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“11 Solutions for Counseling Difficult Clients”

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11 SOLUTIONS FOR COUNSELING DIFFICULT CLIENTS 6 CEU Credit Hours

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Course Description:

Working with non-compliant, manipulating and sabotaging clients can be extremely frustrating. This course offers reasons why clients are difficult - and solutions to overcome these challenges. Eliminate denial, increase motivation and make progress!

Course Objectives:

At the conclusion of this course, the professional will be able to:

- 1) Explore the 10 common reasons why clients are difficult.
- 2) Discuss 11 techniques for overcoming the challenges of difficult clients.
- 3) Learn strategies to motivate the unmotivated client.
- 4) Understand the causes for the behaviors we label "denial."

Purpose of this course:

The purpose of the course is to assist counseling and social work professionals in treating clients in all settings, (in-patient, outpatient and criminal justice) who may be considered a highly difficult client.

Course Outline:

Part 1: Course organization, Documentation and Introduction.

Part 2: Reading of the course materials (this document)

Part 3: Administration and Completion of the Evaluation of Learning Quiz

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6 Clock Hours / CE Credits

If you ever have any questions concerning this course, please do not hesitate to contact **PeachTree at (800) 390-9536.**



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11 SOLUTIONS FOR COUNSELING DIFFICULT CLIENTS

INTRODUCTION

When I was in graduate school and learned how to do counseling, I looked forward to the opportunity to finally treat real clients. After graduation, when I took my first counseling job, I began working with substance abusers. When conducting therapy sessions, I did exactly what I was taught to do in graduate school: Sessions were 50 minutes long, during which time I sat at a 45-degree angle from the client. I used my training in appropriate body posture, which was S-O-L-E-R, or Sit down, Open body posture, Lean forward, make Eye contact, Relax. I reflected back on what I thought I heard my client say. I said “uh-huh” and sounded as if I had a Master’s Degree.

When my substance abusers left their counseling sessions, they all did the exact same thing: they left my office and immediately got high.

Counseling is usually a second career choice. Most of the professionals I speak with were something else before they became a counselor. Perhaps they were a teacher or a salesperson first, or had worked in accounting before going on to finish a graduate degree and becoming a psychotherapist.

For me, counseling was a first profession. When I graduated with my Master’s degree, I was only 23 years old. Because I didn’t have a gray beard and a gray mustache, I couldn’t get the ‘good jobs’ that other counselors had. Instead, I got the jobs that nobody else in our profession wanted. I worked in the halfway house environment, with substance abusers, with adolescents in state custody and with criminal justice populations.

I learned a lot in graduate school, but after becoming a licensed professional and actually providing real services to real clients, I recognized something important: graduate school

had taught me how to think, but it did not teach me the skills necessary to actually conduct effective counseling, especially with highly difficult clients.

Most people don't want to work with highly difficult clients. Consequently, in my young and untenured state, HDC's filled my caseload. I worked with angry clients, raging clients, substance abusing clients, the chronic mentally ill, and the adolescent mislabeled with the "psycho fad" of the day, who probably acted out his behavior only because he was a conduit for parental stressors and had become the identified patient.

I got into the field like most other counselors - not only because I didn't have to take math to get the degree - but also because I genuinely wanted to help people. Therefore, early on in my career I was quite frustrated about being ineffective - not because of low self-esteem, but because I genuinely wanted to have a positive impact on other individuals.

Now, older and wiser and obviously more experienced, as I think back to the highly difficult clients I worked with over the years and the interventions I provided in treatment settings, I realize that those frustrations are conquerable.

Graduate school likely did not prepare most of us for what to do with the suicidal person in our office at 4:45pm, when we're getting ready to leave at 5:00pm. And graduate school probably didn't prepare us to provide effective intervention services to the client who replicates the same self-destructive behavior time after time, every time they leave the doors of our office. Nevertheless, there are strategies that can impact highly difficult clients such as these.

Even the most difficult aspects of counseling - resistance, denial, sabotage, rage, staff-splitting and chronic failure - have solutions. There are even solutions for the couple who shows up for marriage counseling not to repair their marriage, but to begin the mediation process for divorce. There are solutions for the difficult youth in treatment labeled as the identified patient in the family, who would likely be better served if their parents were the ones behind the locked door of the seclusion room.

Highly difficult clients are usually not difficult due to any complexity, and so the solutions offered in this course aren't complex either. Generally, clients are difficult because the behavior we have labeled as difficult serves to meet the client's specific needs.

This text offers eleven key solutions for working with highly difficult clients, which can have a positive impact regardless of the treatment setting, with the old client, the young client, and the mentally ill client, the substance abusing client or the couple on couples counseling, regardless of a client's cognitive abilities.

This course comes with a simple disclaimer: Even though these interventions are easy to apply, like anything else in counseling, they will not all work for all clients all of the time. Clients are human, and therefore every client and every situation is unique. Some interventions will work with some of our clients, some of the time, and others will not.

I think one of the most effective interventions in counseling is to recognize that effective counseling is not about helping most of the people most of the time, but rather it's about helping those who we are able to impact some of the time, with the hope that these healthy individuals can then go on to impact other people in their lives in a healthy way.

When I was in high school things did not bode well for me. In fact, when I was 16, everyone either died or moved. Life was simply not going my way. A friend of mine named Bob worked as the youth minister at a local church. During this particularly difficult time in my life, Bob was really helpful. He opened his home to me; he supported me, prayed for me, encouraged me and helped me enroll in college after I finished high school.

Bob was such a wonderful friend to me, so I kept casual contact with him, calling now and then to say hi and check in. He married and over the years had four children, while I married and had three. I met Bob while growing up in Chicago. Eventually he moved over to Michigan and I migrated to Texas, Oklahoma and now Kansas.

A few years back, I called Bob shortly before Christmas, just to say hello. He was excited that I called, because he had news he wanted to share with me: After 20 some years of youth ministry, he was now going to sell hydraulic hoses.

I was shocked! After two decades of successful youth ministry, selling hydraulic hoses was not a career move that I would have expected Bob to make. I asked, “Gee, Bob, why hydraulic hose?”

He replied, “Well, it’s a commission sales job, and since my four children are getting older, I need to make more money to pay for their education.” He must have sensed my confusion because he added, “Don’t worry; I’ll still be involved in ministry, but just as a layman, not as a professional.”

I then asked, “Um, after 20 years of youth ministry, how do the other kids you’ve worked with over the years feel about your job change?”

The phone was silent. Apparently, Bob was thinking of an answer. Finally, he said, “I don’t know.”

This surprised me. Maybe he just didn’t want to tell me how upset everyone was to hear this news. So, I pressed him a little. “What do you mean you don’t know? When you talk to them, what do other people say about your career move?”

“Well, Richard, now that I think about it, I don’t really talk to too many of the kids who I worked with over the years.”

“What? Twenty years of youth ministry, and you don’t keep up with the kids you worked with over the years?”

“Richard, I work with kids. If they have problems in college during their first year, I usually hear from their parents and sometimes I talk to them, but most just move on. They graduate, relocate and get on with their life. If they didn’t go to college, they joined the military. Occasionally someone will show up in a hot new car purchased with military credit union money, and they’ll cruise around the parking lot a few times, and then disappear. In my role as a youth minister, I’ve come to accept that the young people I work with simply grow up and move on with their lives.”

“Wow, Bob, that must be enormously frustrating - not to hear from the kids later and know how they’ve turned out. Didn’t you wonder if you were having a successful impact on them or not? How could you just keep doing it all these years, without that reinforcement?”

Bob responded with a light chuckle, “Well, you kept calling.”

For Bob, satisfaction as a youth minister did not come from helping most of the kids that he worked with most of the time. Instead, he learned that satisfaction came from helping some of the kids some of the time.

Bob has probably snarfed Jell-O with thousands of adolescents over the years. He probably spent twenty New Year’s Eves at a lock-in, eating cardboard pizza and sharing the Gospel. He probably can’t even count the number of weekend retreats he’s held or the times he’s been on the campuses of Chicago and Michigan high schools.

Of the thousands of kids Bob has worked with, he only positively impacted some of those kids, some of the time. Bob ended his career as a professional youth minister, satisfied with how he had helped individuals, not frustrated by failures of reaching the masses.

The counselor frustrated with highly difficult clients would do well to learn from helpers like Bob. The true measure of our success comes from the quality of help we provide, rather than the quantity.

~ Richard K. Nongard

SECTION I

11 Reasons Clients are Difficult

Every now and then, we have a client who makes our life particularly difficult, such as a patient I once worked with at a locked psychiatric unit. We'll call her Sue. Sue was a 3rd year medical student, admitted after a brief reactive psychosis. Sue had a history of emotional instability, but this particular breakdown warranted inpatient hospitalization due to her increasingly frequent periods of decompensation.

Sue was not a particularly likable person; her personality was abrasive and offensive. Because she had knowledge of the medical field, Sue believed that she was able to dictate her own care to the staff better than we were able to provide treatment to her. After about a week, I started to dread going to work because I knew that as soon as I walked in the door, Sue would be there, splitting staff members and being particularly unpleasant towards me.

One morning when I arrived, Sue had the phonebook open to the "N" section and said to me, "Nobard and Nosmith. You should be right between these two names." She pointed her finger on the page. "How come you're not in the phonebook?"

I thought, am I lucky or what? The only reason I was not in the phonebook is because I had recently moved into a new apartment and had missed the publication deadline for the most recent phone directory. I went home from work that day, called the telephone company, and had my phone number unlisted.

Sue is, of course, not the only client that I have found difficult from a personality perspective. As you know, some clients are more likable than others. In our profession, it is not politically correct to admit these realities, for we have been taught that we should have unconditional positive regard towards all. While I agree with the principle, we are still human, and therefore we will find some individuals to be easier to work with than others and some more likable than others.

I mention this particular patient because as I went to work each day, it became clear to me that Sue derived a great level of satisfaction from tormenting *me* in particular. She sought me out between group sessions, at the nurse's station and at mealtime, specifically to inflict her obnoxious personality disorder and delusions upon *me*. I felt as if she must have decided that her life goal was to make my life miserable.

I have had other patients who I felt this way about. One couple I worked with in couples counseling did not seem to want to make any progress. Since they were not doing their assignments or working together on the tasks that we had outlined in counseling - but they kept showing up - I concluded that they had simply decided to make *me* the target of their misery, because it was clear that their goal as a couple was to pass their misery along to me specifically.

Of course, these conclusions were based on my feelings rather than on facts. In reality, no matter how intense the difficulty with a client is, clients do not decide that it is his or her life goal to make our life miserable. It may *feel* that way at times, but for the therapist to act in accord with that emotional belief is narcissistic.

In reality, clients are difficult because the difficulty that they manifest meets specific needs for them.

We are not the person they seek to torment. We are the targets of their coping strategies.

When we realize that clients are difficult for a reason other than it's just fun to make our life miserable, we can then choose to act on correct cognitions rather than faulty emotional beliefs derived from such experiences.

A few years ago, I was facilitating an adolescent outpatient therapy group. So many members in the group were so difficult to work with that my co-facilitator decided she had to quit. That left me managing 14 highly difficult adolescents on my own. In frustration, I sat down at my computer and I started to organize my thoughts and feelings about the therapy

group. Although it felt like most of those adolescent had set a goal to make my life miserable, when I started to think about why patients are difficult, I came up with 11 frequent reasons.

1. Fear
2. Lack of options
3. Cultural and value differences
4. Over-reaction
5. Impaired by chemicals or catastrophic mental illness
6. Emotional paralysis
7. Limited approaches
8. Needs are met
9. Conflict gains attention
10. Ignorance
11. The familiarity trap

When clients are difficult to work with, it is usually for one of the preceding 11 reasons. Some of these reasons come from within themselves; some arise because of problems or difficulties with us as care givers. The list is not in order; it's not from most frequent to least frequent or most severe to least severe. That said, I do think the number one reason why clients are difficult is fear.

REASON #1: FEAR

What do clients fear? Clients fear success, clients fear failure, clients fear change and clients fear fear itself. For all of us, it is often simply easier to accept life as it is, rather than to contemplate life as it could be.

I think about my experiences working with domestic violence cases. From my perspective as an outsider who has never been abused, I think, "Why don't they just leave?" The reason why the victim of domestic violence does not leave is fear. The victim of domestic violence is most likely to be harmed or killed following a change, such as leaving the hostile situation

and abusive relationship. For many victims of domestic violence, the misery they know is better than the fear of what they don't know.

Therapists often become frustrated when clients don't do what they obviously should do. But clients can't do what they should do when they are consumed by fear. When we recognize fear as one of the most prevalent motivations for sabotaging treatment, acting defensively, failing to comply with treatment protocol and the inability to manage life on life's terms, we understand how it can be a powerful obstacle to recovery from any condition.

Our clients sometimes fear us - our education, our experiences, and the differences they perceive between themselves and their therapists. These fears often manifest in defensive coping strategies, subconsciously designed by our clients to keep them safe from us.

REASON #2: LACK OF OPTIONS

People only know how to do what they know how to do. If they don't know how to do anything else, they don't do it. When I am angry, I have options. I can kick my dog, pat my dog, call my mother, go running, spend time by myself or go to a friend's house. I have options. The clients on our caseload do the things that they do in many cases because they do not know what else to do.

They lack options.

This is often because they did not learn the coping strategies necessary to manage life on life's terms from healthy environments. Sometimes they lack options because the resources available to the healthy person, perhaps even because of their own behavior, are not available to them.

I try to evaluate difficult clients from their frame of reference. I ask myself, "If I was this client, what else would I be able to do?" Asking this question from our client's perspective is a useful tool in understanding some of the limitations that our clients may truly experience, or at least perceive to be real.

