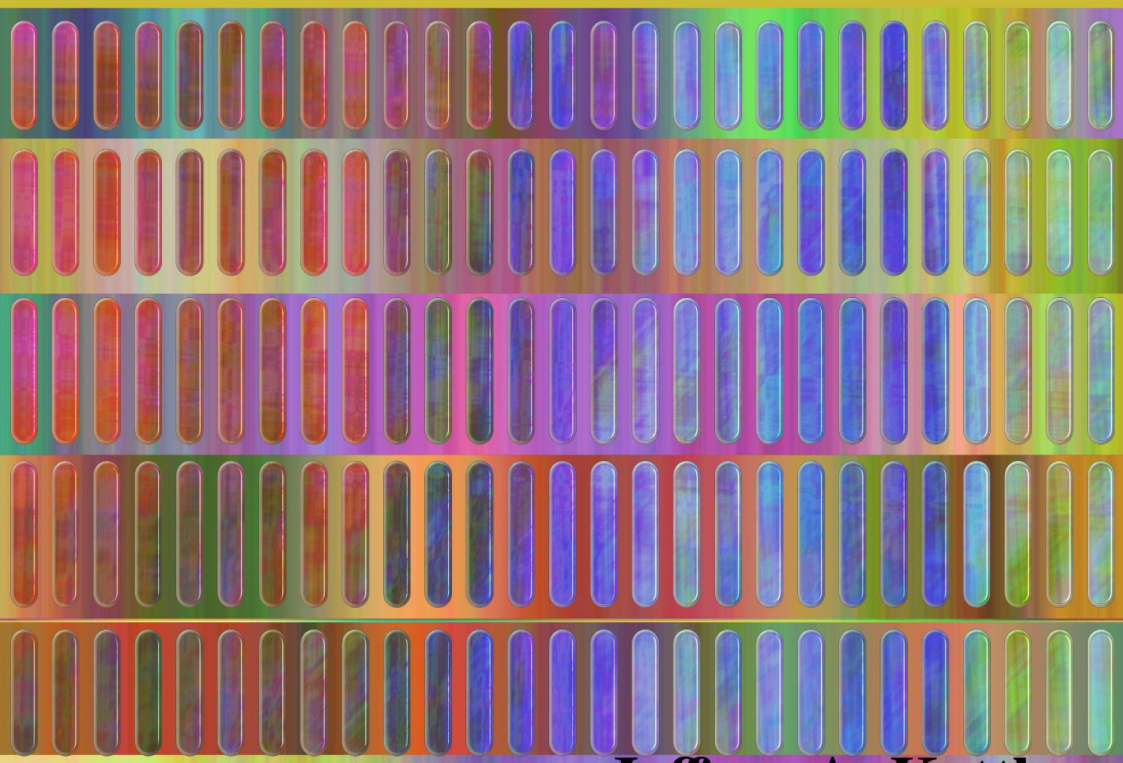
Compassionate Therapy: Managing Difficult Cases

Practical Strategies for Resolving Impasses



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Practical Strategies for Resolving Impasses

Helping difficult clients involves much more than adopting a particular set of attitudes or establishing an effective alliance; it requires intervening, sometimes quite forcefully, to stop a client's self-defeating patterns and to help channel energies in more constructive directions. The particular nature of these action strategies, whether variations of providing structure, using cognitive interventions, setting limits, or employing paradoxical techniques, is probably less important than the practitioner's willingness to equip himself with a variety of therapeutic options he can draw on as the situation requires.

This chapter is not meant to be a comprehensive compilation of all the action-oriented interventions that are at the therapist's disposal as much as a sampling of the most common possibilities. So often with difficult clients we are unable to apply "standard" strategies that have proved effective before; we are usually required to modify and adapt interventions to the unique requirements of a case.

Cognitive Interventions

At the heart of most forms of resistance is some underlying thought disorder in which the client distorts reality and applies erroneous, illogical, irrational, or self-contradictory reasoning processes (Ellis, 1962; Mahoney, 1974; Beck, 1976; Meichenbaum, 1977; Burns, 1980; Lazarus and Fay, 1982; Golden, 1983). This conception of client difficulty falls within the province of cognitive therapists but most practitioners also find it helpful to home in on what clients are thinking and processing that leads them to interpret and respond to the world the way they do.

