PRACTICAL RESOURCES for the Mental Health PROFESSIONAL

with Difficult Clients

Applications of Cognitive Appraisal Therapy

Richard Wessler
Sheenah Hankin
Jonathan Stern

Succeeding with Difficult Clients

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To our children, our students, and all of our clients.

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PART I

Cognitive Appraisal Theory

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CHAPTER 1

What Makes Difficult Clients Difficult

AN INTRODUCTION TO COGNITIVE APPRAISAL THERAPY

The origins of Cognitive Appraisal Therapy (CAT) are primarily cognitive–behavioral in nature. While CAT has developed into an integrated approach to psychotherapy for personality disorders, it can be applied to working with all clients. CAT assumes that affect, behavior, and cognition are interdependent, mutually influential psychological components, and that a significant source of motivation is a person's seeking psychological security by repeating certain familiar experiences. Our approach contains elements of several cognitive–behavioral therapies as well as elements of other approaches to psychotherapy. Its theory draws upon attachment theory, social learning theory, and interpersonal theory, and its procedures include elements of person-centered counseling, experiential therapy, and Rational–Emotive Therapy (RET). Millon's (1996) theory of personality also heavily influenced CAT's conceptualization of the personality disorders.

CAT can be the approach of choice when therapy stalls. Though practitioners hold to the familiarity of a favored set of theoretical concepts and

clients to familiar affective habits, it is helpful for clinicians to experience the unfamiliar and experiment with CAT's approach, especially for personality disturbances and the more recalcitrant clients for whom this approach was created. CAT is not a set of specific procedures laid out in cookbook form. Rather, it is a unique theoretical understanding of affect that a client can comprehend and then use to change.

CAT began as an alternative version of RET (Wessler, 1984, 1987). RET theory assumes that there are two parallel processes of emotion—one mediated by rational beliefs and another separate process mediated by irrational beliefs (Ellis, 1977)—and that rational beliefs result in "healthy" emotions and irrational beliefs in "unhealthy" ones. The parallel process theory of emotions and the RET theory that "musts" are causative factors in psychopathology lack supporting evidence (Wessler, 1996). Having omitted the theoretical cornerstones that distinguish RET from other forms of cognitive–behavior therapy, our approach to therapy could no longer be called RET. The phrase Cognitive Appraisal Therapy was adopted to emphasize the fact that the evaluative cognition (a synonym for appraisal) continued to be a target for therapeutic intervention.

It became increasingly apparent to us that people are seldom aware of some of their most significant appraisals. These appraisals function as nonconscious algorithms—stored routines for the processing of social information (Wessler & Hankin-Wessler, 1989). (Algorithms are specific and separate rules for evaluating experiences, and they are not assumed to cluster together as schemas. The concept of schema is seldom used in CAT.) This discovery also signaled a shift in emphasis from consciously held cognitions to nonconscious cognitions that must be inferred from what people say and do.

Like most forms of psychotherapy in the early 1980s, CAT was used mainly to treat such Axis I conditions as anxiety and depression. Some clients did not improve, did not maintain their improvement, or continued in therapy after they improved (Wessler & Hankin-Wessler, 1991). Why? The answer was found in their *predisposing personality characteristics*. As Millon (1996) expresses it, clinical conditions are the result of psychosocial stressors interacting with personality variables. CAT quickly responded by focusing almost exclusively on the treatment of personality variables and vulnerabilities (Wessler, 1993a,b). We have found that by using this focus and coupling it with integrative, attachment-based interventions, we are able to work easily and powerfully with clients whom many consider to be "difficult."

DIFFICULT CLIENTS OR DIFFICULT THERAPISTS?

After the third session of outpatient therapy, Kiesler and Watkins (1989) asked 36 pairs of clients and therapists to record their perceptions of the therapeutic alliance and to rate each others' behaviors during therapy using an interper-

sonal circumplex inventory. They found that angry, hostile clients and clients exhibiting "extreme" behaviors are correlated with therapists' feeling uncomfortable about the therapeutic alliance. Should we therefore call these clients "difficult" for therapists to work with, or should we instead call into question the therapists' skills at dealing with such clients?

Perhaps there is no such thing as a difficult client; there are only difficult therapists. When we call a client difficult, what we really mean is that *we,* the therapists, are having difficulty working with him/her. When we decide that a client is difficult, the use of this term means one of two things. "Difficult" may suggest that something about the client's personality is different enough from the norm of the client population with whom we have worked to date so as to present novel challenges to us. This term also can mean that a client triggers some of the therapist's own negative (or difficult) feelings and issues (Cashdan, 1988; Kiesler, 1996; Safran & Segal, 1990).

Thus, when a therapist uses the word "difficult" to describe a client, what he/she really means is: "I am having difficulty working with this person due to either my own emotional issues or a lack of experience working with clients like this." In essence, using the word difficult to describe a client should be a signal to the therapist that he/she needs to grow in some way personally (and interpersonally).

It is our hope that the reader will not become defensive when reading that difficulty with clients may indicate that the therapist might have to do some soul-searching as well as possibly making some technical improvements. Similarly, it is our hope that when a therapist is faced with a difficult client, he or she will not stop working with that client to avoid having to learn, grow, and adjust to this challenging situation. Many people in many careers who take their jobs seriously and want to be the best they can be assess themselves critically from time to time and feel badly about themselves. It is only the truly dedicated therapist or counselor who is willing to acknowledge and assess his or her weaknesses honestly, agonize over them (up to a point), and work to improve them.

