Interventions of a "Phantom" Consultant with Difficult Patients

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Below are presented several anecdotal examples of the effective brief interventions of a consultant in enabling therapists to extricate themselves from treatment impasses. Several unique interventions are described in overcoming resistance and facilitating therapeutic progress. The advantages and benefits of introducing a consultant in challenging treatment cases and under what situations and conditions, are also discussed.

Introduction

The use of consultants in medicine is a highly recommended and accepted practice. The consultant is usually brought in -1. For his specialized knowledge and what it adds to the management of a given patient, 2.To provide a second look at a primary physician's diagnosis, and 3. When the physician has lost his objectivity about a patient. (Keith and Whitaker, 1983).

In the psychotherapeutic profession, the bringing in of a consultant into the treatment room is a less acceptable and common practice. Possible explanations for this situation are the issues of transference and confidentiality and the concern of the therapist that this may negatively affect the patient's trust and confidence in him.

Appropriate use of a consultant, even on a one-time basis, can be highly effective and rewarding. The participation of a consultant in situations where the therapist is in doubt, frightened, in a one-down position in therapy, or confronted with a therapeutic impasse, in the treatment of highly resistant and poorly motivated patients, in emergency situations that require an immediate focused intervention, can significantly contribute to more effective and quicker results.

As mentioned above, Keith and Whitaker point out that since the consultant functions with a unique capacity and freedom, as his involvement is brief and passing, he can be more objective, insightful, and free to act and say things that the primary therapist would hesitate or fear to do or say. (Keith and Whitaker, 1983) Whitaker refers to the mother-father (male –female) metaphors when describing the cotherapeutic relationship: "It seems that the initial therapist is contaminated with all the usual problems of being a mother. He's all forgiving, all accepting and minimally demanding. In contrast, when the consultant comes in for the interview, he turns out to be very much like the father. He is reality oriented, demanding, intellectual, much less tempted to accept the original complaints of the original presentation and much freer to think about what's being presented in a conceptual total gestalt manner".

A consultant can make outrageous interventions or suggestions, raise highly sensitive and painful issues and be provocative in questioning the patient's motivation and capacity to benefit from therapy and change, without being concerned about future repercussions or the effect on their relationship. (Papp, 1983) The consultant, after interviewing the patient, can reinforce and support, in an authoritative manner, the primary therapist's diagnostic impression, management, and treatment of the case, and thus strengthen the patient's confidence in the therapist, or can express diametrically opposite views in order to more effectively reflect the patient's ambivalent feelings and expand his perceptions of himself and his surroundings. By taking a provocative and confronting stance, he can cause the hostile and resistant patient to redirect his antagonism and anger from the primary therapist toward the consultant and thus facilitate the strengthening of the patient-therapist relationship. All this, obviously, can be done only after prior discussion and collusion with the primary therapist.

The consultant, though physically absent in future sessions, can become "a salient factor as a shadow member of a triadic relationship" (Bernard, et al., 1980), by the therapist frequently referring to

the consultant's provocative and opposing views and comments in their discussions. In this manner he can confront the patient's maladaptive and unacceptable behavior in a forceful and indirect manner, without taking responsibility for them.

Below are presented several examples of the successful brief interventions by a consultant in cases of treatment impasse.

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Case-1

Rivki, a 19 year old religious Jewish girl, presented herself for the second time to the mental health clinic. She had been seen initially by a senior staff member but after several sessions terminated treatment. At this time, she requested a female therapist, "someone who could understand her background and culture." She also emphasized that a male therapist could not help her.

Treatment

In the first therapy session, Rivki related that she had made several suicidal attempts in the past (ingestion of pills) and much to her chagrin, was unsuccessful. "Even to die, I don't have any luck in life." The precipitating event that caused her deteriorating condition and depression was unrequited love. A year ago she met a boy who captured her heart. For a year they corresponded but never met alone as dictated by tradition. On her eighteenth birthday she was informed by the youth that he intended to marry another girl and several months later he did so.

Rivki became depressed, cried continually, refused to meet other men, lost 20 pounds, and expressed difficulty in sleeping without medication and in concentrating on her academic studies. She lost her trust in men, was disgusted with life and on many occasions attempted to cut it short.