Once clients, even very difficult clients, are helped to realize that their absolutist thinking is a gross distortion of reality, that the "shoulds," "musts," and other dogmatic demands that are part of their vocabulary are actually setting them up for failure, the stage is set for considering alternative ways to look at their situation.

Although greater patience and repetition is needed to reach clients with severe disturbances and

thought disorders, they can often be led to understand that the following statements apply to them:

- You are the one creating the obstacles to getting what you want; it is not being done to you by others.
- Just because you are not progressing as fast as you would like does not mean you will not eventually reach your goals.
- Pain and discomfort accompany any growth; there is no sense in complaining about it because that will not make it go away.
- Setbacks are an inevitable part of life and simply signal that you need time to gather your momentum.
- Just because you are struggling in these few areas of your life does not make you a complete loser and failure.
- You have the capacity to stop making things difficult for yourself and others when you decide to think differently about your situation and your life.

In spite of claims by Ellis and others who argue that cognitive methods are successful in countering the resistant behavior of borderline personalities and even psychotic individuals, I would suggest that these methods are probably even more helpful when we use them with ourselves. One of the hallmarks of the cognitive therapist is supposed to be that he practices what he preaches. As almost any therapeutic impasse involves some contribution by the clinician, it is often necessary for us to challenge our own belief system to understand what is occurring. There are thus parallel processes operating simultaneously: on the one hand we are identifying those counterproductive beliefs that the client is using to sabotage progress; on the other we are confronting ourselves to let go our own irrational demands. These usually take the form of unrealistic expectations we hold for our own behavior or for that of the client, standards of perfection that can never be met.

Providing Structure

Some writers propose that the best way to face reluctant clients is to reduce the ambiguity of the therapeutic encounter by providing more structure (Manthei and Matthews, 1982; Day and Sparacio, 1980; Ritchie, 1986). People become most difficult when they are faced with situations they find

threatening. And there are few encounters in life that feel more frightening than sitting across the room from someone you believe is studying you silently like a specimen, forming judgments that are probably not very flattering.

Client apprehensions can be reduced, anxieties soothed, and cooperation solicited if we accommodate clients who need more structure in order to feel safe. The most effective therapists of any theoretical persuasion tend to be those who are most flexible and pragmatic, who treat each client as an individual, and who design each treatment plan for the unique requirements of a given individual, set of symptoms, and therapeutic situation.

So many ex-clients who dropped out of therapy prematurely or who hold some special animosity for members of our profession complain about how distant and withholding their helper was: "He just sat there staring at me. Every time I asked a question or requested some help, he just looked at me with his smug smile and crossed his arms. Sometimes he would say: 'What do *you* think?' but more often he would just wait. I wanted to strangle him. And no, he didn't remind me of my father!"

There are indeed some clients in whom we bring out the worst when we insist that they conform to our rules regarding conduct during sessions. These rules include demanding that clients trust us before they know us, spill their innermost secrets, and be very patient with us until we can get a handle on what is happening.

These rules seem perfectly reasonable to you and me; they are, in fact, crucial to getting much work done. But I can also appreciate how some people might have a little trouble with them, especially left-brained folks who live in a concrete world where everything has its place. Some people can indeed become quite difficult to deal with when we place them in an unfamiliar environment where everything they do best does not count and where we expect them to violate many of their basic values. Consider, for example, the prototype of the macho man. He has been taught his whole life that (1) if you show your feelings you are weak, (2) if you admit you cannot handle your own problems you are a failure, (3) reflection and introspection are evidence of laziness and avoidance of real work, (4) being sensitive and communicative is for women and sissies, (5) you keep your innermost thoughts and feelings (if you have any) to yourself, and (6) you do not trust shrinks. Now we are asking this guy, whose marriage is

probably ending because his wife has had enough of his macho crap, to abandon his basic values. Even more incredible, we are asking him to do the opposite of everything he ever learned: be open, trusting, sensitive, vulnerable, reflective, and flexible.

It is amazing how often clients such as the man described above do change considerably in therapy, but that can happen only if we offer enough structure in the beginning to allow him to feel at least a little familiarity with the environment. I remember one insurance adjuster I saw who absolutely insisted that he have some specific goal he could work on between sessions. When I was seeing him, I had just sworn off behavioral interventions in lieu of a more insight-oriented approach, so I gave him a hard time about his need for concrete results: "I guess this is exactly what your wife means when she says that you are so rigid." Understandably, he became quite ornery with me until I realized there could not be any harm in humoring him for awhile until he felt more comfortable with this ambiguous enterprise we call psychotherapy. He did eventually stop doing concrete homework assignments every week (although that did seem to be helpful to him) as he experimented with a less structured way of working on himself.

