DILEMMA 1

"I'm just here because of my parents, spouse, etc."

(for clients who are unmotivated to start treatment)

Navigating This Chapter . . .

- Reasons for refusal to take responsibility for wanting treatment
- Introducing the concept of *embedded badness*
- How to instill a sense of ownership in the client for their own treatment and recovery
- Importance of agreement on goals and tasks of the therapy, screening measures, a *judgment-free zone*, and the recovery principle of *self-determination*
- How to formulate the client's difficulties and provide a caring invitation to embark on the journey

As the client walks through the door to my office and gets seated, I turn and ask, "What brings you here today?" The client responds, "I don't want to be here. I just came because my parents forced me to." I am thinking, "Oh no . . . how can I possibly engage someone in psychotherapy who doesn't want to be here? How can I help someone who doesn't want to be helped?"

In our experience, this is a common scenario among suicidal clients, especially among adolescents, many of whom see it as a defeat to admit that they need help or to take the advice of their parents. Beneath the bravado, however, is often a desperate wish to be listened to and understood.

There are other reasons, however, for an inability to take responsibility for wanting treatment. There is a fear of being found out,

exposed for who they really are, and ultimately rejected if they open up to a therapist. Research indicates that suicidal individuals generally have both a negative self-image and low self-compassion (Suh & Jeong, 2021). In Dynamic Deconstructive Psychotherapy (DDP) lingo, we call this combination *embedded badness*, an internalized sense that one is ugly, defective, worthless, or evil under the surface, even though they may present as self-confident. Although the client may wish to be listened to and understood, they may have an equally strong fear of being vulnerable and authentic with someone who they are certain will reject them. Groucho Marx once quipped, "I don't want to belong to any club that would accept me as a member!" The unconscious conflict between a wish for closeness and understanding versus a fear of exposure and rejection can be acted out through distancing in the therapy relationship and the client's refusal to take responsibility for wanting to be there.

Lastly, clients may not know what they want, especially if they suffer from an identity disturbance secondary to borderline personality disorder (BPD). Many, if not most, suicidal individuals suffer from BPD. The largest and most definitive study investigating this was a household survey of 69,000 individuals using structured diagnostic interviews to examine prevalence of various disorders. Among persons who reported a history of suicide attempts, almost two-thirds met diagnostic criteria for BPD (Olfson et al., 2017). Many other psychiatric disorders, such as depression, bipolar disorder, and posttraumatic stress disorder (PTSD), frequently involve suicide ideation as well. Comorbidity of a personality disorder with a non–personality psychiatric disorder contributes to suicide risk more than does each disorder individually (Ryan et al., 2020).

The solution to the dilemma in this chapter involves instilling a sense of ownership in clients for their own treatment and recovery while creating a caring and nonjudgmental therapeutic space. With clients who are disowning having any complaints or symptoms they want help with—for example, "I am just here because of my parents"—therapists will be striking out before even getting to first base. Agreement between the client and therapist on the goals and tasks of treatment is an essential component of the working alliance and a strong predictor of treatment success (Baier et al., 2020). Given the protectiveness and seeming defensiveness of many suicidal clients for the reasons described previously, instilling a sense of ownership in clients for their own treatment and recovery can be a tall order. Here are some things that can help:

1. Send clients an intake packet with screening questionnaires *before* your first meeting with them. Reading and responding to such questionnaires gets clients thinking about what they want changed in their lives and makes it easier for us to flesh it out in our first meeting.

Moreover, if they demonstrate a severe score on one of the questionnaires, you can utilize that information to suggest a focus for the therapy, asking them whether that severe score is something that they are concerned about and want changed. There are many kinds of questionnaires that can be put into an intake packet. We recommend that you include, at a minimum, measures of depression, anxiety, and suicide ideation. We use the Patient Health Questionnaire–9 (PHQ-9; Kroenke et al., 2001) and the Generalized Anxiety Disorder Assessment–7 (GAD-7; Spitzer et al., 2006) for this purpose because they are brief, easy to score, and can be given at regular intervals to measure progress. We also add in measures of self-compassion, social connectedness, functioning, and BPD severity to get a more in-depth look.

2. Because the client has stated they are in treatment only because of their parents, spouse, or other significant person, you can utilize such statements by asking what these other people's concerns are about the client. Sometimes it is easier to start talking about other people's concerns about us than to admit we have the same concerns.

3. Discussing other people's concerns about the client may help them to open up, but it's equally important for the client to know that the primary focus of therapy sessions is on the client's concerns, not those of parents, spouse, or anyone else. We are trying to create a sacred space that is just for them and not for anyone else. Emphasize that they can talk about what is most important to them and not what is important to other people.