The therapist attempted to make a contract with the patient regarding her suicidal behavior but with little success. Instead of contacting the therapist when she felt suicidal, the patient took an overdose of pills. Because of the strong suicidal risk and steady deterioration of her functioning, a psychiatric evaluation was arranged for her. However, Rivki didn't keep the appointment because she was afraid of being hospitalized and because the psychiatrist was a man. "I don't trust men, I don't want their help, and accepting help from them is demeaning."

In supervision, the young psychologist shared with her supervisor her anxieties, fears, and frustrations in working with this patient and her difficulty in accepting total responsibility for the case. It was decided that she would suggest to the patient that a senior staff member would participate in the next meeting for purposes of evaluation. The therapist prepared the patient for the meeting, pointing out to her that though the consultant is a very direct and opinionated man, he has a great deal of professional experience and she respects his clinical judgment.

At the joint meeting, the consultant (S. H.) after speaking to the patient and obtaining an update about the treatment from the therapist, opined that the patient is an immature, impulsive and passive person who is seeking someone to solve her problems for her and lacks sufficient motivation to effectively overcome her emotional problems. When confronted with disappointment and frustration, like a young child, she attempts to solve her problems through suicide rather than confronting them in a mature and constructive manner and expressed his doubts whether she could be treated on an outpatient basis.

The therapist countered, that in spite of her difficulties and depression she had continued her studies, had faithfully attended her therapy sessions, at times, demonstrated mature behavior and good judgment. The consultant challenged the therapist's optimistic assessment and suggested another meeting in a month's time for a reevaluation of the situation.

In the next session with her therapist, Rivki complained that the consultant ruined her whole week. It angered her that every time the therapist supported her, he belittled her even more. She agreed to meet with him another time "to prove to him that he is wrong. I am not a little girl."

In the following supervisory meeting, the therapist requested that the supervisor continue as a cotherapist on a regular basis. However, the latter argued that it was counter-indicated in view of the patient's strong hostility toward him and pointed out that he is already "a salient factor as shadow member of a triadic relationship." (Bernard, et. al., 1980) By the therapist frequently referring to him in the session, his presence will be further strengthened. She would also be able to exploit his absence by attributing to him provocative and confronting views and at the same time, not assume responsibility for them and thereby protect the tenuous relationship between her and the patient.

In the following therapy session, Rivki spoke of her revulsion regarding the traditional marriages where the woman is forced to deny and subjugate her identity to that of her husband and that her sole role in life is to produce and raise children. In spite of her respect for her religion and tradition, she wasn't willing to concede her independence and meet men and get married. The therapist remarked that if the consultant was present, he would insist that this was just an excuse to avoid contact and relationships with men because of her lack of trust and fear of being hurt and disappointed again.

In the second joint meeting, the consultant, in spite of the therapist's positive report regarding her patient's progress, expressed doubts that she was capable of maintaining this positive trend and predicted that when she is confronted with disappointment or difficulty at home or at school or in her social life, she will return to her old destructive ways of coping. The therapist protested and challenged the consultant's assessment and pessimistic prognosis and pointed out that in the last several weeks the patient had not spoken of suicide, had gained weight, and was sleeping better. The patient

was furious at the consultant and remarked sarcastically, "You think you know everything."

Two months later, in spite of the therapist's efforts to prepare her patient to deal with the anniversary of her former boyfriend's engagement to another woman, the patient swallowed a large amount of sleeping pills, in order not to be conscious that day. The following day, she expressed feelings of despair and hopelessness and stated that if she didn't get out of the depressed state within a month, she will kill herself. The therapist responded that it seems that the consultant was correct in his assessment and that maybe it was a mistake to treat her as an out-patient. With the patient's acquiescence, a third meeting was scheduled with the consultant.

At this meeting, the consultant chided Rivki for not being able to part emotionally from her former boyfriend, and that she is still continuing to mourn his loss, and as proof to his claim, he pointed out that she still carried his picture in her wallet. He also opined that she also still harbors a great deal of anger toward him that she isn't willing to relinquish.

The therapist asked the consultant what steps Rivki could take to demonstrate her sincerity regarding her desire to part from her former love and look toward the future. The latter responded that in his view, a meaningful act would be to burn her former love's picture (Van der Hart, 1981) and start dating other men, which he doubts that she is capable of doing. The therapist countered that she thought that her patient was capable of doing the above. The patient vehemently denied all of the consultant's assertions and angrily declared that she wasn't willing to meet him again.

