Exploration of Therapist Characteristics and Therapeutic Models for Work with Difficult Clients

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Abstract

Throughout a therapist's career there will be some clients who challenge clinical skills more than others. For example: these clients may appear to not want to change, they may continue in maladaptive patterns of being in the world or may dispute their responsibility in management of their life. These individuals are often referred to as difficult or resistant clients. These clients challenge the skills and patience of the therapist in ways which can cause the clinician to break or to grow. It is beneficial to explore both the influences of the therapist's characteristics, such as their preconceived ideas, lack of knowledge or understanding, which may elicit or perpetuate the resistance in a client, as well as effective clinical approaches to address such situations. This paper demonstrates with a case study the application of five theoretical approaches. The difficult client in the case study struggles with external locus of control and unrealistic expectations which are addressed through the therapy.

Keywords: *difficult clients, resistant clients, therapeutic skills*

Огляд характеристик терапевта та терапевтичних моделей для роботи з клієнтами, які не прогресують в терапії

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Анотація

Впродовж кар'єри терапевта деякі клієнти не прогресують в терапії і випробовують клінічні навички терапевта більше, ніж інші. Наприклад, може виглядати так, що ці клієнти не хочуть змінюватися, або вони можуть продовжувати дезадаптивні моделі поведінки, не приймати відповідальність за керування своїм життям. Цих клієнтів часто називають складними клієнтами, або тими, які чинять супротив. Досвід роботи з такими клієнтами може привезти як до падіння, так і до зростання клініциста. Часто, стикаючись з ситуаціями супротиву клієнта, з одного боку, терапевти можуть почати сумніватися в своїх клінічних навичках, своїй здатності допомогти такому клієнтові, або навіть поставити під сумнів свою компетентність загалом і почати думати про закриття своєї практики. З іншого боку, терапевти можуть шукати можливість підвищення своєї кваліфікації, консультуватися з колегами, набувати нових знань та компетенцій, що приведе до професійного зростання. Тому працюючи зі складними клієнтами, треба розуміти, по-перше, як вплив особистих характеристик терапевта, таких як, можливо, його упередженість, або нестача знань та розуміння, може погіршити або подовжити поведінку опору клієнта. По-друге, терапевт має знати та володіти ефективними клінічними підходами для роботи з такими ситуаціями. Ця стаття демонструє на прикладі одного клінічного випадку застосування п'яти теоретичних підходів, де важка клієнтка має нереалістичні очікування та проблему з зовнішнім локусом контролю, які опрацьовуються в терапії. Автори статті розглядають наступні теоретичні підходи: когнітивне реструктурування, когнитивно-поведінковий системний аналіз психотерапії, схема-терапію, когнітивну терапію на основі повноти усвідомлення (майндфулнес), когнитивно-аналітичну терапію. Автори наводять приклади терапевтичного діалогу з клієнтом розглядаючи кожний теоретичний підхід.

Ключові слова: *складні клієнти, опір, терапевтичні навички*

Introduction

Every clinician encounters a difficult client that has a personality disorder or attachment style issue that is a challenge in therapy (Sperry et al., 2006). These clients tend to be resistant to many therapies and many clinicians. They challenge the expertise of the therapist, their competence, and ability to accurately diagnose and treat the client (Berger, 2004; Hannah, 2001). Therefore, all therapists would benefit from examining the factors that elicit or perpetuate the resistance response in clients. In addition, each therapist should review most helpful approaches in addressing the difficult clients and modalities that help turn resistance into effective therapeutic alliance. Therefore, by exploring a combination of therapist factors that contribute to resisting behaviors as well as clinical models that help to address those, a clinician can be further prepared for work with difficult clients.

