

Part III

Adjusting Therapeutic Strategy

The general strategy that the therapist employs when working with a client is based on the client's presenting issues, their understanding as formulated in case conceptualisation, but also on the here-and-now presentation of the client. In the next two chapters we will look at the therapist's responsiveness (see Stiles et al., 1998) to the client's here-and-now presentation and to some aspects of the overall treatment strategy which depend on the central problems that bring the client to therapy. The chapters do not provide an exhaustive and detailed account of the situations and problems, but are rather attempting to sensitise the reader to the complexity of the therapeutic process.



Eight

Specific Situations in the Process of Therapy

Abstract

This chapter describes specific situations that may arise in the therapeutic process. These situations include discussion of interpersonal patterns as they are present in the relationship with the therapist, intense emotions present in the session, silence in therapy, crying in therapy, anger expressed towards the therapist, the presence of hallucinations, delusions and dissociations, etc. Research-informed responses to these situations will be discussed.

There is a number of situations that occur in therapeutic process that the therapist has to respond to immediately (Stiles et al., 1998). We will now look at some of them and examine how the therapist can respond.

Working with interpersonal issues in the psychotherapeutic process

Psychodynamic approaches, in particular, look at problematic interpersonal patterns (see Luborsky & Crits-Christoph, 1990, 1998) as the main focus of therapy because they assume that the client's psychopathology lies in an unsuccessful compromise resolution of the client's inner conflict, which is linked to the client's needs in relation to others. Working with interpersonal patterns in an interpretative way, mostly through exploring and interpreting their manifestation in the transference relationship with the therapist, is one of a therapist's basic aims in psychodynamic approaches (see Chapters 1, 2, 3 and 5). The empirically-confirmed fact that the client's interpersonal style presents itself in the relationship with the therapist underlines the importance of being aware of the client's interpersonal patterns in the process of therapy (see Luborsky & Crits-Christoph, 1990). However, an interpersonal aspect of the client's presentation may come to the fore in different ways in different therapeutic approaches.

The client's interpersonal stories are a natural focus of psychodynamic, but also other approaches, to therapy. The link between those stories and the actual interaction with the therapist is obvious. The therapist can thus either explore or interpret the client's interpersonal patterns on the basis of the stories the client tells about relationships with other people or on the basis of their mutual interaction. Van Kessel and Lietaer (1998), person-centred theorists, emphasise that the therapeutic relationship either has an implicit healing function, which is present in the therapist's effort to offer the client an optimal supportive relationship, or provides an option for explicit work on exploring, understanding and potentially altering the client's interpersonal patterns. In the second case, according to these theorists, the therapist observes the following principles in order to use the client-therapist interaction to increase the client's insight into his or her interpersonal patterns (Van Kessel & Lietaer, 1998: 160-165):

- (1) The therapist focuses on the interpersonal issues in the relationship in the sense that the therapist is sensitive to the interpersonal connotations in the client's narrative and to its parallels with the therapist-client relationship. The therapist is also sensitive to the implications of what the client is trying to communicate about others for their own mutual relationship, etc.
- (2) The therapist does not respond in the same way as others in the client's usual interpersonal patterns. This way of responding breaks the usual social reciprocity. For instance, if the therapist is accused of something, the therapist does not automatically start responding in self-defence, but is rather interested in understanding the client.
- (3) The therapist focuses on the clarification of interaction patterns. The therapist uses good opportunities for highlighting the interaction patterns tentatively, and in their historical or more general interpersonal context (other past or current relationships).
- (4) The therapist uses the therapeutic relationship as a medium for therapeutic change by using the focus on interaction, outlined in the first three principles, for stimulating a new way of relating and for experimenting in the therapeutic relationship.

An application of the outlined principles may look like this: The client is talking about how hard it is for her to say something negative in the relationship with her husband. The therapist may offer his observation that it has happened in the therapeutic relationship too, that it was hard for the client to speak about some negative things she had experienced towards the therapist. The therapist encourages the client to look at the fears that obstruct her expression of anger. As these are brought into the open, it may be clearer that it is out of a fear of being attacked. This being something that regularly happened to the client when she wanted to be assertive in her family of origin. The therapist may then encourage the client to express her dissatisfaction in their own therapeutic relationship, so she can build up her justifiably angry and assertive part.

Psychodynamic approaches also highlight the fact that the therapist becomes a model for the client, showing the client how to cope with interpersonal conflicts surrounding the fulfilment of a need that is obstructed by a fear (see Weiss, Sampson, and Mount Zion Psychotherapy Research Group, 1986; see Chapter 3). As Weiss, Sampson, and Mount Zion Psychotherapy Research Group (1986) suggest, the client may be testing the therapist to see whether the therapist is able to put up with difficult interpersonal interaction. The therapist's emotional stability is then central. Similarly, psychodynamic approaches emphasise the function of the therapist's countertransference, which, in an optimal case, helps the therapist to understand the emotional experiencing of the client and eventually to understand the experiencing of people exposed to interaction with the client (see, for example, Giovacchini, 1989; Casement, 1999).

