety. So, I have all the skills and experience to handle any such situation should it arise. Of course, I am fully aware that research participants are NOT therapy clients.

**Benefits**

The possible benefits from this research are likely to serve the mental health community at large. This might happen through bringing new awareness to situation of stuckness in therapy, possibly better understanding what leads to them, and supporting therapists in staying with such situation and letting them manifest as periods of incubation and gestation.

The participants might benefit from the research as part of the larger mental health community. It is also possible that participating in this research will prompt a participant to develop new awareness or insight into their own therapy work in a way that will benefit them and their clients.

**After Study Follow-up**

Once the research part is complete, I will share the preliminary learnings with any participant of the interview phase that expressed interest in that. During the follow-up meeting I will check with each participant regarding their interest in receiving the preliminary learnings.
APPENDIX 2

CONCEPTUAL OUTLINE

Pre-Research Questionnaire
- Send questionnaire to distribution lists and collect results
- Look for common themes in the data
- Formulate a common understanding(s) of stuckness by professionals. Possibly create a definition.

Evoking Experience
- Role-play a stuck client

Expressing Experience
Interview
- Journal about the experience
- Informal interview: ask participant for overall responses to role-play
- Structured interview: ask participant more detailed questions relating their therapy experience to stuckness.

Post Interview online meeting
- Share later understandings and impact on therapy work

Interpreting Experience
Interview
- Ask participants to share their understanding and discuss possible interpretations

Post Interview online meeting
- Ask participants about insights post the interview
- Share initial learnings and ask participants for comments and about their learnings

Integrating Experience
Interview
• Brief meditation at the end of interview

Post Interview online meeting

• Invite participant to share their overall experience and modes of integration into their practice.
APPENDIX 3

CHRONOLOGICAL OUTLINE

Initial contact: primarily by phone, at least two weeks prior to main interview.

I. Orientation and forms
   A. Explain the overall research process
   B. Collect demographic data

II. Overview
   A. Detail what will happen in the interview and follow-up meeting

III. Informed consent
   A. Informed consent and confidentiality. Participant agrees to include research finding in dissertation and hide identities unless participant requests otherwise.

IV. Respond to any questions and thank participants

Main Interview (about 90 minutes individual meeting – audio/video recorded)

I. Greeting, informed consent, review biographical data, connect - 10 minutes

II. Role-play with researcher as a stuck client - 20 minutes

III. Brief meditation – allow participant to reflect - 10 minutes
   A. Invite participant to journal about their reactions to the role-play

IV. Unstructured interview. - 20 minutes
   A. Invite participants to share how the role-play relates to their personal and professional experience.
B. Explore what was evoked.

C. Ask about significant moments

V. Semi-structured interview - 20 minutes

A. Do you recall a case where you regretted intervening actively and decisively?

B. Do you recall a case where you regretted NOT intervening decisively?

C. Do you recall a case where your active intervention was successful?

D. Do you recall a case where holding back and waiting led to a desired outcome?

VI. Exploration of participants understanding of “stuckness.” - 10 minutes

A. What is your understanding of stuckness in therapy?

B. Explore possible connections to the role-play

VII. Closure meditation. Summary. Bell. - Five minutes:

Follow up interview: 15 minutes by phone – One to two weeks after the main interview

I. Express gratitude for help

II. Ask how participant were affected by the interview

III. Explore new learning for participant

IV. Share my initial learning. Explore participant interpretation of the learning.

V. Explore integration into the therapy work

VI. Express gratitude and invite contact if new understanding arises
APPENDIX 4

INFORMED CONSENT FORM

To the Participant in this Research:

You are invited to participate in a study on stuckness in psychotherapy. The study’s purpose is to better understand therapists’ attitudes and responses to perceived stuckness in the therapy process.

Participation will involve three meetings. The main meeting will take place at a therapy office in Berkeley, California and will last about 90 minutes. The other two meetings will be conducted by phone or video conference and will last about 15 minutes each. In the main meeting you will participate in a 15 to 20 minutes role-play with researcher enacting a client. A vignette describing the client and the prior therapy relationship will be sent before the main meeting. After the role-play, we will explore your responses to it. We will use journal writing, open discussion and interview.

The first phone/conference meeting will occur before the main meeting. In that meeting we'll review the overall research process and collect some professional information. The second phone/conference meeting will occur about two weeks after the main meeting. In it we'll review any additional responses and thoughts you might have after main meeting.

All the meetings will be audio taped in order to be transcribed at a later date. The main meeting will also be videotaped.

For the protection of your privacy, all tapes and transcripts will be kept confidential and your identity will be protected. The tapes will be kept in a secure area under the control of the researcher. Transcripts will be backed up on the cloud and will be encrypted and password protected. Only the researcher and a co-researcher will have access to this material. In the final published dissertation and in any future publication of this research, any information that might identify you will be altered to ensure your anonymity.

This study is of a research nature and may offer no direct benefit to you. It might shed new light on the way you conduct therapy, which may be of benefit. The published findings may be useful to therapists and may contribute to the understanding of stuck situations in therapy.

This study is designed to minimize potential risks to you. However, the role-play and the following explorations might evoke strong emotions. Our discussion might evoke reflections on the way you conduct therapy or remind you of past experiences.
If at any time you develop any concerns or questions, I will make every effort to discuss these with you. I, the researcher, cannot provide counseling or psychotherapy, but at your request or using my personal judgment, will facilitate referrals to an appropriate mental health professional, if such a need should arise.

If you decide to participate in this research, you may withdraw your consent and discontinue your participation at any time and for any reason. Please note as well that I, the researcher, reserve the right to terminate your participation from the study at any point and for any reason.

If you have any questions or concerns, you may call my office at (510) 217-6939 at any time and leave a message. I will make every attempt to return your call in a timely manner. You may also contact me by email: soulful.counseling@gmail.com.

You may also contact the Dissertation Director at Meridian University: 47 Sixth Street, Petaluma, CA, 94952, telephone: (707) 765-1836.

Meridian University assumes no responsibility for any psychological or physical injury resulting from this research.

I, __________________________ consent to participate in the study of stuckness in psychotherapy. I have had this study explained to me by Israel Rulik Perla. Any questions of mine about this research have been answered, and, I have received a copy of this consent form. My participation in this study is entirely voluntary.

__________________________________________  __________
Participant’s Signature                  Date

If you would like to receive a copy of the initial learning from this research, please provide an email or physical mailing address.

Email Address: __________________ Mailing Address: __________________

__________________________________________  __________________
APPENDIX 5

TRANSCRIBER CONFIDENTIALITY AGREEMENT

The researcher referenced hereby is Israel Rulik Perla.

The research is “Revisioning Stuckness in Psychotherapy.”

1. I, ______________________________ transcriber, agree to maintain full confidentiality of all research data received from the research team related to this research study.

2. I will hold in strictest confidence the identity of any individual that may be revealed during the transcription of interviews or in any associated documents.

3. I will not make copies of any audio-recordings, video-recordings, or other research data, unless specifically requested to do so by the researcher.

4. I will not provide the research data to any third parties without the researcher’s consent.

5. I will store all study-related data in a safe, secure location as long as they are in my possession. All video and audio recordings will be stored in an encrypted format.

6. All data provided or created for purposes of this agreement, including any back-up records, will be returned to the research team and permanently deleted from my archives. When I have received confirmation that the transcription-work that I performed has been satisfactorily completed, any of the research data that remains with me will be returned to the research team or destroyed, pursuant to the instructions of the research team.

7. I understand that Meridian University has the right to take legal action against any breach of confidentiality that occurs in my handling of this research data.

Transcriber’s name (printed)

__________________________________________________

Transcriber's signature ____________________________________________________

Date ______________________
APPENDIX 6

ROLE-PLAY VIGNETTE

My Name is Rulik. I came to therapy about a year ago after finding you on Goodtherapy.org. I liked your kind face in the picture on your website and felt we could get along. I come to weekly therapy regularly.

I am 52 years old. Originally from Israel and in the US for almost 20 years. Married, no children. I worked for many years as a computer programmer but now I am unemployed, already for almost three years.

I completed high school. Went to the army like all Israelis. Served in some boring office job. Nothing remarkable. It did not give me any transferable skills.

I have an older sister who is a successful lawyer in a big corporation and a younger brother who is a musician. He is struggling financially but delighted with his art. Both live in Israel.

I played the guitar in my early teens, but I was not talented enough and gave it up after a few years.

My parents are in their late seventies. Retired. Still together in a cold relationship. They always provided what was needed for the children but were never too involved. Father was a middle manager in a government agency, something to do with evaluating eligibility for rebuilding and renovation grants. Mother was a high school math teacher.

I went to university and studied philosophy for two years but never finished my BA.
I moved to the US with my wife whom I met in Israel. She is part Jewish and went on a family roots exploration in her late twenties.

My parents were concerned at various points of my life and wanted me to study and become a doctor or a lawyer. They always said I could do anything I wanted. When I got married, they helped me finish a computer course so I could get a job. I hate programming but it pays well.

I came to therapy because my wife was worried that I am going down the rabbit hole. I am not sure exactly what she meant. I did not notice much change. Surely, I am getting older.

In my early twenties I was diagnosed with Bi-Polar disorder and was hospitalized for a week during what they called a manic episode. Since that time, I was on and off medications. Currently taking a low dose of Lamictal. Not always consistently. Often preferring pot chocolates instead as a bedtime treat. My wife does not like it. She says I am not there after the chocolates. When talking about the manic episodes I say that “I was just throwing a tantrum” and smile. It was kind of fun.

I trust you well enough. Over the year of therapy, I shared all the important events in my life. We have talked about school, marriage, girlfriends, friends (only few of either species), interests (very few including soccer), spiritual aspects, sex, family of origin and previous therapies.

I stated a few times that therapy is not going anywhere. You offered in recent months to find a referral, but I declined. I want to keep coming to see you.
I am seemingly open to all the suggestions. Sometimes I try an exercise or a new approach but invariably report later that it did not work and anyway things do not make sense.

I was involved a few times during my life in spiritual explorations. Went for about a year to the Zen center, and earlier in Israel went to some “Est” workshops. We talked about these, but I did not have much to say.

Previous therapy was about relationship and about family of origin. I seem to have a good awareness of my psychological development and how my family of origin affected who I am as an adult.

Financially, things are more or less stable. During the years of work, I saved some and our house is almost completely paid for. Occasionally, my wife’s parents help us with generous gifts that pay for travel. So, the unemployment is not a pressure on me.

I spend my time playing computer games, occasionally walking the dog, although my wife prefers to do that. Rarely do we walk the dog together.

My wife is in middle management in accounting, in a public relations firm and she makes a reasonable salary.

About once a week we go to the movies. We have sex about once a month, usually when she initiates, but not exclusively. Usually we go once a year to Mexico for vacation. Sometime get a vacation package in Hawaii. Once we went to Europe on a cruise. My wife prefers a regular and predictable life schedule and is reluctant to travel.

I exchange emails with my parents every few weeks and on holidays we talk on the phone. I have minimal contact with my siblings.
During sessions I usually sit in a limp position with my head down. You often need to repeat your questions. When I speak, I often go into long stories from the past work or from the army service. You already heard all these stories. Invariably I stop after a few minutes and say “You already know this story…”

Once my wife came to a session after you suggested that we talk together. There was not much talking in that session. She is not a talker. She said the marriage is good and that there are not any serious problems. She likes our lifestyle, but she sometimes worries about me. She is pleased that I am going to therapy. She trusts it helps me.

Ten years ago, when I was still working, there was an attraction with a co-worker. We were together in some conference out of town and drank a little, but in the last minute she pulled back. I was also not sure. It was a little exciting and frightening. I never told my wife.

In my mid-twenties I had a period of depression and people around got worried. But it passed after a few months and that manic episode that ended with medications.

You checked a few times for suicide and I always say that sometimes I think about it. It seems fun to think about it, but I have no specific plans and I will never try it. It does not make any sense.