Different therapists explain resistance from different angles, making emphasis on blocks in consciousness, environment, cognitions, behavior, attachment or trauma. For example, Freud identified resistance as a way for the client to block conscious awareness to avoid anxiety (Otani, 1989). Whereas, Shelton and Levy recognized three reasons for non-compliance in treatment: undesirable environmental conditions, lack of necessary skills or knowledge of the client to follow a behavioral assignment, and negative expectation or cognition of the client about therapeutic outcomes or process (Shelton & Levy, 1981). Berger characterizes clients as difficult when they continue behaviors which cause trouble, such as infidelity, drinking, or substance use (Berger, 2004). Finally, Sperry et al. (2006) categorized three levels of clients: easy, challenging, and difficult with difficult clients having an insecure attachment, history of early trauma, social skills deficits and show reduced readiness for change which may be perceived as lack of motivation.

Therapists also have their own professional struggles such as missing important information or knowledge, making invalid assumptions, not executing an intervention well, not doing something they need to do, having their own unresolved issues getting in the way of their work, and loss of compassion (Kottler, 2013). In these instances, the therapist is responsible for recognizing their influence in the resistant or difficult relationship. Hannah cautions awareness for young therapists in wanting the enjoyable and gratifying feelings which can come from being a help to others, a feeling which can turn into an addiction (Hannah, 2001). Therapists can view their purpose as being helpful, beneficial, effective, or competent and the «resistant» client may challenge this purpose of the therapist (Hannah, 2001), therefore, leading to the label of «resistant», so the therapist can save their own self-image.

The object of the study: To discuss difficult clients and therapist factors contributing to the resistant behavior in therapy, as well as therapeutic interventions to assist in work with resistance in therapy.

The subject of the study: To identify common characteristics of a difficult client, therapeutic steps and interventions in working with these clients, and therapist factors which elicit the resistance behavior in therapy.

The purpose of the study: To explore the influences of the therapist's characteristics which may elicit or perpetuate the resistance in a client as well as effective clinical approaches to address such situations.

Methods and Materials

There are several therapeutic models which specifically address client's who are challenging to work with. First, the authors address the clinician influences that elicits or perpetuates the resistant behavior. Then, the authors review a case study example with the application of five theoretical modalities that may be utilized in treating a difficult client.

Interaction of a Therapeutic Model and Person of a Therapist

Perhaps, counterintuitively, the therapist more often adds to the resistance of the client with his/her personal characteristics, knowledge, reactions, or traits. Berger challenges behavioral health service providers with the statement:

«The inability to effectively help a client deal with this issue has led to considerable theorizing (locus of control, attribution theory, arrested development) as well as to client blaming and labeling (this patient is treatment resistant; she has an untreatable personality disorder). Too much of this, I fear, is in the service of helping therapists deal with their feelings of impotence and failure, rather than helping the client» (Berger, 2004).

Eight difficult clinical situations have been identified (Kottler, 2013). Of these situations only two focused on what the client brings into the relationship: when clients are purposely resistant and when clients are in their own patterns of entrenchment and are unable to act other than resistant. Whereas other six situations are the therapist's responsibility: missing important information or knowledge, making invalid assumptions, not executing an intervention well, not doing something they need to do, having their own unresolved issues getting in the way of their work, and loss of compassion (Kottler, 2013). In these instances, the therapist is responsible for recognizing their influence in the resistant or difficult relationship.

A difficult client may also be determined by a therapist's own narcissism and need for a therapist's high, this high, if not met can result in upset and resentment towards the client (Hanna, 1996; Kottler, 2013). This is viewed as the self-serving need to feel needed and make progress with our clients, fueled by the provider's belief that they should be able to help anyone at any time without limitations

to population or capabilities (Berger, 2004; Kottler, 2013). Young therapists are cautioned in wanting the enjoyable and gratifying feelings which can come from being a help to others, a feeling which can turn into an addiction. However, the «resistant» client can challenge this need for the therapist. Therefore, the label is used of «resistant» so the therapist can save their own self-image (Hanna, 1996).

Therapeutic use of Resistance

Addressed resistance can lead to a successful outcome in therapy while unaddressed resistance may interfere with a successful outcome (Captuo, 2004). The therapist's perspective on the process of change and resistance may impact how resistance is perceived and drive the choice of therapy intervention(s). Fred Hannah identified seven precursors to change: 1) a sense of necessity, 2) willingness/ readiness to experience anxiety and difficulty, 3) awareness, 4) confronting the problem, 5) effort towards change, 6) hope for change, and 7) the social support needed for change (Hanna, 1996).