Working with silence in the psychotherapeutic process

Due to the fact that therapeutic interviewing does not follow the norms of typical conversation, silences are not exceptional. It is especially so in exploratory therapeutic approaches. In such approaches, the therapist typically allows for silences in the hope that the client pauses and reflects on his or her own experience. However, in reality, silences may be spent in different ways. For example, in the early sessions, the clients may pause because they do not fully understand what is expected from them. In such a case, silence may also provoke anxiety (see Dale, Allen, & Measor, 1998). On the contrary, in productive therapy moments, the client may use the silence for thinking, reflecting and focusing on his or her own experiencing. Another form of silence can be experienced when the client feels hopelessness and gives in to a feeling of depression and lacks the energy to continue in the dialogue with the therapist.

An interesting study into the functions of silences in therapy was undertaken by Heidi Levitt (2001). She interviewed seven clients of four different therapists (of different theoretical orientation) about silences in their sessions (sessions were taped and reviewed). She found that silences could be divided into productive, neutral and obstructive silences (see Figure 8.1). In productive pauses, the clients experienced emotions, formulated ideas and reflected on their experience. In neutral silences, the clients either retrieved information or associated inwardly. In obstructive silences, the clients were either disengaged or were focusing on the interaction with the therapist as the alliance seemed to be under threat.

The therapist's way of treating a silence obviously depends on the type of silence. When the therapist encounters an obstructive silence the focus should be on improving the alliance. For instance, at the beginning of exploratory therapy, the client may be confused about what is expected. When a silence occurs at this stage and the client is uncomfortable about it, the therapist may coach the client in the use of silence. For

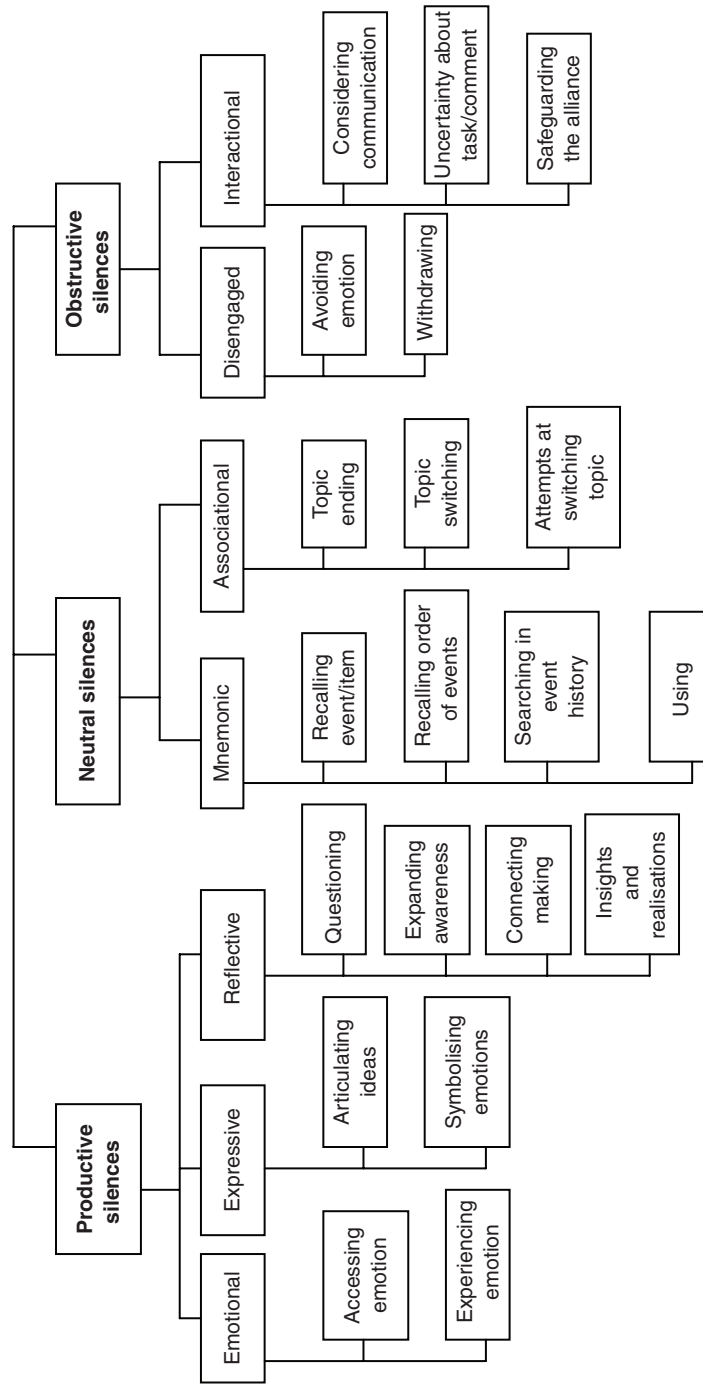


FIGURE 8.1 Pausing experiences found in the study of Levitt (2001: 300). Reproduced with permission by Taylor & Francis Ltd (www.informaworld.com).

example: *I am staying silent so I can allow you to focus on your inward experience and reflect on it. There is no need to rush. Maybe you can just stay with what is happening inside of you, what you feel and what is going through your mind.* The therapist may also check after the client was silent and explicitly ask how the client experiences silences and offer an explanation of how they can be used if they are problematic.