REASON #3: CULTURAL VALUE CLASHES

Another reason our clients may be difficult is because our worldview is often different than their worldview. At its heart, therapy is often about compliance with the therapist's desires and goals, rather than attempting to help a client become the best they can be.

There once was an intensive outpatient adolescent treatment program in Tulsa. The staff at this facility resolutely believed that education was a hallmark of success. Education, they advised, brought about opportunity and the ability to change life circumstances.

Subsequently, one of the ways they measured therapeutic success with older adolescents was by helping them complete their GED or high school diploma. This achievement was a requirement for successful completion of the treatment plan.

An adolescent from rural Oklahoma had a few run-ins with the local judge and police. His behavior was certainly anti-social, but not devastatingly criminal. The judge believed that therapeutic intervention would be a more effective option than incarceration and referred him to this program. When he arrived at the facility in Tulsa and a treatment plan was established for him, it of course included the educational component. The client rebelled, stating, "I don't need no GED."

The staff at the treatment facility said, "But you do. If you complete your GED, it will open up all kinds of opportunities for you. In fact, if you finish your GED, we will be able to get you Social Service money and send you to a technical school. You could go to Okmulgee VoTech and become a heating and air-conditioning repair guy."

The client said, "I don't want to be no heating and air conditioner repair guy. I like where I live. I like my job with the logging company. I don't need no GED."

The staff at this facility - imposing their values on the client rather than simply exposing them - subsequently viewed this client as uncooperative. He was discharged from treatment, and referred back to the judge as a noncompliant client.

The truth of the matter: this client was right. He did not need no GED. What he needed was for the staff to teach him pro-social coping strategies to deal with his insatiable need for adventure, as the antisocial personality disordered person often experiences.

I could probably write an entire book on cultural and value clashes that therapists have with the clients on their caseload. Even though we are trained professionals, we are human, and we always see things through our own frame of reference. The DSM-IV recognizes that cultural bias is inherent in both the intervention and treatment process, which is why throughout its pages, particularly in the personality disorder section, it is careful to state that any assessment we make of pathology must be an assessment made from our client's frame of reference rather than our own values or our own cultural experiences.

The state of Texas requires chemical dependency counselors to have cross-cultural counseling training for continuing education. It frustrates me when the only courses offered in cross-cultural counseling involve racial or sexual orientation. Cross-cultural differences encompass much more than these two obvious areas. I wrote another course titled, *Nose Rings and Belly Button Things, Impacting the Next Generation*, which addresses the issue of cross-cultural counseling needs from an intergenerational perspective, religious differences, geographic differences and experiential differences, because all of these issues must be part of our assessment and evaluation process.

REASON #4: OVERREACTION

Clients have a propensity to over-react to our rigid treatment plans or our non-adaptive approaches to therapeutic intervention. Therapists notoriously overreact to client behaviors. I have co-facilitated many therapy groups where a client has been two minutes late, and the co-facilitator spent the next 18 minutes of group time processing why the patient was two minutes late, therefore wasting the first 20 minutes of the 50-minute session. Over-reaction, whether by the client or us, can certainly lead to difficulty in the therapeutic process.

Our clients also make big deals out of things that really ought to be little deals. The Dallas County Community Supervision and Corrections Division (adult probation) recently raised their fees from \$60.00 a month to \$62.00 a month. Offenders must pay these mandatory fees

as a condition of their probation. In protest over the increase, some offenders have likely had their probation revoked because they simply refused to pay the additional \$2.00 per month.

Teaching intervention strategies that can help scale emotions and therefore responses into perspective is an essential strategy for effective resolution of client difficulties.

REASON #5: IMPAIRED BY CHEMICALS OR CATASTROPHIC MENTAL ILLNESS

Some clients are difficult because they are simply too crazy or too stoned to accomplish the tasks of therapy. This sounds like such a simple truth, but I have met many therapists who talk about their frustrations in providing services to substance abusers, only to discover in case management that the client was continuing to use.

Therapists often believe the same myth that the clients believe: if they are cutting down, they are making progress. This simply is not true.

For the alcohol or drug addict, removing the chemical that is impairing their brain functioning by detox and sobriety is the only pathway to successful treatment intervention.

In this scenario, I am not referring the alcohol abuser or the person who drinks alcohol or uses drugs socially; I am talking about the alcoholic and the drug addict. For the 8% of the US population who meets the diagnostic criteria for substance abuse, continuing to use mood-altering substances will make resolution of therapeutic issues impossible.

It's really quite simple: If you are depressed and you put a 12-pack of depressant in your body every day, no matter how much Prozac you eat, no matter how many journals you keep, no matter how many therapy groups you go to, you will remain depressed.

Many of our bipolar disordered, schizophrenic and Axis II clients are so catastrophically impaired by their mental illnesses that they are often unable to comply with behavioral treatment programs in a milieu therapeutic environment. Or, they are unable to focus on the challenges and tasks that have been discussed in therapy when they return home.

Recognizing that our treatment goals with the mentally ill client are different from our treatment goal with the “well but unhappy person” can help us recognize why our clients are difficult, and how to go about creating interventions that will meet them at their unique point of need.

REASON #6: EMOTIONAL PARALYSIS

I had a client years ago who was known by the staff as Angry Bob. He exuded anger in all that he did and in every relationship he had. Angry Bob was angry while drunk or while sober. Angry Bob radiated anger about life, about himself and about others. Angry Bob found his way to treatment after an outburst at his place of employment.

Angry Bob was unable to feel any emotion other than anger. He was an emotionally paralyzed individual.

Why is it that clients become emotionally paralyzed? In the case of anger, perhaps because it's an energizing emotion. In the case of depression, perhaps it's because it slows us down. In the case of anxiety, perhaps it protects us from the fears we have about real risks. Whatever the reason for emotional paralysis, when the client is unable to feel anything other than a single primary emotion, we have a client who is extremely difficult and probably unable to make progress in any other venues of therapy.

REASON #7: LIMITED APPROACHES

Sometimes our clients are difficult because we do not have a repertoire of intervention strategies that meet our clients at their point of need.

I wish our clients came to us the way that I want them to be, the way they could be or the way they should be, but they don't. They come to us simply the way they are.

I am a good therapist with clients who have certain problems. I have a repertoire of intervention strategies for the substance abuser, for the personality disordered individual,

for the emotionally paralyzed individual and the person who is experiencing family and social conflict. I am not very good, however, with clients that require a special intervention strategy. The reason why I am not good with these individuals is because my repertoire of approaches is limited by my training and experiences.

Therapists are notorious for believing that their value or prestige is threatened by recognizing that we are only good with those who need treatment we are familiar with. We are often resistant to referring clients to other caregivers.

The responsible therapist is able to recognize that their own limitations sometimes contribute to difficulties with the client. By making referrals, we don't decrease our prestige, but rather enhance it by acknowledging our limitations.

New clients are sometimes challenging. When my repertoire of intervention strategies does not meet their needs, referral may be the ideal solution.

However, another solution may be equally plausible: Expand your repertoire of approaches. Take an extra continuing education course. Read another book. Find a new clinical supervisor. Take an additional college course. Ask your colleagues what they would do in similar situations with similar clients.

By expanding our repertoire of intervention ideas and approaches to working with difficult clients, we can often find new solutions to old barriers.

REASON #8: CLIENT NEEDS ARE MET

Everyone who smokes cigarettes knows that they are bad for them. The public has been told that cigarettes are dangerous to our health since the early 60's. Anyone who can read knows that cigarette smoking is dangerous. Right on the side of the package it basically says: "Warning: This Product May Kill You." Other advisories on the pack warn about injury to a fetus, or that cigarette smoking causes lung cancer, emphysema and heart disease. There is

no one unaware of the dangers of cigarette smoking, no matter how low their level of cognitive functioning.

Yet, approximately 48 million Americans smoke cigarettes (about 1 in 6 people) despite our anti-smoking education programs and the warning right there on the side of the package.

Why is it that people smoke, especially if the long-term effects will kill you or at least impair you? The reason is simple: short-term effects. The minute the cigarette smoker picks up a cigarette, it changes the way they feel. It provides a sense of identity. It alters brain chemistry. It relieves boredom. It defines expectations. It creates predictability. It helps a person relax.

Looking at the list of immediate need-meeting results produced by this unhealthy behavior, you may notice that each and every one of them is positive. Cigarette smoking even provides a social outlet, a way to meet and interact with other people. In fact, in any office complex, one of the biggest staff resentments is the one nonsmokers have toward the smokers. They say it's because smokers take too many breaks and aren't getting enough work done, but the reality is, the poor nonsmoker is often sitting at their desk alone, while everyone on the other side of the glass is laughing, joking and socializing with friends.

I'm not trying to glorify cigarette smoking. I'm trying to point out the fact that the moment we engage in any behavior - no matter how detrimental it is to us - the short-term results meet specific needs.

Difficult clients who sabotage treatment, who do not comply with court orders or fail to move beyond the state of emotional paralysis, do these things not because they want to be the identified difficult patient, but because this outlet allows them to meet specific needs. The procrastinator never fails. The instigator always has their needs heard by an audience. The noncompliant client always receives direction. The boisterous client receives attention. Our clients meet their needs through all of their behaviors.

Psychiatrist R.D. Lang was a skeptic in the field of mental health counseling. He believed that insanity did not actually exist in the form of traditional illness, but rather, manifested solely because all behavior meets specific client needs, and even the most catastrophic of all psychiatric impairments were merely a client's attempt to meet their perceived needs at the moment they engaged in those behaviors.

REASON #9: CONFLICT GAINS ATTENTION

Sometimes a client is difficult because they want attention. I do a lot of consulting for school districts, and I'm frequently asked to present on the issue of Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder. One of the first things I always discuss is the root cause of ADD.

I do not believe ADD is caused by a Ritalin deficiency. I do believe that a small minority of children who have a diagnosis of ADD manifest their behavior as a result of a "chemical imbalance in the brain" or some other biological predisposition towards the behaviors they experience. However, I also believe that people are more than the sum total of their serotonin and dopamine receptors. Therefore, when I treat individuals with a diagnosis of ADD or ADHD, I am usually not looking for underlying biology as a cause for pathology, but instead for much more obvious causes.

The younger generation within our current culture is programmed for a commercial every 11½ minutes. If we do not provide that commercial in our educational environments, the students will create one.

And sometimes the obvious is true: a person manifests ADD because they have a deficit of attention. Nobody has been paying attention to them. The term "latchkey child" did not exist 50 years ago, but today this is a common observable fact in our culture. When I went to grade school, a class of 20 students was considered a large class. In today's era of funding and budget cuts, a class of 35+ students may be the norm.

Difficult clients may also manifest conflict simply because it gains attention. Ask any 4-year-old: negative attention is better than no attention. I had a client, Jean, who was continually

spouting all kinds of misbeliefs about herself. She would say things like, “I am worthless, I can’t do anything right, it’s never going to get better.” But, none of these things were true.

Jean described each and every situation in her life as an impasse that she was unable to overcome. She became an extremely difficult client to deal with because in every communication with her, from the telephone to the office environment, she spewed her rigid beliefs about her own inadequacies. I confronted Jean’s disbeliefs on each and every occasion, telling her that the strengths and assets she had to find in herself and that others already saw in her were tremendous.

What I was telling her was the truth, but she always countered with more misery. I finally concluded that her constant self-depreciation was not designed to engage me in a debate or conflict about whether or not she was a valuable person, but instead, this was her way of gaining attention. Not because she really wanted to repeat the negative things about herself, but because she required constant positive attention from those who surrounded her in the form of accolades.

REASON #10: IGNORANCE

The word ignorant seems so insulting. To call a client ignorant would not be a politically correct thing to do, because of the negative emotion we attach behind the word. However, ignorance is a good word. It simply means ‘without knowledge’. Many of our clients are difficult because they lack knowledge.

Take denial for example, an issue that we will deal with much more, later in this text. Denial is something many therapists believe must be overcome in order for therapeutic success to occur. But many of our clients manifest a difficult block to therapy, not because of some mystical concept we call denial, but simply because they are ignorant.

The alcoholic spends most of their time with other alcoholics. We know from family studies that intergenerationally, alcohol repeats itself in family systems. If Grandpa drank a case of beer a day, Daddy drank a case of beer a day, I drink a case of beer a day, and all my friends drink a case of beer a day, and then you tell me that my drinking is not normal, I will naturally tell you that you're wrong, because I drink just like everyone else.

I am not in denial; I am ignorant of the way normal people drink.

Ignorance is a powerful block to recovery from addiction, emotional disorders or conflict in a family system. I meet many couples who have incredible difficulty communicating with one another. Their communication troubles are not because they were born with the 'jerk gene', but because they are ignorant of the difference between assertive communication, aggressive communication, passive-aggressive communication or passive communication.

People only know what they know.

What they don't know makes them ignorant.

REASON #11: THE FAMILIARITY TRAP

The old expression, "Better the devil you know than the devil you don't" certainly applies in therapy. Many clients are difficult because they are familiar with their level of pain or misery. They may not necessarily like it, but they have grown to tolerate it.

Change always requires short-term pain and confronting one's fears. For those afraid of change, clinging to any familiar situation, pattern of behavior or set of adaptive coping strategies is appealing.

Think about your own life for a minute. Do you ever choose not to do something different simply because you know that what is, is? If this is a common behavioral choice in *our* lives

(and we're the healthy ones, right?), how much more so must this be true in the lives of the clients we work with?