My uncle committed suicide when I was 10. He used to take me to football matches. He was also bipolar.

When you asked about what the bipolar diagnosis means to me, I said that I read enough about the window of tolerance. But I am not really bipolar. Maybe I should stop taking Lamictal. I see the psychiatrist in Kaiser every six months, and he asks me a few questions and renews the prescription.
My health is kind of fine. I have migraines a few times a year and manage them with painkillers.

I go to the gym twice a week with my wife, mainly to please her. It is boring.

Occasionally I email with one of my high school friends from Israel. He is very depressed, and I am reluctant to talk too much to him. If we connect more than once a month it seems to affect me.

I do not have friends in the US. When I worked, I sometime went to social functions at the office, but these parties were boring. My wife has two girlfriends she sometime goes out with. They never come to our house. And she sometime goes to social functions at her job. I went with her once or twice, but it was too noisy, and the food was not interesting.
APPENDIX 7

INVITATION EMAILS

Pre-Research Questionnaire

Dear Colleagues,

I would like to invite you to participate in a research project on the topic of stuckness in psychotherapy. This research is part of my PhD dissertation at Meridian University.

Participation involves an anonymous reply to a brief questionnaire on this link:

It should take you no longer than five minutes.

Thank you in advance for your help,

Rulik Perla

Interview

Dear __________.

I would like to invite you to participate in a research project on the topic of stuckness in psychotherapy. This research is part of my PhD dissertation at Meridian University.

Participation involves two short phone or online meetings and one longer face to face meeting at my office in Berkeley or at your therapy office. The total time for the three meetings is about two hours. The longer meeting involves role-playing a brief therapy session with the researcher as a client. This is followed by a conversation about the experience.

If you are willing to participate, please let me know by responding to this email.

Sincerely yours,

Rulik Perla
APPENDIX 8

PRE-RESEARCH QUESTIONNAIRE

Please briefly define stuckness in therapy. A good definition will help distinguish what can be called stuckness from other therapy situations. (Please keep to 40 words or less)

__________________________

__________________________

License: (Psychologist, MFT, LCSW, etc.): _________
Highest academic degree: _________
Years of experience: _________
Practiced modalities: _________________________
Age: _________
Gender (optional): _________
APPENDIX 9

QUESTIONNAIRE RESPONSES

Following are the 84 online anonymous responses to the request to define stuckness in psychotherapy in 40 words or less. All the responders were licensed mental health professionals. The average age was 59 (range of 36 to 82) and the average years of experience 23 (range of three to 50) 55 were women, 23 men and seven did not specify gender. 14 had PhD degree, including PsyD and MD. The rest were at MA level, including MFT and Social workers. 71 respondents live and work in Northern California. The other 13 live in other states, in Mexico and in Europe. 65 different modalities were mentioned as respondents’ main practices, covering most if not all major modalities.

1. Stuckness is when we keep repeating the same issues and exploration without moving forward/making even small, positive changes.
2. Stuckness is an experience of shame, often disowned, that stops individuals from progressing. A freeze response.
3. Stuckness is when therapy is not working to allow the client to change in an area where change is desired. Distinguish it from an impasse and view it as temporary and something that will normally happen when addressing an issue threatens the self.
4. I think of stuckness as an internal ambivalence. While one part may want something and express desire for something. There is another part of the same person with another belief/desire or holding a core self-concept of 'it's not possible' or 'I don't deserve it'. Something in contradiction or polarized with the wanting part. This polarization IS the stuckness.
5. Ambivalence, fear of change, inability to change, or wavering between pre-contemplation and contemplation.
6. Stuckness in psychotherapy describes a situation in which both the pt and the thx feel stuck. Patterns continue to be repeated, both in the therapy office and in the patient’s life, without resolution.
7. Your question is unclear. Do you mean the client’s feelings of "stuckness" that brought him into therapy, or the therapist’s feeling stuck, during the process?
8. Being mired in a protective resistance with which the therapist has not yet developed enough trust to allow the healing process to move forward.
9. It is not when the client isn't changing, it is when the therapist has requirements that the client be a certain way. And the client isn't going the "right" direction.
10. Repeatedly going over the same things without added understanding or change.
11. A client's inability (so far) to shift into an ineffective belief, attitude, or behavior, often caused by a blocked traumatic memory.
12. Not feeling satisfied with one's progress on goals after a significant amount of time working on those goals; perseverating on negative beliefs or thoughts that fuel anxiety, depression, or symptoms of post-traumatic stress such as avoidance, inability to sleep or concentrate or sustain fulfilling relationships or work.
13. A sense in the therapist of not knowing what to do to help the client. The therapist feels "at a loss," wants to contribute but doesn't know how. The therapist believes they are not contributing to the client, not seeing change in the client. Or, if the client is the one reporting stuckness, they are the ones frustrated because of a perception of not enough movement or change. For whoever is experiencing the stuckness, the path forward is unclear.
14. When the client can't move on from their distressing emotion, thought or situation
15. Unable to see around the next corner and paralyzed to move in any direction.
16. My experience can assume many forms -- I or my client and I feel immobilized, my client/s and I are in a repetitive pattern that no longer feels or seems engaged or vital or my client or my client and I are in an experience that feel static. I think the experience often includes an initial feeling or fear of constraint or impossibility or a sense that something else exists elsewhere, that that "something else" might be a better place than "here." I have learned that "stuckness" is often a stage of change.
17. Lack of shift or movement physically, psychologically, and mentally.
18. The experience of being unable to move out of an undesired emotional state or life circumstance, often caused by limiting core beliefs, a perceived lack of inner resources, fear of change or of consequences, all of which are held in a particular somatic organization.
19. Stuckness is the opposite of flow. It is marked by mental fixation and emotional compulsion, usually of the nature of habitual reactivity. Such that attunement to innate intelligence and felt sensing is blocked. It is typically a defensive reaction adhering to a self-ground, rather than an openness to being as such.
20. What happens when one or both members of the dyad experience a lack of freedom or stagnation in a relational pattern, often accompanied by subjective sense of discomfort and/or a transference resistance. These moments are frustrating but can be highly meaningful.
21. When a person has not been able, for perhaps many claimed reasons, and deeper unknown issues in their subconscious, to move forward in a way they would like, they are "stuck." They have decided to do something and cannot get themselves to do it.
22. Stuckness is when the client cannot grow or achieve goals/healing, because of some kind of unconscious dynamic being played out in the therapy relationship that is not yet being made use of, or because of personal limitations or external limitations.
23. Stuckness seems to happen when people talk about wanting something, but they have cross motivations that prevent them from moving forward because of what they would have to give up. The wanting is not compelling enough to say goodbye to old patterns/behaviors/people.
24. The experience of the client being unable to progress to his/her satisfaction.
25. Prolonged lack of progress toward client goals and waning client motivation to utilize tools. Feeling unsure of how to proceed.
26. Frozen state, Inability to feel deep states of trauma which is experienced as a stuck place and inability to move forward internally and externally in life situations.
27. Stuckness feels like a lack of movement. 'Do what you've always done, get what you always got'. Client seems to not take in anything new. I feel heavy, bogged down. They cover the same material with no change or insight.
28. Not making any progress, unable to figure out which direction to move in, stuck in an enactment
29. A sense of not being able to move out of or beyond the present situation or perception of self or situation; frozen identity state, fear of or inability to step forward into whatever might be next.
30. Difficulty in opening up to, softening, in the face of painful/difficult/scary/unpleasant emotions and sensations.
31. Having some insight that behavior is not matching desired outcome, but continuing to use same behaviors
32. When a client keeps doing the very behavior that creates difficult obstacles in love de, wants to stop and can't. Therapy helps a little but not permanently
33. One does not feel that there is positive change occurring. A feeling of helplessness on the part of the therapist.
34. Stuckness can be defined as the slowing down of the therapy process as perceived by the therapist, the client or both.
35. Describing stuckness without assessing in the first place what is progress is bound to lead to confusion. From the non-dual approach, I see progress as the enhanced ability of the client to acknowledge and embrace his wholeness however imperfect.
36. A relational situation in which neither person can advance perceived intimacy and trust by any means known to them.
37. An inability to move beyond old habits, behaviors and continuing to live in a way that undermines hoped for outcomes
38. When stuckness occurs in therapy it's due to perhaps the client going as far as they can go in therapy or needing to revise/refine goals.
39. When a therapist either does not empathize fully with the client’s predicament to build a good alliance or when the therapist does not stick to the client’s agenda, therapy goes awry, the client gets annoyed, and is less motivated.
40. A condition where a therapist and client are seemingly not progressing but perhaps this place is an opportunity to wait until an impulse arrives to take a different direction
41. Emotional blocks, unwillingness to face psychological/emotional issues, inability to do deep work due to trauma
42. Stuckness is a judgment to work with as a factor in treatment.
43. Difficulty in moving forward towards resolution of the presenting problem, often accompanied by a feeling of interpersonal disconnection including a sense that either or both parties do not "understand" or that the same ground is being covered without evident progress.
44. I think of clinical impasses in which the process cannot unfold because of unconscious entanglement between the client's and therapist's complexes.
45. When I run out of strategies to address the client issues. If the client makes no movement toward his/her goal, I see it as my inadequacy or lack of creative thought.
46. Feeling like I don't know what to do to help the patient - and the patient feeling they don’t know what to do to help themselves.
47. Client frozen and unable to move
48. I can generalize a kind of stuckness as a pt's resistance to face the problems in their path. I call it "I'm/Everything’s fine Syndrome" or a fear of individuation in support of homeostasis in relationship, with parents in particular. The stuckness creates a paralysis in the Tx relationship.
Moving fwd into new awareness leaves me as proxy for problem causing others as I try to challenge the pt's limiting beliefs.

49. Stuckness is a feeling I experience when the relationship is not moving in a direction I consider needed. I try to shift & take actions that are different from past actions to allow for a new flow, communication and change. When this does not work, I surrender to the stuckness I feel a helpless (sometimes hopeless) feeling arrives. I then recognize I need to focus on myself and offer self-acceptance without judgment. The act of letting go of expectations and control then allows for the shift.

50. In my work stuckness is something I feel inside after I have worked with a client regularly for several weeks or months and I perceive no expansion of awareness or self-compassion, no breakthroughs in repetitive cognitive patterns, no self-reported positive behavioral changes or symptom relief, when the client reports feeling stuck, and our interactions in the sessions have begun to loop in predictable patterns, AND I am no longer able to imagine a shift in any of these factors.

51. Stuckness occurs when the client experiences no relief from their symptoms after vigorously exploring their deeper thoughts, feelings, history, and related aspects.

52. Stuckness is when there is an unnamed or not properly named disruption in communication between client and therapist. This could be a way the therapist missed something the client was trying to share, or the client has not yet found words to express what is happening and feels left in some way. This is what I have found is happening when there is stuckness in the work.

53. The ego does not want to be dissolved into global awareness. It does not want to die. That are resistances to its own dissolving.

54. Inability to engage with the therapist so as to move forward in therapy. The client "closes down"

55. When the client can't move past the presenting difficulty or can't shift thinking in the same way about an issue.

56. When a person sets a positive goal and makes no progress in achieving it

57. Stuckness is when you feel cloudy, tired, bored with a client. When there is no movement and you are not connecting. The interventions you have tried have failed.

58. A feeling of hitting a barrier/wall, possibly fear-based. As a therapist, not knowing where to go in treatment with client based on countertransference, lack of experience or scope. As a client, lost in process, "stuck" which could be a confused state or the process of an awakening in self, i.e. a discovery of a part of self unknown in the past. Stuckness may feel uncomfortable and motivating and challenging at the same time.

59. With highly active participatory experiential somatic modalities such as Hakomi, Lomi, EMDR, and other forms of mindfulness, relational and somatic practices, some movement is expected each session. Stuckness happens when clients need a slower pace. They are not yet able to integrate new insights and sensations. Stuckness is simply another state to track. Stuckness also happens when clients have little self-reflective capacity, or the therapeutic relationship is not evolving well for a variety of reasons.