Resistance behaviors are addressed not only by the therapeutic intervention, but also by the interaction of the person of the therapist and a client (Sperry et al., 2006). One therapy does not fit all. Often clinicians spend too much time in identification and implementation of the therapeutic modality rather than understanding the client's history, temperament, deficits, strengths, comorbidities, and support system (Sperry et al., 2006). The results of creating a change without the proper support could be detrimental to the client's mental health and to the therapeutic relationship. Instead, clinicians ought not only match the treatment modality, but also the personalized delivery and care attuned to the personality and needs of the client (Sperry et al., 2006). Attempting the same treatment for each client is not only harmful, but also unethical (Norcross, & Wampold, 2011). While early-career therapists are taught a series of foundational skills to start out their therapy practice, this is not the end of learning. It is necessary to continue to learn and build on skill sets to create a series of tools to use for the clients in their care.

Case Study and Theories Application

There are multiple therapeutic interventions which clinicians successfully utilize in the treatment of the difficult client. While most common approaches used to be cognitive or behavioral, there are a number of therapies that have shown to have an improved advantage over the pure cognitive and behavioral models. These include Cognitive Restructuring (CR), Cognitive Behavioral Analysis System of Psychotherapy (CBASP), Schema Therapy (ST), Cognitive Coping Therapy (CCT), and Cognitive Analytic Therapy (CAT).While each of the theories have value for a client's care, the most effective treatment will most likely comprise of a mixture of these therapies. For example, helping a client understand from where the patterns developed (ST and CBASP) may lead to the need to change the maladaptive thinking (CR), with the focus on being kind to themself in the process (MBCT), and bring action when they are ready to make a change (CAT). Therapists practice these theories while holding a positive regard for their clients, understanding their personal internal processes during the therapy session, and continuing to educate themselves regarding therapeutic models.

Below the authors discuss a clinical case of a client who struggles with unrealistic expectations and external locus of control that are addressed in therapy. The authors further discuss the applications of Cognitive Restructuring, Cognitive Behavioral Analysis System of Psychotherapy, Schema Therapy, Cognitive Coping Therapy, and Cognitive Analytic Therapy.

Clinical Case: Elizabeth

Elizabeth came to therapy due to an unsatisfying marriage, difficulty in parenting, and feeling generally «stuck» in her life. Each week she would talk about what was wrong in her life, however, did little to change what she was doing. Every session she would identify what actions she could change during the following week and yet no perceived movement towards change was observed or reported. The therapist sought consultation due to the lack of progress with this client. The consultant first inquired about current complaints, when they started and how they developed. It was discussed that Elizabeth knows she wants a fulfilling marriage and a better relationship with her children, but she does not know how to achieve such relationships. The problems identified include the lack of intimacy and communication with her spouse, sentiment of being the only one to care for the maintenance of the home, children not helping around the home or listening to her, and children having difficulties in school and showing disrespect to their teachers.

Elizabeth also noted that she has a similar marriage relationship as to what her parents had. Her mother took care of things around the home because her father either would not participate or would create more problems when he did participate in care of the children or the household. She notes this has been a similar pattern in her marriage where her husband does not do things «correctly» and she completes the chores by herself to her satisfaction. This has also been a continued pattern with her children, in that they complete the chores and Elizabeth scolds the children for not doing them right and then completes the chore the «correct way».

Cognitive Restructuring

Cognitive Restructuring (CR) is a form of Cognitive Behavioral Therapy (CBT) with a greater focus on identification and disputation of irrational

thoughts to identify more helpful ways of thinking and responding. It involves bringing awareness to the irrational or unhelpful thoughts, recognition of patterns of cognitive distortions, challenging these distortions such as identification of their benefit or disruption in a person's life, and finally creating new helpful beliefs. The focus on CR is not to change the client's thoughts, rather to challenge the emotions which create conflict (Mueser, Rosenberg, & Rosenberg, 2009).