In the following therapy session, Rivki reported that she burnt her former boy friend's picture to prove to the consultant that he was wrong and asked the therapist to relay this information to him. She also reported that a man who had expressed interest in her in the past contacted her and she agreed to see him.

During the next few months, Rivki appeared to be functioning well and coping more effectively and the issue of termination of treatment was raised.

In the last session, Rivki expressed the feeling that she had matured six years and thanked the therapist for believing in and helping her grow. In reference to the consultant, she volunteered that though he was insensitive to her situation and difficulties, she was helped by him because he forced her to confront and deal with difficult and painful issues and change her behavior.

Discussion

The direct involvement of the consultant in the treatment, though limited, (three out of twenty sessions) had an important effect and impact on both the therapeutic process and outcome and on the therapist.

In regard to the former, the consultant's interventions forced the patient out of her passivity and impelled her to deal with issues, dynamics and conflicts that she characteristically avoided. Because of the tenuous relationship that existed between the therapist and the patient, the former dared not confront the patient directly. However, "through" the consultant, she was able to challenge the patient's ineffective defenses and maladaptive behavior throughout the treatment, in a forceful and direct manner. Also the consultant's consistent disparaging and belittling of the patient and therapist, forced an alliance between them against the consultant in order to prove him wrong.

In regard to the effect on the therapist herself, it is obvious that a difficult and frustrating case like this one, with the constant threat of suicide dominating the picture, can be an overwhelming experience for any therapist, let alone a beginner. The limited direct involvement of the consultant in the therapy, first and foremost diminished the anxiety, loneliness and total responsibility that characterizes most clinical work. It also provided the therapist with a direct modeling and an in vivo experience of an experienced clinician at work and at

the same time, the supervisor was able to achieve a better feeling and impression for what the therapist was dealing with.

Case-2

Sara, a 14 year old shy haredi girl was brought to the clinic by her mother because for the last half year she has insisted on being helped by her mother to shower and brush her teeth because she claimed that she was not capable of doing it herself. If she did not succeed in getting her mother to help her, she went to sleep without bathing and brushing her teeth. As a result of her constant nagging and pleading, Sara's mother for the most part gave in since she didn't have the strength or time to fight with her. The mother reported that her daughter is slow in doing things, has difficulties in performing daily tasks as choosing her clothing, preparing her homework, being on time for appointments and has become very attached and dependent on her. She also has learning difficulties and the parents have to sit with her every night to do her homework. In contrast to her daughter, the mother is very quick and active and takes upon herself abundant responsibilities in the home. The mother also reported that she bathed all her children until the age of ten and saw nothing wrong with this.

Treatment

Sara insisted that her mother accompany her to the treatment sessions even though she did not live far from the clinic. In the initial session, Sara related in an open and confident manner. However, when the topic turned to the presenting problems and complaints, she looked down and refused to respond even with the urging and help of the mother. Frequently, out of exasperation, the mother answered for her daughter.

The father, who learns part time in a yeshiva for married men, was invited to the following meeting. In contrast to his wife, he described his daughter as highly manipulative and capable of function-

ing in an independent manner and exploits her mother whenever she can. The mother, on the other hand, insists that that her daughter has serious emotional and psychological problems and is beset by overwhelming fears. It was decided at the end of the meeting that the parents refuse to submit to their daughter's requests for help and that the father will support and help his wife in this.

At the following meeting, the mother acknowledged that she succumbed and submitted to her daughter's nagging and pleading and helped her to bathe and brush her teeth. After several frustrating and non-productive meetings where the patient refused to discuss her problems, and in which little progress was made, the therapist (E. H.) suggested that a consultant (S. H.) be invited to the next meeting which the father will also attend.

In discussing the case with the consultant, a treatment strategy was decided upon. In the family meeting, the consultant, after being updated about the case by the therapist and parents, opined that it appears that there exists a serious problem in Sara's emotional and psychological development as she wishes to be a young child and treated as such. He conjectured that possibly the mother, unconsciously, may want a baby in the house to nurture and take care of, and may have communicated this to her daughter unknowingly. Before departing from the session, he advised the parents to consider relating to her as a toddler at this time and modify their expectations and demands of her, for her benefit. The parents and daughter reacted in shock and disbelief to the consultant's assessment and recommendation and insisted that this was not the case. After the consultant left the room, the therapist expressed the view that Sara was capable of acting her age but since the consultant was a highly experienced and respected clinician, they should seriously consider his opinion.

