Contents

Preface vii
Acknowledgement ix

1 What is rational emotive behaviour therapy (REBT)? 1

PART I
Client resistance 13

2 Dealing with client resistance in the bonds domain of the working alliance 15

3 Dealing with client resistance in the views domain of the working alliance 30

4 Dealing with client resistance in the goals domain of the working alliance 50

5 Dealing with client resistance in the tasks domain of the working alliance 68

6 A process-orientated view of client resistance 86

PART II
Therapist resistance 105

7 Dealing with therapist resistance in the bonds domain of the working alliance 107

8 Dealing with therapist resistance in the views domain of the working alliance 125
9  Dealing with therapist resistance in the goals domain of the working alliance 146

10  Dealing with therapist resistance in the tasks domain of the working alliance 170

11  A compendium of therapist problems 187

12  A process-orientated view of therapist resistance 203

References 221
Index 224
Developing and maintaining a therapeutic relationship is one of the biggest challenges in psychotherapy. Bordin (1979) argued that the bond between therapist and client (which is what most people in the field mean by the therapeutic relationship) is one of three domains of the working alliance discussed briefly in the Preface (see p. vii). ¹

This chapter focuses on tackling those obstacles and difficulties primarily created by the client which block or impair the creation of a successful relationship.

When clients resist forming a therapeutic bond

An appropriately bonded therapeutic relationship will encourage each client to carry out his or her goal-directed tasks. Therefore, it is important for REBT therapists to pay attention to their clients’ anticipations and preferences in this domain, e.g. one client desires a formal relationship based on the therapist’s expertise and authority within her field, while another client seeks an informal ‘chat’ and a more relaxed approach to therapy.

However, some clients’ preferred bonds will actually reinforce rather than help them to overcome their emotional problems. For example, a female client who one of us (MN) saw said that she could not stand much stress or pressure in her life, so ‘could you be very gentle with me’. I did not speak for ten minutes and she enquired if I was going to ask her questions. I replied: ‘I don’t want to put you under any pressure’. She laughed, but the serious point was that if I wrapped her in cotton wool, she stood little chance of tackling her anxiety and social avoidance. This explanation of my clinical rationale for not ‘tiptoeing’ through therapy with her opened the way for her to develop greater resilience towards life’s vicissitudes.

Clients who exhibit dire needs for love and approval (e.g. ‘I must be approved and if I’m not I am worthless’) often expect the therapist to meet

¹ One of us (WD) later added a fourth domain known as ‘views (Dryden 2006, 2011).
these needs. While REBT therapists offer clients unconditional acceptance as fallible human beings, they are cautious about giving clients excessive warmth for two major reasons (Dryden and Ellis 1997). First, clients may feel better in the short term if they think that their therapist greatly approves of them, but will not necessarily get better in the long term because their disturbance-creating beliefs remain largely unexamined and therefore intact. It is far better to teach such clients unconditional self-acceptance irrespective of what the therapist thinks about them, for example:

‘When you’re no longer anxious about whether or not I like you, it will probably be the time to end therapy. Then you’ll be much stronger to deal constructively with the inevitable rejection or disapproval that occurs in life.’

Second, therapists may strengthen their clients’ discomfort intolerance beliefs, (e.g. ‘I can’t face my problems on my own. It’s too hard. I need lots of support from my therapist’). Thus, such clients avoid taking the primary responsibility for bringing about change in their lives and believe that they cannot be happy without the continual support of others. The therapist can repeatedly counter with the self-defeating nature of this outlook, for example:

‘If I have to hold your hand throughout therapy, how will you learn to walk on your own? When I let go of your hand when therapy is finished, what happens to you if there is no one else to grasp it?’

Therefore REBT seeks ‘to help them [clients] become independent, to think for themselves and acquire self-helping habits rather than to remain needy of therapeutic succouring’ (Albert Ellis, quoted in Dryden 1991: 52). However, as REBT is opposed to dogmatism, therapists may decide to display undue warmth for limited periods if it is deemed to be clinically justified (e.g. with suicidal clients or with those recently bereaved).

