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HOW TO DEAL WITH YOUR MOST DIFFICULT CLIENT—YOU

Albert Ellis

Although the literature on difficult and resistant clients is extensive (Freud, 1912a/1958; Wachtel, 1982; Weiner, 1982), much less attention has been given to the difficult and resistant therapist. Psychoanalytic writers, to be sure, have emphasized the dangers of countertransference (Coltrera and Ross, 1967; Freud, 1912b/1958; Greenson, 1967; Wolstein, 1959), but they have often ignored other problems of the therapist. The present paper will attempt to address some of these problems and make a few hopefully educated guesses about how therapist difficulties arise and what may be done to alleviate them.

Before we can consider what are some of the main blocks to the therapist's effective functioning, it would be nice to have a picture of what a fully functioning therapist is. Unfortunately, we have as yet no real agreement on this point. Freudians, who tend to be relatively passive and emphasize looking for unconscious determinants of clients' disturbances, stress therapists' listening with their third ear (Fenichel, 1953; Freud, 1904/1958; Reik, 1948). Rogerians emphasize the therapist's genuineness, accurate empathy and unconditional positive regard (Rogers, 1957) and nonpossessive warmth (Truax and Carkhuff, 1967; Truax and Mitchell, 1971). Behavior therapists and cognitive behavior therapists recommend that effective therapy also include several kinds of teaching and persuasive skills (Ellis, 1979a, Meichenbaum, 1977; Wessler and Ellis, 1980).

I still take the stand I took a quarter of a century ago when I objected to Rogers (1957) seminal paper, "The Necessary and Sufficient

Albert Ellis, Ph.D., is executive director of the Institute for Rational-Emotive Therapy, 45 East 65th Street, New York, NY 10021.

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Conditions of Therapeutic Personality Change," and pointed out "that although basic constructive personality change—as opposed to symptom removal—seems to require fundamental modifications in the ideologies and value systems of the disturbed individual, there is probably *no* single condition which is absolutely necessary for the inducement of such changed attitudes and behavior patterns" (Ellis, 1959, 1962, p. 119).

With some amount of temerity, however, let me hazard the guess that when the facts have been more diligently researched, we will find that the most effective therapists tend to practice somewhat as follows:

1. They are vitally interested in helping their clients and energetically work to fulfill this interest.
2. They unconditionally accept their clients as people, while opposing and trying to ameliorate some of their self-defeating ideas, feelings, and behaviors.
3. They are confident of their own therapeutic ability and, without being rigid or grandiose, strongly believe that their main techniques will work.
4. They have a wide knowledge of therapeutic theories and practices and are flexible, undogmatic, and scientific and consequently open to the acquiring of new skills and to experimenting with these skills.
5. They are effective at communicating and at teaching their clients new ways of thinking, emoting, and behaving.
6. They are able to cope with and ameliorate their own disturbances and consequently are not inordinately anxious, depressed, hostile, self-downing, self-pitying, or undisciplined.
7. They are patient, persistent, and hard working in their therapeutic endeavors.
8. They are ethical and responsible, and use therapy almost entirely for the benefit of clients and not for personal indulgence.
9. They act professionally and appropriately in a therapeutic setting but are still able to maintain some degree of humanness, spontaneity, and personal enjoyment in what they are doing.
10. They are encouraging and optimistic and show clients that, however difficult it may be, they can appreciably change. At times, they forcefully urge and push clients to change.
11. They not only try to help clients feel better and surrender their presenting symptoms but also try to help them make profound attitudinal changes that will enable them to maintain their improvement, continue to improve, and ward off future disturbances.

12. They are eager to help virtually all their clients; freely refer to other therapists those they think they cannot help or are not interested in helping; and try to be neither underinvolved or overinvolved with those clients they retain. They sincerely try to overcome their strong biases for or against their clients that may interfere with their therapeutic effectiveness. They monitor their prejudices (countertransference feelings) that lead to strongly favoring or disfavoring some of their clients and, if advisable, refer such clients to other therapists.
13. They possess sufficient observational ability, sensitivity to others, good intelligence, and sound judgment to discourage their clients from making rash and foolish decisions and from seriously harming themselves.

Assuming that effective therapists tend to behave as just described, which of you practitioners reading this consistently follow this ideal pathway? Very few, I would guess! I fully admit that in the forty years I have been practicing psychotherapy I have by no means thoroughly lived up to this ideal. Nor do I know any, of the scores of therapists I have supervised, who have done so. On the other hand, I have met and supervised many who have fallen far below this ideal.