In family violence situations, the familiarity trap is an obstacle to overcome when providing interventions. With addiction, the familiarity trap is a powerful obstacle to recovery. If I am drinking, I know I am going to spend 8 hours a day sitting in a bar or sitting in front of a TV set drinking a bottle of alcohol or in the pursuit and use of mood-altering substances. However, if I get sober and go to Alcoholics Anonymous, I will spend one hour a day at a meeting and then I'm going to be unsure of what to do with the next 7 hours.

I used to think it was silly for our psychiatric facility to have a leisure therapist. I now understand the importance that the leisure therapist plays in treatment; by specifically addressing issues that often paralyze a client and by assisting them in breaking the familiarity trap with new and healthy coping strategies.

SUMMARY OF SECTION I

Our clients are difficult not because they want to make our life a living hell (even though it may feel that way to us at times), but because they are consumed with fear, emotionally paralyzed or manifest one of the other reasons discussed in this section. When we recognize this truth, we can then create interventions that meet our clients at their true point of need.

The effective therapist is able to look at the client's frame of reference when assessing behaviors such as denial, resistance, sabotage or difficulty, and to use the knowledge from these assessments to create specific targeted interventions unique to our particular client.

SECTION 2

11 Solutions to Highly Difficult Clients

Years ago, Stephen Covey came out with a book titled, *Seven Habits of Highly Effective People*. While doing training for mental health professionals, I was looking for a catchy title for my workshop on working with difficult clients, so I decided to borrow from Stephen Covey's title and name my course, "Seven Solutions to Highly Difficult Clients", and it was well received.

After a while, I looked over my list of seven solutions to highly difficult clients and decided that I had implemented more than seven solutions over the years. So, I added three more and began presenting a workshop titled, "Ten Solutions to Highly Difficult Clients." Those workshops were also well received.

A little later, I then re-titled the workshop, "Eleven Solutions to Highly Difficult Clients," because, although the first ten solutions were effective, I concluded that the eleventh intervention was probably most effective.

The eleventh solution is: "Let the Train Wreck Happen." While this is probably one of the most effective interventions, it's probably also one of the most controversial. In our profession, we have been trained to help people make change, not to allow people to experience the consequences of their own actions.

When we provide solutions to highly difficult clients, many of those clients will choose to stay stuck. There must come a point when we decide to allocate our professional resources to those who we can truly impact, rather than those who simply refuse to take advantage of the opportunities that have been offered to them. This is the heart of the 11th intervention.

It is my hope that the first 10 interventions, as well as ideas we will talk about in the later sections on motivation and ending denial, will be most effective. But I want to introduce the

11th intervention first, because, although it is not my desire that this be a frequently implemented intervention, it probably will be.

SOLUTION #11: LET THE TRAIN WRECK HAPPEN

When I was working at an adolescent residential treatment facility, we took many court referrals. We offered a lot of different services, including a sex offender treatment program that housed older adolescents, some with violent histories. One of these clients, Peter, was on my caseload. Peter was 17 years old, 6'3" and 215 pounds, twice my size and twice my strength, with a long history of physical violence.

He arrived on a court referral, and told us up front that he did not want to be there. Using our best clinical compassion, we explained to him that we understood this, but nonetheless, we had something to offer him, and we were sure he would want to take advantage of it.

He said, "I don't want to take advantage of it, I just want to go back to jail."

As compassionate clinicians, we recognized that this was a foolhardy thought on his part, probably based on inexperience. We knew that because of his age, he would not be spending too much time in a juvenile detention facility and would soon find his way into the adult prison system. So, we admitted him to treatment and began the task of providing therapy to him.

Peter, our new noncompliant client, became more and more violent, not only towards the other teens, but also towards the staff. The clinicians saw his combativeness and assaults as a cry for help. We told him he could not have what he wanted; he could not return to jail because we had something better to give him. But Peter thought he knew better, and violence was his way of insuring that his desires would eventually be carried out.

Over the next three weeks, Peter's behavior escalated to a point where he became unmanageable. He had clearly become a danger to himself and others, including staff members.

With great fear I approached Peter after another outburst and said, “The staff has decided that you are no longer an appropriate candidate for treatment at this facility. We have made the decision to return you to the county jail that referred you here.”

I braced myself for more violence. The psych techs standing behind me were prepared to restrain the patient. However, upon hearing the news that he would be returning to jail, he sat down on the ground and began to cry like a baby. I was puzzled and viewed it as a trap. I moved closer to him, sat down on the floor, and waited nervously for him to strike out or grab me. Instead, he sat on the floor and cried and cried and cried.

Finally, I asked him, “Are you crying because you’re going back to jail?”

Peter looked up at me, gave a weak smile and said, “No. I’m crying because I’m finally out of this place.”

That was a powerful moment in my career. I realized suddenly that some people are happier in a place where I would never be happy.

I am a libertarian, and sometimes people ask me, “Richard, why are you a libertarian?” I am a libertarian not because I endorse the ideals that are sometimes associated with libertarian politics, such as legalized prostitution, legalized marijuana and legalized gambling on every corner. I am a libertarian because I believe in the general philosophy of libertarian politics: You have the right to take control over your own life in any way that you choose, even if it means destroying your own life.

I viewed Peter’s decision as the destruction of his life, but that was a viewpoint based on my own frame of reference, rather than on the reality of his desires. Some people are happier allowing someone else to be responsible for them rather than taking responsibility for their own lives. Prison is a place where a person can live life without ever undertaking much responsibility.

We drove Peter back to the county jail. Whatever happens throughout his life, I'm sure he will always find a way back to prison - not because he's unable to make changes, but because that is how he chooses to live his life; that is where he is comfortable.

Letting the train wreck happen may be a difficult intervention, but it can actually lead to success. We may not have changed that one person, but we have sensibly allocated our resources to help those who will choose to take advantage of what we have to offer.

The remaining 10 solutions to highly difficult clients are practical strategies and ideas. They are not reserved for the 50-minute therapy session or inpatient treatment or outpatient therapy; they can be adopted to meet the individual needs of our clients regardless of the setting where they are found. They should be useful for educators in professional classrooms, supervision officers in criminal justice environments, crisis managers on the telephone and inpatient psychotherapists working with clients on a crisis stabilization unit.

They are general principles of intervention that will need to be adapted and targeted, based on each client's personal strengths. None of these ideas are profound. King Solomon said it best with, "There is nothing new under the sun." My hope is that as I share these thoughts with you and the cases where they have been applied, you will begin to develop strategies that can impact your clients in a way that they have not been impacted before.

SOLUTION #1: ELIMINATE POWER STRUGGLES

Power struggles often make working with the highly difficult client quite challenging. Many therapists report that they leave work at the end of the day more tired than if they had been doing physical labor, simply because of the intellectual power struggles they often experience with clients.

It's often a regular battle to get clients to do what they committed to previously, or to take actions congruent with the treatment goals. Sometimes the battles are very basic, like just trying to get them to speak during the course of therapy, or to pick an adjective to describe a human emotion.

The therapist is responsible for the actions necessary to eliminate these struggles. I gave up on power struggles years ago when I worked in the criminal justice environment dealing with offenders on a day-to-day basis. You must simply apprise clients of their options, and then to refuse to participate further.

I have said to many clients, “When the clock strikes 5pm, regardless of what you choose to do, I’m still going to go home, play with my kids, feed my dogs, sit in the hot tub and watch late night TV.” My point is not to tell clients that I have a nice life, but to explain that regardless of what they choose to do, the world around them will continue. When clients are confronted with this reality, they often choose to give up the power struggle and to participate in real conversation.

I do training on a regular basis for the Dallas County Community Supervision and Corrections Department. One day, training was being held at the Crowley Courthouse building in downtown Dallas. I made my way through the metal detectors and up the escalators to the 5th floor and then on to the training room at the 9th level. (I guess they ran over-budget by the time they put the escalators up to the 5th floor, and consequently you have to take the stairs to the 9th floor.) By the time I made it to the room, I was tired. Looking around, I noticed the officers present for training were also tired. They too had to make their way through downtown Dallas traffic and up to the 9th floor. Unlike me, they did this day in and day out, many of them for years on end.

The Crowley Courthouse, being a county building, is not the most inviting or pleasant place to be. I can imagine working there on a daily basis would be a difficult thing to do. I’d always noticed that all over the hallways and walls were pink and yellow signs with a headline reading “Mission Statement of the Dallas County CSCD”, but I had never stopped to read one. My initial thought was that some bureaucrat for the department must have gone to one of those ‘empower the bureaucrat’ seminars, and whoever had conducted the training had obviously taught them that to post the mission statement for the county agency would be an uplifting and motivational thing to do. My thought at the time was probably the same as other officers, “If they really want to boost moral around here, why don’t they just give us a raise?”

At lunch that day I didn't want to leave the courthouse because that would mean having to go through the metal detectors again and sometimes that process can take up to a half hour. So, I ate in the cafeteria, and as those of you who have eaten cafeteria food know, it doesn't take too long to get your fill of it. I had extra time and I made my way back up to the 9th floor. I wandered around and said "hi" to a few people I knew and then found myself staring at one of those yellow signs detailing the Mission Statement for the Dallas County CSCD. I cannot remember the exact wording, but it basically said: If you work here, your job is to do one of two things - either help the offender make changes so they can function in the community, or keep the community safe from the offender.

I thought, wow, one of those empower the bureaucrat seminars really worked! I was excited by what I read. It meant that I got paid the same whether the offender made changes or their probation was revoked. It meant that I no longer had to sit with clients and try to convince them to do it my way to be successful.

Ever since reading that sign, I have gone into counseling and consultation sessions with clients and said, "Hi, my name is Richard. My job is to either help you make changes or to keep the community safe from you. Which one do you want me to do? I get paid the same no matter which hat I wear."

Put the ball in your client's court. End the power struggles. Let them know you are available to help them, but that you will not work harder than they do to help them achieve change during the course of therapy.

THE CASE OF THE CLAM

While working in a residential treatment facility, an 18-year-old was admitted by his mother. He appeared to be emotionally paralyzed; only manifesting intense anger. However, although it had escalated in recent months, his anger really did not rise to the level that many of our more typical patients manifested.

When I looked over his initial intake form, I discovered that while there were certainly social problems within the family and profound psychological scarring that kept him from implementing a broad range of effective coping strategies, he was high functioning and his educational records indicated he had been successful at school.

We gathered in an office, I introduced myself, the psychiatrist introduced himself, and we informed him that in this initial session we would be asking him some questions, making some assessments and setting some treatment goals.

He looked at the psychiatrist and me and said, "I will not answer your questions. I am only here because my mother wants me to be here. There is nothing wrong with me, but since I love my mother, I will do what my mother has told me to do, which is to come to this facility. But because I am an adult and because I know there is nothing wrong with me, I will not participate while I'm here."

His monologue continued: "I have nothing further to say. You have everything you need to know about me and I do not mean to be rude, but I am not going to answer any of your questions. You will have to ask my mother anything you want to know, because she is the one who thinks there is a problem, not me."

Evidently, this client was going to be a Clam and we were in for a power struggle. I thanked him for his frankness, but went ahead and asked him a simple question. He stared at me with his arms folded, refusing to answer. It was now clear that the records provided by the referral resource would offer the only information for initial assessment. The psychiatrist completed the session without gleaning any additional data and the patient was admitted to treatment.

As his case manager, my job was to hand him over to a psych tech who would show him the dorm and introduce him to the other patients in the therapy group. I decided instead to do this myself and make small talk with him. As I led him to the dorm, I asked him a couple of questions. Again, total silence. He was a human clam. I introduced him to some of the other patients. He did not acknowledge them verbally, and only rolled his eyes when I explained to the other patients that he wouldn't talk.

Recognizing that his silence could easily be interpreted by the other adolescents as a confrontation, and could therefore quickly escalate into a situation of physical risk, I pulled the kid aside into one of the group rooms.

I said, "Look, I've got to level with you. You can be rude to me, you can be rude to the psychiatrist, but if you're rude to the other kids, they're going to come after you. That's not only going to cause a problem for me, but for you as well. So you can choose to be silent to us, but you should recognize that it's in your best interest to at least talk to them."

He looked up and I was quite surprised when he said, "Frustrated. I am incredibly frustrated. I cannot believe that I am here. The only problem I have is that I'm not as good at football as I wish I was."

I thought his statement was a bit odd. Of all the things he could have brought up, he chose football. Well, I don't know too much about football, but since he did actually speak to me, and he did admit he had a problem with football, I decided that instead of continuing to demand he talk to the other kids and eventually demanding that he talk to us, I'd run with what he'd given me.

I said, "You're 18, and most of the other kids here are 16 or 17. You are an adult, so I will treat you like an adult. You don't think you have any issues to work on, but you're here because your mother wants you here. I'm here because this is where I work. And, although I don't know much about football, I would be willing to find somebody on campus that does know about football and might be able to help you."

Incredulous, he asked, “You’re going to help me work on my football?”

I told him that if improving football was the only goal he had, then that was the only thing we would be able to work on. He smiled and asked if he could be excused. I said yes, and he went off to the resident’s lounge area to meet the other patients.

Although he didn’t say much to any of them or acknowledge any of the issues that had brought him to treatment, it was clear that he recognized his need to avoid confrontation with his peer group.

I immediately went and asked one of our psych techs, Glen, who I knew had played football in college, to spend some time with The Clam. Glen said, “Richard, football is one of those activities requiring a Level 2 status. Since he’s a new admission and only on Level 1, he won’t be able to play.”

I said, “Yes, those are the rules in this behavioral modification treatment program, but in this case, we’re bending the rules.”

Glenn said that the administrator wouldn’t like this, and I told him that I would deal with the administrator. I was convinced that this was the only way we were going to make progress with The Clam.

Glenn said, “What kind of progress do you expect to make from a therapeutic perspective, if I’m playing football with the kid?”