In order to determine the type of bond which is clinically effective at any given time in therapy, Kwee and Lazarus (1986) advocate therapists adopting the stance of an authentic chameleon, that is ‘the therapist mak[ing] use of the most helpful facets of his or her personality in order to establish rapport with a particular client’ (Kwee and Lazarus 1986: 333). The role of an authentic chameleon should not lead to a lack of genuineness on the therapist’s part (trying to be all things to the client but without any obvious sincerity or conviction). Properly applied, the therapist as authentic chameleon is a flexible device which allows the therapist to adapt herself to and blend in with the requirements of the bond domain whenever necessary.
Therapists can develop this role by, among other things, giving clients a Life History Inventory to complete (Lazarus and Lazarus 1991). Parts of this questionnaire ask clients to specify how therapists should ideally interact with their clients and what personal qualities they should possess. If clients have had previous therapy, they can be asked what they found helpful and unhelpful about it with particular emphasis on the kind of bond that facilitated therapeutic progress, e.g. ‘He was firm with me. If he had been soft with me I would have run rings round him’. In a similar vein, clients can be encouraged to examine those individuals in their lives who have or had positive or adverse effects on their personal development. Such an examination ‘may provide the therapist with important clues concerning which types of therapeutic bonds to promote actively with certain clients and which bonds to avoid developing with others’ (Golden and Dryden 1986: 370). All the aforementioned methods can help therapists to forge a productive and enduring bond with clients.

**When clients’ interpersonal style promotes resistance in REBT**

Other difficulties in the bond domain relate to clients’ interpersonal styles. Such styles of interaction may include passivity, over-excitability, overly intellectual or dominant. Therapists who reinforce these interpersonal styles run the risk of failing to construct a working alliance which promotes client learning. For example, *passive* clients need to be encouraged to participate so that gradually their ‘brains take more of the strain’ of therapy (Dryden and Neenan 2006), e.g. ‘You might be expecting me to do most of the work in therapy but, in fact, we can’t make much progress unless you also lend a helping hand’. REBT therapists may need to ‘tone down’ their active-directive approach in order to draw increased activity from passive clients. Therapists who actually increase their active style in order to provoke or arouse clients into action may have the opposite effect of encouraging greater passivity on their part.

*Over-exitable* clients are not usually able to examine productively their problems if the therapeutic relationship or milieu is emotionally charged, e.g. through the use of cathartic or abreactive techniques. With these clients, therapists should employ more cognitive techniques such as looking at the short- and long-term consequences of their irrational ideas in the hope of encouraging a more contemplative approach to life. A ‘quieter’ interpersonal style can be adopted by therapists in order to reduce the level of emotional arousal in the sessions.

Clients who present with an *overly intellectual* style of interaction may provide seemingly plausible and ‘rational’ explanations of their problems and thereby avoid or bypass talking about their emotional reactions to
these problems, e.g. ‘My wife’s infidelity was the natural consequence of our deteriorating relationship. Therefore it is totally absurd to suggest I was upset over this when it was bound to occur’. With such clients, Dryden and Yankura (1993: 239) suggest that ‘counsellors should preferably endeavour to inject a productive level of affect into the therapeutic session and employ emotive techniques, self-disclosure and a good deal of humour’ in order for clients to release their feelings.

Clients who like to dominate in or take charge of relationships need to be treated with caution by REBT therapists. Because of the vigorous, persuasive and active-directive approach of REBT, such clients may believe that their authority and sense of control is being threatened or undermined and therefore ‘fight back’ to re-establish their control. This can lead to a power struggle between the therapist and client resulting in an impasse in therapy. Therapists should be mindful to employ strategies that preserve such clients’ sense of control and authority and thereby emphasise that they are in charge of their thoughts and beliefs and whether to change them, e.g. ‘If you decide to change your belief of never showing any weakness, what idea would you choose to put in its place that you consider would be more helpful?’

The choice of which interpersonal style to employ should be based on clients’ accounts of which factors produce the best learning environment for them. Dryden and Yankura (1993: 239) ‘try to develop a learning profile for each of our clients and use this information to help us plan our therapeutic strategies and choose techniques designed to implement these strategies’.