Although therapeutic infallibility is hardly a realistic goal, we may still ask: How do therapists block their own effectiveness and what can they do to overcome their resistances to seeing and eradicating their blocks? If you are a psychotherapist and are ignoring some of the best rules of the game—including several you personally endorse and would prefer to follow—how can you understand your own blocks to good practice, and how can you unblock yourself? How can you decrease, if not quite annihilate, some of your therapeutic fallibility?

Ever since I threw off the shackles of psychoanalytic theory some thirty years ago and started to develop a new theory that soon blossomed into rational-emotive therapy (RET), I have stubbornly insisted that human disturbance is contributed to by environmental pressures, including our childhood upbringing, but that its most important and vital source originates in our innate tendency to indulge in crooked thinking. People not only learn or take over unrealistic expectations, absolutistic ideas, illogical conclusions, and irrational beliefs from their parents and their culture, but they also have a positive genius for inventing and exacerbating these self-defeating cognitions themselves. They don't *have* to think exaggeratedly, perfectionistically, dogmatically, and unscientifically, but they sooner or later do; and they thereby make themselves—yes, creatively make themselves—emotionally dis-

turbed and behaviorally dysfunctional. Their parents, teachers, and peers appreciably help them in this respect. But, being talented screwballs in their own right, they scarcely need such help and can easily louse themselves up without it (Ellis, 1957/1983, 1962, 1971, 1973, 1976).

Being, in spite of their aspirations to godliness, still human, psychotherapists often indulge in the same kind of irrational absolutistic beliefs that other people hold. After giving this matter some thought, reviewing my experiences with therapists I have supervised, and considering the therapeutic irrationalities that other writers have observed (Grieger and Boyd, 1980; Maultsby, 1975; Novaco, 1980; Tosi and Eshbaugh, 1978; Walen, DiGiuseppe, and Wessler, 1980; Weinrach, 1973; Wessler and Wessler, 1980), I have come up with several irrational beliefs that I hypothesize often lead to therapeutic inefficiency:

1. "*I have to be successful with all of my clients practically all of the time*." Although, as RET hypothesizes, strong wishes, desires, and preferences will rarely get you into serious emotional trouble, absolutistic necessities and demands frequently will. If you under all conditions *must* succeed with your clients, you will tend to be horrified and depressed when you don't—and be still anxious when you do. For how can you be sure that you will succeed again next time? You can't!

   Your dire need to help virtually all your clients all of the time leads to several equally pernicious corollaries: (a) "I must continually make brilliant and profound interpretations"; (b) "I must always have good judgment"; (c) "I must help my clients *more* than I am now helping them"; (d) "If I fail with any of my clients, it has to be my fault"; (e) "When I fail, as I must not, I'm a thoroughly lousy therapist—and a rotten person!"; (f) "My successes don't count if I have a *real* failure!"

   When you place golden ideals like these on your therapeutic back, how can you fail to feel inadequate, to have them interfere with your work, and to make yourself a prime candidate for early burnout? Not very easily!
2. "*I must be an outstanding therapist, clearly better than other therapists I know or hear about*." This is another preferential goal that, when you escalate it to necessity, tends to incapacitate you. Some corollaries of this absolutistic demand include: (a) "I must succeed even with impossible clients"; (b) "I must have *all* good sessions with clients"; (c) "I must use the greatest and most prestigious system of therapy and be outstanding at using it"; (d) "I must be famous as a therapist"; (e) "Because I am a therapist, I should have no emotional problems myself and am disgraced if I do."

Like the first irrational belief mentioned, this second one leads to frantic endeavor and to the inefficiencies that accompany such franticness. Panic also results when it appears that this unrealistic goal may not be achieved—or may not be constantly reachieved.

3. "*I have to be greatly respected and loved by all my clients*." If and when you have this dire need—instead of preference—you again frequently have several perfectionistic corollaries: (a) "I must not dislike any of my clients and especially must not show that I dislike them"; (b) "I must not push my clients too hard, lest they then hate me"; (c) "I must avoid ticklish issues that might upset and antagonize my clients"; (d) "The clients whom I like and who like me must remain in therapy practically forever"; (e) "My clients must see that I am thoroughly devoted to them and that I never make any mistakes"; (f) "It's horrible to be disapproved of by any of my clients because their disapproval makes me a bad therapist and a rotten person."
4. "*Since I am doing my best and working so hard as a therapist, my clients should be equally hard working and responsible, should listen to me carefully, and should always push themselves to change*." This irrational belief displays your low frustration tolerance and anger—and leads you to damn your clients for being disturbed. It frequently has several unrealistic corollaries, such as: (a) "My clients should not be difficult and resistant!"; (b) "They should do exactly what I tell them to do!"; (c) "They should work very hard in between sessions and always do their therapeutic homework!"; (d) "I should only have young, bright, attractive, and not too difficult clients!"
5. "*Because I am a person in my own right, I must be able to enjoy myself during therapy sessions and to use these sessions to solve my personal problems as much as to help clients with their difficulties*." This irrational idea partly contradicts the nature of paid psychotherapy, which indeed may be of help to therapists but ethically puts the interests of clients first. The philosophy of self-indulgence that underlies this belief often leads to several corollaries that also sabotage therapy: (a) "I must mainly use therapeutic techniques I enjoy using, whether or not they are very helpful to clients"; (b) "I must only use techniques that are easy and do not wear me out"; (c) "I must make considerable money doing therapy and must not have to work too hard to make it"; (d) "If I exploit some of my clients amatively and sexually that will do both them and me a lot of good"; (e) "Because I am so helpful as a therapist, I should be able to get away with coming late to appointments, canceling them at the last minute, sleeping during sessions, and indulging myself in other ways."