Silences may also be promoted by the therapist differently depending on a particular task of therapy. For instance, when the client is working on developing a hierarchy of anxiety-provoking situations, it may well be suitable to encourage the client to pause and search in their memory for different anxiety-promoting situations. In cases when the client is using silence for an emotional exploration, it is important that the therapist is in contact with this process and checks what is happening with the client (e.g. *What is happening in you right now?*). Sometimes, when a silence is painfully overwhelming (e.g. because of deep sadness or emotional pain), it is important that the therapist tries to empathically respond to that experience in order to provide a holding presence which breaks the existential isolation. In such instances, the therapist also conveys his or her presence by making eye contact and speaking with a concerned and compassionate quality of voice, all of which stem from a genuine concern and care for the client.

The use of silence is an important therapeutic skill. Silences bring an important quality to the therapeutic process. They provide a space for the client to stay with their experience. They also allow the therapist to use a pause for the purpose of reflection on the therapeutic process. It may be in such silences that the therapist formulates a new question or strategy that can be offered to the client.

Working with severe psychotic or dissociative symptoms in the psychotherapeutic process

Psychotic symptoms such as hallucinations and delusions, which are accompanied by very pronounced anxiety, disorientation and confusion, may be encountered, for instance, by therapists working with psychotic clients or clients with dementia. Such states are characterised by a loss of contact with reality. Similar symptoms may be displayed by clients who experience very intense emotions (e.g. anxiety). They may have experiences of panic, dissociation and depersonalisation. The main, immediate goal of the therapist encountering such a presentation in the session is to contain the client's experience, as it can be uncomfortable and frightening. Clients with more severe difficulties (e.g. acute psychotic disorder) may present with paranoid experiencing and demonstrate potential distrust towards the therapist.

As the main problem of clients with such experiences is their loss of contact with their surroundings and reality, the therapist's responses may focus on the strengthening of it by explicitly referring to the current reality (environment) and placing the

client in it. Different interventions can be used to orientate the client, such as *You are here with me in my office talking to me....* The therapist can offer a calm presence, such as *I am here with you in this difficulty, I will try to assist you in finding appropriate help....* The therapist can strengthen the coherence of the client's experience by verbalising it in a coherent and clarifying way, such as *You feel like that because....* Gary Prouty (1994), a person-centred therapist, developed a pre-therapy approach that targets confusion in such clients and provides holding and meaning for them. Prouty suggested several interventions targeting the client's contact function:

- (1) *Situational reflections* – the therapist orientates the client, for example: *Now we have our regular session in X facility.*
- (2) *Reflections of the client's facial expressions* – the therapist can respond to the facial expression, for example: *You seem to be frightened....*
- (3) *Word-for-word reflections* – the therapist repeats the client's statements word for word, so the client's expressions can be acknowledged and reflected back to the client, meaning the client can stay in touch with the verbal expressions of his or her experience.
- (4) *Reflections of the body* – the therapist may non-verbally or verbally reflect the body posture of the client, so the client's experience can be mirrored in this way as well.
- (5) *Recurrent reflections* – the therapist repeats those reflections to which the client responded, as these were the expressions that developed conversation and the contact with the therapist.

The goals of the therapist's interventions when working with the client's disorientation and confusion is to contain it and give it a meaning. Thus the frightened state can be 'survived' by the client and instead of experiencing other people as threatening, the client can see other people as helping him or her to cope with the difficult state. This, however, may be difficult with acutely psychotic clients, who can experience the presence of the therapist as contributing to the frightening experience. It is especially so if the client feels disrespected and manipulated by the therapist into making choices (such as being admitted to hospital) that the client does not see as viable, but rather as potentially traumatic. In such cases, the therapist has no other option but to be patient and attempt to collaboratively ensure the client's safety.

Working with crying in the psychotherapeutic process

Crying is often present in the therapy process. It can be an expression of various emotions and experiences, such as sadness, sorrow, being moved, hopelessness, despair, but also happiness, etc. In general, it accompanies variations of sadness. When crying is part of the expression of primary adaptive emotion such as normal grief (see Greenberg,

2002; also Chapter 3), it can be a catalyst for relieving (physiological and mental) tension. On the other hand, crying can also be experienced as painful, embarrassing and as something that does not bring any positive physiological effect (see Cornelius, 2001). The latter is the case when crying is an expression of secondary hopelessness or primary maladaptive unresolved grief. In such instances, crying may be tiring and may not bring any relief. Its containment and regulation (e.g. by breathing) or using it to access primary adaptive emotions may be more appropriate (see Greenberg, 2002). The therapist therefore needs to be able to determine whether the emotion that goes with the crying is primary and adaptive.

The therapist needs to allow the client to cry in the session as it is an important aspect of the expression of felt experience. Emotion-focused therapists may also facilitate crying explicitly (e.g. when the client is on the verge of tears, they may point this out, give permission and invite the client to cry: *These are important tears. Let them come.* See Greenberg 2007). Permission may also be communicated by the presence of tissues in the room, although this may be seen by clients who are avoidant of emotional experience as pressure to cry. The therapist also has to be mindful of the fact that crying may be considered by some clients as an ‘embarrassing’ thing, showing their inability to cope (especially for some male clients). The therapist may normalise this by responding to crying as to other emotional expressions. Some inexperienced therapists may feel a need to comfort the crying client immediately when the client starts to cry, as it is often considered socially appropriate in such a situation. However, to the client, it may signal that the therapist is disturbed by the client’s crying and wants to stop the client’s discomfort (experience). Therefore, though the therapist may show compassion and empathy, it is important that it is done in a way that validates the client’s experience, does not want to stop the client from crying and wants to help its expression or containment. In this, an important role is played by empathic responding, which captures the client’s experience in words that show the therapist’s experiential understanding of the client’s state.