Problems in client–therapist matching

This refers to bringing together a corresponding or suitably associated pair of individuals to create a working bond. Poor matching in REBT (e.g. the client thinks the therapist is too old, the wrong sex or too confrontational) can lead to obstacles in the client’s progress as she becomes more pre-occupied with what she dislikes about the therapist rather than focusing on her problems. The therapist should ask the client what particular quality or characteristic of his blocks therapeutic progress. The client might reply: ‘You’re a man. How can you possibly know what it is to be raped? Therefore you can’t help me’. The therapist can state (if he has worked with survivors of rape):

‘It’s perfectly true I’ve never been raped. I’ve counselled individuals, both male and female, who have been. What I do with these individuals is to help them tackle their ideas, among others, of worthlessness or self-blame and their feelings such as shame and guilt. Do you want to commit yourself to a few sessions and see if I can help you?’
If the client agrees but the poor matching continues, the therapist should respect the client’s preferences and refer her to a female counsellor. Another tack that the therapist can use is to compensate for his client-perceived ‘flaws’ and adopt some of the client’s recommendations (e.g. ‘My therapist should relax more and let things unwind at a gentler pace’) in order to form a good therapeutic relationship. Alternatively, the therapist may wish to maintain his hard-working stance (e.g. ‘This really is the best and quickest way to overcome your problems’) and through such sincerity the client may naturally overcome her dislike of or aversion to certain of his qualities as a therapist.

When clients believe that therapists can’t help them unless they know what it’s like to have their problem

Matching problems can occur when clients think that their therapist should have had the same problem and recovered from the problem with which they are struggling. This frequently occurs with substance misusers. One of us (MN) is frequently asked if I have had a drink or drugs problem. When I reply that I have not, clients usually respond: ‘If you haven’t been there yourself, then you won’t know what it’s all about. You haven’t got a clue what heroin withdrawals feel like.’ I point out that medication can be used to moderate the severity of the withdrawals, but therapy is not about endlessly discussing the drugs they have used and swapping lurid anecdotes with the former addict-turned-counsellor. Therapy is focused on looking at the emotional and behavioural problems clients are attempting to keep under control through drug use. As one of us (MN) is trained to deal with such problems, this will also produce a significant decrease in or eventual elimination of my clients’ drug use. I have found that this kind of rationale has persuaded the vast majority of my clients to stay in therapy with a non-addict. For those few not convinced, I have given them the phone numbers of local self-help groups such as Narcotics Anonymous or Alcoholics Anonymous. Therapists who deal with clients who devoutly believe in the ‘I’ve been there’ school of psychotherapy require convincing arguments to maintain credibility in their clients’ eyes, e.g. ‘Do you expect your doctor to have experienced your problems before they can help you?’

When the therapeutic relationship becomes too cosy

Different kinds of problems may emerge if the client and counsellor have an enjoyable relationship and avoid the hard work and discomfort usually associated with therapeutic change. If the client does eventually tackle their problems, this may well lead to a deterioration in the ‘feel good’ atmosphere of the relationship and therefore there is a tacit agreement to prevent this happening. Dryden and Yankura (1993: 238) suggest that this ‘problem
can be largely overcome if counsellors first help themselves and then their clients to overcome the philosophy of low frustration tolerance implicit in this collusive short-range hedonism’.

**When clients have doubts about the therapist’s credibility and/or trustworthiness**

Resistance in REBT can occur if the client has doubts about the therapist’s credibility as a helper or about the therapist’s trustworthiness.

**Doubts about the therapist’s credibility**

The main goal of REBT therapists is to help clients to surrender their irrational philosophies of living and replace them with rational ones. Such an ambitious aim may engender doubts in some clients as to whether the therapist has the clinical competence or expertness to help them achieve such a goal, particularly if the problems are of a long-standing nature. For example, a client might say: ‘Have you dealt with these kind of problems before? Have you helped others to get rid of these problems? I’m not sure anyone can help me’. In order to convey credibility, therapists can present clinical examples of past successes, training qualifications, accreditation to a professional body, articles and/or books written and so on.

Grieger and Boyd (1980) suggest that once therapy gets under way the therapist’s behaviour can quickly confirm or contradict the impression of expertness that she has been trying to create. Confirmation is much more likely

by getting right to work [in the first session], the client is sensitively yet firmly led into a productive diagnostic exploration of the problem(s) . . . there is no fumbling around, prolonged and unnecessary chit-chat, or sparring back-and-forth in terms of the relationship.

(Grieger and Boyd 1980: 54)

Through the therapist’s manner and actions he or she is implying to the client: ‘I know how to help you overcome your problems, so let’s get going’. If some clients are still sceptical about the therapist’s ability to help them, the therapist can suggest some trial psychotherapy sessions as a means of establishing her credentials.