60. When client is not experiencing adaptation, resolve, change, movement, progress toward their goals or expectations of therapy. May be that client is not engaged, not ready, not willing. May be therapist is stuck - not engaged, not feeling movement in therapeutic dynamic.

61. When a client is not ready to acknowledge their defenses. When it feels like you are having the same session over and over.

62. When the client is struggling with situations and emotions I haven't personally dealt with before, like MDD and ADD. Some personality d/o's I don't understand and don't work effectively with, like BPD.
63. Not knowing which way to go, after trying every which way and ending up back in the same spot, stuck. Sometimes ambivalence is here, and we are afraid to pick a decision, hoping someone or something else might make it for us. While we go around and around, but stay stuck, in the fear. Usually two or more inner parts of us are in conflict and it causes much distress.

64. Apparent lack of progress. No quantifiable changes in behavior, feelings or circumstances. Person can be trying or not trying to change.

65. The therapist feels stuck when they cannot think or associate or imagine a way to help the client think or feel about themselves. A client might feel stuck when they cannot think or associate or feel or imagine being in relation to themselves in any other way than the way they are. An impasse is when both therapist and client feel stuck for the same period of time.

66. What comes to mind — Un-readiness/unwillingness to let go of a certain world view/experience; i.e. a need to remain with a way of being in the world; avoidance /fear of an anticipated experience; a body based trauma; a need to force the therapist co-experience the painful place; difference between therapist and clients perceptions of what needs to happen next; lack of expertise in the therapist regarding how to access/ be with the client's suffering; fear in the therapist to go where client needs to be met.

67. Stuckness in psychotherapy is when there seem to be no progress, or no change, in the client's life. Many times, that would bring up feelings of helplessness and thoughts of incompetence in me, or frustration with the client.

68. A lack of apparent progress. However, it is not really possible to know for sure that progress is not being made, since the therapeutic process would have difficulty in measuring any achievement present in the unconscious mind.

69. I see stuckness as the experience of someone who is so mired in their identifications that they can't see possibility.

70. Where it appears, there is no movement in the work.

71. Burn out, biology of freeze.

72. 1) Client is unable to modify self-defeating behaviors and/or mood disorder while continuing therapy sessions., 2) Imprint of early attachment injury and/or trauma on the body, brain and central nervous system is deep, pervasive and is unresponsive to interventions (so far),, 3) A habitual coping strategy (i.e., addiction) prevents access to corrective experience.

73. When there is an impasse. At least 2 different states which are in opposition usually unconsciously and stuck. Occurs.

74. Stuckness = adaptive response to stress, threat to safety, potential conflict or distress that signals one to stay within one’s comfort zone.

75. I find stickiness happens when I pressure myself to get my clients somewhere - or, the client does not sense any agency in moving forward.

76. Resting In safety before going onto the next level.

77. The main symptoms are there, don't improve.

78. Not feeling metaphorical movement forward in life or therapy, ruminating about the same issues without resolution or transformation.

79. Client is in a survival state; no blame - rather, client and therapist not able to create system that supports growth and transformation.

80. When a client is stuck, they are using only the conscious bandwidth of their awareness. This 10% cannot resolve our deeper issues. The other 90% of our awareness is a treasure trove of innate wisdom that, when accessed, gives the client more relevant information, and more possibilities open in their field of awareness.
81. When a client longs to make changes or move through a certain limiting belief or construct and can't. When the therapist isn't seeing movement in a client issues, nor is the client experiencing growth, awareness or progress.

82. Sitting with a client and feeling/believing that the tools I have will not suffice to help them improve/meet their goals.

83. Stuckness: Client unable to make progress in increase of functioning due to a variety of possibilities: misunderstanding of how to move forward, overwhelm of the nervous system, a break in trust with therapist, or possibly a need to integrate fully changes that have already begun.

84. PTSD and preverbal and/or chronic childhood attachment injuries program the primitive brain, central nervous system and cognitive function. Healing requires time, determination and contemporary reprogramming techniques.
APPENDIX 10

SUMMARY OF THE DATA

The 10 interviews generate close to 20 hours of video recordings and 100 pages of transcript. This appendix includes about two pages selection from each interview, eliminating most of the questions and large parts of the conversation, while keeping the salient points made by the participants and all the parts quoted in the learnings.

All the 10 participants were licensed mental health professionals. The average age was 54 (range of 32 to 73) and the average years of experience 20 (range of six to 40). Eight were women and two men. Seven practice as MFT, two as PhD and one as PsyD. One of the MFTs also holds a PhD in Psychology. All participants live and work in Northern California, six of them in the Bay-Area. The modalities they practice include CBT, DBT, EFT, Somatic, Psychodynamic, Rogerian, NVC, EMDR, Play-therapy, Narrative, Solution focused, Object relations, mindfulness, Hakomi, Relational, Brief, Psychosynthesis, Existential and NLP.

Interview 1

R: Any other notable moments?
P1: That as soon as I get close to emotions you dissociate.
P1: About the case? Frustration…Yeah (softly-thoughtful), I think I worked up too hard, I am a cheerleader, like your wife, except she stopped presenting it. She is a pursuer that turned a withdrawer in EFT language. So now you have a withdrawer-withdrawer relationship if you ever want to go into that. In a future session we might want to explore that. To bring your wife into one of these sessions. But you are both withdrawers… you are a typical withdrawer.
P1: What I see is that she was a pursuer and she is now resigned. So she is now a pursuer that turned withdrawn.
P1: That I am working too hard, that I am frustrated, and that I was sad for the client.
(Thoughtful) Yeah.
R: Frustrated, not impatient?
P1: Mhmh. But also the impatience I had, which I always have, is that I am going to give the answers.
P1: I think I would probably feel that I would like to…find ways to move things. But me as a psychologist I cannot do same… something has to change, I am a change junky. So I would probably walk home thinking, how can I inject something that would probably reduce the fear of the excitement… because what were you saying? You did not say scared, “scared” is much more traction word for me, you said ‘threatening’. Threatening is like “don’t go there.” So I would try to get traction. My brain would work like “How can I get traction with this client?” To inject something that would help them to be less threatened by joy.
P1: I never met the spouse. Anyway…so I am constantly looking for traction, sending him home with homework,… as a clinician, working with this client I would be very active. I will find myself in a super active modality. I will not have 52 sessions! No way! (Laughing) you see how I am triggered even from a 30 minutes role play. So as a clinician I will not be able to continue that level of going nowhere every week.
P1: I will not kick him out. I fired one couple one time because they were violent. I said they needed to get other help. No, but I am not… as you know me I am very active. I will use my will to get them to want to be more involved, in the process. Together we would create the situation. Like this client was saying, so we do journals, we do writing, we do CBT as soon as possible, we do acupuncture, and I mandate it. I do my job, you have to do your job. But I don’t mandate it as an ultimatum. I make them want to do it. They make me happy.
R: Does this relate to what you said before about working too hard?
P1: Yes. I think it leads more to burnout. So there are two things, one is that I do believe it leads to more wear and tear on me, and possibly on cutting the client resources, that they are not given opportunity. They do not develop their own resources because I give them the answers. I provide them the answers, I don’t know if that belongs here, but that is one reason I love Sue Johnson’s work. It does that, and it helps me not get too overdrawn. But in Emotionally Focused Therapy we are very active. We are orchestrating,… in every session we are a producer, and I love it. Jeff too (Talking about Jeff Zeig). And I gravitate to that because that is who I am. So that downfall of that, is that unless you know how to do it, like Sue or Jeff, it can be very exhausting. Asking the client: “How do you feel? How do you feel?” Is not for me. If I know the answer I am going to give it! And I am not going to spend an hour, and I am telling this to you now, not knowing if it is part of the research…
P1: For me, spending an hour helping someone access their inner resources is a good idea, and yet, and it is also for me, if I know a shortcut, why not give you a shortcut.
So when I have a couple in, I know their dance. I know the dance of the relationship right away. I don’t spend two months for them to figure it out. That’s the point. That is why I am doing workshops. I teach, and then people break into the couples, they do all their work in private and <co-therapist> and I walk around, and I kind of Para shoot in. And I orchestrate, I talk for the man, I know you have seen Sue <Johnson> work.
P1: Literally? Everyday! I am referring to couples. Completely. Yesterday, a couple that almost separated and he has been quite a withdrawing and shutdown, and she has been a pursuer-pursuer, and finally she checked out. And I helped her, I helped him, I work with the withdrawing first, and then in the second session, I helped him to access, the part of him, that’s where I overlay things I was talking about, the inner child. The part of him that has done that, because he has been such a withdrawing and she gave up. To access, within one session, his childhood part, that never feels confident, and always afraid to fail, because of a very abusive father. And then to share with her, that he is always feeling, like when she asks him to do something, and does not do it, that no matter what he does, he is going to fail. If he does it he is going to fail, if he doesn’t do it he is
going to fail and it becomes catatonic. So access that, one session, share with her, and she says “I never knew that” and him start crying, have her start crying, and I could have been done with the therapy … in EFT the second session is “Raw Spots,” which is the thing that, attachment injury basically. When you take the inner child work and you put it on attachment injury, you go “Bingo!” Anyway, I’m sure you know that.

P1: Sure they can benefit from resting. When I first went to <her therapist>, I was OK, rest, slow down, but after some time it became a diminishing return. That’s what I’m saying. With you, I would get bored, as a client. But I could see the value, on two levels, I can see the value, because part of me appreciates that piece of me that is missing. Which is being more calm, being more a listener, asking more questions. I miss, I know that there is a part of therapy that I am bypassing. So I think that is important,…it is essential, and then, I am missing that piece. There is something for me to learn! If I could break through your more quiet, maybe more ego-psychology, psychodynamic, somatic, then I might go somewhere. I just can’t go there. So as a client I would just be bored, Yeah.

P1: For me, stuckness must be a temporary phase. It must be something to recognize, diagnose and break through. Even if it means cutting it, cutting it, cutting it. Because sometime with clients, I give them a big movie and they go wow, like I did with you, so I simplify it. Dilute it, dilute it, dilute it, but I never stop. Its too much though, ok, I’ll pass it by you but in a little slow phase, so we still talk about it, cutting it. So stuckness for me is just not going anywhere.

P1: Yes. Its lack of movement. That’s why I say to you: if this was our last session and we are done, and you say why be done, the client says “why be done,” I will not take this as an answer. So I have this magic question, what if that’s our last session. There lies another modality, or what do we call it?, that for some people, therapy is maintenance. So I shift and we call it maintenance. So now we are not going to meet every week. We’ll meet every other week, and then monthly and quarterly. And I am more likely to actively pushing them into that. If they have a lot of money and they like me and they just want to come because they know,… that is fine… that is fine, I have a couple like that.

P1: (quietly) So many therapists are codependent. They go to become therapists because they are co-dependent. Ok, now I am on my soap box.

R: How do you see the causes of stuckness?

P1: I think it is the part that is afraid to get better. The part that is afraid of the unknown. I think it is a childhood part that somewhere, sometime decided that it is more safe to stay stuck. Either because of abandonment issues, rejection issues, …

P1: How do you say, without shadow… without light there is no shadow, so we need both. You need to get stuck in order to get momentum to not be stuck.

R: connecting back to the role play, could you see that as grief work?

P1: Absolutely. So if I had longer to explore that work, I would go there, not only that this is a process of grief, but that there is grief somewhere that needs to be identified. Not that we are going to spend two, five, ten, fifteen years in grief…in this vignette.

P1: You know, in many ways, people are stuck in relationships, I move them one way or another. I am more of the “shit or get of the potty” kind.

P1: (question about the role-play) to help him hit bottom? It’s a good question. I don’t know.