Certainly, theories of competence (e.g., White, 1960) and research on self-efficacy (e.g., Bandura, 1977) and response expectancy (e.g., Kirsch, 1985, 1990; Ohlwein, Stevens, & Catanzaro, 1996) teach us that we will improve and succeed as professionals as long as we expect that setbacks and struggles are part of positive change—that the road to success is and should be paved with failure (as long as we are willing to keep on walking).

WHAT CREATES "DIFFICULTY" FOR A THERAPIST

In general, difficult clients can leave the therapist feeling either confused and stymied or feeling a variety of negative emotions. The first of these possibilities, confusion, occurs when a client says something that the therapist has

never heard before or says something in a way that the therapist has not previously heard. Confusion also ensues when the client plays out an interpersonal pattern of interaction that may be alien to the therapist or that is so "out of sync" with what the therapist is trying to say or do that the result is confusion on the therapist's part (and often on the client's part as well). My (Jonathan's) initial experience with this category of difficulty often felt like somebody pushed me into a revolving door, spun me around in it, and spit me out again, leaving me dizzy and directionless.

While confusion is often the predominant in-the-moment experience for the therapist, negative feelings may subsequently arise. A therapist who has felt stuck, confused, or helpless during a session may subsequently, depending on his/her own personality, feel ashamed, embarrassed, angry at him/herself or at the client and self-critical or judgmental toward the client. Depending on the therapist's personality, he/she may feel these emotions only in relation to working with this particular client ("This is one of the most daunting, frustrating people I've ever worked with. I'm no good as a therapist with him/her.") or may generalize these emotions ("You see. I don't know what to do with clients. I'll never be an effective therapist. I'm just fooling people that I'm any good."). Some therapists, however, may simply experience confusion with these clients without negative feelings and use this confusion as a signpost that they are working with a challenging client and perhaps need to take a somewhat different approach.

The second category of difficult clients, those who stir up negative feelings in the therapist immediately and powerfully, has two subsets. The first involves negative feelings elicited in the therapist by the client and the second occurs when feelings stemming from the therapist's own issues emerge during the session. This is basically the important distinction made by contemporary psychoanalysts between objective and subjective countertransference (Epstein & Feiner, 1979; Kiesler, 1996). These two subcategories can co-occur during a session, but it is possible to tease them apart. For example, the following interaction between a client and a therapist occurs during the early portion of a third session:

Therapist: What would you like to talk about today?
Client: I don't know. You're the shrink. You tell me.
Th: Whatever you'd like.
Cl: I don't think this therapy is helping me. You're too wishy-washy. You're not giving me helpful suggestions or a sense of direction.
Th: Well, I'm sorry you feel that way.
Cl: That's all you're going to say? I'm paying a lot of money for this and you're not delivering. You went to graduate school to learn how to sit there and just listen to me? A chimpanzee could do the same thing and would be a hell of a lot more entertaining.

The client here is clearly being challenging in a disrespectful way toward the therapist, and many therapists might feel justifiably angered and insulted by this interaction, not so much by the fact that the client has concerns about the therapy but by the demeaning put-downs and challenging, confrontative style of the client. And chances are that this client elicits similar angry, potentially rejecting reactions in others in his life.

The therapist's angry reaction, however, may be amplified further in a therapist who, for instance, has little self-confidence. The initial internal response of "This client is putting me down" might give way in this therapist to "Damn it, the client's right. I don't know what the hell I'm doing. I hate the client for finding me out and I hate myself for being a failure." The therapist may then find a way to punish the client, react defensively and/or, after the session, wallow in self-criticism and self-pity. Thus, difficult clients can elicit feelings in the therapist which they evoke in many others in their lives and the therapist can also react with the feelings that he/she brings to difficult situations in his/her own life.

Additionally, therapists can experience certain clients as difficult when they are not eliciting negative feelings in the therapist but incidentally trigger issues for the therapist which are laden with negative affect. A client who is histrionic might frighten or subdue a therapist who came from a buttoned-down family, or a client who is passive–aggressive may frustrate a therapist who derives his/her self-confidence from quickly and efficiently fixing problems.

In chapter 3 we will discuss in detail what the predominant negative feelings are in difficult clients (and, in essence, in all clients). However, at this point, it is worth noting that similar negative feelings may arise in the therapist during a session with a difficult client: shame, rage, and self-pity. These feelings arise because the client speaks the language of these emotions and is therefore adept at evoking them in the therapist and/or the therapist him-herself has longstanding issues which are intertwined with these affects. It is therefore a central part of the therapist's job to notice when he/she is experiencing shame, rage, and/or self-pity during or after a session and to pinpoint whether these feelings are elicited by the client or come from within. We will discuss throughout this book not only how therapists can teach clients to manage their longstanding negative affect more effectively, but also how they can identify and manage these feelings in themselves during and between sessions.

A WHO'S WHO OF DIFFICULT CLIENTS

If you were to ask a large sample of therapists who they consider to be the most difficult client to work with, probably most would respond the borderline personality disorder. However, we have not found this to be true, given our