Now I am not contending that all you therapists reading this frequently and strongly hold many of the above irrational beliefs. Some of

you—lucky souls—may hold none of them or may maintain the few that you do hold very lightly. What I am hypothesizing is that when you resolve to work at doing effective therapy but then sabotage your own efforts and wind up with strong feelings of anxiety, depression, hostility, guilt, or self-pity about your therapeutic endeavors, you then tend to subscribe to some of these irrationalities. And I am suggesting that you may be resistant to finding and surrendering them. Why? Because, first, you may be reluctant to admit that you, a psychotherapist, really have deep-seated emotional difficulties. Second, you may be so preoccupied with helping others that you rarely think about helping yourself. Third, you may wrongly assume that your authoritative knowledge of disturbance and your self-explorations during your training protect you from being disturbed about the therapeutic process. Fourth, you may have the same kind of low frustration tolerance—commonly known as laziness—that prevents so many of your own clients from working to change themselves. Fifth, you may be so involved with yourself that you myopically fail to see shortcomings and emotional difficulties that a more objective observer would see.

For reasons such as these, you may well be your most difficult client. If so, don't despair, bolster your defenses, and run away from facing and dealing with the situation you are in. As a therapist, you often meet clients' resistance and do your best to overcome it. Why not similarly tackle your own?

I have been outlining, in a recent series of articles in the *British Journal of Cognitive Psychotherapy*, the RET theory and practice of resistance in regular and difficult clients (Ellis, 1983a, 1983b, 1984). Let me, to conclude this paper, apply some of these practices to resistant therapists. If you have been consciously or unconsciously subscribing to some of the irrational beliefs listed above; if you have consequently felt disturbed about yourself as a therapist: and if your effectiveness has consequently suffered, here are some of the cognitive, emotive, and behavioral techniques you can use to deal with your most difficult client—you:

1. Assume that some strong irrational beliefs lie closely behind your therapeutic upsets and that these include one or more absolutistic shoulds, oughts, or musts, such as those listed previously.
2. Search diligently for those that specifically apply to you and your therapy. Don't give up until you find a few.
3. Consider these irrational beliefs as hypotheses, not facts, that you

can dispute and surrender. Use the same scientific methods to challenge them as you would employ to question any other dubious hypothesis. For example: "Where is the evidence that I *have* to be successful with all of my clients practically all the time?" "Who says that I *must* be better than other therapists?" "Where is it written that *it is necessary* for me to be respected and loved by all my clients?"

4. Carefully think about these hypotheses until you come up with disconfirming evidence and therefore are really willing to give them up.
5. Create alternate rational, preferential statements to substitute for these unrealistic, unconfirmable hypotheses. For example: "I clearly don't *have to be* successful with all of my clients, though that would be lovely! Because I would *like to* help most of them, let me work at that goal."
6. Convince yourself that you can unconditionally accept yourself as a person—that is, see yourself as deserving to continue to live and enjoy yourself—*whether or not* you succeed as a therapist and *whether or not* your clients (or other significant people) approve of you. Acknowledge some of your deeds and traits (such as your acting irresponsibly in therapy) as ineffective and deplorable but refuse to lambaste your *self* or your *being* for this failing.
7. Refuse to awfulize about anything. See that it's most inconvenient and annoying when your clients refuse to do their agreed-upon homework. But it's not awful, horrible, or terrible. *Just* annoying! (Ellis, 1979b, 1980).
8. Instead of mainly looking at the ease of staying the way you are and the discomfort of changing, make a comprehensive list of the pains of maintaining your disturbance and the advantages of giving them up. Review and think about this list every day until you are much more motivated to change.
9. Give yourself the strong challenge and excitement of doing one of the most difficult and most rewarding things you can do in life—pigheadedly refusing to make yourself needlessly miserable about anything.
10. Actively talk your clients (and friends and relatives!) out of their irrationalities and thereby encourage yourself to talk yourself out of your own.
11. Reduce some of your self-defeating ideas to absurdity and see the humor in some of the profound stupidities that you rigidly hold. Tell yourself, for example, "I really *should* do only what I enjoy doing during my therapy sessions. What do you think those blasted clients are paying me for, anyway—to get better?" Sing to yourself one of the rational humorous songs made famous by RET (Ellis, 1977)—such as:

"Whine, Whine, Whine!"
(Sung to the tune of the Yale "Whiffenpoof Song,"
tune by Guy Scull—a Harvard man!)