In view of the patient's resistant and non-compliant behavior, the therapist decided to work with the parents in order to attempt to modify their ineffective handling of their daughter. It was clear that the mother communicated to her daughter double messages—you

have serious psychological and emotional problems and are in need of help together with the expectation that she should act and behave in a responsible, independent and mature way. Since the mother appeared to be weak, unstable, impotent and readily manipulated, the father had to be more active and involved in the upbringing of his daughter.

At the following session, the parents complained that Sara continued to act helpless, infantile and very demanding. The therapist responded that this behavior is consistent with that of a three year old who demands and doesn't give and therefore the consultant suggested that you relate to her accordingly and lower your expectations and demands. The mother complained that she was tired and exhausted with her daughter's constant nagging and demands and plans to go to a great rabbi to receive his blessing. The father chimed in that Sara was manipulative and capable of doing things for herself but prefers to exploit her mother's weaknesses. The mother countered that Sara was weak and the blood tests indicated that she lacked iron and that a great rabbi told her that this was the reason that she was depressed. The therapist countered that the reason that she was depressed was because she acts and is treated like a three year old. At this point the therapist "summoned" the consultant and informed them that if the parents and school authorities are not able to consistently relate to Sara as a three year old, the only other solution is to place her in a dormitory where she will not be infantilized by the mother. Again the parents reacted in shock to the consultant's proposal and said that this will break her and she would refuse to go. The therapist countered that Sara was not weak but very strong as she has succeeded in controlling what goes on in the house. The mother again argued that her daughter was anemic, doesn't eat well and that we have to go slow with her and eventually she will be able to be more mature and independent. At this point the therapist turned to the father and informed him that the consultant was of the opinion that if Sara is not removed from the house she will continue to regress unless he

became more active and involved with the upbringing of his daughter and minimized the negative influence of the mother. The therapist added that she agreed with the consultant that he is capable of being more authoritative, consistent and assertive with his daughter and will have a more positive influence on her. The father was very pleased at this assessment and added that he didn't pity her like his wife and is more capable of setting limits. The mother was clearly upset about these remarks and insisted that she was capable of being assertive and set limits, and then added, "Where is the consultant? Why isn't he here? Tell him I can be strong."

In the following meetings the parents reported marked improvement in Sara's behavior as a result of the "change of guard" and in the manner that her parents dealt and related to their daughter, and therapy was terminated with the proviso that they could request a consultation with the therapist if needed.

Case-3

Joseph, a married 40 year old ultra-orthodox Jew was seen by the clinic's psychiatrist who diagnosed him as suffering from social phobia and recommended psychopharmacological and psychological treatment. The patient refused to take medication and was referred to one of the social workers in the clinic for cognitive behavioral therapy.

Treatment

In the first meeting, Joseph with considerable anxiety and hesitation related that for many years he led the services in his synagogue (cantor) from which he received a great deal of enjoyment, satisfaction and approbation from the congregants. A year ago, in the middle of chanting the morning services, his voice "betrayed" him. Joseph experienced a choking sensation felt faint and weakness in his legs, and completed the service quickly while sweating and shaking all over.

This traumatic incident changed his life dramatically. From then

on he avoided social contacts, avoided attending his synagogue, refused invitations to spend the Sabbath at his in-laws' house for fear that they will pressure him to lead the services at the synagogue, refrained from participating in singing with the family at the Sabbath meals and fled from the synagogue when asked to lead the services. Joseph developed extreme sensitivity to the comments and criticism of others and was fearful that others were judging him and would detect his anxieties and weaknesses.

The initial sessions were devoted to strengthening the patient's poor self-image and battered self-confidence and challenging his distorted automatic thoughts. (Beck, 1995). The therapist enlisted the aid of the clinic staff in exposing him to new social situations by asking them to be present while he spoke in the sessions, all the while focusing and challenging his distorted automatic thoughts. Eventually, he succeeded in singing in the treatment room in the presence of staff members.