Working with overwhelming and suppressed emotions in the psychotherapeutic process

There are two main problems in relation to the client’s emotional experiencing in therapy. The client’s emotion may be either overregulated, i.e. the client is restricted, tense and not experiencing or aware of an emotion(s), or underregulated, i.e. overwhelmed and flooded by emotion (see Greenberg, 2002).

With regard to the overregulation of emotions, the main therapeutic strategy is to bring avoidance to awareness by pointing it out or asking the client to enact avoidance so the client is more aware of how he or she avoids the emotion and what experiential impact it has (see Greenberg, Rice, & Elliott, 1993). For instance, when the client reports a flat emotional state but experiences tension, the client may be asked to

create tension purposefully and thus to stop his or her own emotional processing and observe how he or she is doing it and what experiential impact it has on him or her. This may increase awareness of the fact that the client is doing it and it may also help to uncover the function of it, which is generally protection from being emotionally hurt or traumatised. The restriction and avoidance typically obstructs a need, such as to get appropriately angry when violated. The localisation of such a need, together with an increased awareness of the avoidance, may sometimes be sufficient to overcome the overregulation and bring the experience and expression of the emotion to the fore. However, if emotional avoidance is pervasive and is the central problem of the client, this process has to be repeated and the client may need a lot of coaching in accessing the obstructed needs and experiencing and expressing the emotions linked to them.

On the other hand, during the therapeutic process there may occur moments when intense emotions are experienced as overwhelming, unpleasant, leaving the client too vulnerable and unclear. Those moments are frequently characterised by high agitation linked to the problematic experiences that are not yet assimilated and are still painful. The client may feel helpless in regulating such experiences, threatened by their uncontrollability and not fully focused or integrated. The therapist may help the client to regulate such experiences by either suggesting slow breathing or using the 'clearing a space' technique or other relaxation-producing interventions (see Chapter 7 and Box 8.1), but mainly through offering an empathic verbalisation of the client's experience. This may have a holding and containing effect. The therapist's attempts to symbolise the client's experience may bring a meaning to it but also convey the sense that it is possible to understand and label it. The therapist's firm presence is also calming, as it conveys that the therapist is not overwhelmed by intense emotions. The therapist's sensitivity and caring presence may also help to dissipate the client's embarrassment about being exposed to vulnerable and uncontrollable states in front of the therapist. The therapist's empathic attempts to understand the client's experience may also encourage self-empathy in the client (see Watson, Goldman, & Vanaerschot, 1998), which has a regulating function as well. Finally, the therapist's empathic attempts to symbolise the client's experience also help the client to unravel the plethora of information contained in such emotional experiences.

Box 8.1 A version of the 'clearing a space' method of Leijssen (1998).
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An experiential therapist, Mia Leijssen (1998: 131–132), provides a good example of regulating emotional experience through the 'clearing a space' technique. She describes working with a client who is afraid of dying.

- C: *There is a terrible pressure here (indicating her breastbone); I cannot take it any more ... It is such a strong counterforce preventing me from living ... I can hardly go on breathing!*
- T: *Could you try to push this counterforce a bit further away?*
- C: *I wouldn't know how to do it.*
- T: *Could you give me an idea of how you experience it? Apart from preventing you from living, how are you getting along underneath it or what sort of feeling does it give you?*
- C: *It is an enormous, heavy block of concrete on top of me; I don't get any air under there!*
- T: *OK. Now I understand that you cannot push away something like that! We'll leave the heavy block where it is, and you may try to imagine that you yourself step back ... Try to imagine making a step that gets you from under this block. (Client nods while therapist suggests it; such small bodily signs are an indication that we are on the right track.)*
- C: *Yes, that feels good (deep sigh) ... I can breath again (silence) ... and all of a sudden I also see that the block of concrete is my mother, who always prevented me from living!*

When working with emotions it may be important to assess them differentially (Greenberg & Safran, 1989; Greenberg, 2002). As Greenberg recommends, it may be more meaningful to respond to primary emotions as they contain the most valuable information. This may be relevant when overwhelming experiences contain several emotions, some of which are primary and some of which are secondary. For example, if the client's response to being abandoned by a partner is interminable despair, the empathy communicated towards the hurt and the sense of being unjustly hurt may provide more meaning to the client than just the acknowledgement of despair of a trauma caused by the abandonment. Also, it may be important to differentiate between productive and unproductive overwhelming and unresolving emotions (Greenberg, Anszra, & Herrmann, 2007). While productive emotions may need to be attended to, the unproductive emotions may need to be regulated so they can be used in a productive way (for more, see Boxes 8.2 and 8.3).