**Doubts about the therapist’s trustworthiness**

Trust in the therapist enables clients to disclose often intimate problems secure in the knowledge that they will not be humiliated or ridiculed, their
problems trivialised or the therapist will make any personal gains from their disclosures. However, not all clients will automatically trust their therapist and therefore therapists need to create a milieu in which it can develop. Clients can be congratulated whenever they make a disclosure and assured that it is safe to do so (the information is not going to leak out of the psychotherapy room). Therapists can make use of their own clinically relevant self-disclosure as an example of ‘how to open up’ or offer encouragement to the client to make initial or further disclosures. If the client is slow to respond to these techniques, it is important that therapists do not display an attitude of discomfort intolerance (e.g. ‘For Christ’s sake, when are we going to get started!’) or put the client under pressure through their unvarying active-directive style. Walen et al. (1992: 44) point out that it is important to ‘take some time to get to know the client and get a feel for his or her thinking. The patient is more likely to discuss personal problems if he or she believes that the therapist is truly interested in listening’.

REBT therapists also need to be alert to the dysfunctional aspects of some clients’ difficulties in developing trust with them, e.g. ‘Because I’ve been hurt badly in the past, I absolutely must be sure that you won’t let me down. I couldn’t stand it if this happened again’. Therapists need to probe for examples where their clients believe their trust has been betrayed in order to understand their current wariness, e.g. do they place absolute trust in others and therefore demand unimpeachable behaviour from them? Have they been too quick to trust others and thereby feel easily hurt when things go wrong? If they are let down again, why do they see this as the final straw? As well as tackling some of these ideas, therapists can suggest that they be granted a small measure of provisional trust as a means of testing them out while acknowledging the uncertainty involved.

Other forms of relationship-focused client resistance

When shame prevents self-disclosure

Fear of personal disclosure resulting in feelings of shame may lead clients to be reluctant to talk about the full extent of their concerns. Thus, a client who thinks, for example, that he can’t admit to the therapist that he has sexual feelings towards his sister as it is disgusting, and therefore he is disgusting, will withhold disclosure for fear of being shamed by the therapist.

By offering clients a general stance of unconditional acceptance as fallible human beings, therapists can encourage them to reveal their ‘shameful’ thoughts and feelings and engage in the disputing of their associated self-defeating ideas (e.g. having sexual feelings towards siblings does not mean that you are going to have sex with them or that such feelings mean you are a bad person). Through such methods clients can learn to be more open
Dealing with transference and non-transference issues

Resistance to creating a productive relationship can occur through the process of transference, i.e. clients displace on to therapists the feelings and attitudes they have towards significant others in their lives. For example, a person who believes she must defer to authority figures in her life tells the therapist: ‘I will work hard in therapy because you know what’s best for me’. The client in this case will probably make good progress but for non-therapeutic reasons. The therapist can applaud her determination to work hard but question her obeisance, e.g. ‘It’s more important that you independently decide what’s best for you from a position of self-acceptance rather than automatically accepting wisdom from on high’. The client might agree with this viewpoint but again for the wrong reason – because the therapist told her. To overcome this problem, the therapist needs to leave most of the decisions involving therapeutic progress to the client without confirmation from him that she is making the right ones. By developing independent thinking, she can challenge her ‘worshipful’ attitudes towards others in her life.

Clients may develop non-transference feelings for the therapist whereby, for example, a female client falls in love with her therapist because he embodies certain qualities she finds highly desirable in a man, and not because he represents a father figure to her. Thus resistance can develop as the client impedes her own progress in order to stay in therapy as long as possible. The therapist needs to tackle this problem sensitively but firmly: first, by revealing and disputing the irrational ideas underlying her strong feelings, e.g. ‘As I’ve fallen in love with my therapist, I must stay in therapy indefinitely. I couldn’t bear not to see him again’; second, while pointing out to the client that he is flattered by her feelings for him, the purpose of therapy is working hard to tackle her presenting problems and not to foster a romantic relationship. Such a ‘cold water’ approach may have the desired effect of dampening her romantic ardour and refocusing her attention on why she originally came to therapy. However, if her feelings are unabated, a referral to another counsellor is indicated.

When clients are wilfully resistant

Ellis (1985, 2002) described clients who deliberately and obstinately fight against therapy and frequently attempt to initiate and win power struggles with the therapist as wilfully resistant. In an effort to make the therapeutic relationship more productive and less obstructive, the therapist can point out to such clients how self-defeating their behaviour actually is:
Therapist: It seems that everything I say about your depression and this theme of failure in your life is immediately shot down in flames by you. Wouldn’t it be better if you actually considered some of the points I’m making? Some of them might even help you.