Joseph continued to slowly overcome his social anxiety and was able to spend the Sabbath meals at his in-laws and also participate in the family singing. Gradually he exposed himself to social situations which he assiduously avoided the previous year and spoke more openly and freely in the treatment sessions. However, in spite of the urging and encouragement of the therapist, Joseph adamantly refused to attend his synagogue and expose himself to relatively minor challenges, such as being called up to the Torah where he was required to quietly recite two short blessings.

After several frustrating and fruitless sessions, the therapist (E. H.), after receiving the patient's approval, decided to invite a consultant (S. H.) to participate in the treatment because of the treatment impasse.

After the consultant was briefed by the therapist regarding the patient and the impasse which impeded further progress and after listening to the patient's description of his difficulties and the progress of the treatment, he said that in his opinion the patient's avoidance

and passive-resistant behavior were sabotaging the further progress of the treatment and that the therapist was colluding with the patient by being too soft and tolerant of his lack of progress. He pointed out that there were only several more sessions allotted to the patient and there was no way that the patient will achieve his goals unless he takes bigger steps in overcoming his social phobia. He suggested that the next session with the therapist be conditioned on whether the patient accomplishes the task assigned to him by the therapist. The patient protested that he had improved and that he has to take small steps and progress slowly and accused the consultant of being insensitive and unrealistic in his expectations and demands. The therapist sided with her patient and argued that the patient had progressed significantly, demonstrated strong motivation in overcoming his problems and questioned the consultant whether he was not raising the "high-jump bar" too high. The consultant insisted that she was being overprotective with him and expressed his doubts whether the patient will reach his therapeutic goals if treatment continued at the same pace. The patient attempted to convince the consultant of his difficulties and fears but to no avail. After leaving the room, the therapist mentioned to the patient that even though she felt that the consultant was very opinionated and demanding, since she respects his professionalism and expertness in these cases, the next session will take place after he succeeds in accomplishing the prescribed task.

The following week, Joseph proudly reported that he successfully accomplished the assigned task but was puzzled by the consultant's behavior. He described him as very critical and demanding and insufficiently sensitive to his difficulties and questioned his professional capabilities. At this point Joseph for the first time was able to speak about his problematic relationship with his father who had many similar characteristics to the consultant. In the following sessions, it was evident that the presence of the consultant was in the room, even though physically he was absent. (Bernard, et al. 1980) At times when the therapist was confronted by the patient's resistance to undertake

further challenges, she conjured up the consultant to use as a prod to propel him onward.

As treatment was reaching its conclusion, the therapist, with Joseph's consent, invited his wife Miriam for a meeting. Miriam, a soft and endearing woman, described in a very emotional manner the significant changes that her husband underwent as a result of the psychological treatment he received and added, "Where is this Seymour, this doctor; he understood exactly what to do—to pressure Joseph and not relent and this is what he did." Joseph, obviously irritated by his wife's remarks, stated sharply, "Stop thinking that by pressuring me something will happen. You do not know what I went through." At this point the therapist intervened and went to the defense of her patient and explained that Joseph underwent a difficult process without the aid of pills and succeeded in obtaining his goals. Even though the consultant was not present in the room, the focus was on him and his treatment approach. "I am not sure that the consultant knows how to treat people. I am sure that other patients would have fled from him," exclaimed Joseph at the end of the session. It was apparent that a coalition was established between the therapist and Joseph and his wife and the consultant.

On the last session, Joseph expressed in a highly emotional manner his sincere appreciation to the therapist who believed and encouraged him throughout the arduous treatment process and requested of her to inform the consultant of his accomplishments.

The four cases presented support Peggy Papp's assertion that, "Outrageous suggestions are often more effective coming from an unseen authority outside the session than from a trainee who is then called to defend them". (1983)

The therapist in the last two cases shared an interesting observation concerning her experiences in working with a "phantom" consultant: "I felt a great amount of freedom throughout the treatment case since I was able to express myself without any constraint and

without any fears of endangering the therapeutic relationship and process".

In summary, the introduction of a consultant in treatment impasse situations can facilitate:

1. Destabilization of pathological systems and rigid ineffective defences.
2. Strengthen the relationship and working alliance between the patient and therapist.
3. Introduction of information, ideas, challenging and divergent views into the treatment situation without endangering the therapeutic relationship.

It goes without saying that the success of this intervention depends on the appropriateness of the case, the timing, and the cooperation and mutual trust and respect between the therapist and consultant

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(Estee Herman was the cotherapist and co-author of the last two cases.)