Box 8.2 Differentiation of emotions (Greenberg, 2009)

Emotions

1 Primary

Adaptive – productive (e.g. fresh and new, in the moment, in response to shifting circumstances, change when circumstances change, feel good even if not happy, bring relief/changes)

(Continued)

(Continued)

Maladaptive – productive (e.g. difficult but bearable and contained; it is possible to work with them further so they can be transformed) or unproductive (e.g. feel bad, stuck in it, familiar old feeling, overwhelming, feel as bad as the last time, deep, distressing, sobbing, can include tantrums or ranting)

2 Secondary

Maladaptive – unproductive (e.g. obscure, reactive, diffuse, emotion in response to an emotion, upset, hopeless, confused, inhibited, low energy, whining, complaining)

3 Instrumental

Maladaptive – unproductive (e.g. emotional expressions aimed at eliciting a certain response from others, such as crocodile tears)

Box 8.3 Features of in-session productive emotional experience (Greenberg, Ansra, & Herrmann, 2007).

Productive emotions are characterised by a specific manner of processing that involves:

- attention to the emotion;
- symbolisation of it;
- congruence between verbal and non-verbal aspects of experiencing emotion;
- acceptance of emotion;
- optimal regulation of emotion;
- experienced agency in emotional experiencing; and
- differentiation of different aspects of emotional experiencing.

Working with hopelessness in the psychotherapeutic process

Depression is one of the most common problems that therapists encounter (I will focus on therapeutic work with depression more in Chapter 9). So are the experiences of hopelessness and helplessness that are so common with this disorder. Experienced hopelessness and helplessness are examples of overwhelming emotions. The difficulty with them is that they are painful and inhibit productive emotional experiencing and expression. Hopelessness and helplessness, as well as other depressive symptoms, manifest themselves in, for instance, the client's slow pace of verbal expression and overall demeanour, sometimes a silent voice, non-specific sadness, despair, proneness to feelings of guilt, irritation (anger) with the self and/or others, loss of perspective, fear of the future, etc.

To provide containment, holding, experiences of support and validation, the therapist needs to adjust his or her own communication to the client's pace and respect the client's 'slowness'. The therapist needs to be patient in helping the client to differentiate aspects of the emotional experiencing. In this, the therapist may need to move beyond secondary hopelessness (Greenberg & Watson, 2006) and into more primary emotions related to specific aspects (narratives) of the client's life situation. There is a great difference between feeling down generally and feeling put down by a specific comment of a boss in front of other colleagues. The therapist may feel spontaneous compassion towards the client's clearer and idiosyncratic experiences of hurt than towards an unspecific universal distress.

As the client's pace is slow, it may be up to the therapist to move actively in the client's world and to differentiate emotional experiences and their meanings. It is important that the therapist also responds to the nuances of difficult and painful emotions (e.g. sadness, powerlessness, despair, anger). The therapist may need to respond to aspects of the client's experience that are unclear to the client (Gendlin, 1984). An important skill is the capability to recognise the client's needs that are not being met and affirm the client's right to have them met and actively pursued.

All the above-mentioned suggestions aim at providing a supportive presence that hopefully enables the client to be able to sustain those difficult emotional experiences. An empathic presence can thus offer not only relational and emotional support, but also help to name aspects of the difficult experience and in this way make them more comprehensible (Watson, Goldman, & Vanaerschot, 1998; Watson, 2002). Especially important is an increase in the awareness of unmet needs that need to be attended to.

Working with suicidal risk in the psychotherapeutic process

Suicidal behaviour in clients is the most worrying situation for every therapist. According to Westefeld et al. (2000), 97% of psychologists in the USA worked at least once with a suicidal client, 29% had at least one client who attempted suicide and 11% had at least one client who committed suicide. This just underlines the significance of the suicidal threat in therapeutic work.

The worst aspect of a suicide attempt lies in the fact that it can lead to the loss of life or serious injuries. This loss is a loss for the client's loved ones too. Furthermore, the suicide or suicidal attempt is a huge trauma for all involved. The trauma includes the regrets of close ones, thoughts about whether it could have been prevented or whether one contributed to it. Following a suicide attempt, the guilt of the survivors for traumatising others and the trauma of one's own despair also need to be taken into account. The therapist is part of this too, as he or she may be haunted by a professional conscience and legal responsibility. All of this must be realised within the context of

knowing that, straight after an unsuccessful suicide attempt, the majority of survivors are happy about the fact that they survived (Chesley & Loring-McNulty, 2003).

Suicidal behaviour is most typically present in difficulties that can be classified as mental health disorders, such as bipolar disorder, certain forms of personality disorders (especially borderline personality disorder), schizophrenia and depression (see Westefeld et al., 2000). The potential suicidal risk may have different qualities ranging from a vague and general talk about the possibility of suicide (suicidal ideation) to a determined expression of an intentional decision to kill oneself (suicide planning). Suicidal ideation typically stems from a range of painful emotions that the client wants to avoid, such as shame, guilt, trauma. These may be unbearable and mixed with helplessness and hopelessness that these emotions are not resolving. Suicidal ideation is often an expression of the wish to avoid them. The actual planning of the suicide often comes after a period of emotional suffering, when the thought of suicide is experienced as a solution. The suicidal attempts, however, can also be sudden, when the option of suicide comes to the fore of awareness out of the unbearable emotional pain felt at that moment. This often happens when judgement is impaired by substances (alcohol) or overwhelming emotions.