I cannot have all of my wishes filled—
Whine, whine, whine!
I cannot have every frustration tilled—
Whine, whine, whine!
Life really owes me the things that I miss,
Fate has to grant me eternal bliss!
And since I must settle for less than this—
Whine, whine, whine!

12. Show yourself that so-called intellectual insight into your difficulties is not enough and that what is often called emotional insight consists of at least three major kinds of knowledge: (a) the realization that you, rather than external events, largely create your own disturbance; (b) the understanding that no matter how and when you originally started to think irrationally, you still stubbornly persist in thinking that way today; (c) the insight that only considerable work and practice—yes, *work and practice*—to challenge and dispute your irrational beliefs and only persistent *action* against the dysfunctional behaviors that accompany these beliefs will suffice to make and keep you undisturbed.
13. You can use rational-emotive imagery created by Maultsby (1975) and adopted by me (Maultsby and Ellis, 1974) to change your intensely disturbed feelings. Thus, you can vividly imagine yourself miserably failing as a therapist, let yourself feel very anxious or depressed as you imagine this, implode this feeling, then (while still imagining this gruesome scene) make yourself feel only disappointed and regretful (and *not* depressed), and finally practice this new appropriate feeling every day for at least thirty days until you automatically begin to feel regretful and disappointed instead of anxious or depressed whenever you think about failing.
14. You can publicly perform one or more of the RET shame-attacking exercises (Ellis, 1969, 1972). The purpose of these exercises is to do some act that you normally consider foolish and shameful—for example, singing at the top of your voice while walking down the street—and make yourself feel *un*ashamed while performing it. You thereby show yourself that you never *have to* denigrate yourself even when other people clearly disapprove of you; and you help convince yourself that you *prefer* but do not *need* your clients' (and other people's) approval.
15. Whenever you can do so, unequivocally, strongly, and persistently *act* against your irrational beliefs. If, for example, you abhor diffi-

> cult clients and think that you *can't stand* them, deliberately take some on and show yourself that you *can* tolerate what you don't like and that you *can* accept (and learn from) clients who behave obnoxiously. If you find yourself using only the techniques you find easy and enjoyable, force yourself to try some of the more difficult ones and keep trying them until they become familiar—and probably rewarding.

As you can see from the foregoing suggestions, dealing with yourself and your problems as a therapist may involve some of the same techniques you would often employ with your own difficult clients. The difference is that they have you to monitor them in following these techniques while who do you have to monitor yourself? Answer: You, of course! You can, if you deem it desirable, go back into therapy yourself and thereby acquire a paid monitor. But unless you are an unusually D.C. (difficult customer), it would be better if you go it alone. Why? Frankly, to make things a bit more troublesome for yourself. For if you try to change yourself at first, without guidance and support from another therapist, you may be able to appreciate better the struggles of your own clients when they strive to effectuate self-change; and you may thereby come to accept them with their struggles and their setbacks. In any event, if you find that you do not satisfactorily change on your own, you can always later work with another therapist. And had better!

CONCLUSION

Therapists are human—and, believe it or not, fallible humans. Ideally, they are supremely well informed, highly confident, minimally disturbed, extremely ethical, and rarely under- or overinvolved with their clients. Actually, they are hardly ideal. If you, as a therapist, find yourself seriously blocked in your work, look for the same kind of irrational beliefs, inappropriate feelings, and dysfunctional behaviors that you would investigate in your underachieving clients. When you ferret out the absolutistic philosophies and perfectionist demands that seem to underlie your difficulties, ask yourself—yes, *strongly* ask yourself—these trenchant questions: (a) Why do I *have to be* an indubitably great and unconditionally loved therapist?; (b) Where is it written that my clients *must* follow my teachings and absolutely *should* do what I advise?; (c) Where is the evidence that therapy *must* be easy and that I *have to* enjoy every minute of it?

If you persist in asking important questions like these and insist on thinking them through to what are scientific and logical answers, you may still never become the most accomplished and sanest therapist in the world. But I wager that you will tend to be happier and more effective than many other therapists I could—but charitably will not—name. Try it and see!

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