Resistance can often be managed by providing more structure until the client feels less threatened. Sometimes this requires you to explain more than you usually do about what you are doing and why, where things are headed, and what you expect from the client in order to be helpful to him or her: "You seem confused by my request that you report on what happened during the week. I am trying to get a handle on what you thought about and how you felt after our last session. I wonder what ideas, if any, you found useful. And I am interested in what changes you may have noticed that have taken place inside you. This information will allow us both to decide what has been helpful to you and in which direction we should head next."

There are instances, of course, when we provide structure in sessions more to appease our own anxieties than to aid the client. There are times when it is best to allow the client to flounder a bit and find his or her own way out of the maze of uncertainty. But it is also important to assess the reasons a particular client may be uncooperative. If, as an experiment, we reduce the ambiguity of the therapeutic encounter and provide more direction and then notice that the client becomes more responsive, we have some idea that instituting more structure may be just what the client needs in order to function more effectively.

Accentuating the Positive

Any discussion of difficult cases seems to focus on problems, negative factors, failure, and what has gone awry. This focus is easy to understand: resistant clients are themselves obsessed with disaster. They revel in their role as tragic heroes —misunderstood, hopeless, doomed to spend their lives as failures. In therapy they talk about what is not working, what is going bad in their lives, and how useless it feels to try anything different.

Often, we inadvertently reinforce their tragic roles by allowing them to complain on and on about their troubles. We even ask them how things are going, knowing what to expect. We are, after all, trained to examine the pathological and ask people about their troubles. Some clients who have more than their fair share of problems can easily spend hundreds of hours listing everything that is annoying, disappointing, and frustrating for them.

It is quite a departure from our normal mode of operation to follow a path suggested by O'Hanlon and Weiner-Davis (1989) and to concentrate almost exclusively on what is going right and what is working well. Granted, for some difficult clients, we must dig quite deeply and probe very patiently to get them to admit that *anything* is going well. But unless we can move away from a focus on the negative aspects of a case, and get the client to do the same, we will go around in endless circles listening to others complain, and then complain ourselves about their complaints.

Some of the more solution-oriented brief therapists advocate spending most of the time exploring what is already working for the client instead of what is not working. This technique allows us to find exceptions to the presenting problem as well as a hint about the directions we might move toward. "It is as if there is a television screen that gets filled with whatever is in front of the camera of therapeutic conversation. If the camera is focused mainly on problems and pathology, both therapists and clients perceive problems and pathology. In a similar manner, if clients can be brought to either perceive or act upon strengths and solutions outside of the session, that perception or experience will fill the screen of their lives outside of therapy as well" (O'Hanlon and Weiner-Davis, 1989, pp. 39-40).

When I read the preceding quotation for the first time I happened to be stumped with a case that was proving to be beyond my resources. I definitely thought we were spending altogether too much time

on the client's various complaints — that her health was failing, that her husband was neglecting her, that her children were a burden, that her mother was a nag, that her colleagues were insensitive, and, yes, that I was not being much help. In fact, we both seemed to have defined the structure of therapy as an opportunity for her to dump everything that was bothering her.

One day, I decided to try a novel approach suggested by the quote above. As soon as the client sat down, but before she had a chance to open her mouth, I held up my hand for silence. I told her to indulge me, that I wanted to try an experiment. I wondered if she would depart from our usual plan and talk about something a little different. She seemed somewhat hurt but eventually agreed (but not before extracting a promise that we could stop whenever she wanted to). I simply asked her to tell me only about what was going well in her life, only the things she felt good about, only the areas that were smooth.

"Well, I suppose relatively speaking, my stomach problems have gotten a little better. I only had to go to the bathroom four times this morning, and, I have got to tell you, I'm getting sick of this. These doctors..."

"Wait. Wait. Wait. Hold on. Remember our experiment? We are only going to talk about the positive."

"I would like to talk about the good things, but frankly, there aren't any that I can think of."

"I like the way you put that (*I was trying to be positive*). At the end of your statement, you said 'any that you can think of.' Whether you realize it or not, you implied that there may be positive things going on in your life, but they just don't immediately come to mind."