P1: It was fun. I think in someway I stopped learning. I am going deeper in a very narrow area. So this reminded me of going to school.

**Interview 2**

P2: there was a pre-feeling. The proposal of coming into a session where we will do 20 minutes with a client who is stuck. Definitely brings up dread. So coming in I had to battle my own
internal feeling… what is stuck going to feel like. Because I have my own feeling of being stuck.

I have to do a lot of internal self-soothing just to be with a person wherever they are stuck.

P2: I did not feel him pulling anything from me, in the past the person did not really want to be stuck, and I did not feel him not wanting to be stuck. So that did not pull on my “fix-it.” This is not comfortable,

So I did like him, I like when he said that I really cared about him. I was looking more for his curiosity. I saw it going more into the video games …Well, I was looking for the connection, I could not tell if the person wants to change … And maybe it is again because I was not actually sitting with him for a year. I was mostly looking for the connection. Theoretically we would have already been connected after a year. Maybe not… maybe that is part of stuck. Sometime I visualize the connection. And he just was not aware where the stuck was for him.

P2: I was noticing that when feeling came up, his hands where doing this a lot. And I wanted to ask how he experiences these things physically, and then when he talked about playing soccer. He mentioned soccer several times, it seemed like an asset, because that was active and he mentioned having fun and feeling closer to the person he was playing with, so that made think about action and activity and walking, but again, I was trying feel for,…. he did, I feel very, and that me more about me than him, I feel, I don’t want to get into a yes-but situation, when I got “not a big deal” I backed off and observe more, I did not want to get into a dynamic of push-pull, that is where the dread is coming in, I think when the client is stuck, there is a risk of soliciting my agenda. So I want to really careful, it solicits my fix-it, what are you going to do about it, so I tell myself to slow down, just be with him where he is. And with him, because there was no urgency, because he wasn’t feeling urgent, I felt I can do that, I can be here with you,

P2: Well, I don’t know if this is me making myself feel better, or would in fact be an outcome. But my really stuck clients, that I think about, that I was dreading, I often need to back myself off to “He is finding value in this connection…even if I don’t know what it is.” You know. There is presumably some pain relief…that’s it. I don’t know. He is in kind of steady state. I think he would be more happy if things were happening for him…with his friend so … wondering what he meant by confusion, and challenging … he might be one… there was something about giving him homework…(looking at vignette) I stated a few time that therapy is not going anywhere. I would be curious about that. (Mumbling) I guess I want to get him moving. I don’t know how that would be.

P2: I have been seeing that one person, who was in college when we started, we worked for two or three years, maybe five years… and then there was a five years gap, and then he came back for another three, four , five years… I will be very kind of active and then buffeted back, it was really due to direction of supervision in our group, I got super pushy, (loud) how do you say “I can’t” and not “I won’t.” and oh my word, I know that was not the right thing to do. I don’t know right or wrong… whatever his stuckness is protecting him from something, and as miserable as he might be now, it is less miserable when that thing was bullied too fast. And that felt like it kicked of a period of suicidality and depression.

P2: (checking the connection to suicidality) No, I am not that powerful, but because I did something that was out of character for me, that he was relying on me, and when I came with feedback that was not really me, it was me trying something else, from other people, that was weird, “What are you doing? What do you mean?” … however I did it that felt like…I would not say regret… it was just not very useful. I think it was coming from a place of me having a problem with him rather than him having a problem. You know, and bafflement of why I was working for him. But it seems to be. I would be gasping for breath because I could feel the stuckness (gulping for air) it felt like he was just wasn’t breathing, he wasn’t taking anything in. I really want to know why.

P2: Maybe, in the one it was a need I identified in the moment. And I went with it, even though it is unusual for me to just say “Don’t do that!” And the other one it was the blind leading the blind. Because in the consultation group, you guys don’t know him, basing your feedback on what I was
telling you, so that intervention came from outside of the room, and nothing to do with what was happening in the moment for me and him. It had to do with me feeling stuck with him, and not with him.

P2: It builds trust, especially in a situation where the person is “Everybody has demands, you do not care about me, you care only about money” thinking back about client Rulik… if you want to be on this planet you need to find something or someone to trust. Otherwise you just stay in the cave, don’t you? Who does he trust? And does he trust me? It was pleasant enough to be with but … maybe it is asking for awfully big leap. I don’t know, it makes me think about all the little stories with little axis of betrayal, small and large, like the story of hospitalization, what happened around that? I am wondering, it sounds like he was not stuck before the move. Not necessarily… maybe, but he was always stuck in the family…

P2: I have to start with Ester Perel definition, she talks about it as extreme stability. I guess I think about it more as immobility. Whatever forces are at play on me, I am in this spot and I cannot move in any direction or else.

P2: I think of it as trauma, combined with temperament, combined with social circumstances. You know, exception to the rule, resources they are not aware they are using. Need to redefine their abilities to move. With that particular really stuck client that I worked with his whole life… I don’t know if I ask him: “Does it matter to you that I value your writing?” he might say of course … but it does not touch the stuck part. I guess in that case it is coming back to grief.

P2: Yes. This is a better choice. Pretty intolerable, I would like to find a way out. When we did our group you guys talked about helping him own wanting to be there. Patricia’s take was that it is working great for him. But I think he feels great shame about it.

P2: (about shame) I did not feel it, it makes sense as so many people do, but I did not feel it. The anger being fun was curious. I guess I would think of it more about being more than shame, something about the hospital, that event seem to cut him off from vitality, and I am not sure about shame specifically, more like “I am used to that flat world now.” Learned helplessness maybe more than shame. As a strategy, I did not hear shame so much.

P2: I think some people can feel contentment, and another person might call it stuckness. The last line in so many DSM4 definitions is “is it a problem for the person?” So if stuckness is not causing a problem for the person, I don’t know if it necessarily a bad thing. I definitely worked with couples where the person who is with them feels they are stuck and it is causing a hell of a problem for them. That couple we talked about, she needed him to earn money, but for him it was not a problem, until he was going to be on the street, and even then he was not sure.

P2: …so it’s part of our job to figure out how it is not working for them. And helping them figure out how it is not working for them. If indeed it is not working for them. My judgement would be outside of them, I am enjoying my life, if that is not working for you… that’s why it was a weird intervention with that client, when it included the kids and it was really clear. When it comes to adults I guess I don’t have too much of “you should this.” If I have some should it is about “you should not treat that person that way,” but when it comes to their own experience and what they like and don’t like I am pretty, let’s see, easy on opinions…But I did not feel it was not working enough for him to move him somewhere else.

I guess I am curious about these moments when he thinks about dying. Because that would be an indication about what is working for him.

P2: No. The most powerful feeling I had was dread, anticipating stuckness. What I think about these last few questions you are asking is, where is the locus of motivation in relation to stuckness? I’m trying to think if I felt stuck, feeling empathy for the person being stuck.

My client felt stuck, like, get me out of here, but that what landed urgency to it. He wanted to not be stuck, he felt stuck. And he did not see the ways he was slamming the door in his own face. So it was different than this guy’s version of stuck. He probably wanted something, but “ I could not
get it anyway.” Hopeless.

**Interview 3**

P3: I think of stuck as, like, when you want something but you can’t get it? But, I have no idea what he wants yet. So, I don’t know, I don’t think I would say he’s stuck yet without knowing what, if he wants something. I’d say he’s…I mean, he seems depressed.

P3: Like I almost felt like… I felt self-conscious when I wasn’t matching his energy.

P3: Like I was… I felt, like, young.

P3: Yeah. I felt, like, young and kind of innocent and a little naive, and like, I didn’t feel like I was being serious enough… in some moments. One the one hand. And on the other hand I was, like “no. I’m just being a human being relating to another human being.”…Felt like it was important to answer directly because it felt like it was a reaching out for a connection. …And I wanted to meet him in that.

P3: I think if he was my client I would be more anxious.

P3: But it’s nice to just have 20 minutes where I’m just like “Ok it’s not my responsibility, I can just be with him.”

P3: But I don’t think I wanna do anything differently. I liked how I was with him. I liked being with him.

P3: (telling about NVC group) …I felt with a new person. And I was sick of it. I was sick of my own stuckness. And the leader, said... I kind of looked at him and said “You must so sick of like how I’ve just been repeating this for like five years.”…and he was like… Or I said “How I’m not making any progress with this.” And he was like “Not at all.” He’s like “I’m not monitoring your progress. I’m just loving you.”…And I believed him and it was so healing.

P3: And that’s one of the tricky things about therapy. You gotta give progress… and I try to put that aside and just like be with the person and not even think about progress. So then stuckness is not that relevant.

P3: So I was doing the like suicide assessment thing and the presence thing. And I felt like I, my self judgement was I… It was like I was judging both… This is why I don’t like consultation, cause then I like operating with him from, like what she’s telling me I should do. And then I’m like less, have less access to my own presence. So it was just like kind of disjointed and I felt not very connected to him and not, just anxious. And he left. I mean I had a couple more sessions with him, but then that was the end of the work. And then he transferred to a lower pay clinic.

P3: Yes suicidal clients bring up a lot of anxiety for me. It’s hard to think clearly…And I really feel like I am supposed to do something. And I’m supposed to do the right thing. And if I don’t…

P3: Very serious consequences. The pressure’s too much. So if this client told me he was suicidal when, you were playing it...that would be an interesting session. That I probably wouldn’t of felt good about. Because I can, I get stuck. So what that means to me is I can’t really access, it’s like I don’t have access to my confidence or my inner knowing or my self-trust. It’s like part of me is like offline and I’m just like in terror and self-judgment and fear. Yeah, a lot of fear.

P3: … if from like an NVC perspective if our needs aren’t met we blame somebody else rather than yourself instead of acknowledging that are needs that aren't met…and it’s often the therapist’s sense of effectiveness.

P3: One that’s coming to mind: I saw this couple this week and I did a very unusual thing. Which is, they were already out the door and I said “Oh come back.” And they came back in. And I said, “I want to send you a document that will help do things that you’re trying to do. Is that ok if I send that to you?” And they said yeah. And then I went home and wrote it. It wasn’t written yet, but I wrote it up and then I sent it to them. So that was like I wasn’t gonna…I was just gonna let them figure it out. And then I was like oh there’s a little that I want to offer.
P3: (regret not being more active) No, not that I can think of.
P3: The thing that just happened is I’m thinking, “that’s interesting, I don’t regret it.” So maybe I can trust it more. If it’s hard to remember times I regret not being more active. Because there are times that I doubt that this less directive, less active approach is enough. But saying that helps me trust it more.
P3: That it is enough. But there’s kind of a constant doubting of it. I think because of the culture, not just the larger culture, but the psychotherapy culture here. The progress oriented...So, maybe it is, maybe I am doing enough… It’s a good to get out of this.
P3: The redeeming quality is that it’s what is. It’s like true.
P3: (about impasse) Like That it’s inevitable and that it’s ok, it’s not a problem? And it proceeds change. So it’s OK to be there in it. It’s not a problem. To, Yeah, to like trust that it’s part of the process.
P3: I’m thinking with the character you played. Like if he’s at an impasse. I don’t know that he’s at an impasse...It’s like that in-between where like, the old way is not working, the new way you haven’t figured out yet and you’re in the middle.
P3: Limbo and it’s not clear, it’s really foggy, it’s not clear what to do.
P3: (about getting the pupa out of the cocoon) Wow. That’s powerful. That’s a powerful metaphor. They’re just like letting the process unfold…Like they might seem ok after you interfere. Like they’ll have the skills...But, you know what I mean, about like, you know it’s still a butterfly, so it looks like everything’s fine but it’s not.
P3: So, I’m like just comparing that to, like, you know, you have these DBT scales or the CBT scales and it looks like you’re fine but ...
P3: Yeah, that’s great. You’re going to use that? That’s really powerful. So it’s really like trusting the process. And managing our own anxiety when we’re trusting the process. Trusting the person's process. They’re, like organic unfolding. Which is what I love about Carl Rogers.
P3: How do you...how would you encourage more stuckness?
P3: Would it help to share with him my perspective? Sure. But more, I think, just because if I’m thinking that, like the transparency, I think, might bring some more aliveness to the connection. And I think if the connection is more alive that might help him feel more energy. But not for the purpose of, like, convincing him that my perspective is true.
P3: But yeah. If I’m thinking he’s stuck and I’m not sharing that with him and I keep thinking about it. Yeah I think I would want to share it with him. Just for the sake of authenticity and the connection and the aliveness that could come from that.
P3: But I would probably say it like, you know, “This is how I’m seeing it. What do you think of that?” or “Does it match how you’re seeing it?” or “How do you see it differently?” Or something like that.
P3: Because stuck is both a feeling but it’s also the way you’re using it like a judgment or an evaluation...There’s a benefit to reaching bottom
P3: Yeah, it reminds me of like radical acceptance… (talking about a non-dual teacher) They’re not trying to change what is true, they’re welcoming of it. I can’t wait to read your dissertation.
P3: I like it. I really like talking to you about it, thinking about it. It’s something I think about a lot. Not stuckness, but like the kind of tension in our field around progress and acceptance. So...Yeah, it’s just nice to be able to talk about it a little.