While CR can work with some of the challenging populations, Sperry, et al. writes that CR does not work with chronically depressed clients because they are disconnected from their environments and tend to function at the preoperational level of cognitive and emotional development (Sperry et al., 2006). The preoperational stage, as defined by Piaget, is the stage in which children are learning about the world by experiencing. In this stage, children are unable to fully manipulate the information they learn. Therefore, persons in the preoperational stage experience the world in the present and are unable to change their unhelpful thoughts and emotions into something more positive. CR skills, such as thought stopping or not taking things personal are not available to them. Therefore, these clients exhibit resistance in treatment when the focus is to connect them to their environments (Sperry et al., 2006).

A therapist using CR would assist Elizabeth in identification of the irrational beliefs and unhelpful emotions that support the troublesome behaviors. These unhelpful beliefs and emotions may include how others in her life «should» behave, how her house is supposed to be maintained, rigid views of how chores should be completed correctly, and how relationships in the family are supposed to be.

The therapist would use identification of cognitive distortions such as black-and-white thinking, catastrophizing, or personalizing. Elizabeth will learn how to monitor her own thoughts and expectations. She may note a pattern of thinking: «The house is dirty and with the house being dirty the Child Protective Services is going to come to remove my children from the home, the same way my friend was removed from my life. I can't lose my children therefore the house has to be perfect.» Once the thoughts are identified they can be challenged by identification of the evidence in asking questions such as: Is this based on fact? What is the evidence supporting and refuting this belief? Is this really the truth? How can I test this assumption? The therapist can then lead the client through looking at the cost of holding this belief (Clark, 2014). «What do you get out of keeping the house perfect? What are the long-term effects on your relationships?» The therapist would then help Elizabeth in developing alternative behaviors such as allowing the house to be cleaned by her family members in «semi-correct way» and children to complete the chores according to their abilities. With that the client will attempt to focus more on the relationship with her children and spouse than the condition of the house for certain days of the week. She would look at the benefits of these patterns of behaviors and choose one to attempt for the week conducted as an experiment. In an experiment there is no success or failure, there is only trying something different and reporting back the results, thereby reducing anxiety produced by changing a behavior or thought pattern (Clark, 2014).

Cognitive Behavioral Analysis System of Psychotherapy

Chronically depressed patients often have a disconnect from their environment and do not see consequences for their actions in their lives, much as a child in the preoperational stage of development. Cognitive Behavioral Analysis System of Psychotherapy (CBASP) was originally developed to help such clients see that what they do has an environmental consequence and they need to develop empathy for people around them. The therapist in this approach is modeling a positive behavior that the client is learning to differentiate from some negative behaviors of others in the client's environment (McCullogh, & Goldfried, 1999). Further, the therapist applies proper reinforcement to encourage clients' progression into the formal operations stage of thinking and learn how they are able to impact their environment in healthy ways by changing their behaviors (Claiborn, 2001). The main focus of CBASP is on behaviors, though negative thoughts are also getting addressed to a lesser extent. The therapist uses negative reinforcement where he/she helps the client to remove something unpleasant to increase the likelihood of a positive behavior happening again and aid in positive changes of thinking and behavior. The goal of CBASP is also to teach disconnected patients how to function in a «reciprocal and deterministic» manner (McCullogh, Schramm, & Penberthy, 2016, p.4) as such the clinician is more involved in the process of helping the client to learn a skill of interaction.

A therapist using CBASP would assist Elizabeth to come to an understanding of how her behaviors influence the behavior of her family members and will learn ways to take steps to change maladaptive patterns of interacting. Through therapeutic interactions with the clinician, Elizabeth would learn how she comes across to others. The therapist's dialogue with Elizabeth may look like the following: «Elizabeth, do you realize you are speaking in a tone of voice which conveys you to be younger than your age, this creates frustration in me as I know you are capable of interacting as your age.» Elizabeth will also identify the significant others who have had positive or negative influences in her life. She will understand the stamps these significant others