The risk of suicidal behaviour needs to be routinely assessed as a part of basic intake information. For example, if, after asking about the client's problems and suffering, there exists any hint that the client may have thoughts of suicide or plans for attempting it, it needs to be explicitly explored. The same applies if the state of the client, who originally did not seem to be at risk, deteriorates. When working with potential suicidal behaviour the therapist first has to assess its risk properly. Both ideation and suicide plans are assessed. Experts in the area suggest asking explicit questions on ideation and suicidal plans. For example, *Have you been feeling so badly lately that you have thought about harming yourself?* (see Westefeld et al., 2000: 453). The therapist assesses not only the current level of ideation and plans, but also asks the client how it is in situations when the client is at his or her lowest. The client's impulsivity also needs to be assessed, as well as the potential triggers of an unbearable emotional state and the environmental conditions that may contribute to suicidal behaviour.

Established psychological tests can be used in this assessment. Many screening measures, such as Beck Depression Inventory (Beck, Steer, & Garbin, 1988) or the Clinical Outcome in Routine Evaluation – Outcome Measure (Evans et al., 2000) contain items measuring suicidal ideation or plans. Specific measures solely devoted to suicide risk assessment exist as well (e.g. Scale for Suicide Ideation – Beck et al., 1979; Suicide Behaviour Questionnaire – Linehan, 1996; Suicide Status Form – Jobes et al., 1997).

A knowledge of risk factors (and of their possible combination) may be helpful for the therapist. Westefeld et al. (2000), in their thorough review of suicide risks, consider the following:

- mental disorder (e.g. depression, schizophrenia, personality disorder, bipolar disorder);
- reduced ability to regulate affect;
- hopelessness, helplessness, perfectionism;
- abuse histories and lack of social support;
- drug and alcohol consumption;
- previous suicide attempts;
- chronic pain or chronic illness;
- age (i.e. adolescents and the elderly);
- gender (men are four and a half times more likely to commit suicide than women; see Centers for Disease Control and Prevention, 2007);
- minority status (ethnic or sexual).

The assessment also includes the client's current stress factors, available environmental support and capability of constructive coping (see Westefeld et al., 2000). As the risk of misjudgement of suicide urgency is considerable (Westefeld et al., 2000), it may be prudent to evaluate the suicidal risk more conservatively. If the risk exists, assessing its acuteness is also important. An immediate, acute threat of suicide may warrant the therapist suggesting hospitalisation and this is something that the therapist can collaboratively explore with the client in the session. An alternative could be mobilising appropriate relatives to monitor the client, although issues of confidentiality would have to be carefully discussed with the client and the breach of confidentiality should be a last resort (always done transparently with the client).

If the client is in crisis, but there is not an immediate threat of him or her attempting suicide, the therapist may suggest increasing the frequency of sessions. This not only provides support for the client, but it also allows the therapist to monitor the client's emotional state and risk behaviour. An intervention that is often considered when an attempt is not immediately imminent is contracting around suicidal behaviour (see Bond, 1993; Westefeld et al., 2000; Bateman & Fonagy, 2004). Contracting is typically performed in writing. It includes not only the commitment of the client not to commit suicide, but also outlines the steps the client can take when in crisis. Such a contract is explicit about its timeframe, commitments and the steps to be followed in the circumstances of a suicidal urge. However, the 'Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviours' of the American Psychiatric Association (2003) point to the limitations of suicidal contracts and caution clinicians not to overestimate them.

A suicide ideation and wish to die is always explored in therapy. It often has a clear meaning (e.g. unbearable emotional pain, unbearable shame). The therapeutic work therefore needs to focus on these underlying vulnerabilities that lead the client to consider suicide as a resolution of suffering. The therapist's understanding of suicidal behaviour in the context of the client's overall difficulties is crucial. The suicidal ideation may be different for an adolescent who has broken up with a girlfriend than for a client with schizophrenia who is haunted by a delusion that he is going to be tortured so he has to kill himself. With regard to interventions used at times of crisis,

a skilful, containing and supportive presence may be essential. Suicidal clients are sensitive to the respect and validating presence of the therapist (Paulson & Worth, 2002). The therapist's firmness is also recommended by some (Fujimura et al., 1985). Outside the therapy session, it is important that the therapist engages the client's social support network (Westefeld et al., 2000; see Chapter 9), if one is available. The client's activity for days of crisis can be planned as well. When appropriate, a referral can be considered as well as other forms of care or treatment (e.g. medication).

Excellent sources on the issues of suicide include Westefeld et al. (2000), Bongar (2002) and 'Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviours' of the American Psychiatric Association (2003).

Working with deliberate self-harm in therapy

Deliberate self-harm – behaviour aiming to harm or destroy body tissue and cause physical injury (e.g. Gratz, 2001) – just like suicidal behaviour, presents serious risks for clients in therapy. It is especially so as it may already be present in clients of adolescent age (Hawton et al., 2002). Deliberate self-harm may be present in the client with affective and personality disorders (Haw et al., 2001). Work with clients who deliberately self-harm, just as in the case of suicide risk, requires careful case management strategies, such as proper assessment and contracting, when it comes to addressing this behaviour during the therapy. Especially in the case of adolescents, issues of confidentiality and its limitation needs to be addressed. The safety of an adolescent is of utmost consideration.