We went on like this for awhile. It was not easy by any stretch of the imagination. I almost longed for the usual litany of complaints; then, at least, I could daydream. But this was like pulling teeth—just to get her to admit that there were a few nice things that were happening. With perseverance and determination I continued pushing, drawing her out, but stopping her whenever she would lapse into complaining. Fortunately, she forgot she had the power to stop our little game whenever it grew tiresome. Or maybe she sensed unconsciously that however difficult it was for her to change her focus, such a task was necessary if she was ever to improve.

Although I would not have counted the experiment an unqualified success, it did break the monotony of our routine. Actually, I was fully prepared to return to our usual pattern in the very next session. But when she came in, I noticed that there was a perceptible change in her behavior: she spent five whole minutes in the beginning of the session telling me about a good thing that happened to her during the week! Then she returned to her monologue.

Over time, the distribution of our energy eventually reached a fifty-fifty split with a significant part of our time together spent focusing on what was going well in her life in addition to the ugly stuff. I thought this shift was truly remarkable. I realized that in my training, in my discussions with colleagues, even in the internal conversations I have with myself about cases, I focus mostly on psychopathology, symptomology, problem areas, impasses, and mostly difficult cases in which I do not understand what is going on. I also noticed a pattern in which those clients I like the least are those who complain the most. It occurred to me that maybe that is what they think I want to hear, that the appropriate role for a client in therapy is to come in and bitch. Further, it seemed quite possible to reduce all this attention on what is wrong and to spend at least some part of every session devoted to the positive dimensions of a clients life.

Clients improve more quickly when we balance the difficult aspects of life with those that are relatively stable. In addition, they learn to pay attention to what is working for them and to do those things more often. Such a conceptual switch makes the sessions *feel* more productive for the therapist as well. When our morale improves, the client's positive attitude quickly follows.

Managing the Therapeutic Environment

Difficult clients have little respect for external boundaries established by others. They often feel entitled to operate under their own rules of convenience. If they want extra time after a session has ended, they take it. If they feel like letting loose a barrage of abuse, what is a therapist for if not to be a receptacle for garbage? If they wish to call us late at night for a consultation, instant gratification is just a phone call away. If there is something about the fee structure, time schedule, office arrangement, or therapy style that they don't like, it is a simple matter to insist that we do whatever needs to be done to change it.

It is Sklar's contention (1988) that while working through the difficult client's intrapsychic conflicts is certainly important, the greatest priority should be placed on managing the therapeutic environment with its accompanying boundaries. The disturbed client's rage, fear, anxiety, resistance, and need to control are most often expressed in her efforts to circumvent whatever rules have been established. This often includes coming late to or breaking appointments, creating crises, and challenging clinicians to alter the customary practice of their profession.

These terrorist tactics can begin in several seemingly innocent ways. An example is a sweet, little old lady who requested a session on the first floor because she didn't like climbing the stairs, and then escalated her demands to include appointments at odd hours. Another client expressed a preference to sit somewhere other than in the waiting room before the session began. Still another client asked for a glass of water as each session began, knowing that the therapist would have to walk to the other end of the building for it. When the therapist refused, she began a series of coughing fits that lasted until she got what she wanted.

Once we understand the meaning and function that ground rules have for difficult clients, we can establish and maintain a therapeutic environment that is secure, stable, and predictable (Langs, 1976). This is, of course, standard operating procedure for many psychoanalysts and also those practitioners who spend much time treating borderline disorders. The point is that *any* client who is being difficult is probably playing with boundaries and testing limits. Many outcome failures occur not only because therapists intervene at inappropriate times but also because they do not do enough to set limits on provocative and obnoxious behavior (Fiore, 1988). It is our job to institute whatever limit setting is necessary to keep the client within acceptable bounds.

The most challenging part of this task is to establish and enforce limits in a firm manner while still retaining our tact and compassion (Groves, 1978). Along these lines, Hamilton, Decker, and Rumbaut (1986) distinguish between "punitive limit setting" and "therapeutic limit setting." Imagine, for example, a borderline client who has repeatedly threatened suicide, but as yet, has not followed through on any gesture. The most natural inclination is to inform him that such behavior will no longer be tolerated and that if he will not cease this manipulative behavior, you will no longer work with him. Although on the surface this appears to be the most clinically appropriate response, the therapist is

actually feeling abused and angry. The ultimatum is delivered coldly, conveying a message the client has probably heard many times before from his parents: "Unless you follow my plan I won't love you any more and I will leave you."