Interview 4

P4: (talking about a client) He was absolutely disappointed and hold this huge grudge against her, in his case, he is very intellectual, he intellectualize everything. So he does not know what his feelings are, he does not know what she is feeling, every time she says something, he goes back
to his list and checks, she did this, this and this. The account is growing. And this is his modus operandi. It is not the same, but what is remarkably the same, is that he has no desire to make it better because he is disappointed daily. There is negative reinforcement so he is stuck.

R: What is going on for you?
P4: Its teeth pulling and I am pulling teeth. I am a dentist, we don’t know which tooth it is. So we got to pull them all. But I don’t want to pull them all, it is very painful. I don’t want to suggest trauma, I don’t to suggest that someone beat them up, I don’t want to suggest that he was suffocated when he was two, you know, I want… But I do guess from him that he is afraid, so he had some sharp rebuke somewhere, that he buried or he does not want to talk about, or he does not know, he truly may not know.

R: May not know, you mean it is unconscious?
P4: He may know and not want to talk about it, or he may not be aware of it. In his subconscious. Something has been buried for him. But with this client I don’t feel, it could be, it’s a little bit all this resistance, which negates everything. It puts one off.

R: It puts you off as a therapist?
P4: Yes. There is no handle, nothing to hold. Like looking at a smooth cliff. How do I go up this? What do we hold on to here? What I find for my style, I have to find some place that we have some agreement. You know, like the guitar is the closest it got.

R: That’s the closest it got. You got an agreement.
P4: Yeah, and then we can work from there.

R: Is this a place where you felt you were getting in?
P4: No, No (laughing) but it was better than anything else. No, it was not getting in, I was not sure if he was saying it just to say OK, I’ll do that. But he, at the end he was saying yes I will do that. He did not want to do the guitar, but he wanted to want to do that. Because I suggested it. And that’s the kind of thing that makes one very curious. Who, who, where did you stop calling balls and strikes in your life? You stopped deciding which way to go. Does everyone tell you what to do? What’s going on? You know. That kind of being unplugged reminds me more of chemical depression than anything. Because people are helpless if they are chemically depressed. They cannot lift themselves up by the bootstraps. They cannot play the guitar.

R: You are curious? What is the feeling for you? You said “pulling teeth”
P4: I am curious that he is not curious. I am curious the he really lost caring. I can understand, if I flunk a test and the teacher says “don’t you care” I understand that, but I wonder, is there anger in that, is that repressed anger I am looking at and…,

R: or afraid of it
P4: Yeah, but afraid of what? That wasn’t clear to me. Afraid of going to the hospital? I can understand that, that is terrifying.
P4: (about the role-play) Well, I have a criticism...And I have a client who is like this, but he is not like this. This was really overdrawn; I felt it was cheating (laughs). He is stuck.
R: who?
P4: The patient Rulik is so extreme, and he is facing any sensation, that it was impracticable
P4: But you see, I have a problem. I don’t meet with client unless they do define something. They can take 10 years to do that, but there must be more getting on board to go in some direction.
R: Can it be in the middle, we say we are going to Paris, and then we are in Marysville and we get stuck there for a few years.
P4: Yes, or like the guitar thing. Ok, that is a beginning. That would be enough, he was willing to do that. But I would have to change to conditions for that, it would not be enough because I have suggested the guitar. It has to be something from him. At some point in the next... it isn’t so much if I am patient enough, although it is connected to it, I am sure, my patience is connected to
, do I see anything from him?
R: So what if the client does not buy in?
P4: I don’t do diagnosis. What do you want to do? What can we do together? We need to have a language we agree to. So I think you need to be more active. You need more stimulus. Maybe play the guitar. Ok I play the guitar. That was good so we try more. What stops him, how does he feel about that? If he keeps saying he does not feel anything, than I can’t work with him.
P4: I have clients actually that are doing this, because they are paying I cannot hear their pain... and I feel very guilty about that. I say I want to hear something, or I say I want to help you but you but you had this for 15 years
P4: Yes, so I would raise it as a challenge to him. When you can come up with something that you want to change, I will interact with you on that. Until then I can’t help you. You know, that is what I would say.
P4: I think those are very good distinctions to make, because I think someone’s impasse is not resistance. A person, this client, Rulik, may have an impasse regarding his desire to be seen a certain way and then he gets sent to the hospital. He gets in touch with his internal kid and they put him in the hospital. So he learns not to manifest at all.
P4: It is not related to anything. There is not any volition. It is a blip. I don’t know what I want to do. An impasse is that he wants to get to the top of the mountain and he gets to the middle and he can’t. I want you to love me and you don’t. Yes, the want. And that’s a key in therapy. You know, I can work with someone that wants something different from what I want.
R: So maybe he is afraid to want.
P4: Yes, that would be worth a few sessions exploring. Yes, I am amazed that if you sit with people long enough, what comes up is usually what they do want.
P4: ...But therapy is a great dialogue of spirit. If you congrue? With people than they feel confident, and then they mobilize, and then they do something. Wow it is already an hour, I did not notice.
P4: Stuckness is a form of despair. It’s like Sartre “no way out” no hope. But it’s worth than no hope, because you don’t even know that.

Interview 5

P5: One of my big reflections was I wish I could have been there sooner. I wish I’d ended up in the body sooner. As soon as you went there it was like, “Oh this is where we could’ve been 15 minutes ago. Yeah, I wish we had been there 15 minutes ago.”
P5: Some. But the very first thing I wrote down when I was reflecting was I would’ve kicked this person out of therapy ages ago. That for me I tend to work with folks who have more concrete goals or can create more concrete goals earlier in the process. So I do have folks who are
absolutely stuck in my practice and we don’t keep going for a year. Because when I read the vignette the sense I had, was this person’s been stuck for the overwhelming majority of the time we worked together. And I’m not sure I would’ve stuck with someone that long.

P5: ... Part of my clinical style is being an active presence. And most of the time when I do that the client’s able to come back and meet me. The people who choose me as a therapist, right, and stay with me. Usually they’re a little more active in the room then this client was. So I’m not sure where he would’ve gone. But I think I would’ve started pushing an agenda on my side of things. I did a little bit of that with him today. But I don’t think he has clearly defined treatment goals. And that’s worrying to me. It’s worrying to me that he doesn’t know why he’s here.

P5: The big thing that came up for me is I was, I felt myself chasing around trying to come at all angles. I was not very effective at just sitting in the stuckness. Which I can sometimes do really effectively but sometimes, like today, not so much. Today I found myself really wanting to fix. And usually when I’m in my best, when I’m in my best therapeutic self I don’t try and fix.

R: So, how do you sit with the stickiness?

P5: There’s a lot more silence. There’s a lot more silence. There’s a lot more, “Yeah, we don’t know where we’re going. No we don’t know what we’re doing. Yes that’s overwhelming.” I think if I had more time I’d have wanted to delve into more why he made the choice between boredom and fear that he did. Because I commented about the really uniquely personal choice. But I didn’t, I didn’t ask about what went into making that choice beyond fear is scary, boredom is not.

… So I am OK clinically if he ends up in boredom as long as he is choosing boredom. Does that make sense?...So, on my side of things I ended up more in a fix-it mode than I wanted to be. Which I’m more likely to fall into with clients early into therapeutic process than later. Because early on I want to set the tone. I want to say, “Here’s what we’re doing.” I want to make the treatment plan. And once we have a plan in place I feel very comfortable sitting in the ambivalence. Sitting in the stuckness. Sitting in the “I don’t know what we’re doing...

P5: I noticed how hard boredom is to treat. That I’m not necessarily sure I would call what he’s experiencing right now depression. It looks like depression from the outside, right? When I sit with him and he feels depressed. But I’m not convinced that it’s clinical depression.

P5: … And so we can treat boredom. I can say, “Let’s go find interesting things for you to do client.” And none of them will be interesting to him. He’s done interesting things and finds them all boring. I am very curious about, kind of, the process by which he got so bored.

P5: For me that was a moment like, that was an aha moment for me. I wish I’d gone here sooner. The language you used like the relax, something that he can’t avoid. The relaxation or release he can’t avoid. That felt very real. And I watched your face turn and it was like there was this moment of like, “dammit she’s got me.”

P5: I know, it’s like, that’s where I wish I had been. And so, I from there that was very significant to me because it felt like the moment where I tried an angle and got in. And it was a good reminder for me clinically that I forget about the about body more than I want to…And so it was surprising to me in some cases that questions that I did not mean to cause discomfort were causing discomfort. Those I think are the big… felt that you wanted something to give and I cannot give it.

P5: There was this one moment in particular, I don’t remember what I asked but your gaze went soft and you started looking off to your left. And I was like, I want to know what’s going on in there right now and I don’t want to ask.” Like I want to know but don’t think he wants to be asked. And so I just kind of tracked that for myself.

R: so sharing your feelings you perceive as push.

P5: In this moment yes. Sharing my feelings would have felt like pushing…Yeah, I wonder how it would have been if I had said “I’m so curious.” I wonder if I had taken it up level on meta, if had said, “I’m curious about what you’re feeling right now, and I don’t want to push you.
Because it feels like this is a tender, fragile moment.” I think that would’ve been a better intervention
P5: (regretting an active intervention)… And that I was so focused on having her take ownership that she felt like I was blaming her for being assaulted.
P5: (regretting not being active)… And I didn’t say anything because I didn’t want him to feel like I didn’t like him or was stigmatizing him. And again it’s that razor thin line between saying: “You’re OK, this behavior is not.” This belief is wrong. You are the adult, you’re the counselor.
P5: (Successful active intervention) she came in and sits down on this couch, smooths her skirt over her knees and says, “I decided that I’m going to stop lying to you.” And I’m like “Alright. Hands are here. Hands are here.” And she leans forward and sets her hands on top of mine. And I’m like, “We’re OK. Go sit back down.” And so I give your hands a quick squeeze, release her and she sits back down. First time we ever touch. … “I feel really proud of us that we’ve built a relationship over, oh god I’m tearing… And that built a really nice foundation where I can now sit. I can now intervene less because she, I know that she will let me. And that I will know when the right point is.
P5: So, this is so funny to reflect on. My active interventions are me interrupting someone who’s talking and then the moments where I am pleased that I don’t intervene are moments where I do not interrupt silence.
P5: It’s a natural part of the therapeutic process for so many clients and so many therapists. That because progress isn’t linear it’s not always being pushed forward. In general my sense of stuckness, personally and professionally, is that it’s a sign that something wants to shift. That either we haven’t evoked enough internal motivation toward whatever the goal we say we’re working on or we don’t have a sense of where we’re going or we don’t actually really care about the thing that we said we were going toward. That it means that there’s something different or wrong or off about how we framed what we’re doing with our time here.
R: So you take responsibility as the therapist for the stuckness?
P5: Often times yeah. It doesn’t necessarily mean it’s my responsibility to fix it. But it certainly, I think of it is my responsibility to track it and noticed when it’s happening…But I pride myself on keeping folks moving towards whatever the goal they set for themselves is. So I want to refocus the conversation on moving them toward that goal. And sometimes stuckness will happen because person just wants an opportunity to rest. Change is tiring, change is exhausting.
P5: Yeah. I would be going back to values and be like, “What do you care about? What do you want to work on?” I’d be looking for like, what are the internal things that motivate this person? I’d be going back to essentially like the first six sessions. We’d be starting over in a certain way. So my sense of stuckness is that it’s not always bad. It’s rarely bad, I mean bad is such a judge mental word. It’s not always a problem that requires treating, but it is something I’m always gonna want to give attention to.
P5: Resistance? Resistance is one of my least favorite terms. Because I don’t think that clients are resistant. I don’t think people are resistant.
P5: I do need the client want something. And so, even if that thing is “I want to feel differently than I do now and I don’t know what that looks like.” That’s enough. But I do need them to want something.