4. Because the client is likely to expect harsh judgment from the therapist as the client begins to open up and be vulnerable, it is also important for the therapist to state explicitly that a *judgment-free zone* will be provided in the therapy sessions. The therapist can elaborate that no judgments will be made regarding agreement or disagreement with the client's values, opinions, or actions. In this way, the treatment becomes consistent with the recovery principle of *self-determination*.

Adolescent Hypothetical Scenario

THERAPIST: Whose idea was it to come here today?

CLIENT: My parents made me.

THERAPIST: Ah, a lot of the adolescents I work with say the same thing! Since you are here, I am wondering if there is something you are hoping I could help you with, if anything?

CLIENT: I don't know.

THERAPIST: Well, I'm not here to force treatment on you, it's really

up to you. But I'd love to work with you toward getting to a better place, if that's what you want. Have you been struggling lately?

CLIENT: Yeah, I've been pretty depressed.

THERAPIST: Can you tell me more about your depression?

Adult Hypothetical Scenario

THERAPIST: What would you like help with?

CLIENT: I don't know, I'm just here because of my spouse.

THERAPIST: What is your spouse concerned about?

CLIENT: (*Shrugs.*) You had better ask them.

THERAPIST: I'm more interested in what concerns you, rather than your spouse. I want this to be a place that you feel like is your own space, where you can bring up any concerns regardless of what your spouse thinks about it and regardless of what I think about it. I want this to be your treatment, and not your spouse's treatment or my treatment. How does that sound?

CLIENT: Okay.

THERAPIST: I noticed that you scored high on many of the outcome measures that were in your intake packet. For example, you rated yourself as scoring very high on depression, with frequent thoughts of suicide. Is this something that you would like to see get better?

CLIENT: Yeah. (*Nods head.*)

THERAPIST: How long ago did the depression start?

At this point in the interview, there is the beginning of a chief complaint, that is, depression and suicide ideation. Once clients take responsibility for wanting a given symptom or other aspect of their lives to change, the rest of the evaluation can progress with less risk that they will feel that something is being done to them without their consent, and they will be more motivated for treatment.

Once the chief complaint is established, there are some other ways that the therapist can facilitate a sense of client ownership for their own treatment and recovery. The first is to present a brief formulation of their difficulties within whatever theoretical framework the therapist is using. This should be done within the first two sessions in order to get the client on board with the goals and tasks of treatment as soon as possible. The most convincing formulations are those that incorporate the client's chief complaint and other difficulties that they have shared

during the evaluation process. Then the therapist can provide a framework that explains why the client is suffering from those difficulties and what the client can do to initiate progress toward recovery. The formulation should be presented with therapist confidence and hope, laying out a pathway to recovery through psychotherapy and personal participation. After laying things out, the therapist can ask whether the client agrees with the formulation or whether they have any disagreements or modifications. Do they want to give the treatment a try? The following vignette provides an example of a hypothetical formulation that we would provide within a DDP framework.

THERAPIST: Let's summarize what you have been going through and see if I have it right, okay?

CLIENT: (*Nods.*)

THERAPIST: You stated that you have been struggling with depression, anxiety, and thoughts of suicide since your early teens, but that these symptoms have worsened since your partner broke up with you a couple of months ago and entered another relationship. Is that correct?

CLIENT: Yeah.

THERAPIST: You also have described feeling stuck in a pattern of unfulfilling relationships where you don't feel that you can be authentic and are afraid to say the wrong thing or the person will reject you or leave you. So you go along with whatever the other person wants or believes in, but then you feel hurt and resentful that your own desires and opinions are not being taken into account. Then you get rejected anyway and become more suicidal. Did I get you correctly? I don't want to put words in your mouth.

CLIENT: (*Sighs.*) No, that's right.

THERAPIST: The other pattern I'm seeing is that you have difficulty identifying your emotions and describing basic interactions that you have recently had with other people. This is a common difficulty for people who struggle with thoughts of suicide. We know from neuroscience research that the emotion-processing systems of suicidal individuals don't work very well. There is even atrophy in some of the brain regions. Under emotional stress, the higher levels of the brain become deactivated. However, the lower and more primitive parts of the brain become hyperactivated, leading to anxiety, depression, and impulsive use of cannabis, such as you described to me when you are

upset. This brain deficit can be repaired through repeated practice of describing recent interactions and labeling your emotions. It's the same kind of work as physical therapy after having a stroke, where you are building new pathways in the brain through repeated practice, essentially rewiring it, and are sometimes able to achieve complete recovery. You will find the therapy to be difficult because you are not used to connecting to your experiences and emotions in this way. In fact, it goes completely against what you have done your entire life of trying to avoid and shut down your emotions, instead of processing them, through the use of distraction and cannabis. Avoidance helps in the short term, but the long-term consequences are continued depression, anxiety, suicidal thoughts, and being stuck in a pattern of unfulfilling relationships. I wish that there was an easier solution, but the good news is that if you fully engage in the treatment, you will be able to get to a much better place. I'm not saying that it will be a complete cure, since recovery is a lifelong process, but you can get to a much better place.