Therapeutic limit setting, on the other hand, delivers the needed firm message that certain behaviors can no longer be tolerated, but it does so with caring: "This is the fourth time you have threatened to kill yourself. That is four times I have been seriously concerned about you. If you do decide to kill yourself, I will feel sad, but there is not much I can do to stop you. If you and I are going to continue working together, you have to develop some other ways to cope. The next time you tell me that you intend to kill yourself, I will interpret that to mean that you are out of control and you are asking me please to put you in the hospital. I will do that because I care for you and realize that you would be asking for my help."

The difference between these two styles of limit setting is not so much what you do, or even precisely how the message is delivered, as much as how you feel inside as you work with clients. When we are clearheaded and do not take the clients' actions personally, we are able to establish limits without striking back or punishing them to meet our own needs for retribution.

The same is true for the use of confrontation when we are working with difficult clients. Confrontation, like limit setting, comes in two major forms: the kind that originates from the therapist's indignation and the kind that stems from a deep caring. In the first variety we feel angry and frustrated. We lash back under the guise of being helpful. The "confrontation" in this situation is actually a punishment designed to put the client back in her place. This behavior is contrasted with confrontation that is truly intended to help the difficult person to accept responsibility for behaviors that are hurtful, both to her and to others.

Warner (1984) describes himself as having been traumatized by a controlling client who did everything possible to defeat both him and the therapy. Such clients feel powerful when they are able to find ways to obstruct progress. They delight in getting under other peoples skin and enjoy irritating powerful figures like therapists most of all.

For this reason, Warner (1984) reminds us that working with abrasive people is qualitatively

different from working with other kinds of clients. You must do something; you cannot ignore their obstructiveness; it will not go away by itself. "They find far more reassurance in your confronting them with what they are doing that is really ?macceptable" (p. 34).

Even psychoanalytic practitioners such as Kernberg (1984), who advocates technical neutrality as the ideal therapist posture, will, when faced by a difficult client, adopt a more aggressive and confrontive stance: "My point is that it is better for the therapist to risk becoming a 'bull in a china shop' than to remain paralyzed, lulled into passive collusion with the patients destruction of time. At the very least, an active approach reconfirms for the patient the therapist's concern, his determined intolerance of impossible situations, and his confidence in the possibility of change" (Kernberg, 1984, pp. 245-246). Most practitioners of varying theoretical approaches would therefore stress the importance of being more confrontive and more conscious of setting limits with those clients who are interpersonally difficult.

Paradoxical Interventions

The physicist Niels Bors invented the complementarity principle to describe the paradoxical nature of light that exists as a particle of solid matter and yet behaves as an oscillating wave. Until Bors's time, every aspect of the physical world was classified as having either-or properties. He pointed out that almost everything about Nature is paradoxical and therefore expressed as polarities of good and evil, yin and yang, useful and useless (Goldberg, 1990).

What we often call difficult behavior in clients may alternatively be viewed as their attempts to exercise freedom in spite of the efforts of a therapist who is diligently trying to eliminate choices (even if they were self-destructive) that previously were available to them. An example of this reactance theory, originally conceived by Brehm (1966), is described by Tennen, Rohrbaugh, Press, and White (1981, p. 15): "Thus if a therapist implicitly or explicitly tells the client what to do, the client could restore freedom *directly* by disobeying or doing other than what the therapist requests. Or s/he could do it more *indirectly*, by implication —for example, by complying now but disobeying the therapist's next request." The authors then suggest that the best way for the therapist to avoid eliciting reactance in the client is to employ strategies that are designed to arouse defiance instead. This, of course, is exactly the rationale for paradoxical techniques.

It would be nice to have another name for these techniques that can be so manipulative. "Nondirective" interventions is much less obtrusive sounding, implying that the therapist does something by not doing something. And certainly there are few alternatives more attractive to us than those strategies that do not involve butting heads with clients who are obstinate. There is something brilliantly simple and elegant about refusing to acknowledge the existence of a boundary that the client has just dared us to cross.