What is especially important is to explore what the deliberate self-harm is an expression of. This behaviour can be linked with suicidal behaviour (see Rodham, Hawton, & Evans, 2004). Often it can be an expression of anger directed towards the self. It can also be an attempt to override emotional distress by an act that brings attention to the physical pain. However, it can also be an interpersonal act of trying to communicate despair and the extent of emotional distress. In other cases, it can be an attempt to impress others (see Rodham, Hawton, & Evans, 2004; Hawton & James, 2005, for the variety of reasons; see also Box 8.4). The reasons need to be examined so that an appropriate therapeutic strategy can be employed. In a case where it is an expression of emotional dysregulation and/or anger towards the self, emotion regulation strategies can be developed (see Linehan, 1993; Menin, 2004). If the self-harm has interpersonal connotations, these can be unfolded and healthier ways of communicating can be worked on. Linehan (1993), in her dialectical behaviour therapy, presents many useful suggestions for learning how to contain the urge to self-harm (e.g. distracting strategies) (see Low et al., 2001; McKay, Wood, & Brantley, 2007). However, with young clients, the work on changing self-harming behaviour may involve more strategic interventions that include their environment, which may be contributing to the reasons for such behaviour. More on self-harm with adolescents can be found in Fox and Hawton (2004).

Box 8.4 Potential reasons for self-harming according to Hawton and James (2005)

- To die
- To escape from unbearable anguish
- To change the behaviour of others
- To escape from a situation
- To show desperation to others
- To change the behaviour of others
- To 'get back at' other people or make them feel guilty
- To gain relief of tension
- To seek help

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Encountering manipulation in the psychotherapeutic process

Occasionally, the therapist may encounter a client who follows specific, undisclosed goals that the client does not reveal to the therapist. For example, the client may be involved in a court battle with an ex-partner (e.g. for custody of their children), engages in counselling and in the middle of counselling requests a written report from the therapist. The therapist is then in a difficult position. The therapist may not like the situation that the client has got him or her into but still has to respond to the client's needs. In such cases, the therapist has to make his or her own judgement about whether preparing the report would be within their competence, whether such a report can be seen as corresponding with the contract the therapist had with the client, and whether it would be ethically sound to provide it. The therapist also has to examine his or her own feelings in such a situation – not only what would be appropriate professionally, but also personally.

Similarly, the therapist may be caught in an ethical dilemma when a client reports how he or she manipulated somebody they describe in their story. The therapist may then focus the work on highlighting and acknowledging the ethical aspect of the client's account of his or her interpersonal behaviour (see Chapter 4). Furthermore, some clients reveal so-called instrumental emotions, that is they intentionally or unintentionally express emotions so that they elicit an expected response from the therapist (e.g. crocodile tears to elicit comfort) (Greenberg & Safran, 1989). As Greenberg, Rice, and Elliott (1993) nicely present it, in such cases it is important for the therapist to acknowledge it and to look for the underlying

primary emotional experiences that need to be responded to (e.g. fear of loneliness if I don't 'moan' enough).

Different intentional or unintentional manipulation may be encountered in the psychotherapy process. It may be more characteristic when working with people with certain types of problem (e.g. personality disorders such as histrionic, narcissistic and borderline). One must therefore remember that the different strategies often employed by clients either towards therapists or towards other people in their stories are led by anxiety, fear, and their own insecurity. It is this vulnerability that the therapist needs to attend to most in such instances. Therapeutic strategies should focus on how to therapeutically address those vulnerabilities and build resilience towards them in the client.

Working with anger directed at the therapist

Clients often express anger during the psychotherapeutic process. Mostly, it is anger aimed at a third person not present in the therapist's office. Occasionally, it can also be anger aimed at the therapist. It can be expressed directly or indirectly. Research shows that the client's expression of anger is very difficult for therapists, especially if it is a direct expression of anger (Hill et al., 2003).

I showed some examples of anger directed towards the therapist and the ways of dealing with it in Chapter 2, which was devoted to solving a conflict in the therapeutic alliance (see the models of Safran & Muran, 2000). The initial step in the therapist's dealing with the client's expression of anger towards the therapist is that the therapist will not start to be defensive. Though the therapist may share the impact the anger has on him or her, it is important that the therapist is also able to stay with the client's anger and explore and unfold the reasons for it. Often it is important to acknowledge the therapist's own share of responsibility for the client's anger, though at times it may be more to do with the client's 'dynamic' (see Hill et al., 2003). If the anger is not directly expressed, it may be important to facilitate the client to express it more directly (Safran & Muran, 1996, 2000). The therapist may also explore what hurt and vulnerable emotional experiences in the client underlie the anger. These need to be responded to and looked after (see Chapter 2). Indeed, in the case of some clients (especially the ones with certain types of personality disorder) this may be a central issue to work on in therapy.

The danger of instances of expressed anger in therapy is that they may signal a threat to the therapeutic alliance and may indicate a risk of a premature termination of therapy. Hill et al. (2003), in their study, showed that in cases where the directly expressed anger was not resolved, it was more typical of situations in which the therapists felt anxious and when the anger stemmed from the client's personality. In cases of indirectly expressed anger, it seems that helping the client to express the anger more directly was crucial for the resolution.