have had and the impact of these stamps on her ongoing functioning and relationships. Through the transference hypothesis the clinician will expose Elizabeth's core interpersonal fears and thereby, would proactively teach Elizabeth to discriminate between those who disappointed or hurt her in the past and the interactions with the clinician who does not want to hurt her. Once rapport and the transference hypothesis are established, the therapist would use situational analysis to aid Elizabeth's understanding of what happened in an original interaction that resulted in the current negative pattern of relational behavior. In that, Elizabeth would first tell the therapist her narrative of what happened in that original situation including beginning, middle, and end as well as who was involved with the story. Second, Elizabeth would review the original situation and discuss further how she interpreted the other individual's actions at that time. Third, Elizabeth would think back on the situation and identify how she behaved, how she would have looked to someone observing and what words she said. Fourth, she would state the outcome of the situation in one sentence and then fifth, how she would have liked the outcome to be instead, stating it from the observer's point of view (making a statement in a third person), using only one sentence. Sixth, the therapist would challenge Elizabeth to note if she obtained the outcome she wanted in the situation, and finally, Elizabeth would be directed to identify what she did or did not do to obtain the desired outcome.

For example, the therapist discusses with Elizabeth an argument with her children about clothes laying on the floor instead of a dirty linen hamper that she perceived as disrespect and laziness. Elizabeth's response to the situation was yelling and picking up the clothes while berating her children. The desired outcome for Elizabeth would have been for the children to have picked up their clothes and then spent some relaxing time with them before bed. Elizabeth would further discuss this desired outcome and identify it if it is reasonable to happen. Elizabeth would determine if her interpretation of the situation was accurate, determine in what ways her interpretation led to the undesired outcome, and would help Elizabeth to understand how her behaviors may change when she interprets the situation in a new way..

Schema Therapy

Schema therapy (ST) specifically addresses the pervasive underlying factors which impact the functioning of difficult clients (Griffith, 2003). These factors are often seen in clients with personality disorders and psychosis and include symptoms such as inaccurate thinking, critical views of the world, and behaviors which drive people away. Schema Therapy has two phases. First, early maladaptive schemas (understanding of the world) are identified and related to current functioning. Second, the therapist blends cognitive, experiential, behavioral, and interpersonal strategies to move towards healthier and more adaptive schemas. Along with ST, the use of psychodrama can aid in the processing of changing maladaptive schemas by allowing the client to act out the role of the protagonist and group participants act out other roles in the client's life for the purpose of allowing the client to see how their choices influence their environment (Griffith, 2003).

In ST Elizabeth would gain an understanding of how her ways of relating to the world she learned in childhood continue to influence her relationships and patterns of relating in her current family system. Through the use of psychodrama she will experience the effect of her actions' influence on people around her and how she can change her behavioral and thinking patterns to lead to more fulfilling relationships in her family.

A therapist's dialogue with Elizabeth could proceed as follows: «Elizabeth, let's talk about this relationship you had with your own parents, you mentioned how your marriage is similar to theirs.»

Elizabeth: «Yes, my father was lazy and didn't help around the home. My mother would yell at him and tell him he needed to help out. I could never do anything right. Whatever I did had to be better and better. Even when I did my best, she always found a way to yell at me.»

Therapist: «What do you think you learned from your mother that you still hold as your truth?»

Elizabeth: «I can't do anything good enough. I will never be enough for her or anyone else.»

Through understanding the root of her internalized beliefs Elizabeth can begin to challenge these ideals to break unhealthy patterns of behaviors and thinking.

Mindfulness Based Cognitive Therapy

Mindfulness Based Cognitive Therapy (MBCT) is originally derived from Buddhist tradition. It focuses on 1) a person's awareness of the present moments, 2) the development of a sense of self-compassion from what is thought and felt in the moment, and 3) the conscious analysis if personal thoughts reflect reality (thinking something does not make it true) (Melaero Centorla et al., 2020). MBCT also helps chronically depressed patients by reducing vindictive or self-centered behaviors and rumination (Cladder-Micus et al., 2019; Probst et al., 2020).