Some clients are difficult not only because of attempts to defend their turf or because of characterological defects but also because of specific patterns of communication that take place between therapist and client (Watzlawick, Weakland, and Fisch, 1974). Erickson (1964) pioneered a series of techniques with which to manage resistance that stems from interactive effects, the most famous of which involve paradoxical methods of encouraging the difficult behavior. He discovered something that every parent knows: if you want a child to stop doing something, tell her to keep doing it. The theory behind this method is that people cannot oppose us if we are ordering them to be oppositional; resistance is transposed into cooperation once we join the difficult client in his efforts to resist change (Otani, 1989b).

At about the same time that Erickson was experimenting with indirect directives in the United States, Frankl (1960) created paradoxical intention in his efforts to apply logotherapy to resistant clients. It seems supremely ironic that two such different practitioners might approach several clients in quite similar ways. An insomniac might be ordered to deliberately stay awake. A stutterer would be directed to stutter more often and for longer periods of time.

Predicting a Relapse

One of the infuriations about working with difficult clients is the persistence and rigidity with which they maintain dysfunctional behavior. The self-defeating patterns seem impervious to all but the most dramatic interventions. About the only weapon that seems available to the therapist is the ability to anticipate these behavioral configurations. Shay (1990) suggests that we capitalize on our ability to predict what will happen next as a way to disrupt the sequence before it fully unfolds. For example, a client goes on a spree of overeating whenever she faces a Saturday night without a date; a child gets kicked out of school every time his parents have a major fight. The therapist jumps in at the opportune

moment: "So, Jacob, I suppose since your parents had a real knock-down skirmish this weekend, we can expect you will find a way to leave school."

It is fairly important that these predictions be accurate or one loses a lot of credibility as an expert — unless, of course, the prediction was designed to be wrong. The simple elegance of this technique is illustrated in Haley's (1973) description of "predicting a relapse." A client becomes easily discouraged. She has just made some minor advance in her efforts to expand her social world, but you can feel her trepidations that her progress is short-lived. Surely something disappointing will happen. Again. And you utter your worst fears aloud: "I want to warn you that this probably won't work out the way you expect it to. At least half the plans you made will fall through."

If this prediction turns out to be true, then the client has been adequately prepared to hold off a disastrous relapse; she can take the disappointment in stride. And if the prediction turns out to have been unduly pessimistic, then the client feels even better about her ability to prove the therapist wrong.

With those cases who are even more stubborn, Haley (1973, p. 31) describes a method by which you not only predict a relapse, but *encourage* one. "I want you to go back and feel as badly as you did when you first came in with the problem because I want you to see if there is anything from that time that you wish to recover and salvage."

Doing the Opposite

The essence of creative problem solving, according to Rothenberg (1990) in his study of Nobel Laureates, is the resolution of polarities or the blending of opposites. So often, he observes, new discoveries in science, art, or philosophy are the opposite of previously held ideas. "Even more surprising is this: not only is the opposite true, but both the opposite and the previously held idea are operative and true" (p. 25).

Nowhere is this more evident than in our own field where we have learned that the following opposite polarities can coexist:

1. Nurturing clients facilitates change, but so does confronting them; blending the two techniques is even better.

2. Dealing with unexpressed feelings promotes insight, as does exploring underlying thought processes; combining the two strategies is ideal.

3. Seeing clients in individual sessions is quite effective, as is working with them in groups or families; sometimes a combination approach is even more powerful.

4. Dealing with the past promotes changes in the present; looking at present behavior helps explain the past; both approaches combined make for a more productive future.

Some practitioners employ insight as their principal tool; others prefer to ignore self-understanding altogether and concentrate on action strategies. Some clinicians stay objective and detached in the therapeutic relationship; others present themselves as authentic and genuine. It is apparent, therefore, that our whole profession is grounded in polarities that contradict one another and that reconciling opposites is a requirement of the practitioner.

Creative professionals tend to think in the language of opposites. When administered a free association test, Nobel prize winners are more likely to respond to a stimulus word by supplying its opposite. Rothenberg (1990) cites several examples of how this Janusian Process (from Janus, the Roman god of beginnings who faces in opposite directions at the same time) operates in problem solving. Albert Einstein had been greatly perplexed as to how he could develop an all-encompassing general theory of relativity similar to his special theory of relativity applied to light. He was convinced that there was some underlying order to the physical world, that "God does not play dice with the universe." The idea came to him that if a man was falling from a building he would be in motion and yet at rest relative to an object falling from his pocket. The reconciliation of this paradox led to Einstein's most famous theory.