I replied, “Simple. He is never going to talk to me. But, when you’re out there playing football, he will talk to you. If you sit in on group therapy with us, when he’s not saying anything, he will know that you know the issues he needs to bring to group. In an effort to avoid a power struggle with this kid, I want to use your relationship with him, developed through his only self-identified problem, as the catalyst for opening the door to the real treatment issues that exist.”

I did, of course, have to justify the treatment strategy to the administrator, because when she saw our new admission out playing football with the psych tech, I was immediately summoned to her office. She did not agree with me initially, and she only allowed me to try it my way because she felt a need to give me benefit of the doubt.

It worked.

In this case, I recognized that if I was going to make any progress with the client, I needed to play by his rules and avoid the power struggles that would have been so natural for me to engage in. Any way we can eliminate power struggles - by giving clients options, defining our roles for them, or doing it their way - is an effective tool in therapy.

Many therapists are enormously frustrated by managed care. One reason is the requirement that we have individualized treatment plans for each client. I have found that one of the easiest ways to avoid power struggles with clients over treatment goals is simply to let them write their own treatment plan.

I've learned that a good treatment plan is nothing more than a set of goals. I stopped telling my clients what they need to do, and I now teach them how to set their own goals. I teach them that a goal is clear, concrete, specific, beneficial and attainable within a reasonable time frame. I explain that goals are just wishes unless they are written, and I have them write their goals on the treatment plans.

The burden of paperwork that Managed Care has put upon us is now an enjoyable task, because I no longer write my own treatment plans - and, I've eliminated another source for power struggles in the therapeutic relationship.

Our clients are not responsible for eliminating power struggles - we are.

SOLUTION #2: FEED YOUR CLIENTS THERAPEUTIC BIG MACS

Today's society is exciting. We have 24-hour news networks. We have 999 channels available on our satellite dish. Every 11-½ minutes we have a commercial as exciting as the TV show it interrupts. We have extreme shopping, extreme bowling, extreme eating and unbelievably extreme reality TV. Our society is connected via jet-interstate system. Our nation's incredible wealth offers opportunities for even the poorest citizens to experience excitement and adventure.

What does this mean to the therapist working with difficult clients? It means that the goals we establish for clients in treatment are often forgotten or set aside by the client between sessions. It means that when they leave our office on a Monday afternoon and aren't scheduled for another session until the following Monday, the excitement of the world is going to defocus them from the tasks that we established during the course of therapy.

It means that even in an inpatient treatment environment, when they leave group therapy and go back to the patient lounge to watch TV - and then head back to their room for visiting hours - and then go to occupational therapy, art therapy, leisure therapy, relaxation training and patient education group - the goals we established in our morning session today will be long forgotten by tomorrow.

We live in a society where people no longer eat; they graze. Instead of eating three big meals a day starting with a hearty breakfast, today's society snacks on a breakfast bar, eats a quick 10 a.m. tide-me-over snack, enjoys a moderate lunch, then has the 3:30 after-school snack, scarfs a burger at Wendy's for dinner, drives over for fries at McDonald's, and then eats dessert later on in the evening, before they sneak in their late night snack.

This is the way we now consume our food (and most everything else) in America. This is also the most effective style of therapeutic intervention in the new millennium.

Therefore, I feed my clients what I call Therapeutic Big Macs. I look at the treatment goals and try to assign homework - written assignments, journaling assignments or cognitive

assignments - to assist my clients in keeping focused on the treatment goal, despite the excitement in the world around them between contacts.

I think journaling is an excellent idea, although I have found that when I ask clients to journal, they give me odd looks and refuse to do it. So, I use the language familiar to my clients. Instead of telling them it's a journaling assignment, I tell them they have a "damn assignment" to do between now and my next contact with them, and that the "damn assignment" requires that each and every day they write down certain things.

This language may offend some clients. However, when I work with adolescents, offenders, or substance abusers, they have certainly heard and probably use much coarser language. My goal is to frame a task in the context of the language they understand. My clients won't keep a journal, but they will do a "damn assignment".

I also ask clients to think about a specific task or perhaps recite a mantra (not a spiritual mantra, but a 'countering mantra') throughout the day, to keep them focused on the things established as their treatment goals during the course of therapy. For example, they may recite, "I can leave when I am angry. I can sing when I am angry. I can take a bath when I am angry."

When I give my clients assignments to complete sometime between now and our contact, I find that they often become less difficult to work with. They have remained focused on their treatment goals, even though I have not spent time with them each and every day.

SOLUTION #3: TEACHING IS COUNSELING

I have been both a teacher and a counselor. I received teacher training when I was an undergraduate, and counselor training as a graduate student. Until I started working with highly difficult clients, I actually thought teaching and counseling were two different disciplines. I have since discovered that teaching *is* counseling, and that counseling *is* teaching.

Therapy is a very traditional occupation. The influence of Carl Rogers from a traditional perspective crosses theoretical orientations. As counselors, we believe one of the most important aspects of counseling is listening. While I certainly will not discount the importance of listening, I think as counselors we spend too much time listening and waiting for the 'ah-ha' experience to occur, and not enough time teaching our clients.

The first question in therapy should not be, "So how do you feel?" or "What would you like to work on today?" I think the first question in therapy is one that we must ask ourselves: What does the person in front of us not know in order to choose to do something different?

In my mind, the first stage of the counseling process is education. We must teach our clients the things that they need to know, so they can then make a choice to do one of two things: return to the starting point and stay stuck, or move forward through the change process.

Teaching is counseling. Usually, my clients need to be taught one of two things: (1) specific skills, or (2) counters to the cognitive errors they believe. Until they can be taught new skills, they often can't choose to do anything other than what's already familiar to them. Until my clients are taught that their beliefs are wrong, they cannot change their actions.

I carry a marker board with me when I do training and continuing education workshops for mental health professionals. When I'm teaching a class, I rarely write anything on the marker board other than Welcome! But when I do therapy, I write on the board almost constantly throughout a session. Why? Counseling is teaching. Our clients come to us because we are experts - we have knowledge that they do not have. Before they can choose to do something different, we must teach them what it is they need to know.

THE CASE OF JIM

I had a client named Jim in a halfway house environment. At this halfway house, the rule is: you are either actively seeking gainful employment, or you are gainfully employed, or you are enrolled in the job readiness-training program. Jim had completed the job readiness-training program and he was actually actively seeking gainful employment. At least that's what I thought.

One day while on my lunch hour, I went through a What-A-Burger drive-thru window. As I was waiting for my cheeseburger, I glanced down the alley between two buildings near the drive-thru. There was Jim, sitting in the alley, throwing a piece of stale bread to the pigeons. I went back to my office and at the end of the day and when Jim came in, I asked him how the job search was going. He said it was going slow, but that he was working diligently on it.

I said, "Are the pigeons hiring?"

He said, "What do you mean?"

I said, "I saw you sitting in the alley feeding the pigeons this afternoon. Were you taking a break in your job search?"

At that point, he let his exasperation and frustration show, "Look, I have been to every restaurant in Houston and I have not been able to find a job. I have exhausted my search. I can't find a job. Do you want me to pack my bags?"

I told him to sit down, and that I did not want him to pack his bags, but I had a hard time believing that he had been to every restaurant in Houston and none of them were hiring. He was looking for a job as a dish man or prep cook because he had heard that these positions often allowed for extra overtime and could be gotten with relatively little experience.

Jim had been to JRT and had learned to wear clean clothes and how to answer the question on an application like, "Have you ever been convicted of a felony before?" But he had not learned what he needed to know to actually get a job.

I asked him to tell me about his job search. He said he had been going in, getting applications and filling them out. "The girl at the desk" always told him that they would call back. But no one ever called back. He said he had been out all day going to every restaurant, but had heard from none of them.

Understanding his problem, I told him what I knew about the restaurant business. Going out all day was a waste of time, because restaurants only hire between 2pm and 4pm. I also told him that filling out an application was a waste of time, because the positions he wanted are not obtained on the basis of an application, but by direct contact with a manager. I explained that the “girl at the desk” (the hostess) had no authority to make any decisions, and that the only way he was going to get a job would be to go in between 2 and 4pm and simply walk up to the hostess and say, “My name is Jim, and I’m here to see the Kitchen Manager.”

The hostess, who does not know that the Kitchen Manager does not know Jim, is going to then walk into the kitchen and say to the Kitchen Manager, “Hey, Jim’s here to see you.” At that point, the confused Kitchen Manager is going to walk out into the lobby, poke his head around the corner and say “Yea?” I told my client that as soon as the Kitchen Manager says “Yea?” you hold out your hand and say, “My name is Jim. I’m looking for a job as a dish man or a prep cook. I have reliable transportation and can be on time.”

I went on, “If you do that, I can almost guarantee the Kitchen Manager will then say, ‘You have reliable transportation?’ and ask you to come back to the kitchen. He’s not going to ask you to fill out an application; he’s going to ask when you can start. You need to say, ‘I can start today.’”

I told Jim that if he would follow my advice, he would probably be gainfully employed before the dinner rush tomorrow. On his third attempt the following day he found a job as a prep cook. Jim remained a contributing member of that halfway house, successfully completing the rest of his treatment goals and graduating.

Jim was successful in treatment not because I was a great therapist, but because I recognized he could not choose to do anything different until he had the necessary skills. Teaching is counseling, and it is one of the most effective interventions with highly difficult clients.

1SOLUTION #4: STOP BELIEVING IN DENIAL

Denial has been a cornerstone of chemical dependency counseling, sex offender treatment, couples counseling and most other modalities in professional counseling for a long, long time. New counselors are often taught that before a client can make any progress, the therapist is responsible for creating interventions to help a client 'break through' their denial.

It's my belief that denial is a creation of the therapeutic process designed to allow the therapist to do something during the course of treatment. In other words, so that we can feel important, we have created situations of denial that not only give us something to address, but also give us power over our clients.

In staff training, this is perhaps one of the most controversial things that I say: I believe that belief in denial meets *our* needs, it makes *us* important, but it does our clients a disservice.

Yes, there are behaviors that we have labeled denial, but I think that's really all they are: behaviors we have labeled denial. They have no further meaning to us as therapists.

There is no such thing as denial. Instead, there are behaviors we have labeled denial. What we call denial is always a manifestation of one of these three things:

1. It is smart to deny wrongdoing.
2. Ignorance.
3. It is easier than being responsible.

#3 - IRRESPONSIBILITY

I am a firm believer that our client may not know that the word to describe their problem is alcoholism, but they know (even though they define addiction behaviorally, excluding their own behaviors), at the end of the night when they are alone in the dark at home, that the problem is them and their drinking.

I am convinced that in couple's counseling, although Don may not know the word is aggressive communication, deep down inside at the core of his being he knows that because of his relentless yelling at Bertha and saying that all the problems are her fault, he is in part to blame for the failure of their relationship.

I believe that even our lowest functioning clients, at one level or another, ultimately know that the problem is within them. If I did not believe this, I probably could not conduct therapy any longer. Every major model of counseling theory has been predicated on this reality. Rogers seeks the 'ah-ha' experience. Behaviorists tell us that innate biological drives dictate healthy living. Freudians believe that analysis leads to personality restructuring and that it comes from an awareness of one's own psyche.

It wasn't until the 1970's that clients were "in denial" and the denial platform was adopted as a way for both the client and the therapist to avoid personal responsibility.

Denial now manifests itself as a difficult behavior in treatment because we have attached some mystical importance to the word. From a social perspective, we have taught society that you can blame your own denial for your irresponsibility, and we have taught clinicians that they can't be blamed for not helping a client, if the client will not admit they are in denial.

#2 - IGNORANCE

If denial is not irresponsibility, then it often stems from ignorance. This is far different than our traditional understanding of denial, for ignorance implies simply a lack of knowledge. We generally deal with denial by confronting, but ignorance is more effectively dealt with through education. If our client is manifesting a behavior we call denial - and they are a responsible person - then they may simply be ignorant.

Back to the example from earlier: If Grandpa drinks a 12-pack of beer everyday, Daddy drinks a 12-pack of beer everyday and all my friends drink a 12-pack of beer everyday, and then you tell me my drinking is abnormal, I won't understand what you mean. This is ignorance, not denial.

This is something we resolve by teaching clients counters to cognitive errors, not by putting the client on the hot seat and acting like the 'bad cop' seeking an admission of guilt.

#1 - SELF-PROTECTION

If the client's denial is not irresponsibility or ignorance, then it may simply be self-protection.

If I'm an offender on probation and I've been smoking pot, when my probation officer asks me if I have been complying with the terms of my probation, my answer is going to be Yes. Now, I know I've been smoking pot, but I'm still going to lie to my probation officer because I believe it will keep me from getting in trouble.

So, my probation officer says, "I'm not sure I believe you, so I'm going to give you this urinalysis, but I'll give you one more opportunity to come clean. Have you been smoking pot?"

And, my answer is still going to be, "No, I haven't been smoking pot, and yes, I have been complying with the terms of my probation."

Even when confronted with the imminent prospect of a laboratory result, I will still intentionally lie to my probation officer. Why? Because there's a 2% chance that the lab will screw up, and there's a 3% chance my PO will be too busy to check the results. Therefore, if I continue my lie, there's a 5% chance I'll get off the hook, but if I tell the truth, there's a 100% chance for a Motion for Revocation of my probation.

This is not denial. From the client's perspective, this is smart. This is not denial - this is self-protection.

With sex offenders, we know that for every molestation reported, there are probably 20 more that go undetected. In group therapy, we want clients to share and disclose their criminal activities, but we know that most offenders will never reveal the details of any event other than that for which they were caught, because to provide the therapy group with any additional information would only mean further legal consequences. Every sex

offender I ever admitted to treatment was always caught “the very first time.” Again, this is not denial; this is self-protection.