Client: Nothing you’ve said has been remotely helpful. In fact, I don’t think you’re going to be any help at all. You head shriners are all the same – bloody useless!

Therapist: How many ‘head shriners’, as you call them, have you seen in the last year?

Client: About six.

Therapist: You don’t stay long in therapy then?

Client: What’s the point if no one’s helping me?

Therapist: What sort of help are you looking for?

Client: I don’t know. You lot are supposed to be the experts. That’s a joke.

Therapist: Well, I don’t know what those other therapists did with you, but I will help you to locate some attitudes that you have which contribute to your depression and we’ll work together to get rid of those attitudes and replace them with more constructive ones. This therapy will require a lot of work from you, particularly outside of sessions.

Client: I’m supposed to do your work for you then? I thought I was the client. You’re supposed to tell me what’s wrong and get me better.

Therapist: I don’t have a magic wand to make you better. If you don’t do any work then therapy will be a waste of time for you, like your previous encounters in therapy.

Client: And for you. If you fail with me you won’t be able to tell everyone how wonderful you are. Oh dear.

Therapist: Let’s get something crystal clear in your mind: I have no personal interest whatsoever in whether your problems are sorted out, but I will do my professional best to help you if you commit yourself to change. The decision is yours.

Client: What are you trying to do – scare me? You’re just trying to be tough. If I tell you you’re ‘crap’ and walk out right now, it’ll be a different story then. I wonder how you handle failure?

Therapist: I would assume better than you do as I don’t get depressed over it. I don’t put my ego on the line in that I have to get you better in order not to feel worthless or useless. Whether we make a lot of progress or, what you
seem to want, to emerge victorious from therapy having beaten me down is irrelevant to me personally. If you remain miserable and depressed, which is highly likely, it certainly won’t stop me enjoying my life. So if you want to waste time or leave, please go ahead. You will lose out, not me.

*Client:* All right, keep your hair on. No need to be like that. You might be able to help me after all. I just wasn’t sure about you, that’s all. Okay, so how are you going to get me over my depression?

*Therapist:* As I said earlier, we (emphasises word) are going to do it, not just me. I think one of your major problems is what is called in REBT ‘discomfort intolerance’. This means that you don’t do any sustained hard work to overcome your problems because you believe it is too difficult or uncomfortable. Instead, you just waste time in therapy playing games, sabotaging progress, that sort of thing. This time you could behave differently if you choose to.

*Client:* (reluctantly) All right, I’ll give it a go, but I’m not promising anything.

*Therapist:* Okay, let’s see how we get on then.

By not engaging in a power struggle with the client or desperately trying to persuade him to stay in therapy, the therapist shows that she has kept her ego out of the psychotherapy room and therefore will not be crestfallen if no progress is made, the client abruptly terminates or he continues to act in an obnoxious manner. The therapist’s forthright approach starkly illustrates to the client the likely consequences of his recalcitrant behaviour – he will remain emotionally disturbed. The therapist hypothesises that this disturbance is partly maintained by the client’s discomfort intolerance ideas which lead him to fritter away valuable therapy time rather than confront his problems. By persistently and forcefully maintaining a clinical focus and thereby not getting ‘sucked into’ the client’s attempts to undermine therapy, she eventually secures his tentative agreement to participate constructively in it.

**When clients are involuntary**

Involuntary clients are those who reluctantly come to therapy at the insistence of others (e.g. parents, partners, courts, employers) and claim that they have no emotional or behavioural problems. The following techniques can be employed with such clients. First, agreeing with clients that others are probably wrong about them but examining their claims anyway,
e.g. ‘I’m sure your wife does exaggerate how much you drink, but as we have this hour together, shall we try and see why she’s upset about it?’ Second, agreeing with clients that others have probably ‘got it in for them’ but that still does not solve their problems, e.g. ‘It must be very bad living at home with your parents on your case all the time, but your own behaviour in response to theirs is making life more difficult for you than it has to be’. Third, agreeing with clients that therapy is probably a waste of time and even though they have to be here, they still retain the upper hand, e.g. ‘I know being here is part of the probation order but you still have the choice whether to cooperate. In that sense, you have more power than the courts or myself. So why not use that power in a way that might actually help you?’

Such methods may turn involuntary clients into voluntary ones and thereby entice them into the orbit of therapy.