I believe this same process underlies our most creative work in therapy. When we are stymied with a difficult case, it is usually because we are trying the same things over and over again. Therefore, the simplest prescription for practitioners who feel stuck is to apply the strategic dictum of doing the opposite of what has already been tried. This could involve several strategies mentioned by Dolan (1985):

1. If talking doesn't work, become silent; if silence doesn't work, try talking.

2. If you feel stuck while sitting, start moving; if you feel stuck while moving, try sitting immobile.

3. If the mood is impersonal, soften it; if the situation is emotional, shift to a more objective tone.

4. If you feel anxious, take a few deep breaths to relax; if you feel bored, do something to heighten the intensity.

The formula for becoming unstuck in any situation is to identify your pattern of ineffective responses and then to alter something in a systematic way—whether it is the style, the content, the context, the direction, the pace, the intensity, the frequency, the force of impact, the speed of action, the amount of pressure, or the degree of investment in the outcome. Tinkering with individual variables might be plotted something like this: the therapist asks the client pointed questions about her history and background, after which she becomes evasive. The therapist then tries using more open-ended inquiries, but the client begins to ramble and drift off track. Finally, the therapist stops asking questions altogether and tries the opposite —sitting quietly. This time the client volunteers useful information.

Fabian Tactics: Doing the Unexpected

The strategy of confusing an opponent in an adversarial position by adopting an unexpected series of moves is described by Goldberg (1990) as Fabian Tactics. Named for the Roman general Quintus Fabius Maximus, who was able to out-maneuver Hannibal during the Punic Wars, this approach seeks to avoid direct confrontation in those situations where one is clearly overmatched. Throughout history, other military leaders have defeated vastly superior forces by using tactics designed to delay, harass, and confuse. Thomas J. (Stonewall)Jackson during the Civil War, Francis Marion (the Swamp Fox) during the Revolutionary War, and Erwin Rommel (the Desert Fox) during the North African campaign of World War II were able to throw opponents off balance with completely unpredictable and incongruous behaviors.

The strategy of General Fabius against Hannibal was not simply to evade battle or stall for time; it was designed to destroy the enemy's will to fight, to so thoroughly demoralize and frustrate him that he would give up and go home. This was also the strategy of the Viet Cong that proved so effective during the Vietnam War.

Difficult clients are hardly "enemies" or "opponents," even if they sometimes see us in that role. Yet

the principle of avoiding direct confrontation and employing indirect interventions with an entrenched and resistant client was a particular favorite of Milton Erickson. Many of his hypnotic induction procedures that proved potent, even with those most determined to resist, were based on Fabian Tactics of doing the unexpected.

When Marshall enters the office and demands that I accommodate every one of his detailed requests before he will agree to work with me, he is expecting me to turn him down so he has an excuse to fire me. He tells me that in order for us to proceed further (Marshall is an attorney), I will have to agree to the following:

1. Schedule appointments on a week-by-week basis with his secretary.

2. Bill his office once a month and wait for payment until he has received insurance reimbursement.

3. Agree not to schedule anyone else immediately before or after him so he will not be seen entering or leaving my office.

4. Allow him to bring his portable telephone into the session in case anything from the office needs his immediate attention.

5. Permit him to sit in *my* chair because it has maximum support for his back problem.

6. Stick to *his* agenda of matters he would like to address. If he does not wish to talk about something, I will agree not to push him.

7. Keep on hand for his exclusive use his brand of herbal tea, which he will supply.

I was so stunned by the sheer audacity (not to mention volume) of his demands that at first, I did nothing except stare at him openmouthed. While Marshall adjusted his posture in *my* chair (that had been his first request to which I had innocently acquiesced), I considered my options. If I told him what I really thought—that I would not stand for his manipulative, controlling behavior, nor would I tolerate his games to undermine my position —then it seemed clear that therapy with Marshall was over. I must say that idea appealed to me tremendously. Next, I considered what would happen if I tried to negotiate with him. I mean, this man was a professional litigator. He chews people up and spits them out for a living. He even carries a telephone with him so he can intimidate someone whenever the mood strikes

him! And I think I am going to go up against this guy and get him to back down? I felt like General Fabius facing Hannibal's hordes astride their elephants.

I therefore considered my third option: give in to his demands, but with a few conditions of my own. This I reasoned, might disarm him completely and we could stop with the jousting.