Later on, we will end denial and find an easier, softer way to work with our highly difficult clients.

SOLUTION #5: USE STRENGTHS TO COMPENSATE FOR DEFICITS

When we first developed the NSRI, we knew it would have applications to the specific clients that we were working with at the time. However, over the years, many clinicians have found many other uses and applications for the material in the Nongard Strength and Resources Inventory. (See our website to get your own copy!)

The importance of understanding client strengths first occurred to me years ago in the hospital environment. I would typically spend a couple of hours interviewing a new client, and then spend an hour or so dictating their psychosocial evaluation. As I was reading the material from the patient interview, I often thought that we tend to focus so heavily on our client’s problems, and very little on their strengths.

I would spend 18 pages writing about client’s vocational problems, social problems, problems related to their drug or alcohol abuse, legal problems, family problems, economic problems, political problems and sexual problems. It always struck me as odd that at the conclusion of the psychosocial evaluation, the very last question for the client was about was their strengths and resources. By the time most clinicians spend two hours with a client they’re ready to go home, and spending a brief amount of time on the last question becomes the norm.

But the question we spend the least amount of time on, is really the most important. In the era of managed care and limited time and resources, we truly do not have the ability to fix all of our clients problems. What we actually have the ability to do is to take our clients strengths and use those to compensate for their deficits.

Ideally, the goal of Freudian psychoanalysis is personality restructuring. A patient would see Sigmund Freud twice a week for therapy while laying on the couch, for fifty weeks a year (two weeks a year off for the clinician), and at the end of a ten year process they would emerge from psychoanalysis with a newly restructured personality.

While this process may be a theoretical possibility today, fixing our client's problems in this way is probably not a practical reality. We don't have ten years, two hours a week to work with a client, and we don't have the capacity to wait years into the therapeutic process to see the emergence of client change.

What we have the ability to do in the era of managed care and six capitated outpatient sessions; what we have the capacity to do on a 23-hour crisis stabilization unit; what we have the capacity to do in a 21-day residential treatment center; what we have the capacity to do in couples counseling - is take what is right with the client and use those strengths to compensate for the deficits that exist.

The purpose of the Nongard Strength and Resources Inventory is to help the clinician understand our *client's* perception of their strengths and resources - their skills, attributes, abilities and social supports.

It is important for us to recognize that while we may see the strengths another person possesses, however, we will be unable to use these strengths effectively in the therapeutic environment unless the client also recognizes them. Additionally, clients are often acutely aware of the problems that they possess, but are unaware of their own strengths until they are sorted out.

USING STRENGTHS IN INDIVIDUAL COUNSELING

In my book, *The Perfect Victim Factor*, I gave the example of Sheila, a depressed counselor. Sheila came to me during a lunch break at one of my workshops and said, "Richard, I have a hypothetical questions to ask you."

I said, "Go ahead, tell me about yourself."

She asked, “What would you tell a person, who for ten years has been going to recovery groups, who for ten years has been taking anti-depressants, for ten years they have been journaling, for ten years they have been doing everything they needed to do, and at the end of ten years, they are still depressed?”

I said, “What I would tell that person is to stop defining themselves as ‘Sheila, the depressed counselor’ and start defining themselves by their strengths.”

Sheila gave me with a puzzled look. I had an index card sitting on the desk and I handed it to Sheila and said, “I want you to do something for me. It’s clear that you’ve been waking up every morning and instead of saying, ‘Good morning, God,’ you’ve been saying, ‘Oh God, it’s morning.’ You have been defining yourself by your deficits.”

I gave her a moment to think about this then said, “I want you to take this index card and write down three things that are right with you; three strengths that you possess; three things that you admire in yourself.”

She looked almost heart-broken and said, “There is nothing right with me.”

I laughed and said, “I have your CEU certificate. Until you come up with three things that are right with you, I’m keeping your certificate.” (I was only joking with her, but I wanted her to realize that the assignment was serious.)

Sheila stared at the blank index card. I smiled at her and went to get a quick bite to eat. When I returned 20 minutes later, she was still sitting at the table, clearly frustrated. So far, she had written only one word on the card.

It took Sheila over 35 minutes to define three adjectives that described what was right with her. Unfortunately, I cannot remember exactly what Sheila wrote down. I think it was trustworthy, honest and loyal.

She brought the card to me and asked, “Okay, I did it. Now what am I supposed to do with it?”

I said, “Tape it to your bathroom mirror where you can see it each and every morning. Then, instead of defining yourself by what is wrong with you, you will know that while you may be a depressed counselor, but you are also these three things, too.

“Start out your day by saying, ‘Good morning, Sheila, the trustworthy person. Good morning, Sheila, the friendly person. Good morning, Sheila the courteous person.’ Begin to define yourself by your strengths, and the importance of your deficits will be decreased, while the usefulness of your strengths will be highlighted.”

Remember this: Sheila was a licensed mental health counselor, and it still took her 35 minutes to define her own strengths. Now, consider how much more difficult it must be for our clients to recognize what is right with them.

Not only are there applications for using strengths in individual counseling, but also in couples counseling, and certainly with some of our most difficult clients.

USING STRENGTHS IN COUPLES COUNSELING

Let’s say Don and Bertha come in for couples counseling. After 5, 10, 15 or 20 years of marriage to Bertha, Don has a long list of complaints or things that are “wrong with her.” Bertha also has a fairly long list of complaints, things she thinks are “wrong with Don.” Typical of couples counseling, Don wants to talk about Bertha, and Bertha of course wants to talk about Don.

Over the years, I’ve decided that these complaints are usually valid. They may be expressed in some rather mean ways, but what Don says about Bertha is usually correct, and what Bertha says about Don is usually correct.

Now when couples come in for counseling, there is often an interesting dynamic at play. Most couples do not come to counseling to get well - most come to start the mediation

process. What that means to me as a clinician is that I only have six weeks, a handful of sessions, to change the dynamics of what's been "wrong" for the last 5, 10, 15 or 20 years of marriage. The only way I know to effectively do that is to tell them to stop trying to fix what is wrong with each other.

Instead, change is brought about by helping Don recognize what is *right* with Bertha, and helping Bertha recognize what is *right* with Don, so that they can use the strengths that they possess as a couple to begin a problem solving process.

I give this assignment to every couple: Take a spiral notebook, write The Jones' Family Treasure Chest, or Don and Bertha's Treasure Chest on the cover. Then, each day, write down one thing that you value about your partner. I tell them, "You do not have to do this together, and you don't even have to talk about this between sessions. Put the Treasure Chest in the bathroom, the bedroom, the kitchen or wherever both of you will pass through each day. Make an effort each day to write down one word, one sentence or one short paragraph. The topic is simply one thing you value about your partner today."

This assignment is often the first time in 5, 10, 15 or 20 years of marriage that Don has looked at what is right with his wife. This is the first time Bertha has looked at what is right with her husband.

The Treasure Chest assignment seems simple, and it is. It does not fix what is wrong, but it does reframe the couple's relationship in the context of what is right. Using strengths to begin the problem solving process is one of the most effective tools for producing change.

USING STRENGTHS WITH PERSONALITY DISORDERS

Even with the most catastrophically ill clients, clinicians are able to draw on client strengths to begin a problem solving process. I meet many clinicians who are very frustrated working with the personality disordered client, and particularly with the borderline or antisocial.

Personally, I love working with the borderline client because they are mercurial; they are flexible and adaptable. I love working with the antisocial because they are adventuresome

and they are risk-takers. I wish more of my clients would take risks. In fact, when it comes to personality disorders, each has some specific strengths that are problem solving attributes. It's up to the helper to discover them and make use of them.

Personality disorders are diagnosed on the second axis because it is presumed that they are a lifelong constant. There is no medication to cure personality disorder, and although treatment can reduce the severity of complications our clients experience as a result of personality disorder, it will not restructure a personality.

Because our clients who have personality disorders will still possess the personality disorder when they leave our caseload, it is important for us to find an intervention that draws on their strengths to solve problems, rather than trying to create a new personality dynamic.

I like working with the paranoid client because they are cautious. Our schizoid clients are autonomous, and our schizotypal clients are creative. The narcissistic client has high levels of self-esteem. The histrionic already knows adjectives to describe their feelings and emotions. The dependent personality disordered client is a loyal individual, and loyalty is an attribute that can go an incredibly long way in the problem solving process. The obsessive/compulsive client is able to function within rules, structure and order, and the avoidant client has empathy and is able to see how their actions affect others.

As you can see from these examples, we can create interventions predicated on understanding client strengths with even the most catastrophically ill clients.

USING STRENGTHS WITH TARGETED INTERVENTIONS

Targeted interventions take our client's unique strengths and use them to implement specific counseling strategies for resolving client problems.

For example, let's say you have a client who needs to complete some journaling assignments, but he or she doesn't read or write very well and is self-conscious about it. Depending on their level of embarrassment, they may not even tell you that they can't read

or write, but instead may just become non-compliant and make up excuses for not doing the assignments.

Remember the saying “A picture speaks a 1000 words”? With one client where I suspected illiteracy might be an issue, I suggested that she draw pictures instead, and then had her tell me about the picture - much like you would do with a young child.

You should reassure the client that they don't have to be Di Vinci or Michaelangelo - stick figures are okay. I, myself, draw great crayon-colored stick people, but that's as fancy as I get. However, just like with a 2nd grader, you can usually get the idea of what my stick people are doing, especially if I tell you about it.

This same idea can be applied to goal setting as well. Have the client draw a picture of the goal they are going to reach. They can also draw out representations of the objectives they must accomplish in order to reach the goal.

If they need to be somewhere on time, they can draw a picture of a clock. If they need to eat healthy, they can draw pictures of fruits and veggies. If they need to practice communication with their family, they can draw cartoon bubbles and telephones. Get the idea?

Goal setting may be a need that all of our clients have, but the way we accomplish goal setting must be predicated on the individual client's strengths.

This is why tools like the NSRI can be particularly useful to the clinician in defining the client's individual strengths and resources, creating interventions, managing client behavior and beginning the problem solving process during the course of psychotherapy.

SOLUTION #6: MOTIVATION IS THE KEY TO CHANGE

Highly difficult clients are often caught in the familiarity trap, paralyzed by emotions and believe they have no options to exercise. These feelings and beliefs lead to the three “I”s. When people lack motivation, they may believe that their situation is Intolerable, Inescapable and Interminable. Finding keys to motivate the highly difficult client is essential.

People are motivated by one of two things: pleasure or the avoidance of pain.

It’s interesting that when I ask people what motivates them more, they will usually say it’s the pursuit or experience of pleasure. In reality, however, most people are motivated by the avoidance of pain.

Think for a moment about any major life changes that you have made. Chances are good whether this was divorce, career change, finishing school, smoking cessation or any other significant change, you were motivated not by the pursuit of pleasure, but by the avoidance of pain. Although the pleasures derived from the change may in fact keep us from relapse, ultimately the avoidance of pain motivates a person more often than the pursuit or rewards of pleasure.

Cigarette smokers get tired of smelly clothes and the inability to breathe while doing simple tasks like walking through a busy parking lot or having sex. People get divorced not because they believe it will bring them pleasure, but because they are tired of the pain of an emotionally or physically conflicted relationship. People in couples counseling often say they are getting divorced because they are simply too tired to continue fighting for resolution. A lot of people have jobs they actually enjoy, but the pain of small paychecks or difficult hours motivates them to make a vocational change.

As we create interventions for our highly difficult clients, we must find the tools to motivate them.

One of my favorite textbooks on the subject of substance abuse counseling is titled, *The Handbook of Alcoholism Treatment Approaches*, edited by Reed Hester and Willeen Miller.

This text offers a number of practical solutions to the problem of addiction counseling, beyond our traditional 12-step approaches. My favorite chapter is called, “Increasing Client Motivation, An Intervention Toolbox.”

Now, I’m not very mechanical and I don’t own too many fancy tools, but I do have a toolbox that I bought at Wal-Mart a few years ago, which has a number of different basic tools in it. If something minor breaks around the house, I can usually find the right tool necessary to fix it. Every now and then, I have plumbing problem, a major automobile problem, or an electrical problem in the house and I need to call an electrician, plumber or mechanic to solve those larger problems. But most of the tools in my Wal-Mart toolbox can be used to solve most of the problems that I have around my house.

In their book, Hester and Miller offer a toolbox filled with eight ideas to motivate the unmotivated client. Their toolbox of intervention ideas is kind of like my Wal-Mart toolbox: it contains a lot of great basic tools that will work with some of the folks, some of the time. They may even work as interventions to help motivate most of our own unmotivated clients most of the time. But unfortunately, as with any single intervention, none of these tools will work with everyone all of the time.

I have adopted the strategies they offered into eight principles for increasing client motivation.

1. Advice
2. Remove Barriers
3. Give Clients Choices
4. Decrease Attraction
5. Set Goals
6. Manifest a Helping Attitude
7. Provide Feedback
8. Draw on External Contingencies

#1 - ADVICE

If you were to do a random survey of whose advice society would rather take, Dear Abby's or a professional therapist, I would venture to say most people would choose Dear Abby. Why? Because Dear Abby, whether she is right or wrong, actually gives advice.

Therapists typically reflect back what they thought they heard a client say, and this can be enormously frustrating to a client. From a theoretical perspective, we believe that rephrasing what our clients ask us is a tool for helping them to develop insight. But many of our clients will never develop the insight necessary to come up with their own answers, and as a result, our clients respect advice.