Interview 6

P6: Well the significant moments for me was when I could get an eye contact.
P6: A lot of them actually. How much pain he was in. How difficult a treatment would be with them? How long it would take. Whether or not, I had thoughts about, I always think, and I do think about this with patients, are they willing to do the work? But on the other hand are they able
to do it, do they have the capacity to do it? Because some people don’t. You know it just is true. And so, as I was listening to him, and not really having sat with him for year I was really wondering whether he did have the capacity, … I would refer him out certainly. I’d want another evaluation.... I’d want to know…he is not taking the medication… How hard it would be, I’m pulling. I’m gonna be pulling for a long time. And he’s going to P6: How tired would I get, how discouraged would I become. Would I be seeking consultation? And then am I going to P6: … I guess a premature feeling of tiredness and exhaustion. Burdensome. P6: Make it better. Fix it. And with that kind of client, that’s the only kind a client I get to hooked with that. So I have to be very mindful for myself that this is not about fixing Rulik. This is about listening to him. P6: Well just exactly what we were doing. Is trying to get him to think. Trying to offer him ways of grappling with his own distress and his own sense of sadness. That’s a way, the only way I can think of doing it. So rather than fixing it, I’m trying to help him engage with himself. P6: Well the belief that because he was excited and curious he ended up being hospitalized. That’s not right that’s not true. He has a chemical imbalance. Yes, he may have become more excited in a manic phase. But you can be excited and interested and curious in a non-manic phase and still find more of a life. He has, he’s empty. P6: There are very many ways to be stuck. I don’t know that I have experienced, I don’t think I’ve had anyone that’s been, No I don’t think that I haven’t had anyone that’s been stuck. P6: (regret not being active enough) I would be more decisive. At that time I just kind of listened and I really didn’t interact with her in a productive way. P6: (Successful active intervention) She got up to walk out one day, she was angry. I stood up and sat on the edge of that chair. And I said “I’m not gonna let you leave.” P6: And she said, “Well I can unlock the door.” And I said, “You can but I really don’t want you to leave. Would you be willing to think about sitting down and talking about this?” And she stood there for a few minutes and then she sat down. I said, “You know, what happened?” And she said, “You didn’t understand what I was saying.” I said “Help me. Help me. Tell me again. So that maybe I can understand this time.” Now she saw that as one of those intersections. We had a number of those over the years. But she saw that as one of those intersections of somebody caring enough to say “I don’t want to let go of you.” That’s how she took it. P6: So I would say that’s probably one of the ones where I took, I mean I really wanted her to leave because I was so tired of her that day. I just really wanted her out of here. But I knew in my gut that... if she walked out she was going to be in very very frightening place. So I thought about it before I actually stood up and did it. P6: My understanding of stuckness is that there’s usually an experience someplace, whether it’s in childhood and in my mind it’s usually in childhood. … And so I considered stuckness a trauma of some sort at some point. That’s how I experience stuckness. R: Where in our session did you notice stuckness or how did you notice it? P6: “I don’t know.” When he kept saying, “I don’t know.” P6: Because that’s where he’s paralyzed. He can’t think. And when we can’t think we’re stuck. P6: I think resistance is a, it’s a judgment. And in some way says I can’t do anything about it or, I don’t know. I just don’t think it’s useful to me, anyway. P6: So I could say OK he was resistant when I would kind of pull for him. And he would kind of be resistant, that would be a resistance, because “I don’t know.” I mean if you were looking at it with that model in mind that’s what you would say. R: So, that’s what I’m saying. From that model is it the same to say resistance and stuckness. P6: Not for me. P6: (where is the difference?) That’s a good question. You know I was trained in CPMC and they would’ve loved this conversation, because that’s all they talked about is resistance and all that paraphernalia. Where is the...it’s so hard for me to even think in those terms. I guess I see
resistance not only as an out for the clinician but also as an out for the client. Because then it’s as if they close the door. That you can knock us much you want to and you’re not gonna get in. So fuck you. That’s my notion of resistance. That there’s some element of, I never thought about it this way, but I guess for me there’s some element of anger or challenge in it. And I don’t find anger or challenge useful in a room.

P6: And stuckness. I guess when I think of impasse I think that if I felt I were at it an impasse I would need to have a conversation about a referral. Because I wouldn’t be, I would feel that I, it was beyond me help to you. I don’t think stuckness is the same for me. Stuckness is more of a “Let’s give it a little more space. Let’s see if we can give little bit more time. Let’s see if we can open up some doors and windows and get a little light in there.” But impasse is I’ve given up.

P6: We don’t know what that is. I guess the other piece of it that I would find interesting is because we live in such an isolated world as clinicians we don’t, we’re not good about sharing our work. That’s one of the reasons I was, you know, I was anxious actually to participate in this. I don’t think that we’re very generous and I wish we were more generous about sharing.

Interview 7

P7: When I read the vignette I was nervous because the vignette really blocked off a lot of dead ends. Right? That...so it felt very limited. I feel like what stands out for me is I may have been less inclined to explore and be patient if I had truly been seeing you for a year … I guess what I’ve, my first thought is maybe I close myself off and get more impatient and I think, I have… yeah, when I start to feel stuck in real life with my clients I think it’s more my fear or impatience that feels I want to hurry things along or have something show up. And I felt that before with clients and that’s never been useful. …when I get stuck I, kind of, start to, I do I run things by her and it’s really helpful because she’s known me for a while and she can tell me my blind spots. Right? And often this is a blind spot, getting impatient. What is the outcome I am desiring? Instead focus on the outcome the clients desiring. Maybe this is me needing … When I get stuck or I start to feel like I’m not sure, right, then those bring about a discussion about us. … I also realized I’m not necessarily a gauge of what the client needs or is getting or not getting. There is this back and forth in the room but better to have it be overt…and for them to say what it is they’re really getting and for me to focus on that instead of what I think they should be getting. It is a tricky thing…

P7: … Because in your depressed state you could remember happiness. I felt that was really a real point, an arrow, to start there. … And I felt hopeful when I heard it. I was like, here’s something. There’s a little glimmer.

P7: Well, yeah. When you said sad I felt sad with you. Like I could feel the… And I guess that’s why I pointed out is sort of that acknowledging. But I also saw,…these sort of little glimmers of bright, and physically I could see that in you. So it’s once again those little, maybe that hope, you would brighten a bit and smile a bit and your posture was different. For just brief. And so what did that evoke in me? … And then sadness, because it feels like there’s this sort of cloud right over you, in your posture and things. But also these glimmers. I don’t know how to say it right. Which I felt was important to reflect it when I noticed. And then maybe, maybe a sort of wanting more of those glimmers for you. It was a lot of hopefulness but, hoping we could explore and find it some more.

P7: Oh yeah. They’re depressed or stuck or... I changed the…” My first thought is... And that’s the conversation I would have. “I’m not sure if this is useful.” I have some other things we might
try. Do you feel like this is useful to you? Because I want to make sure that the session you know
the way that were interacting is useful.” And that’s not a blame which is nice.
P7: Yeah. Because I would want to be sure... But in this session I felt like it was useful because
we had those glimmers that I felt were useful to notice. And to find easily. So it depends, I guess
the hardest part would be... Sometimes I reflect things back to people that I see and they don’t,
they can’t, sometimes it’s clarifying. And sometimes they can’t see them or acknowledge them. I
think that’s the hardest. It doesn’t happen very often though, usually they’ll look knowledge. I
feel pretty connected in the room.
P7: (regret of not being active) One of the, the first client that I had, the startup started in August.
And I still don’t know. What I would have done with? I have regrets but I’m not sure that they’re
reasonable. Let’s see. You know what my regret is? It’s so funny. I regret that I didn’t have the
SRS, or a conversation for us, about us and what was working at that time because I hadn’t, I had
to develop and put that together. I didn’t have a mechanism for checking in with her. And so I felt
like a thread was kind of getting lost. That’s what I, you’re right, I regret not intervening. Or not
even knowing how to do that. Because that would’ve been very useful. And I feel like we sort of
lost this thread of connection over time to straddling a lot and [ . ] and stuff. I felt unsure of what
she needed. I wish I would have the tools to intervene like I do now.
P7: (successful holding back) Well, I didn’t do the SRS with her. I saw her yesterday. But since
they’re in my mind. There was an intervention that I was going to have yesterday with a client,
my last client last night. And I just, it’s funny how after I talked to my consultant on Monday and
worked through this…
P7: That’s funny, I haven’t even written that note yet. It’s like, it just the feeling of like “This is
my agenda not his.”....
P7: (explaining stuckness) something's getting in the way from the client moving into, towards
the goal they have set for themselves. It’s a block to movement
P7: Yeah. There’s lots of things that can lead to it. First of all, I think we were talking about, I
think fear and defensiveness, they’re all kind of circling around, you’re getting too close to
something that’s painful. That would probably be my primary hypothesis, I think. Fear, pain,
getting close to something they haven’t wanted to look at. Trying to think of people who are
stuck. Sometimes
P7: Sometimes, I think, it’s I’m not sure if he trusts me. The alliance isn’t ready for it yet. Too
fast is sort of once again what I’m thinking. The speed is too fast, the expectation. It needs to go
slower. I don’t know what, how that fits in. But exactly, there’s a pacing and a trust that needs to
be built more before we go there.
R: And how does it resolve, if it resolves?
P7: Slowly. That’s what I thought. It resolves by having something moving.
R: What makes the moving possible?
P7: (about resistance) only because it sounds like you’re blaming the client, right? Even defenses,
because defenses makes sense to me. When you’re poking around into something really painful
or really sensitive, you know, defenses accord. You know my defenses go up. And there’s a
safety. You need to feel very very safe. And so I think I... Resistance feels like something the
client almost doing on purpose or doing against you or doing... And it doesn’t seem, it’s not my
experience really. No one’s doing it on purpose right?
P7: Impasse to me sounds so impossible. So, no. All I, I don’t think anything’s impossible. It can
be slow. See this is what I think. Slow, there’s a trickle, at times. But impasse seems done
forever. Too permanent.
P7: (feedback on the interview) Actually, here, this will be maybe my sort of closing statement.
Actually thinking about it more like this is actually very affirming for me. Interestingly enough.
Because I have been really working on incorporating a really certain... Since August in the new job and having a lot of clients. Incorporating this different way of working for myself is more congruent for me. And so it’s actually really satisfying to almost like, look back and see where I have shifted.

P7: And there is, if there wasn’t some stuckness why would people need to come in? Right? They’re doing it, they’re going alone. Evolving the problems, solving. But if they’re stuck...