"Sure," I said. "What you are asking sounds perfectly reasonable to me. I have no objection to anything you ask. In fact, I like a person who states what he needs. That is why I will accept your conditions if you will accept mine."

Wary now, Marshall's initial signs of triumph evaporated. "What do you have in mind?" he asked in his silkiest, lawyer-like voice.

"Nothing much. Just a few modifications of your requests. First, if you are going to sit in my chair, I ask you not to lean back, as sometimes it tips over. Second, you are more than welcome to keep your tea here —I think that's a great idea—but you will also need to bring your own cups, sugar, spoons. Oh yes, and a teapot. I think it would be best if you made your tea with your own things.

"As for your portable phone, that's fine. But if you are going to take calls during the session, I would like to do the same thing. And the scheduling arrangement, I would be happy to arrange things with your secretary—that is, if you will remind me the day before I am supposed to call her. . ."

I continued no further as his laugh interrupted my "negotiations." (I was just warming up, too!) He moved out of my chair with the exasperated remark that he did not know shrinks were so temperamental about where they sat. But now we had an understanding, even an alliance of sorts.

I am not saying this guy did not continue to be a challenge to deal with, but I found that whenever he did resort to similar controlling tactics, I could best neutralize them through indirect, unexpected means.

The Use of Adjuncts

Audio and video recorders are excellent devices by which to help difficult clients hear and observe

themselves in action. To a large extent, they get away with their games because they do not have to admit that they are acting inappropriately. Consequently, hard, documented evidence is an invaluable tool for helping them to face themselves. Often, the therapist does not even have to point out what is occurring, thus avoiding the danger that the client will lose face or feel humiliated. Some clients are quite able to find the patterns themselves once they have the opportunity to monitor their behavior in a less threatening situation.

During a therapy group one young woman persisted in denying she had any bone to pick with the leader. She maintained this position even though every time he spoke to her, no matter how gentle his approach or how inane his comment, she would flinch as if she had been struck and then retaliate with sarcasm and hostility.

Several times the group leader pointed out the pattern in a number of different ways, including a very direct approach:

> Group leader: I notice every time I open my mouth you seem to become enraged. I wonder how you feel about me?
>
> Hostile client: I don't feel anything one way or the other. Why do you always pick me out to ask these stupid questions?
>
> Group leader: See, even now, you are doing what you say you don't do. It's almost as if I remind you…"
>
> Hostile client: Never mind. Since I can't seem to say anything right, to say it the way *you* think I should, I'll just keep my mouth shut. Somebody else talk. You won't hear another word from me.
>
> Group leader: Backing away isn't going to change the pattern that keeps recurring here. Has anyone else noticed the dynamics of what occurs between us? Maybe someone else could describe this in a way that you can understand.
>
> Hostile client: I just told you: I DONT WANT TO TALK ABOUT THIS. ARE YOU DEAF?

The therapist had a policy of recording each session and giving the tape to the client who had received the most time during the group session. This practice allowed the client to review what had transpired but to do so at a time and in a place less emotionally charged. The client would then bring the tape back the following week to protect confidentiality of members and then report on issues he or she had heard that were missed during the actual group session.

This structure provided a major breakthrough for the young woman. She was absolutely stunned to

hear how she sounded on tape —so angry, so cantankerous, and so unwilling to hear what others had been saying to her. She was now painfully aware of what she had been doing and was prepared to explore its meaning. She could ward off confrontation, tune out what she did not want to hear, and attack rather than be defensive. What she could not do, however, was ignore what she sounded like to herself on the tape recorder.

Developing a Multidimensional Plan

We can be virtually certain that none of the strategies mentioned in this chapter, or throughout the book, are likely to be successful with the truly difficult client unless they are integrated into an overall treatment plan. Sex offenders, for example, are among the most challenging populations to work with because of the complexity of their disorder and everything that maintains it —high intensity arousal, compulsive drives, low motivation to change, and low probability of being caught. The only thing that works is a multidimensional attack combining no less than five different treatment efforts offered simultaneously: social skills training, victim empathy, hormone suppression medication, sex education, and direct attacks on deviant arousal (LoPiccolo, 1985).

This same multipronged approach is necessary in our work with most difficult clients. We simply cannot afford to stay with a narrowly focused treatment strategy that neglects some crucial element that helps to maintain the dysfunctional patterns. Other "rules of engagement" follow in the next chapter.