**When clients have hidden agendas: The importance of accepting clients unconditionally**

Hidden agendas are the covert but real reasons why some clients enter therapy rather than the ostensible ones they disclose to the therapist. For example, a drug addict enters therapy ‘to get off drugs for good’ but actually seeks to sabotage it in order to prove he is a ‘hopeless addict’ and thereby continue his drug use; a woman attends couple psychotherapy to save her relationship although in reality she wants to end it, but guilt prevents her from doing so.

By giving all clients unconditional acceptance as fallible human beings, Ellis (1985, 2002) suggested that REBT can provide a therapeutic milieu which encourages the development of an honest and open alliance that makes it more likely that clients will reveal their hidden agendas. Thereafter, disputing of their associated irrational beliefs can be undertaken. In the above examples, the therapist tackles the drug addict’s hopelessness, ‘I’ll always be a junkie. I was born one’, and the woman’s self-damnation, ‘I would make him so miserable if I left him. I would be such a terrible person for doing that to him’. It is important that therapists remain alert for clues that might be offered by clients as to their real motives for being in therapy, e.g. the woman’s frequently stated worries about her partner’s inability to cope on his own if she left him rather than focusing on how she can help to save the relationship.

**When clients want to argue**

Some clients may turn the therapy room into a place for an argument. Whatever the therapist says, they will argue with it. They hold that therapy will not be able to help them, that they will never change or that the
therapist does not understand ‘real life’ problems. They argue with every response the therapist makes to them. Here it is important that therapists do not engage in arguing with clients over such issues because it may help to create a power struggle which results in an impasse in therapy. Dryden and Neenan (1995) suggest the following possible resolution to this problem:

If you win the argument you also lose it because you will remain emotionally disturbed. If I win the argument you will also win because I can help you to overcome your emotional disturbance. Now whom do you want to win the argument?

(Dryden and Neenan 1995: 7)

Clients usually suggest the therapist and then therapy can constructively proceed. If some clients state that they want to win, they are likely to find they have secured a Pyrrhic victory, i.e. won at considerable emotional cost to themselves (see the section of this chapter on dealing with wilfully resistant clients, above).

Certain clients may wish to engage in a prolonged discussion of or argument over the use of the terms ‘rational’ and ‘irrational’. As these terms are widely used in REBT, the impression might be created that the therapist has a superior understanding of or greater insight into these concepts:

<table>
<thead>
<tr>
<th>Client:</th>
<th>Who can say what is irrational or rational? It’s all subjective anyway. Isn’t it rather arrogant of you to claim that you have a monopoly on these terms?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist:</td>
<td>Well, it would be if we claimed such a thing, but we don’t. In REBT, the terms ‘rational’ and ‘irrational’ have commonplace meanings of, respectively, ‘self-helping’ and ‘self-defeating’. In other words, whatever helps or blocks the clients from achieving their goals in life. These terms are used in a relative sense and not an absolute one.</td>
</tr>
<tr>
<td>Client:</td>
<td>Relative to what?</td>
</tr>
<tr>
<td>Therapist:</td>
<td>To the client’s subjective view of reality. We stand behind the client, so to speak, so we can try to understand his or her view of reality and those aspects of it which are causing trouble.</td>
</tr>
<tr>
<td>Client:</td>
<td>But if people are disturbed they are obviously not conforming to some fixed and external objective reality. So getting better means agreeing with that reality if they want to be happy.</td>
</tr>
</tbody>
</table>
Therapist: Clients certainly don’t have to conform to anything in REBT. As I’ve said, we look at reality from their viewpoint, not ours. Obviously empirical reality acts as some form of objective standard clients can test their beliefs against. But we don’t have, as you seem to think, some objective reality kit that clients can take home, assemble and then follow the instructions for a happier life.

Client: But someone’s view of reality is true to them and yet you’re trying to get them to see it differently.

Therapist: If someone is depressed because he believes he is utterly worthless, do we agree with him and let his suffering continue?

Client: No, I suppose not even though he truly believes that he is worthless.

Therapist: He sees his beliefs as facts while we see them as hypotheses. By seeking evidence for and against his beliefs we hope that the evidence will prove to him that he is not worthless and thereby moderate or remove his depression. Remember, clients come to see us asking for help because there are things in their lives that they want to change.

Client: I can certainly agree with that but I think our ‘nature of reality’ debate is still clouded by certain issues.

Therapist: Well, I think more discussion will be counterproductive as it will drain away therapy time and, I think, prove largely ineffective.