CLIENT: I don't know; that just doesn't sound possible.

THERAPIST: Thank you for sharing that. Given how long you have been suffering, I can totally understand how it can seem impossible that things could ever be any different. But if you are willing to give it a try, I would love to work with you to get to a better place. It's up to you whether you are willing to take that risk. Only you can decide.

CLIENT: Yes, I want to give it a try.

THERAPIST: That's great! I am looking forward to working with you.

In the preceding vignette, notice that the therapist checks in multiple times with the client to make sure that the client is on board with the summation of their difficulties. Notice too that the therapist incorporates what the client has told them regarding their depression, anxiety, suicidal thoughts, unfulfilling relationships, and use of cannabis. This helps the client to feel heard and understood. In this instance, the therapist uses primarily neuroscience constructs, rather than psychological constructs, in formulating the client's difficulties, as clients usually feel that their symptoms are more legitimate and justified if they are suffering from a brain disease. But psychological constructs can also be used as long as they make sense to the client.

The therapist injects hope by describing reasons for the client's difficulties and a rationale for the focus of psychotherapy, thereby laying

out a clear path to recovery. Finally, the therapist provides a caring invitation to the client to embark on that journey, while acknowledging that the treatment is going to be challenging and respecting the client's decision-making capacity as to whether to give it a try.

In a subsequent session, the therapist can explain the psychotherapy model in more detail, outlining the therapeutic tasks and the kind of commitments that the client needs to make in order to successfully achieve those tasks. After that, the therapist again needs to ask whether the client can agree to those commitments and wants to give it a try. (See Dilemma 3 and Figure D3.2 for an example of a list of Recovery Commitments).

When describing the psychotherapy model, it is also helpful to add a discussion of other types of treatment, such as family and group therapies, medications, 12-step or peer groups, and so forth. For adolescents or young adults still living with their parents, we strongly encourage family therapy sessions, in addition to their individual therapy sessions. The social environment is a well-established determinant of suicide (Blosnich et al., 2020). There are two ways to approach this determinant in a recovery-based model. One is by changing the social environment through family therapy and other means, and the other is by building inner strength and resilience to endure that environment through the use of individual psychotherapy. Ideally, it is good to work on both. We recommend that the family therapist be a different provider than the individual therapist in order to preserve the individual therapy as a safe space to explore issues regarding family members without the worry that this will get back to them.

Group therapy can also be a helpful adjunct to the individual therapy. If suicidal thoughts emerge when individuals are feeling stuck alone with overwhelming pain, then it is easy to see how group therapy has the potential to help individuals feel less alone, isolated, and alienated. This is especially true of groups with a more here-and-now interpersonal focus, which help to build a capacity for more authentic and safe relationships for the individuals within the group.

Medications can also play an important adjunctive role in the recovery process. They can sometimes take the edge off of depression, anxiety, psychosis, and mood reactivity, and in so doing they enable the client to be more engaged in the psychotherapy process. The primary danger is the temptation for clients to focus on medications as a quick fix to their suffering, thereby avoiding the hard work that they need to do in psychotherapy to address their underlying vulnerabilities to suicide. We have found that focusing on a medication change can also be a temptation for therapists when they are feeling stuck in one of the dilemmas in this book. The discussion of medications with clients must therefore

be nuanced, being clear on their secondary rather than primary role in the road to recovery. See Dilemma #2 for a more complete discussion of these issues.

Finally, during the subsequent treatment sessions, it is helpful to provide the client with some degree of choice in setting the session agenda. In most psychodynamic models, this principle is already baked in, as the clients have responsibility for bringing in material to explore. However, even in more structured treatment models, it is possible to introduce a degree of choice regarding the treatment tasks to be covered during that session or subsequent ones. In so doing, the therapist is instilling a sense of ownership, thereby undercutting the client's passive resistance, which in our experience is so common among suicidal individuals.

KEY POINTS

- Instill ownership in the clients for their treatment using the following techniques.
  - Spend the time and effort to elicit a chief complaint directly from the client.
  - Provide the client with a formulation and a pathway to recovery with psychotherapy.
  - Ask the client whether the formulation makes sense to them and whether they are willing to give psychotherapy a try.
  - Provide the client with Recovery Commitments and ask whether they are willing to commit to them.
  - Fully describe the psychotherapy model you are using, its rationale, and adjunctive treatments that you think will be helpful. After doing so, ask again whether the client is willing to give it a try.