If Elizabeth were to attend Mindfulness Based Cognitive Therapy, she would learn to be more compassionate towards herself and to gain an understanding of the internal thought process for the separation of thought and reality. For example if Elizabeth is re-doing a chore and believes her family does not care for her this may lead to a depressed mood. Elizabeth can instead identify that the belief of her family not caring for her is just a thought and does not in actuality mean her family does not care.

A therapist may take Elizabeth through the following exercise: «We are going to practice an exercise to keep you in the moment and help manage your thoughts when you are in a situation where you may become frustrated. I want you to take a moment and breathe regularly, then start slowing your breaths down by extending your exhale, and then extending your inhale. I want you to focus on how you are doing right now, at this moment. Focus on your breathing. Notice what is happening in your body. We are going to sit in this space for a few moments, with you taking time to just be in this moment, nothing else matters.»

«Now imagine you are walking through the house and notice something not cleaned how you would like. Before you act I want you to take some time and be in that moment. Notice your body, notice your breathing. Take a few moments to be in that moment rather than letting your mind move back to how your mother wanted her home to be. If you choose to clean, I want you to be in the moment cleaning, using your breath to relax into the action, and focusing on your body during this time. Your goal this week is to stay in the moment for 3 3-minute spaces each day just as a start to practice. It won't be perfect and I don't expect perfection, this is an experiment to be where you are and allow the past to be in the past.»

Cognitive Analytic Theory

Cognitive Analytic Theory (CAT) was developed to treat clients in a shorter duration. The basic theory of CAT is that clients respond with aim-directed behavior. This model looks at the procedure of formulation of the aim, evaluates the environmental options, plans an action, acts, evaluates the results and determines if the goals were reached or if the plan needs to be reevaluated. CAT has been successfully used with clients with schizophrenia, psychosis, PTSD, and borderline personality disorder (Asmundson, 2019; Evans et al., 1996; Taylor et al., 2019).

A therapist using CAT would create an action plan for Elizabeth to complete each week. In session she would identify a possible series of actions. Then, during the week she would act on this plan, and in the next session analyze the results.

A therapist's dialogue with Elizabeth could proceed as follows: «Ok, Elizabeth. Your goal this week is to have less arguing with your children. What are our options?»

Elizabeth: I can leave the house for the week and not be around my children, I can just let the house stay a mess and not care like anyone else, or I can just clean silently and be the only one angry in the home.

Therapist: «Which of these allows you to reach your actual goal of a better relationship with your children.»

Elizabeth: «None of them.»

Therapist: «Then let's look at something which may help with this relationship.»

Elizabeth: «I can clean the kitchen alongside my child at the end of the day. This way we can spend time together and I can help them to see what it looks like to have a clean kitchen. Maybe we can put on music they like while we clean to make it go faster.»

Therapist: «This sounds like a very workable idea. Do you want to try this every night, or do you think one night with each child will help to move forward in reaching your goal?»

Elizabeth: «I am not sure I can do it every night. So, maybe plan for 4 nights of the week total. Then Friday I will plan to have pizza night and will clean that up myself because we can use disposable dishes.»

Therapist: «So the experiment we are going to do is to have you clean the kitchen at the end of the day with your children and will listen to their choice of music. This will help to reach the dual goals of spending time with them and teaching by example. Next week we will see how this goes and in what ways we may need to improve the experiment.»

Conclusion

Difficult or resistant clients are a challenge for most therapists. While there are common presentations of these difficult clients, there are also individual differences dependent on the clinician involved. Just as the clients learn how their interactions fuel the responses of others, the same can be said of the therapist. The interactions a therapist has with a client may engage resistance, maintain resistance, or allow the client to walk through the resistance. It is both the client and the therapist who partner together in a way to make meaning from the therapeutic relationship and the external interactions in the life of the client.

A commonality among the interventions discussed above is a linear process which has a focus on awareness of the thoughts and emotions as seen in CBT. These, however, also emphasize a collaborative relationship and positive regard towards the client. In mastering clinical skills, it is important for the therapist to be able to use these skills in their own lives. As a clinician teaches the client how to be understanding towards themselves they also must be accepting and understanding of the client. The therapist needs to be open and provide grace in a way which allows the client a safe space to be vulnerable enough to share and heal.

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