Clients will often ask, "What should I do?" Therapists typically answer with something like, "I hear you asking me what you should do." This type of response is typical in the therapeutic environment. Consequently, many clients angrily say to therapists, "Can't you ever answer a damn question?" (This is, of course, usually met with the response, "I heard you ask me if I could ever answer a damn question.")

When our clients ask us what they should do, I "should" on them. Albert Ellis is famous for saying, "We should not 'should' on our clients." But I think Ellis is wrong. I think our clients want us to "should" on them.

I do recognize that when I give my clients advice, most of the time that advice will be discounted. However, when I actually 'answer the damn question' it communicates to my clients that I have thought about their needs and I care about them as a person.

I told Alcohol Joe to quit his job. (This is the only client I've ever given that advice to!) In fact, I told him to walk into his place of employment of 15 years, hand over his uniform, give the boss the keys, walk out of the store and never go back even to shop there. Joe did not take my advice. I am sure he still works at the same place, to this day.

I did not give him the advice lightly. He was in a position to quit, and he needed to leave that place of employment immediately in order to resolve some of the issues he had established as treatment goals.

When Joe asked me what he should do, I gave him my answer. My answer was discounted, but I still believe I did the right thing, because I communicated to Joe that I actually cared enough about him to give him a direct answer.

#2 - REMOVE BARRIERS

Every now and then, our clients are unmotivated because they see nothing but barriers in their way to making change.

A lady on my caseload a few years ago was in trouble with the Department of Human Services for neglecting her children. A Case Manager visited her on a regular basis to ensure that the neglect did not occur again. At about this same time, she was arrested for driving while intoxicated. The DHS social worker told her not to neglect or leave her children. The judge ordered her to attend two meetings of a 12-step program each a week.

She threw up her arms in frustration and said, “If I leave my children to go to the meeting, I’ll tick off the social worker, and if I stay at home with my children, the judge will say I’m non-compliant. What am I supposed to do?”

This particular client was in Tulsa, which has several 12-step meetings every day. She had made the effort to wade through a meeting schedule directory, but had never attended any because of her perceived contradicting orders.

I happened to know something that she did not know. Although there are hundreds of 12-step meetings in Tulsa every day, most of them do not have childcare. But one did. When I told her this she was thrilled because now she would be able to comply with both the concerns of her social worker and the order from the court.

Removing barriers to our client’s recovery is an incredibly powerful way to instill motivation.

#3 - CHOICES

Giving our clients a choice is a tool for motivation.

Clients who are unmotivated to make change often use this as a way of entering a power struggle, which of course only prolongs making changes. I let clients know that whether they do what they are supposed to do or not, I am still going to go home at 5 o'clock, cook dinner for my kids, sit in my hot tub and surf the Internet. I let clients know that whether they choose to do something healthy or unhealthy, my mother is still going to love me and I am still going to have a great life.

Giving clients a choice and allowing them to choose unhealthy options is a way to provide motivation. How? It helps them to recognize that someone else is not going to assume their responsibility - they must take responsibility for their own life and their own actions.

If they choose unwise behaviors, they are the ones affected negatively; life still goes on for the therapist or probation officer. And, if they choose wisely, they are the one affected in positive ways.

#4 - DECREASE ATTRACTION

Decreasing the attractiveness of negative or unhealthy behaviors is a great tool for motivating the unmotivated client.

When I was an adolescent, I learned how to dip Copenhagen snuff while working on a golf course as a caddy. Nicotine is an addictive substance and snuff is one of the most effective ways to deliver nicotine to the blood stream. Consequently, 15 or so years later, I was still dipping.

In the late 1990's, the government decided that snuff cans needed health-warning labels just like cigarettes. When the new cans of snuff came out, I of course bought one. Driving down the interstate after a hard day of work, heading home on an 8-hour drive, like always, I took out my can of Copenhagen, opened it up, and put in a dip. I then, as usual, tossed the tin of

Copenhagen onto my dashboard. But this time, the new warning label stared back at me - WARNING: This product may cause mouth cancer.

For some reason, this dip did not taste as good as usual. It did not satisfy like the slogan promised. I kept thinking, "Mouth cancer? How awful!"

I spit the dip out and drove down the highway for a few more hours. When the craving for more nicotine kicked in again, I opened up that can of snuff and put in another dip. I tossed the tin back on the dashboard and again, the same label glared at me - WARNING: This product may cause mouth cancer.

Now, I've never seen anyone with mouth cancer, but I instantly conjured up a mental picture of what mouth cancer must look like, and it was revolting. It was horrifying. It was terrifying.

I know we're not supposed to litter, but I was so appalled by the mental images I had created that I took that can of Copenhagen and threw it out the window onto the side of the road. That was the last time I ever had a dip of snuff.

In chemical dependency counseling, the First Step assignment, regularly given in group therapy, is designed to help a client associate (often for the first time) negative consequences of their drinking behavior, which they had long viewed so positively. This aversion therapy technique is designed to decrease the attractiveness of drinking. This concept will not motivate all clients all of the time, but can certainly serve as a tool for motivating some of our clients some of the time.

#5 - GOAL SETTING

Dan O'Brien won the Olympic gold medal for the decathlon in 1996. What's interesting is that just four years before, he had bombed out of the Olympic Games. In an interview he gave after winning, he talked about what was different that time around.

According to Dan O'Brien, it wasn't that he was in better physical shape, or that he had worked harder, or was more motivated. Dan O'Brien alluded to the fact that the difference in his performance had everything to do with learning how to set goals. For Dan O'Brien, goal setting made the difference between being a great athlete and wearing the Gold on a box of Wheaties.

I believe that the fundamental difference between a goal and a dream is that a goal is written. It is essential to teach our clients what a goal is and to have them write their goals down, on paper.

Clients who are new to goal setting should actually write down a goal once a day and tape it to the bathroom mirror. Why the bathroom mirror? This is first place they go in the morning and the last place they go at the end of the day before bed.

If the client does this, in a month's time they will not necessarily achieve every one of those goals. In fact, many will never be achieved. But the purpose of this assignment is not to help them achieve all of their goals; it is simply to get them in the habit of goal setting.

Goal setting is essential, because if you aim for nothing, you will hit nothing. A goal is (1) concrete, (2) clear, (3) specific, (4) attainable, and (5) has a reasonable time frame. I teach my clients the difference between dreams (I want to feel healthy) and goals (I want to lose 10 pounds over the next two months by eating right and exercising).

'Objectives' are the necessary tasks that must be completed in order to reach the written goals they have established. Setting objectives is as important as writing specific goals.

Goal setting is a universal need, even for clinicians. The way the intervention will be implemented is based on the individual client's unique strengths. With most of my clients, when it comes to goal setting, I give them a cognitive therapy worksheet. On the left side, it has a picture of a tree and a box near the top that says, "My Goal Is:" and has a spot for objectives. I ask my clients to use this worksheet to begin writing and establishing goals for themselves.

Once upon a time, I had a 19-year-old client named Tom, who was, as a psychiatrist described in the mental records, “of average, dull intelligence.” Tom came in for treatment of depression. His girlfriend had just dumped him and he was failing out of massage therapy school. His father, another therapist in town, had actually referred him to me. Although I did not know his father personally, he had attended some of my workshops.

When Tom showed up for his 7pm appointment, I was standing outside in front of my office. He got out of his car, walked up to me and said, “You must be Richard, the therapist.”

I agreed that I was, and invited him in.

Tom paused for a moment and looked at the evening sky, taking in the sunset and said, “Wow. That’s beautiful. I wish I had a camera.”

I looked up at the sky and replied, “Yes, that’s a beautiful sunset,” and we walked into the office.

As I took his history, I discovered that Tom didn’t usually wake up until the crack of noon each day. His girlfriend had dumped him because she felt he was unmotivated and didn’t want to do anything but sit around and smoke pot. He still lived with his mom and dad and was failing out of massage therapy school, just as he had failed out of every other vocational training program he enrolled in.

Common sense told me that one of the most effective interventions with Tom would be goal setting. I gambled that, because he seemed to be of low intellectual functioning, using my standard cognitive therapy tree assignment was not going to work. Even though he needed to goal set, writing and verbalizing things and taping them to the bathroom mirror wasn’t going to appeal to this kid or meet his needs.

Because he had noticed the beautiful sunset, which I had not until he pointed it out, I guessed that one of his strengths might be in the area of art. Although he was not

particularly articulate, he did have the ability to see beyond the obvious and could appreciate creativity and visual imagery.

So, I asked, “Hey, Tom, does your Mom have a bunch of magazines around the house?”

He responded, “She sure does. So does Dad.”

I said, “Tom, I want you to go through your parent’s magazines and I would like you to make a collage, kind of like in 5th grade.”

“Oh, cool. What kind of collage?” he asked.

I said, “Get a piece of poster board, go through the old magazines and every time you see a picture that represents something you wish you had in life, glue it to the poster board.”

He said, “Like what kind of stuff?”

I said, “Well, I saw the junky car you drove up here in, so let’s say you wish you had a nicer car. If you see an ad in a magazine for a cool Chevy, cut it out and stick it to the poster board.”

I continued, “If you see an ad of a guy and a girl walking down the beach and you wish you had a girlfriend, cut that picture out. You said you were depressed, right? Well, if you see a yellow smiley face in a Wal-Mart ad and you wish you were happy, cut out that smiley face and stick it to the poster board.”

I asked Tom if he would be willing to try this project. He thought it sounded like a groovy idea. I told him that when he was done with the poster board, he needed to tape it to the inside of his bedroom door.

He asked, “How come the inside of my bedroom door?”

Because, I told him, that's the first place he looks in the morning on his way out into the world, and the last place he looks every night when he's ready to end the day. In the morning, when he steps out of his bedroom, he should look at the pictures and recognize that in everything he does during the day, he should be focused on attaining the things in the pictures.

Goal setting is an important strategy for motivating the unmotivated client. Adapting targeted interventions to meet out client at their particular point of need is an essential task, which must be based on using the clients existing strengths and resources.

#6 - HELPING ATTITUDE

Chemical dependency counselors are notorious for playing hardball with clients. Their philosophy is: You were willing to go to any lengths to get drunk, so you must be willing to go to any lengths to get sober. Subsequently, doing things that assist clients in completing referrals, reminding them of appointments or reminding them to complete their journal assignments are all viewed as enabling behaviors rather than helping behaviors.

Maybe I spend too much time with social workers, but I don't think that enabling our clients to get better is a bad thing to do. Yes, helping may become enabling if we are working harder than our clients, or when we want something for them more than they appear to want it for themselves. But for most, having a helping attitude and assisting with tasks while functioning as a coach rather than as a constant confronter can go a long way toward motivating the unmotivated client.

People are more likely to accomplish something if they believe someone else is with them. I know that in my own life, when I have somebody with me doing something, I generally do it better.

We got in this field because we really enjoy helping other people. Communicating a helping attitude by doing things with clients and assisting them in completing tasks is not enabling, it's simply good counseling.

#7 - FEEDBACK

Feedback is a tremendous way to motivate the unmotivated client. Almost every group therapy session in any treatment center ends with a segment where the group members are asked to give feedback to the person who brought up issues. I know that in my work and in my family, I do better when I receive both positive and negative feedback, and I become extremely frustrated in environments when I receive no feedback.

Maybe one of the reasons why I enjoy writing books and teaching classes is that I get a lot of feedback from customers. Some is highly critical, some is extremely positive, and some is in the middle. I enjoy it all because it means that someone cared enough about what I said to respond, so I must have been doing something right, and that, in and of itself, motivates me to continue the work that I do.

I teach a lot of workshops on suicide intervention and prevention. A few years ago, I was at a Kinko's copy center in east Texas and a man walked up to me who said he had attended one of my classes. He wanted to let me know that even though it had been a few years, he found the information helpful. I asked him how and he said, "Well, I didn't use it with a client, I used the material with my son." He went on to say that he had applied some of the interventions we had talked about in that training session and that his son was doing much better.

I walked out of that Kinko's feeling empowered because of the feedback I received. The next morning I was scheduled to present another workshop. I was excited about the topic and motivated to do a good job - based on the feedback I received the day before about a workshop I had presented years before.

#8 - EXTERNAL CONTINGENCIES

Using the 'big guns' can be a powerful tool for motivation. In community supervision work, nothing seems to motivate the unmotivated client more than telling them a Motion for Revocation will be filed if they do not comply.

Holding clients accountable to the EAP who referred them or to their spouse in couples counseling may seem like an extreme measure, but with the proper Release of Information forms on file, using these external contingencies can sometimes motivate the unmotivated client.

These are usually tools of last resort. But using the big guns, the external contingencies, can be a powerful agent for change.

There is one caution though: When we make a threat, our clients must know that we will act on that threat.

I meet a lot of parents who say that no matter what they do for discipline, their child is still out of control. A chief reason for this lack of control is often the parent's inconsistency in following through with the external contingencies, threats or punishments that they promise. A lot of parents say, "If you do that one more time, you will get grounded." Then, when the kid does it one more time, the parents give them one more chance, instead of actually grounding them.

Working with clients is a little bit like parenting, in that when we threaten to use the external contingencies available to us in a client's life, we must be willing to follow through, even if it's something we have a difficult time doing from a personal perspective.

SOLUTION #7: GIVE YOUR CLIENTS A MILLION DOLLARS

I once had a client, Joe, who was just miserable. His finances were in shambles, he didn't like his job, his car was crappy, his family life was stressed, and he didn't have a steady girlfriend. He was depressed, anxious and angry. And he had no solutions.

One day Joe came in for a session, plopped down on the couch and said, “Richard, it’s just no use. Nothing is ever going to be right for me. I’m just one of those guys who will always have a crappy life. Unless, of course, I won the lottery or something.”