Interview 8

P8: The thing that stands out the most was the challenge of stuckness. Like, “Oh...That’s like pulling teeth.” That was the sense. Like, “OK, I going to do with you?” It wasn’t overwhelming or a lot but that was the predominant... like, “OK what do I do with this guy?” So, some burden of that. Underneath that was, there’s my own personal stuff, but I can notice some layers of fear, “Oh, am I going to be good enough? I’m not going to be effective.” So it’s a layer of that. And I could also detect waves in and out.

P8: Waves of... Not that it was overwhelming, but knowing the challenge of depression. Will I stay with him enough? Or will I not just bypass it? Will I feel? Do I have the willingness and capacity to go and stay with the depth of where he’s at and not mandate it or something? …The opportunities are the places I felt light up about our connecting at the deepest challenging places. And knowing that here we are human to human, no bullshit. Those moments I feel myself light up and enjoy it…

P8: Both, I think a constant back-and-forth of trying to allow space, to not be too invasive and push and also my challenge to direct the experience of... So for example, how about eye connect? The challenge of not just let’s talk about nothing and let stay there. The challenge to go but not be invasive to push either. I don’t want to be another burden on the depressed life...

P8: Eye contact. A couple times you took just a natural deeper breath. And we stopped the session but there’s something in terms of attachment or somatic cues like that. …, “That’s OK. That’s fine.” It’s sort of like a, “It’s not.” So I can feel myself wanting to challenge that? Not right away but, “No it’s not.” But at some point take a stand. “No it’s not OK. You live a life alone.”

P8: This one client, it was a woman. I knew she had borderline traits but I sort of underestimated the borderline fragility there. And it was a closing session. It was sweet. And I saw a wound where I thought “Well we can do a little shift here.” And I got too hungry. I got too “Oh, let’s do this little... some healing here, this little moment.” And it was too much for her. And too immature on my part. I should’ve … I think she just wanted to have a nice conversation. And I got therapeutically unreal. “So, there’s this part of you just wants to have a nice conversation and part that feels just a little softer, a little vulnerable.” … “Oh, OK she even told me in the beginning I don’t really want to go anywhere.” So I feel my regret and a little embarrassment of “Oh why do I have to be productive or….” …I don’t like when people are mad at me. Other people are fine with it. I get kind of... it’s a lot for me. I can take sadness or lot things but anger directed at me, at other people I’m fine but at me I’m like, “OK…!”

R: I’m curious about your expression of hunger, therapeutic hunger. Can you say more about that?

P8: hungry. OK, this is my own work to do. There’s something about I would feel guilty if someone paid me just for an expensive conversation. And so, yeah… It’s my own work of distinguishing how much is, “No, I have a job to do. They do come pay me to get an ally to their healing. Not just...” Even if they tell me “I don’t want to do anything today.” “OK, be nice but don’t believe them they come here so you’re the bigger container. So, there’s part of me that
holds that. There’s also part of me that feels that’s my own work, ”Inadequate, don’t actually produce something valuable here.” That’s my own healing to do.

P8: I think there’s sessions where I don’t intervene more decisively and it’s getting … wanting them to like me. It’s usually when a client talks a lot… Those moments where I’m like, “OK. I should’ve had more of my own agency.”

P8: Yeah, it feels awful at the end of the session feeling like I didn’t do anything. The client didn’t get any value out of it. It feels yeah… like wet noodle therapy. You could call it. … “This is lame therapy you didn’t do anything.”

P8: … “Oh I’m doing my job. I’m not going to tolerate the superficial conversation.” And, oh, it’s a lot for her. So I can feel both the… that of it. The wins with the same client are…actually get enough of her buy in to actually she’ll go […] with me and stay connected. And actually have her get to the, she actually got to some tears and “I get it now. I have no voice…

P8: It was naming something more clearly in the somatic mindful experiment piece. “OK let’s be this together and spend a little bit on the missing experience.” Or an ally to her for her vulnerability not just shucking it away. Then her coming to her insight “Oh that’s what it is. I do deserve a voice.” Or whatever. So those moments are really rewarding for me.

P8: …She arrives at her own insights her own epiphany. Which is fine with me, I’m great. So that is a benefit and I didn’t have to feel like I was pulling her pushing her… There were those sessions where “OK, good. It was beneficial.” I think I value that through time. […]

P8: … And she’s, “[quickly] No. I just want to download today.” “OK, let me just make it clear.” That’s sometimes we’ll do that and other times in the moment I’ll monitor that, “No, they’re kind of on a roll.” Or they’re kind of just, I don’t know if agitated is the right word, but there’s a sense that they just need me to listen. There’s that sense when “They don’t need some fancy therapeutic experiment. They just need some space to not be judged and just be.” So there’s moments where I’ll make that assessment, or whatever.

P8: I think stickiness for me is when the client really isn’t connected to their own agency and their own spirit. Their own sense of life. Their own sense of vitality.

P8: All these words come to my brain. The sense of this unknown emptiness. It needs something else but we don’t know what it is. It’s sort of a “I need more but I just don’t know what more is but I know this isn’t it.” And this is sort of a, a sense of being lost, a sense of, almost like a “Someone help me” but there’s […] to bagging, there’s that sense of “What now?” A sense of helplessness.

P8: What leads to stickiness... A couple of things, this is a little more theoretical, but what can lead to stickiness is either a fear of actually being connected to what the feeling is, deeper, could be terror, could be anxieties.

P8: Yeah, no engagement. With a client’s lack of wanting to engage. There’s that. It could be the therapist, […] of not wanting to go that deep of course.

P8: We don’t find common ground, could be engagement. It could be my own ignorance.

P8: (what resolves stickiness) My answers are twofold that’s why I am sort of pausing... “Well anything that changes the pattern.” So I’m willing to suggest doing anything that changes the pattern that’s helpful. For me anything that changes the little... Breaking the trance, whatever the heck that is, that “I have to do it this way.” I am marching more towards getting back to a sense of, “My sense of selfhood.”

R: OK. So looking at it from another point of view.

P8: Looking at it from another point of view...

R: And you’re just repeating in another […] of words. […]

P8: Acceptance of the lack of change, yes. And the client’s unaware that they’re choosing not to feel themselves, look at themselves, to be self-reflective. Not just in meaning, but also the felt sense of the body, “You don’t know that you’re not actually feeling stuck. You’re just, you’re sort of in this malaise of…”
P8: In some way that’s sort of using compassionate empathy as a bully like, “Hey if you don’t let me in your offending me somewhat.” A something that sort of...
P8: I enjoyed it the connection. I could see the trance break and that caused me to see, I could see both... I was looking for my vulnerability and I could see your eyes that just was not just here but look at, also bigger too, “Oh there you are.” I could feel that. Those moments are always enjoyable, too.
P8: … stuckness and resistance is the same? I think stuckness is general because it could be contributed to for a lot of reasons, resistance being one of them. Or it could be for, whatever, trauma, or a bunch of reasons. Resistance itself...a subcategory…
P8: I never heard impasse…
P8: I think we covered all of it. Bust that stuckness can be frustrating or demoralizing...
R: Is there any redeeming aspect for stuckness?
P8: Yeah. My first go to is no. But maybe let me see about that. Ongoing stuckness, no. I think a session, end the session, “This was stuck today.” Or I think maybe, for a couple of weeks, or whatever. That session was stuck. Yeah we just didn’t anything.” I think that’s in the big picture in the big arc therapy. I think those are appropriate. Two human beings genuinely trying and then later on put in context in hindsight.
P8: What I’m hearing is the transformation...I should’ve explained it differently. The hit I’m getting more and more is just the maturity from the soul. The maturity of the soul. Allowing.

Interview 9

P9: Well, I was thinking that when I am working with an extremely passive person I get active. And it’s the opposite if I’m working with a really active person I get really backed off. So, I didn’t want to be flirtatious but I really felt, I wanted to feel engaged. … So I was being really bossy and really pushy. But I was working from the idea that there needed to be some kind of evaluation after a year... I guess I was thinking about Davis Burns. I was thinking about him saying to someone, “You know I can listen to this or we can do something about it. Which do you want?” … Oh well, plus I was not focused really on treatment but on getting unstuck
P9: OK. Like, we have to agree that you want to be unstuck and then it’s treatment after that.
P9: It’s certainly not when I saw it and it’s not what I tolerated for a long time. Because really if I felt like I couldn’t get anywhere with someone I would refer them.
P9: I was feeling really pushy. And I would, and I doubted, I was uncertain that that was gonna work. But I think there were a few times when I talked about having fun when you responded in such a way that I thought, “No, this is OK. I’m not pushing too much.”
P9: I was cautious about putting words in your mouth. But watching when you agreed and didn’t agree with what I was saying I thought it was reasonable to explore the medication… There was a lot to go back to and I felt like I wanted to change the contract and then we could go back to those things…it seemed at the beginning that you were just determined to not engage. And when you did sort of engage it felt like it was almost in spite of yourself. But there was a glimmer of something in there that felt it just gave me some optimism.
P9: Alright. No I don’t think there was a moment, but I think, I felt like I was taking a big leap from the beginning and I just felt like you were responding
P9: I liked it when you corrected me about the number of hours in the week. I can never remember what that is. But it felt, that told me you were listening. You know. Even though you were slammed and indifferent, it told me that you were…
P9: Yeah. If that was humorous I don’t know what to say but OK. You were really present, even though... so what I thought, “Here’s a sullen angry guy who may be tamped down by drugs or
not. But he me needs a venue to be who he is. And I didn’t see it anywhere how that could happen.” I wouldn’t of worked for year at all, like that. OK?
P9: … I can be a forceful person anyway, and I never think of my own stimulus value. So I think when I was younger and cuter there was one time where maybe I scared a guy.
P9: Yeah. I would never prescribe stuff… oh I don’t know I probably would. But if you feel like you’re doing it as a team then it’s not a mistake it’s like “That one didn’t work let’s try another one.”
P9: I was working with a young woman …but proposed some more stuff she might’ve gotten further. And I wasn’t comfortable at that point exploring with her the changes that she might want to make. …what she was going to say. Instead of just listening.
P9: trying to be aware of what’s… Going down one path and other paths will be possible later. You know? I mean, what’s another example? Trying to think of the impulsive people I’ve worked with where part of the job was like, “Well let’s think of the consequences, the possible consequences of that?” You know. For me to back away also is to model slowing, slowing down and thinking about it. Which I would never have done with this guy. …So keeping my mouth shut while she did A before we tried B.
P9: Yeah well when somebody keeps coming back week after week you have to believe they have a goal.
P9: Unconscious I think. But what I also think is generally when people look for therapy it’s because they changed already but they don’t know how to show the world.
P9: (what is stuckness) I would say it’s not addressing the right issue. It’s missing the thing that needs to be worked...
P9: Either one. The client is still too loaded with shame or two loaded with something, they can’t yet say what it is... I think shame and fear will keep people from saying what it is they’re really coming to talk about. So it looks stuck. But it’s just that the real thing hasn’t come up. And for therapist, I mean for me stuck is when I just cannot find any for empathy.
P9: I came to it in the vignette because I found myself... I will react to passive anger in a way that’s not comfortable for me particularly.
P9: Well, a therapist, I think failure of empathy. You know it just blocks your imagination. And insufficient training. …you know most of the plots have been covered. And so, the exploration, uncovering, it just doesn’t have the same compelling interest for me that it did. So I don’t know what that says about stuckness.
P9: …if the therapist is not curious I don’t know how the therapy, you know, it’s mechanical then. You can do it but there’s not the joy or the spark…But also identify the wayside work that works for you so you’re not, how do you say, Procrustes bed? So you’re not trying to fit somebody else’s model,
P9: So then I mean, not being bound by a theoretical orientation especially when it doesn’t work anymore or it has garbage jargon. You know? But that puts you outside the conventions sometimes.
P9: ... With this guy I would not work with somebody who wouldn’t do the exercise. And I would be clear about that. So it would be like, “How are we going to find something that you want to do?” So you can see how the endorphins affect your mood.
P9: I would like to say that I think, I mean, it’s hard to sort out you from the role-play from…But in the vignette as I read it I felt a lot of frustration and anger on the part of the guy with nothing getting better. I don’t think I made that up. I don’t think it was just hopelessness and helplessness. I think there was a lot of like, kinda stubborn anger. Not, “You can’t make me,” but “Nobody gets it., Nobody’s helping.”
P9: As stuck. There was some way that the right approach hadn’t been found. And some frustration and anger about that. I mean, this is a stubborn guy, right? And that’s his strength.
P9: I understand resistance as an imbalance in relationship and a power struggle. So, there’s an absence of rapport. It’s, that’s about, not feeling… When I’m resistant it’s because I don’t feel
understood. I feel like somebody’s trying to fit their framework on to me. And so that there’s not
a team.
P9: Well, it’s a refusal to proceed until the contract is written right. I don’t know. It’s a
P9: Movement is not happening. So the question is “Why is the movement not happening?”
P9: Well, unless it’s something is just too hard to face or figure out. I mean, there’s stuckness
when you don’t wanna know what you know.
P9: Resistance is like a Freudian phrase, that’s about an issue that the client has. And that is
different to me from the possibility of a client therapist mismatch or a failure of empathy on the
part of the therapist. Right? Resistances it’s a piece of stubbornness. It’s somebody saying, “No
you’re not getting me.” They’re so there’s more to stuckness than resistance.
P9: He was... OK, I would say he had felt unheard for long enough that he was reluctant to take a
leap, he was reluctant to move.
P9: …impasse means people are, people want to move, they want something to happen. They are
not indifferent…But I would say an impasse is temporary. Hopefully. And it means we are not
sure how to proceed right now but it doesn’t mean we can’t. You know, there’s all kinds of
stuckness, I guess that’s what we’re saying.
P9: So the other way I think is that sometimes when people can get a little activated then they’re
able to talk more about, you know they’re able to communicate…
P9: OK. So what you said was, “When people don’t, when people are stuck they get active.”
That’s what you said. “They don’t just wait. When there’s stuckness they get active they don’t
just wait for the next thing…Well I think that’s entirely appropriate. And the reason I think that is
out in the world where some, many of the people who really need therapy can’t possibly pay for
it. If they're paying you don’t get to waste their time and I really believe that. I really believe it.
You know, two bucks a minute or three bucks a minute? No. You got to be earning your money.
So sitting and listening and not...