Client: Obviously that’s your hypothesis and not, therefore, a fact. Further discussion could help me to be more receptive to REBT and give me greater insight into my problems. I believe, as a general rule, that every important issue has to be discussed thoroughly.

Therapist: My hypothesis, which is based on previous encounters with clients who wanted prolonged debates of a similar nature, is that we will get distracted from the real purpose of therapy which is tackling your guilt and procrastination. What is really needed to overcome these problems is concerted action and not more philosophical discussion. Philosophical indecision might be one of the reasons for your procrastination.

Client: So now you are imposing your views on me. You’re telling me what is best for me. My view of things no longer counts. My problems are unique and not to be brushed aside so flippantly.
Therapist: I assure you that I am neither imposing my views on you nor brushing aside your problems. Your problems are unique in the sense that they belong to you and no one else. However, the reasons for your problems and the solutions to them are usually anything but unique.

Client: I’m not persuaded that we can reach a compromise yet when we are still clashing on the question ‘what is reality?’ How can we know that what we believe can ever be objectively validated or that you’re right in what you say? Can my problems be so readily understood?

Therapist: Well, I think that I have sufficiently explained the REBT position on these issues and that the clinical way forward is to start assessing your presenting problems so that we can devise some strategies for change.

Client: And if I disagree, what then?

Therapist: Then you might wish to find another type of psychotherapy approach which suits your philosophical outlook. I can certainly make a referral for you.

Client: And if I decide to stay?

Therapist: At the start of the next session, as this one is now drawing to a close, we will focus on those irrational or self-defeating ideas underlying your procrastination and guilt. Then we will look at ways of challenging those ideas through a variety of homework tasks. The choice is yours.

Client: Well, obviously I want help with these problems otherwise I wouldn’t be here, but I’m still very concerned that you have prematurely shut off debate on what I consider to be important issues.

Therapist: Okay, let me make a suggestion. As we are working through your problems and certain philosophical issues naturally arise from our problem-solving approach, then we can set some time aside to discuss these issues without holding up our work schedule. Is that agreeable?

Client: I can live with that. So we get down to business, as you would say, at the next session.

Therapist: We’ve already started.

Important points to note in this extract from therapy are the following:

1. The therapist explains the terms ‘irrational’, ‘rational’, ‘the nature of reality’, etc. only from the REBT viewpoint and does not launch into a more general discussion of these issues as she considers this would be
clinically inappropriate. Therapy provides a platform for change through direct action and not a forum for abstract arguments.

2 Even while the therapist is discussing these issues with the client, she is forming hypotheses about his presenting problems and suggests that his desire for prolonged philosophical debate might be linked to his procrastination.

3 The client’s reluctance to be drawn into an early problem-solving focus gives the therapist the opportunity to push the client to make a decision about whether to stay in REBT. If he chooses to remain, his expected role is described for him.

4 In order to develop a therapeutic alliance with the client, the therapist suggests a compromise that provides for some philosophical inquiry within the overall strategy of ‘more work and less waffle’. The therapist’s final comment demonstrates that REBT therapists are always looking for ways to introduce efficiency into therapy.

When clients want their therapist as a friend

Sometimes clients can make the mistake of viewing the therapist as another (or the only) friend in their life and therefore expect the therapist to ‘indulge’ them, e.g. meet them outside of sessions, turn up for therapy only when they feel like it, lend them money, be a taxi service for them, allow them to bring alcohol to the session. Clients can become indignant, hurt or rejected when the therapist turns down their requests, e.g. ‘I thought you’re supposed to be on my side’. As Walen et al. (1992: 44) point out: ‘the basis for the therapeutic relationship is not friendship but professional competence, credibility, respect, and commitment to help the client change’. Therefore the therapist in his or her role as a concerned professional can respond:

‘If I behave like your friend, how much real progress do you think you are going to make? The business of therapy is lots of hard work to overcome your problems. So let’s sort out what our respective roles are.’

The earlier this is done in therapy, the less misunderstanding will occur.

The foregoing account of clients’ difficulties in forming a productive relationship with the therapist is not meant to be exhaustive; also these and other problems can occur at any time during therapy rather than all appear in its early stages. Therefore the therapist should be prepared to monitor continually the bond domain of the working alliance. The strength of the bond will be tested, often severely so, as the therapist introduces the client to the ‘ABC’ model of self-created disturbance, which is discussed in Chapter 3.