I suddenly got an idea. I asked Joe, “So tell me, how would your life be if you had a million dollars?”

Joe immediately perked up. “If I had a million dollars? Wow! My life would be fantastic! I could do anything!”

I asked Joe to be a little more specific and to detail what he would do if he had a million dollars.

He said:

- 1) I could be a rock star
- 2) I could be debt free and have nice stuff
- 3) I could get along with my family

I asked Joe to explain to me what each of these three ideas really meant or represented to him. At first, he didn’t understand my question, so I asked: Why would you want to be a rock star? What would this mean to you?

1) Joe said that if he had a million dollars, he would have the money to buy a guitar and take lessons like he’d always wanted to do. Then he would be able, for once, to say that there was something special that he could do really well. For once he could experience pride, respect, and glory.

2) If he had a million dollars, he could pay off all his old bills, and would be able to pay his new bills on time without fear of collectors calling around the clock. He would also be able to buy a decent car and some nice clothes, and maybe a dog.

3) If Joe had a million dollars, his family would get off his back about him being a “loser” who was always broke, and maybe he could visit with them without feeling bad.

I told Joe that I thought all these things would be great for him, so I was going to give him a million dollars.

Joe, of course, was shocked by my statement. “Richard, dude, I didn’t know you were rich! Why are you working doing therapy? Are you really going to give me a million dollars?”

I couldn’t help but laugh. “No, Joe, I’m not that rich with money, but I can help you get all the things you want, just as if you had a million dollars.”

Now he was confused, and probably a little disappointed, but definitely curious.

I explained to Joe that as I understood him, the core importance of the things he told me were as follows:

1) He needed to feel that he was good at something (pride, self-respect, self-esteem, personal accomplishment, productivity).

2) He needed to be in control of his finances and get out of debt.

3) He needed to be able to interact with his family without feelings of shame or guilt or embarrassment.

I told Joe that I would help him discover something that he either already was or could become good at, with little or no expense. I would help him sort out his finances and budget his money to both pay off his old debts and save some for the future, maybe even for college. And, I would teach him some healthy communication strategies that could help reduce the stress of interacting with his family.

In short, I was going to give him a million dollars, just like he wanted - and needed.

The point is that we often become overwhelmed in life by all the little things, and feel that there's no way out save for a miracle. If we can back up a bit and break down just what that miracle represents to us (peace, security, love, self-respect, etc), we can usually find a practical way of meeting those core needs.

SOLUTION #8: PARADOXICAL INTERVENTION

With our highly difficult clients, especially those who sabotage treatment, paradoxical interventions can be quite effective. Assisting clients in attaining their own unhealthy goals can sometimes be effective, as can following ideas through to their illogical extreme.

I have had couples who state that they are committed to resolving their marital difficulties, however, when I prescribe strategies for increasing intimacy, managing conflict and opening communication, they frequently will not engage in these tasks. Instead, they come back to therapy the following week saying they didn't have enough time or didn't spend enough time together completing the tasks.

After several weeks of making no progress and failing to complete the homework assignments necessary to effectively engage in couples counseling, I have been known to take a piece of paper and tear it in half, giving half of the paper to the husband and half to the wife. I then tell them that since we have spent the last four weeks engaging in a competitive misery contest and they have failed to complete the tasks assigned as part of the treatment protocol, it is now clear to me they do not want to be married any longer.

Usually this will get me an odd look from both the husband and the wife. I then inform them that I charge the same for divorce mediation sessions as for couples counseling. I then let them know the good news: mediation is far less expensive in the long run than a traditional divorce battle with attorneys, and so in light of the choices they have made by not following through on their marital resolution assignments, they are now switching from couples counseling to mediation.

I tell them that mediation does not take place on the love seat, but instead occurs in different rooms. I then tell the husband he will be spending the next hour in one room, while the wife can remain in my office, and what I want them to do with the piece of paper is to write down all of the stuff that they are going to keep after they get divorced.

After they are done with that, we will merge the two lists together and anything that appears on both lists we are going to eenie-meenie-minie-mo. That way, everything will be split up here in the mediation office, and then the divorce can then proceed without the traditional cost or need for multiple attorneys and nasty fight scenes.

Every single time I have provided this intervention to clients in couples counseling, they have pleaded with me not to send them to separate rooms, claiming, “We really do want to work this out!” When I confront them on their failure to complete the tasks which we have outlined to this point, and underscore that their noncompliance really tells me they would rather be in mediation than counseling, I’m usually met with either tears or pleas to continue the counseling process.

This is a prime example of paradoxical intervention, which can be helpful with many difficult clients.

Anxiety disorders are also particularly responsive to paradoxical interventions. The panic disordered client usually experiences panic attacks in a particular situation. For example: on the highway in heavy traffic or when getting on an elevator. The panic disordered client almost never experiences panic just sitting in his or her own living room late at night or when reading a book while lying in bed.

I ask my clients who suffer from panic disorders to try and make themselves panic at a time when they normally would not. I give them the assignment to essentially create a panic attack in the privacy of their own home when nobody is around and there are no stressors present that would usually trigger an attack.

They look at me oddly, but there is value in the prescription, especially if they follow through on it. The value comes from the fact that the panic disordered individual almost always reacts to the cues around them.

It is important for the client to be able to identify the precursors to crisis that lead to their increased anxiety and continued panic. In the DSM-IV, Panic Disorder lists about 20 common indicators, of which the first half is almost all physical. If the client can recognize these triggers, they can begin to either avoid panic-causing situations and/or begin to tackle handling them without panic, one “baby step” at a time, in more controlled situations.

My favorite movie of all time is “*What about Bob?*” In that movie, Richard Dreyfus plays a psychiatrist treating a highly difficult patient named Bob who suffers from anxiety disorders. At one point in the movie, Bob comes in to Dreyfus’ office and is having a heart attack. He says his left arm hurts, he’s feeling shooting pains, his chest feels like it’s caving in, and he’s short of breath and has broken out in a cold sweat. He *knows* he’s having a heart attack.

Dreyfus is not accustomed to such catastrophic medical illness in his counseling office and not knowing what to do, *he* begins to panic. Bob, sensing Dreyfus’ panic, turns to him and says, “Relax, Doc, I’m not really having a heart attack.”

Dreyfus pauses and looks confused. Bob then continues with something like, “You see, I’m afraid of having a heart attack, so I’m making myself have a heart attack, so that way I will know that I am not really having a heart attack, because I will know that it is actually me causing the heart attack.”

In the movie, Bob learned to manage his anxiety through paradoxical intervention.

SOLUTION #9: BRING IN OTHERS

One of the most effective solutions for highly difficult clients is often simply to refer them to people who can provide the services we can’t. This deals with recognizing our own personal and professional limitations, and recognizing the kinds of clients who we work well with, and those clients who we don’t work so well with.

To be effective with our clients and to truly meet their needs, it's essential for us to build relationships with other professionals who are experts in other areas of counseling. Additionally, I have on many occasions used the psych techs in an inpatient facility as a tool for creating therapeutic change. In the example of The Clam that I gave earlier, I knew the client would disclose information to the psych tech while playing football that could be brought to group therapy later. By building this alliance, I was able to accomplish the therapeutic goals.

Sometimes we get a client who is unlike any other we have worked with before. In this situation, bringing in another therapist to co-facilitate a specific group therapy session, patient education session or even an individual therapy session can be a wonderful idea for assisting a highly difficult client.

I have never been too proud to ask for help, and I think this is one of the reasons why I have been an effective therapist. I don't attribute my success as a therapist to my incredible skills, but rather to my recognition that I cannot be all things to all people at all times, and that by bringing in others, I truly serve the needs of my clients.

Those in private practice may have a particularly difficult time doing this because it may not only involve swallowing a little pride, but perhaps may mean that we lose another billable hour. From a business perspective these are real concerns, however, this should not affect the care we provide our clients. As licensed professionals, we are responsible to the clients we serve, and not our mortgage company.

Learning how to refer is essential. One of my first jobs at a private psych hospital was that of Intake Counselor. I had recently moved to this new city where I had never lived worked before, and I began taking calls. Callers who were not clinically and financially viable would need to be referred to an appropriate caregiver, and the company provided me with a resource directory of local agencies and statewide resources.

A potential client called our 1-800 Help Line number one night, and although he was clinically viable, he was not financially viable, and so I made a referral: I gave him the name and number of an agency listed in the directory that would be able to meet his needs.

I was now sitting at my desk, glad that in my new position as Intake Counselor I was able to help somebody by making a quality referral. A few minutes later, the phone rang. It was the same person again and he said, “Richard, I dialed the number you gave me and it was disconnected.” I told him that, well, sometimes agencies move and change their number and books become outdated, but I had another referral resource to give him that would be able to meet his needs, and I gave him that telephone number.

I kicked back, put my feet on the desk, and again gloated over my ability to assist clients by making appropriate referrals. About 30 minutes later, the phone rang and again it was the same person. He said, “Richard, that program is wonderful. They have the type of services that I need. Their cost is affordable. They are an excellent organization.” As I listened on the phone, I smiled and said “uh-huh.” He then shouted at me through the telephone, “There is only one problem Richard, *I am not a woman!*”

I had referred the male caller to a women’s treatment program. I went home at the end of the day and recognized that I had done a bad job. I had done a bad job not because our agency could not serve the client, and not really because I made an inappropriate referral, but because I was not familiar with the referral resources in the area.

I made a decision that night that I would never make a referral again to a phone number that was disconnected or to an agency that I did not know for sure would be able to meet my client’s specific needs. When I went back to work the next day I went through the resource directory and called every single one of those agencies. Every number that was disconnected or changed, I noted the correct number. Every agency that answered, I asked for the name of the clinical director and asked to speak with them. I talked with them about the programs and services they offered. For those agencies that were close by, I asked if I could stop by, visit with them, and see their facilities. For those that were out of the immediate geographic area, I asked them to send me additional information, which I placed

in a file cabinet. Since that time, I have never made a referral to an agency that was unable to meet my client's needs.

Sometimes we learn how to do a good job of therapy by doing a bad job. I am fortunate that I recognized this in one of the very first weeks of one of my very first jobs in this profession.

(As an aside, for those in private practice, following this procedure and meeting potential referral sources face-to-face can be of great reciprocal referral benefit to your practice as well!)

SOLUTION #10: HEALTHY MODELING

I was presenting a workshop at a training conference in the Texas Hill Country for a university-sponsored event directed toward criminal justice professionals. The brochure they mailed out said that the ranch offered swimming, horseback riding, tennis, hiking, and a full-service bar, and that you were encouraged to take advantage of these amenities in your free time. At the conclusion of my workshop, for presumably lighter entertainment, they also offered a vodka-juice punch making session.

Since the majority of people who drink alcohol in our country are not alcoholics, I have no problem with a person over the age of 21 drinking alcoholic beverages. However, I did find it odd that the university sponsoring this criminal justice training event encouraged individuals to take advantage of the bar and the vodka punch making session.

It is impossible to live a perfect lifestyle, but clients will notice if you are living a healthy lifestyle or not and will respond to what they see.

The last time I had a drink, James Brady was Ronald Reagan's press secretary. As a substance abuse counselor, I was always confronted with the question, "Do you drink?" My answer was easy, and required no explaining or justification: No.

Does this mean that someone who drinks cannot be an effective counselor as long as they are not impaired by their alcohol consumption? Of course not. It just means it's easier to be an effective counselor when you model healthy living. For example, if you're going to work with obese clients, you probably want to make it a habit to exercise regularly and eat healthy foods.

A counselor I know in East Texas keeps a bowl of fresh fruit in his waiting room. The first thing he asks his clients when they come in is if they've eaten anything yet that day. If not, he has them eat an apple or banana before he'll start therapy.

I have worked as a counselor both as a cigarette smoker and as a nonsmoker, and I've learned the hard way that it's a whole lot easier to gain the respect of your clients in substance abuse counseling when you do not have to leave in the middle of a session to take a smoke break. As soon as I quit smoking, I noticed I had become a much more effective counselor.

Healthy modeling can contribute to working with clients in an effective manner. Of course, I still do some things that are unhealthy. Sometimes I don't sleep right. Sometimes I don't eat right. Sometimes I don't manage my relationships effectively. Nobody has to be perfect to be a counselor. But we must recognize that if we are not taking care of ourselves, it will be apparent to the clients on our caseload.

And, if we deliberately live an unhealthy lifestyle on a repetitive basis, it will impair our ability not only to confront the behavior we have labeled as denial, but also to objectively treat our client's mental health and substance abuse related conditions.

Another thing we need to watch out for is the language we use. Do we cuss during therapy sessions or group therapy? Do we rage at clients who have not completed projects? No therapist is perfect, but projecting self-care and a pro-social manner of living allows our clients to learn from us - often from one of the only healthy people they know - the strategies that can facilitate positive change in their own lives.

SOLUTION #11: LET THE TRAIN WRECK HAPPEN

At the beginning of this section, I talked about this eleventh solution quite extensively. I'm not going to spend a great deal of time on it now, but I do believe that there is a time and a place to cut clients loose for the purpose of allocating our resources to others who are able or willing to take advantage of what we have to offer. This is important not only for the client who is now able to participate in treatment because of another person's choice to stay stuck, but also because we are able to provide better care when we are not in a power struggle with the client who simply refuses to get better.

A major issue we often face is dealing with the client who is mandated to receive services, yet remains noncompliant. How do you let the train wreck happen in these scenarios and situations? Counselors working in prison systems, in school districts and in the public sector are often faced with this particular dilemma. Sometimes it's impossible to do so without feeling the consequences or burden from administration or judicial systems. These are difficult issues probably best addressed in clinical supervision by talking with another counselor, peer or professional about each specific case that we must continue to treat, despite the fact that they refuse to take advantage of the services we provide.