Working with attitudes and beliefs related to the client's problem

Therapists encounter clients with different beliefs and attitudes. Some of them sometimes seem to be not conducive to mental health. Typically, it is not the attitudes or beliefs themselves, but rather their rigid experiencing that can be an expression of a mental health difficulty. Occasionally, clients may come with problems linked to beliefs and attitudes that appear delusional or based on hallucination. In some instances, there exists an 'unspoken' consensus among professionals that something is delusional; in other cases (often religious and spiritual beliefs) there is no consensus. For instance, an elderly female client may be convinced that the devil is threatening her. For a secular therapist, this may be very difficult to follow. A male client may be uncertain whether his parents' belief in UFOs is a sign of their problem or not, as he himself is not sure whether there are indeed aliens among us or not. Clients' attitudes and beliefs as well as their worldview may differ from those of the therapist in many instances. When those beliefs or attitudes are central to the therapeutic work, it may be necessary to work with them. The therapist has to respect the client's autonomy and free will, while at the same time the therapist may consider some beliefs or attitudes as harmful to the client. Finding the balance when approaching a client with a hopefully informed view that a certain belief or attitude may contribute to the client's problem is very difficult to do.

There are good models in the area of multicultural counselling that can be used when working with the 'personal culture' of a specific client. It is important that the therapist understands the client's attitudes and beliefs and explores with the client how they are connected to the experienced difficulties that brought the client to therapy. The therapist may also use the client's beliefs and support the healthy elements of those beliefs. For example, an OCD client of Catholic denomination who feels sinful five minutes after confession may be helped to distinguish between a healthy attitude towards living an honourable life and an expression of anxiety in the self-condemning attitude 'I am sinful as I had a bad thought, a thought of anger towards somebody'. Therapeutic work typically focuses on the experience of beliefs and attitudes and whether they lead to unhealthy psychological and physical distress, rather than the content of such a belief. The therapist therefore needs to be knowledgeable about different 'cultures' or at least be prepared to learn about them. The therapist also needs to monitor his or her own respect of others and any countertransference reactions that can prevent the therapist from working with the client in the therapeutic framework. If the therapist allows him or herself to get to the client's world from the inside, the therapist can then adjust his or her own approach to the client's worldview. In Box 8.5 I describe a tentative model of working with spiritual and religious issues in therapy that may serve as an example of the principles of working with clients' beliefs and attitudes when they are intertwined with their psychological problems.

Box 8.5 A tentative model of working with spiritual and religious issues in therapy (Davis & Timulak, 2008)

Core assumptions:

- Spirituality can be a resource in dealing with psychological distress.
- Spiritual difficulties can contribute to psychological distress.
- Some clients want spiritually sensitive help as their spirituality may not be separate from their psychological well-being.

The religion- and spirituality-sensitive therapist will have an awareness of the following in his or her practice of therapy:

- The effects of religion and spirituality on mental health and its relevance for psychotherapy.
- Personal spirituality and religiosity and any biases they may have.
- The limitations to their expertise.
- Training and supervision needs which include an understanding of the major religions, the difference between religion and spirituality, and the role these may play in an individual's life.

The client in religion- and spirituality-sensitive therapy will be aware that:

- Their spiritual/religious beliefs and practices may be a source of support which helps them to cope with mental health issues.
- Their spiritual/religious beliefs and practices may be relevant to their psychological distress.

The therapeutic relationship:

- The therapist is congruent, gives unconditional positive regard for the meaning of the client's beliefs (working within an *ecumenical* framework of spirituality) and is empathic.
- The dangers are transference/countertransference.

Assessment:

- During the assessment process, alongside other background information, a question regarding the role of religious/spiritual beliefs and practices in the client's life can be included to establish whether or not the client perceives this to be relevant to the therapeutic process.
- If this is done in an open and accepting manner, then the client will know that the therapist is willing to explore these issues alongside any other issues that the client wishes to bring to therapy.

Interventions:

- Interventions which accommodate the client's beliefs are most helpful when they are requested by the client and agreed on by the client and therapist mutually. It is essential that the client's autonomy is respected during any intervention. The therapist will endeavour to understand the way these beliefs impact/work out in the client's life and tailor the intervention accordingly.
- Examples of these interventions will be guided meditations within the client's religious/spiritual framework. Also some mainstream therapies have manualised versions for highly spiritual or religious clients.
- Religion- and spirituality-sensitive psychotherapy can also accommodate an exploration of aspects of the client's beliefs which they consider to be either helpful or unhelpful to their psychological well-being.

Referral:

- The therapist needs to be mindful of his or her own limitations in terms of expertise and personal bias. When assessing what the client needs, it may be appropriate, in collaboration with the client, to refer him or her either for additional support from a spiritual/religious advisor or to a more explicit religious/spiritual psychotherapist.

There are a vast number of situations that the therapist may encounter in the therapeutic process. I have selected just a few to bring a flavour of the complexity of the therapeutic process and the expectations put on the therapist. The situations and the therapist's response to them may be quite similar among therapists, irrespective of the therapist's overall strategy or therapeutic orientation. In the next chapter we will deal with more strategic issues when encountering typical problems and disorders for which counselling and psychotherapy are used.

Recommended reading

There is no single textbook that deals with the different situations in the therapeutic process, but I could recommend some of Yalom's books as they nicely describe the immediacy of the psychotherapeutic process. For example:

Yalom, I.D. (2002). *Gift of Therapy*. New York: Harper Collins.