Interview 10

P10: I was really feeling the pace, the slow pace and the low energy. There was a fragility, a
fragileness. Because the... I thought it was interesting when I was asking, “What did you want to
do today?” And how that was triggering. So that stood out as “OK there’s some wounding there.”
Yeah, there’s a wounding. And that I was just kind of figuring out, “OK, is that part of why
there’s no zest for life?” It’s like being pushed. But then there there’s no pushing from him.
P10: I felt there was some anger. There was... Maybe the refinement of just, like, wanting to
shake him, you know, like get some energy in and, you know, “Come on, get out of this.” There
was also... I was also feeling lulled to sleep? It was just… I can merge into some of the sadness.
Or just the, yeah, the apathy.
P10: Apathy.... Well maybe there was some sadness, because of what was really triggering was
being hospitalized. It seems like there was a lot of, maybe, repressed sadness and anger.
P10: The countertransference. It was like I wanted to advocate for you, I wanted to get angry with
you about like, yeah I don’t want to be forced without my will to be hospitalized because that’s,
because it’s wrong. That was my transference. I guess there was when I asked “What you want to
do?” and then you were like, “Oh that felt,” I forgot what word you used, “pushed.”
P10: (Talking about the conflict on the role-play) That kind of, so that threw me. I was kind of
confused with that. But it didn’t throw me off tooo, you know, So, I was like, “Why would you do
that?” So then after I think I was able to calm myself down and then I felt, “OK I can see this
really objectively.” You know it’s like, “Oh instead of taking it as like I did something
wrong”…or “Oh, like that was a violent act against you.” Instead I was like, “No, it’s not me, so
let’s figure out how that was to you.” An issue that’s not felt. And so I think I, I didn’t do this consciously, but I felt like I need to repair really quick. So I could’ve went there like, “Oh, I’m so sorry I’d never ever do that.” But I think that wouldn’t have served the therapy. Because it wasn’t about repairing the feelings it was more about what exactly got triggered.

P10: Hospitalization? And remembering the insights with wanting relationships. And that you’re open to maybe doing bridge.

P10: I guess it’s just more that the content just feels like the client was really isolated. That there was no deep connections that he was having. And it was interesting too when I said, “thirst.” And you were like, “Oh that’s strong word.” You said, “want,” and I was like… Because the character is not embodied. And so that was too deep.

P10: A lot of it for me is intuition. And pacing. I’m really feeling in, like the right timing, I’m waiting to see if they’re going to come up with it? Or is this theme keeps coming. Then it’s like “I need to intervene here.” I’ll touch in and either say something and see how that impacts, or if I get a certain insight maybe then I’ll lead to… I guess it depends. So then how do you intervene? As I fill in the landscape I see, like, “Oh is it a trauma? OK.” Then I might introduce EMDR. Or if it’s trauma, “OK maybe I’ll do Hakomi…and if that actually goes then I know “OK they have the capacity for that type of work.”

P10: (regret holding back) That doesn’t happen as often. I think I’m more restrained than I am more active or vocal.

P10: (what is stuckness)… it also means kind of looping for me. Just kind of…in the same spot again and again… Sometimes I feel stuckness is a resistance pattern. Or if they’re, like, kind of like digging in their heels. Because when I was reading it or when I heard your stuckness I was like, “OK well, if I am not, if I’m not attached to stuckness then I’m OK.” You know, if I’m not tied for, tied to “unsticking” that person then I’m OK. But if I’m tied towards oh we got to get this person unstuck then I think there’s, then I have to make more pushing or having to do.

P10: I think maybe our society feels like being stuck is bad. And especially here in Silicon Valley it’s like “OK everything’s about progress in moving forward.” So I think there’s a tendency to wanting to get somebody moving. And I have to remind myself, and that’s why I checked with you about well “Is this OK?” Because what’s more important is the desire of the client. And so if the client doesn’t have a problem being stuck then it’s my issue. So, then it’s like, OK, then being OK with the stuckness, “Oh OK. So we can be stuck… And you like coming in? Great. You don’t see much progress? I’m fine with that. You don’t, I don’t need progress. If you just like to come in because I’m one of the few people that you can talk to? Then that’s the therapy.

R: And you do feel there is a cultural pressure to get unstuck and make progress?

P10: Yes. Definitely. “What are we doing?” I mean that’s what they are, sometimes I have to start… It’s like, “What are we doing? I don’t get this. I don’t see the progress.” …The client is saying that. Yeah. “I don’t want to be here forever.” So all of this is kind of in the direction of like there’s got to be movement. (What leads to stuckness) I would say confusion, analysis paralysis, too many options so they get overwhelmed, fear… fear, doubt and then just different resistance patterns. Maybe because it’s actually something, it’s going against, something deeper than themselves.

P10: Inner conflict or it could be external conflict of, like, if a parent sends a child in here and the child is like “I don’t want to be here.” Yeah, so they’re just going to be stuck.

P10: (resolving stuckness) By one, identifying what is it, and then once I find out which one it is then I am working with that piece… So we just kind of, just keep exploring all the fears around it. To see then whether it’s, is that the base of the fear, that helps the person to move, or whether then it’s also connected to other things as well. Or confusion, same thing, it’s like well, “I’m stuck. Do I stay in this relationship or do I leave?” And so then really exploring kind of, that indecision. And maybe doing some gestalt and between the two sides or I’ll work with the head, heart and the gut. “What is the head say? What is the heart say? What does the gut say?” Having a conversation between those three. So that we can try to have an alignment with the
three…sometimes is if the fear is, “I can’t see it.” So maybe the problem is too big or the goal is too big so then chunking it down.

P10: Opposing forces, if it’s an external thing then trying to empower the client more. And finding out “What do you want?” Versus “What does this opposing force want?” So, shoring that up. Analysis paralysis, then I’d get them into their feeling because they’re stuck in their head or get them into their intuition. Sometimes there’s one where there’s too many choices…Did they take the first step or did they not? Because then I teach them about action, which is like theory and so that gives more evidence, if you go towards that and there’s… “Either you take a step and what happens is it works out. So you take another step and it works out, take another step, take another step and you get to that… You take a step and then you’re hit with resistance. And one of two things is going to happen with the resistance is, either you’re hit with resistance and it’s too much... Or … you figure out you want the goal bad enough that you go over the resistance and keep going.” So then that’s more of a behavioral.

P10: I would say, not wanting to choose what he wanted to do…That was his stuckness.

P10: (resistance) It can be the same. But I think they’re two different things. Because being stuck could be one of those many options that I illustrated. Resistance I feel it can show up and be expressed as stuckness. If the reason is because it’s like protecting a fear of pain or a wound. So therefore that client will maybe feel stuck or just dig in their heels, you know, “I’m not gonna move.”

P10: Yeah. There can be, you can be trapped in a dynamic. So like in Hakomi we talk about jumping out of the system. So that you can just be caught this similar dynamic so then there’s no change, this just keeps happening. And the

P10: Have I reached an impasse? I know what it means but I…

P10: Yeah. I think it takes a really skilled and confident therapist to be able to sit with that, to be able to sit with stuckness.

P10: Yeah. And also with the… Because I think it’s how each therapist is with their own stuckness, and that whole value system. So for me it’s like, yeah… Because I have that pressure in me. So my own spiritual work is to be more compassionate about my own timing and pacing. You know, I don’t like to be pushed either. And so if I’m able to really see that in a client then I can really respect their timing and pacing and I can slow down and feel their pace and be like, “OK I can be here.” I’m wondering too, looking at your data, because you’re asking how long you’ve been practicing to see if there’s a, “Oh the ones were able to sit with stuckness are more seasoned.”
APPENDIX 11

SUMMARY OF LEARNINGS

This research explored the meaning therapists ascribe to stuckness and the attitudes they hold towards it. The research looked at therapists faced with stuckness and asked: “What tendencies can be seen in their thought process that inform their choice between active, change-seeking interventions and passive, encouraging and accepting interventions?”

I learned that when faced with stuckness, therapists often feel dread and shame. These feelings arise from the therapist’s need to know that their work was meaningful and that they were ‘doing something’ to bring change and help the client.

When the therapist was not able to stay present with stuckness and less aware of the difficult feelings it evoked, the deeper connection with the client was often lost. Sometime the client felt abandoned as a result.

A surprising finding was that some therapists require the client to know what the client wants or what their goals are. These therapists claim that they cannot do the work without clarity of the client’s goal. That passes the responsibility for the therapy to the client and sometimes add to the disconnection between therapist and client.

The main hypothesis of this research states: “When faced with stuckness, some therapists tend to want to do ‘something’ even when they do not know what to do. Their discomfort prompts them to choose active, change-seeking interventions against their intuition or deeper knowing.”
It was supported by the last two learnings that find on the one hand that although therapists usually recognize the need to slow down or wait, they sometime don’t give themselves permission to do so. On the other hand, therapists often chose to ‘give the right answer’ to the client and chose other active interventions, instead of giving priority to the therapeutic alliance.

All the learnings from this research revolve around the sense of “Return to the common source” using the language of the Tao. Returning to the source is simply accepting what is. The serenity prayer asks: “God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.” The dread feeling mentioned above does not allow for serenity. The disconnection from the client that the difficult feelings sometime lead to, cannot happen when there is acceptance. Demanding the client knows their needs and goals as Learning Three describes, does not demonstrate the wisdom of discernment between the courage to change and deep acceptance. In psychodynamic language, returning to the source is taking back projections. When the therapist can sense their own body and dread feeling and return to the source by being aware of their feeling of dread, there is no longer a need to distance the client or demand that the client knows what is still unconscious.
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