I think that while we may continue to provide monitoring or support services to these clients, one of the ways we can let the train wreck happen is by holding them accountable for their actions to the best of our ability within the systems that are provided, and simply choosing to allocate our energy and resources to those who are willing to take advantage or have the capacity to take advantage of what it is that we offer.

I don't think any counselor needs to feel bad about letting the train wreck happen once all reasonable efforts have been exhausted. Sometimes people choose to stay stuck because it's most familiar or simply because that's what they want to do.

Years ago, a client was admitted to our substance abuse treatment program because of his heroin addiction. He had worked at a factory for over 15 years assembling part A onto part B. The doctor prescribed Methadone as the treatment intervention.

Personally, I'm usually opposed to Methadone as a treatment. Why? For most heroin addicts, Methadone typically just frees up their heroin money for cocaine purchases, and then they end up worse off than when they first entered treatment.

In this case, however, the doctor had made the decision that Methadone was the appropriate treatment. Why? Not because it was going to offer him a greater quality of life; in fact, his quality of life would not change much. His presenting problem and his treatment goal was not abstinence. His goal was to avoid the legal and health consequences of his heroin use.

When I work with substance abusers, I of course want their treatment goal to be "becoming happy, joyous and free", but this individual did not want to be happy, joyous and free; he simply wanted to be left alone and allowed to continue his employment without anyone else interfering with his life choices.

Methadone kept him from getting AIDS and it kept him out of legal trouble. And although it was less than I think he could have accomplished in life, it was the best intervention for this particular individual - because his immediate needs were met and treatment was a success.

SECTION 3

The Paradigm of Denial

Even if you disagree with the point I made earlier that denial is a concept therapists have created to make themselves the most important person in the therapeutic relationship, I think you will still get your money's worth out of the other ideas in this course. But if you consider this controversial point, I think you will benefit even more.

Denial, as practiced in our profession, has become a mystical and powerful force controlled by the therapist in both group and individual therapy. The importance therapists have placed on the existence and the resolution of denial has been over-emphasized. Denial has become, in and of itself, evidence of pathology.

The behaviors we label as denial are problematic for us as therapists, because they are actually coping strategies our clients have employed to meet their deepest needs. Because we insist on believing in denial, the paradigm of denial typically manifests as follows:

- There's a new client.
- That new client comes to see me, the enlightened therapist.
- The client, because of ignorance, because they are irresponsible or because they are protecting themselves, is resistant.
- I then become indignant because the client has become resistant to me, the expert therapist
- The client then becomes angry at my indignation.
- I will usually then make a threat, such as, "If you don't comply with treatment according to my terms, something bad will happen to you."
- The client then typically becomes compliant (although still angry).
- I then label this breakthrough in the client's chart, as evidenced by his compliance, as a success in counseling.

Admittedly, this is a rather cynical view of the paradigm of denial as it currently exists in our profession. Nevertheless, I think it's worth reading again, because I think my description is probably accurate.

The paradigm of denial sets up power struggles and makes the therapist the most important person in the client's life, rather than helping them find the most important person in their life. This creates conflict between the therapist and client when conflict does not need to exist.

Earlier we identified three things that the behaviors we have labeled as denial actually are: (1) Irresponsibility, (2) Ignorance, and (3) Self-protection. We are also going to add one more reason: (4) Didn't do it.

I think there is an easier, softer way to deal with the behaviors we have labeled as denial than the paradigm we usually employ.

The Easier, Softer Way

The easier, softer way is pretty simple: Rather than a confrontation with clients, rather than group therapy time wasted on a hot seat, rather than conflict over what is real and what is not real, let's simply address the behaviors that truly are the root cause of what we have labeled denial.

- When clients are irresponsible, let's hold them accountable.
- When clients are ignorant, let's educate them.
- When clients are protecting themselves, let's recognize that one of the limitations of therapy is the need for our clients to protect themselves from a therapist who does not have the same liberties an attorney or priest for maintaining confidential information.

When we handle behaviors that we have labeled as denial with these three techniques, we can often end one of the most difficult components of therapy by treating our clients in a humanistic fashion at their particular point of need, rather than doing what we have simply been trained to do during the counseling process.

A couple of quotes are worth discussing as we consider the subject of denial. One comes from Stanton Peale's book, The Diseasing of America. Peale has been a very controversial author in the area of substance abuse counseling because he questions the party line. He does not take a one-size-fits-all treatment approach and apply it to each and every client. Because of his willingness to consider approaches that fall outside of the Hazelden 12-Step model, many substance abuse professionals have alienated him. Although I certainly do not agree with everything he has written on the subject of substance abuse, he is one of those authors who always makes me think; he helps me confront why it is that I believe the way I believe.

Stanton Peale talks about how denial is misused in treatment and he states, "If they (the alcoholic) continue to disagree with such diagnosis, this denial can be used as *evidence* that they are really alcoholic. Moderate treatment philosophy insists that denial is a keystone of alcoholism and must be attacked before recovery can occur."

This quote, I think, summarizes current treatment philosophy on the subject of denial. Denial is something therapists view as a power they have over clients who can not choose to make change until we accomplish something in therapy first - that being the resolution of their denial.

Substance abuse counseling is not the only area where denial has taken on a life of its own. In the area of sexual abuse counseling and working with perpetrators, denial has also taken on a profound level of importance.

Family Therapy Networker Magazine, in October 1993, had an article containing the following quote: "In a psychotherapeutically inspired double bind, typical of our times,

denial itself is evidence of denial, the pathological indicator that makes declarations of innocence virtual proofs of guilt.”

In a California case that made national headlines, a daughter accused her well-known father of sexually molesting her when she was a child. There was no evidence - none at all - but the prosecutor took the case to court based on the allegations of this adult child who had recovered the memories during therapy. In the trial where the father was originally convicted, the prosecutor used the father’s denial as evidence of guilt for the crime.

This type of misuse of the concept of denial can lead to tragic consequences, and in this particular case, the destruction of a family.

Fortunately, for this father who was falsely accused, the appeals court overturned the verdict, highlighting reason #4 for denial: He didn’t do it.

Perhaps because we have come to believe so heavily in denial, or perhaps because we’ve become so cynically accustomed to everyone claiming “I didn’t do it!” no matter what they’re accused of, we may often overlook the simple fact that maybe, just maybe, they really didn’t do it.

BONUS SOLUTION #12: CREATE TARGETED INTERVENTIONS

To this point, we’ve talked about many ideas that can be useful for impacting the highly difficult client. A course like this could perhaps be a little bit frustrating because although I have given many practical examples from my experiences, perhaps I have not given applications of the ideas for the clients on *your* particular case load. It would be impossible for me to do so, since I do not know your clients.

When I do training, I talk about targeted interventions. By ‘targeted interventions’ I mean specific strategies for applying a concept to a particular counseling situation, based on our client’s unique strengths. In a previous example, I talked about the 19-year-old depressed pot smoker who needed to goal set. I recognized his strengths, the ability to see beyond the

obvious and his appreciation for art. His low cognitive abilities were certainly a deficit, but instead of being frustrated by his inability to do the assignment I would typically use with most clients, I adapted the goal-setting intervention strategy to his particular strengths by having him do a collage.

Targeted interventions always draw on the strengths of a client and utilize the specific resources available to them to resolve difficulties. Ending power struggles is an essential solution. How we go about doing it with a particular client is going to be predicated on their strengths.

Fortunately in the case of The Clam, I had a high functioning client. Clients with high intellect are always easier to deal with than low functioning clients, because we can be cognitive in orientation rather than behavioral.

Ending denial is an effective intervention strategy. How we go about doing it is, again, will be predicated on our individual client's strengths and resources. It would be easy for me to conduct a therapy session for assessment and to identify what *I* perceive to be my client's strength's. However, these will prove to be useless to me in the counseling process. Why? What *I* perceive the client's strengths to be are not necessarily the things my *client* perceives as his strengths. Interventions cannot be created based on my perceptions, but rather, must be prescribed based on my client's perception of his or her own strengths.

As mentioned before, a useful assessment tool we developed is titled the **Nongard Strengths and Resources Inventory**. The NSRI allows me to assess what my client believes is right with him - the attributes, attitudes, skills and situational supports he or she has in their world. Using such a tool in the assessment process can yield the information I need to target my interventions to my client's specific point of need, based on his existing strengths, resources and situational supports.

For example, it will do no good for me to tell my client to drive over and fill out a job application if he does not have a car, know the bus route schedule, or have money for a taxi. My client, however, may know that his sister will take him if he asks her nicely. This is

one kind of resource that the NSRI will pick up. And, as we know, clients are far more receptive to utilizing situational supports that they bring to the table, over those that we suggest.

CONCLUSION

I Wish I Had a Magic Bullet

I wish I had a magic bullet - the one tool that would work for all of our difficult clients all the time - the one single tool that could end sabotage, end resistance, end conflict and denial. But I do not. This course has been a collection of ideas that have worked for me with some of my highly difficult clients. I hope the stories and illustrations I have provided can be adapted by the reader and applied to the work that they do and the clients they serve.

I think it is important to recognize though, that no magic bullet will ever exist.

It seems that psychiatry is continually in search of this magic bullet, believing that all human problems are the result of a “chemical imbalance in the brain.” Because psychiatry always seeks the psycho-pharmaceutical product that will once and for all end all client suffering all of the time, society has been led to believe that a simple cure for difficult problems will exist or one day be found.

Reality, however, is far different from this magic bullet dream. For every problem we label, there is probably a multiplicity of causes unique to each and every client. Therefore, applying intervention ideas in a targeted fashion will be effective with some of the clients we work with some of the time, but certainly none of these ideas will be effective with all of our clients all of the time.

As I conclude this text, I want to draw your attention back to the story of my minister-friend named Bob. I think I learned more from Bob on the telephone that day about counseling than I ever learned in graduate school about how to measure our success as a therapist.

Success is not measured by the quantity of Kleenex used during a therapy session.

The number of clients who come and see me does not measure success.

Success is not measured by a low recidivism rate in a criminal justice population.

Success in our field needs to be measured by our ability to help some of the people, some of the time, who then hopefully goes on to impact others in a helpful way.

If this text has given you any ideas that may be useful with some of your clients some of the time, then this text will have been worth reading and the ideas, as you apply them, will benefit society as a whole.

THANK YOU FOR YOUR PARTICIPATION IN THIS COURSE

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"11 Solutions for Counseling Difficult Clients"

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The purpose of the following Evaluation of Learning questions is to:

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➔ ANSWER THE FOLLOWING EVALUATION QUESTIONS – TRUE OR FALSE.

- T F 1. I have read the required .pdf text file for this course.
- T F 2. One of the most effective interventions in counseling is to recognize that effective counseling is all about helping most of the people most of the time.
- T F 3. The true measure of our success comes from the quality of help we provide, rather than the quantity.
- T F 4. Clients are difficult because the difficulty that they manifest meets specific needs for them.
- T F 5. Treatment goals with the mentally ill client are different from our treatment goal with the "well but unhappy person."
- T F 6. Counselors should recognize that fear is one of the most prevalent motivations for sabotaging treatment.
- T F 7. Therapists rarely overreact to client behaviors.
- T F 8. Sometimes our clients are difficult because we do not have a repertoire of intervention strategies that meet our clients at their point of need.
- T F 9. The inexperienced therapist recognizes that their own limitations sometimes contribute to difficulties with the client.
- T F 10. The moment we engage in any detrimental behavior, our needs are met.
- T F 11. In family violence situations, the familiarity trap is an obstacle to overcome when providing interventions.
- T F 12. In our profession, we have been trained to help people make change, not to allow people to experience the consequences of their own actions.

(The Evaluation Quiz is continued on the next page -->)

EVALUATION OF LEARNING - PAGE 3 of 4

"11 Solutions for Counseling Difficult Clients" **6 Hours of Approved Continuing Education Credit**

- T F** 13. Letting the train wreck happen may be a difficult intervention, but it can actually lead to success.
- T F** 14. Put the ball in your client's court and end the power struggles.
- T F** 15. A good treatment plan is nothing more than a set of goals.
- T F** 16. Teaching is counseling, and counseling is teaching.
- T F** 17. According to the instructor, denial is real; it is not a creation of the therapeutic process designed to allow the therapist to do something during the course of treatment.
- T F** 18. The Treasure Chest assignment does not fix what is wrong, but it does reframe the couple's relationship in the context of what is right.
- T F** 19. Highly difficult clients are often caught in the familiarity trap, paralyzed by emotions and believe they have no options to exercise.
- T F** 20. Feedback is a tremendous way to motivate the unmotivated client.

GRADE THIS ONLINE COURSE! – Page 4

*It is helpful to us if you return this form via snail mail or fax,
along with your Quiz and Payment. Thank-you!*

Participant Assessment of Home Study CEU Course

11 SOLUTIONS FOR COUNSELING DIFFICULT CLIENTS 6 Credit Hours

**Please Rate the Following Statements from 1-5
(1 being the Lowest, 5 being the Highest.)**

- _____ 1. I found the PeachTree Online Home Study Course Instructions simple to follow.
- _____ 2. I found the PeachTree Online Home Study Course materials to be of professional quality, and easy to read.
- _____ 3. I found the PeachTree Online Home Study Course materials to be of educational value, relative, and useful to my counseling practice.
- _____ 4. I completed the 6 Hour PeachTree Online Home Study Course in approximately 6 hours.
- _____ 5. I would take another PeachTree Online Home Study Course, and/or recommend them to a co-worker.

ADDITIONAL COMMENTS: