



THERAPY WITH TOUGH CLIENTS

EXPLORING THE USE OF INDIRECT
AND UNCONSCIOUS TECHNIQUES

GEORGE GAFNER, MSW, LCSW

Praise for *Therapy with Tough Clients*

As Gafner takes the reader through the therapy of two of his most challenging clients, he presents what he calls directed unconscious therapy and often transcends the “translucent membrane” between hypnosis and non-hypnotic therapy. This book is intended as a hands-on resource and is replete with clinical wisdom. Wonderful-Serious-Wise, this is the work of a true master, *Therapy with Tough Clients* should be required reading for all entry level therapists and most seasoned therapists as well.

Stephen R. Lankton, MSW,
author of *Tools of Intention*

Therapy with Tough Clients was primarily written to be of help to the clinician by offering a variety of approaches to treating challenging cases. But the book does much more than this: Gafner challenges us to recognize and transcend our own limitations, encouraging a personal growth that will no doubt spill into performing more creative and effective psychotherapies. Read this book and you will be better in more ways than one!

Michael D. Yapko, Ph.D., author of
Trancework and Depression is Contagious

When searching the bookshelves it is evident that there is virtually no literature available devoted to exploring the tricky subject of handling challenging clients, especially from a hypnotherapy perspective. Not afraid to meet this difficult aspect of the therapeutic relationship head on, George Gafner has written a thought-provoking book that admirably fills this glaring void. Espousing a refreshing pluralistic approach to therapy he explores working with overt and covert resistance, whilst openly discussing the often taboo subject of the therapist’s personal cognitive and emotional reactions.

One of the many highlights of this engaging book is that approaches are illustrated through on-going case studies, which are constructively dissected, affording the reader the opportunity to fully get to grips

with every nuance. Ostensibly based around PTSD, there is much to learn for those not versed in the treatment of trauma as each approach is adaptable to any client that presents a challenge to the therapeutic process.

Gaffner is an expert in therapeutic story telling and therefore this book is unashamedly based around metaphor. That said, other aspects of hypnotherapy, including the use of paradox, are effectively demonstrated in situ in the abundant therapy transcripts. The author also includes informative discussions on the potentials and pitfalls of using cultural metaphors, whilst reviewing hypnotic language and hypnotic phenomena for those new to hypnotherapy. With therapists from every background in mind, the author discusses how approaches can be applied both hypnotically and non-hypnotically. He also explores their application in a diverse range of settings, from couples therapy to those working with people held in correctional facilities.

This is a well-rounded book that holds something for everyone, irrespective of their therapeutic background.

**Peter Mabbutt FBSCH, CEO/Director of Studies
London College of Clinical Hypnosis**

Fans of Milton Erickson and his work with metaphors will love George Gaffner's new book, *Therapy with Tough Clients*. From the very beginning, it is obvious that the author has mastered the use of metaphors as he discusses different categories of metaphors: darkness, weight, captor, and descent. In addition, he refers to "overused metaphors" as well as misunderstood cultural metaphors and he also listens to his clients' metaphors even before the hypnotic experience begins.

The book focuses on two case histories, Maggie and Charles, both veterans who are suffering from a number of problems since their return from combat. They are introduced in the first chapter, and we get to follow their progress throughout the book, but the book is not limited to only Maggie and Charles. One interesting case was how he successfully handled a potentially volatile situation when an angry spouse burst into the middle of her husband's session.

Although the book is filled with various metaphors, the author also believes in the value of ego strengthening, and devotes an entire

chapter emphasizing it. At the same time, he shows his human side by sharing a couple of “oops” comments to let us know that he also makes mistakes. Gafner says, “therapy is more of an art than science,” and I totally agree. It is obvious that he is a master of the artistic use of metaphors in therapy, and his book is easy to read.

**Roy Hunter, FAPHP, DIMDHA,
author of *The Art of Hypnotherapy***

George Gafner is a seasoned clinician who provides a variety of creative ways to use hypnotic procedures and storytelling to treat diverse clients. He uses case vignettes effectively to illustrate the process of therapeutic decision-making. Anyone who is a follower of the Milton Erickson mode of intervention will find this book engaging and informative.

**Donald Meichenbaum, Ph.D., Distinguished Professor Emeritus,
University of Waterloo, Ontario, Canada and Research Director of
the Melissa Institute for Violence Prevention, Miami, Florida**

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Unconscious Techniques

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To Sam Atterbury

Foreword

George Gafner is a storyteller and all of his clients know this. It is not unusual for his clients to ask him to tell them stories during a session. He is also a hypnotist, and has had many years of experience as a therapist. Storytelling and hypnosis seem to go seamlessly together for him (as they do for me). When the story is sufficiently engaging the listener goes into a kind of reverie state, there is focused attention, and most therapists would recognize that their client is in what can be described as a natural everyday trance. This interaction between therapist and client is comfortable and provides a useful instantaneous rapport. What better way for a therapist to help a client work through difficulties?

George has worked with many clients during his professional career in institutional settings such as the Veterans Administration (V.A.) system and jails. These settings and clients are amongst the most difficult to help with psychotherapy. Many of the veterans have PTSD; prisoners and others in institutional settings may be sociopathic and abuse themselves with drugs and alcohol. Yet, somehow, stories and the metaphors embedded within them are so universal that they become the “royal road” to establish a productive therapeutic alliance. People appear to be more receptive to suggestions when listening to stories. In that sense the therapist is communicating directly with the client’s unconscious or inner mind. The more possibilities the therapist builds into the story, the more likely it will be that the listener will latch onto one or more of the embedded suggestions, and use them to reframe themselves out of their stuckness. George is well aware of this, and especially the need to put into the storytelling sufficient pauses so that the listener can process information in his/her own unique way. He also understands that in the interpersonal interaction time in his office that he has to be himself and from time to time share some personal things. (The latter, of course, is done cautiously and with conscious design!)

FOREWORD

In this volume, there are many clients whose concerns are discussed in detail. They illustrate George's experience in working with a diverse population and the ways he chooses to help them. As a kind of leitmotif he focuses on two clients—Maggie and Charles—who appear repeatedly in the book. Most therapists would regard them as being difficult to work with, and George illustrates this in detail, including his own mistakes. He worries about these sessions and mistakes, and we all learn along with him as he freely lets us participate in his progress with Maggie and Charles. It is almost like looking over his shoulder as he ponders what to do next—stories seem to come to the rescue time after time! And he is not afraid to be directive from time to time.

This book is strewn throughout with gems of wisdom and practical things to do, and it is well worthwhile studying. As an added bonus, Chapter 14 contains a number of useful story transcripts which can be adapted to many different circumstances.

Rubin Battino, MS
Yellow Springs, OH

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Introduction

An enduring teachable moment

When we do unconsciously-directed work with clients we are privileged, as they open for us that window to the deepest part of them. When we direct therapy through that window—with story, anecdote, hypnotic language, pacing of ongoing response, or various other techniques—I call this an *enduring teachable moment*, as it is a time of heightened receptivity. But this is not a one-way glass like we used in the 1970s to view trainees doing therapy. We, as therapists, also have an ongoing process, much of it unconscious, reflected back through that window, and in this book I try to capture both sides of that window as I take you through therapy with two engaging and multidimensional people, Maggie and Charles. They represent two of the most complicated and challenging clients I ever had, and by working with them I demonstrate a host of techniques that you may find useful in doing therapy with your toughest clients.

Once I heard someone say that a delight in poetry is “discovering something I didn’t know I knew.” Now, recalling that discovery is an example of this enduring teachable moment, and I’d bet that whatever that person read that day in a poem continues to sit there deep within, waiting to be triggered in the future by a like association. So, too, an enduring teachable moment is evident when I run into a client I saw 15 years ago and she mentions, “You know, that old woman in the woods you told me about, I still think about her.” Something triggers the memory of the woman in the story. It may be mention of a cold day, a forest, or of some other aspect of The Three Lessons story she heard from me years ago, all inextricably linked to the meta-message of the story, that people have resources within to help themselves with their problems. That memorable tale, which I adapted from a story of the same name by Lee Wallas (1985), is an example of what *you* can do in your practice, borrowing from a story

or technique in this book, adapting it to your needs, and fashioning it for whatever clinical scenario you encounter.

Luis, back from Afghanistan

As the unconscious is certainly the aegis of hypnosis, and as this book deals in part with hypnosis, let me share a clinical example that opened up this window to me as much as the client. Around 2005, I was referred a young Hispanic soldier, Luis, who had recently returned from Afghanistan. His problem was erectile dysfunction. He was in perfect health, on no medications, did not have depression or PTSD—despite months of harrowing combat—and like many hypnosis referrals, it came out of frustration after all else had been considered. Luis was married, of average intelligence, spoke good English, and said he didn't drink or use drugs. He was calm, in no distress whatsoever, and said he wasn't bothered at all about the war. His only concern was that he was impotent.

The next session we began hypnosis. He responded with deep trance and amnesia to a conversational induction and The Three Lessons story, which embeds the suggestion that people have resources within to help with their problem. The next session I employed a similar procedure but added an ego-strengthening story and set up finger signals for unconscious questioning. Using age regression, I asked him to go back in time to “any time in the past that might have to do with the problem ... and when you're there, Luis, you may let your ‘yes’ finger rise.” After about a minute his index finger twitched and he began to mutter some words that were unintelligible to me, but I did glean a fragment of a phrase, “I-U-D, I-E-D.”

I re-alerted him and discussed today's session. It soon was apparent that his unconscious mind had mixed up the improvised explosive devices (IEDs) in the war with his wife's new intrauterine device (IUD), and impotence resulted. Discussion normalized and integrated this phenomenon, the problem immediately resolved, he was seen one more time in a month and was doing fine, end of story.

Now, how many sessions of talk therapy might have been needed to resolve that problem?

Peter in jail

Therapy with Luis was during a scheduled appointment in a comfortable office at the Veterans Affairs (V.A.) Medical Center. The conditions were optimal. But such conditions aren't always necessary to elicit a similar response within unconsciously-directed therapy. For example, I am now retired, for the most part, but I used to work about four days a month at the local jail. The other day one of the psychiatrists grabbed me as I was walking by and asked me if I would see this very anxious client I'll call Peter, a Black male being treated for bipolar disorder. I sat with Peter for a few minutes in a busy hallway outside the exam rooms in the medical section of the jail. The first thing I noticed was Peter's very fast and shallow breathing.

I showed him deep breathing and asked him if I could tell him a little story while he practiced this better way to breathe. "You can close your eyes or keep them open, whatever you wish," I told him. He chose to close his eyes and I told him The Three Lessons story, which I often use early on. People continued to walk by in handcuffs and chains, doctors and nurses were talking, and it was business as usual while Peter responded highly favorably to the story. In two minutes we were done, his anxiety was allayed, and he left with some tools to help him in the future. I have had similar responses in even worse conditions there, like talking to them through the food trap in the door in segregation, or standing in the corner of a busy day room with the curious walking by, straining to hear what was being said. In other words, a nice office with a recliner and wind chimes music is nice, but if you don't have it, you can improvise, even in the midst of rapists and murderers.

Standing on broad shoulders

In my years in this business I have learned from many, from my family, colleagues, people in the field, and my trainees, who came from

divergent backgrounds and theoretical perspectives. However, my clients probably taught me more than anyone. For 38 years I worked at clinics and hospitals, and for 28 of those years I directed a program in family therapy and hypnosis training in the V.A. in Tucson, Arizona.

I learned from people who had extraordinary experiences, like the men who had been prisoners of war in World Wars I and II, as well as in later wars in Korea and Vietnam. I learned from the reactant and hostile, like the spouses and children who involuntarily attended family therapy, or those who were directed to attend one of the two anger management groups I conducted for 20 years. One Vietnam veteran with florid PTSD said he was eager to attend because “this is my 12th marriage and I intend to keep it.” He did well in the group and his wife was eternally grateful. Years after the group, when I encountered that man or many others, I asked them what they remembered about the group, and invariably they answered, “To take a deep breath or a time-out ... but what I liked best was the stories you told.” Indeed, stories and anecdotes, both indirect, or unconsciously-directed techniques, have been my allies for many years.

I learned from my long-term therapy clients and I learned from the ones I saw only once or twice, like the paranoid personality disorder who defied me to try and help him. The V.A. is a fascinating place to work because you encounter a wide diversity of people with every kind of clinical problem. The youngest veteran I saw was 19 and the oldest 102. The oldest couple I saw had been married 76 years. Their recipe for a successful marriage? “Always talk things out and never go to bed angry.” I learned from the elderly schizoid woman whose eyes I never saw because of her mirrored sunglasses. I learned from the overly compliant and passive, the therapy addicts who lived in their heads and were resistant to all change however small. I learned from the 200 trainees I had over the years in psychology, psychiatry, nursing, social work and other disciplines. I estimate that over the years I had to do with some 10,000 clients that I either saw directly or whose cases I supervised. In this business we quickly learn that

some we help, some we don't, and some we never know because they just fade away.

Trying new things as we counter resistance

For years on Tuesday evenings I was a volunteer therapist at the refugee clinic of the University of Arizona where I saw victims of torture. These people from Central America, Africa and the Balkans had experienced all manner of cruelty, loss and humiliation. I've always done therapy in either English or Spanish, but sometimes at this clinic an interpreter was employed, usually a French-speaking medical student who had done a rotation in Africa. From those in the refugee clinic I learned how fleeting and precious life is, and how we need to make the most of those few minutes or hours we are with any client. Seeing people who were able to overcome the most awful circumstances somehow made it easier for me to help the majority of my clients, people whose problems were understandably dear to them but which paled in comparison to those of survivors of the Bataan Death March, or the lone survivor in a village where all were killed.

Along the way I learned patience. With patience you don't give up on clients and you keep trying new things in order to make an impact. As we try new approaches and techniques we discover what may work in certain situations, but we especially learn what may work for *us*. From these successes we build confidence, and this confidence is immediately apparent to others. I intended this book to be not only an aid to your practice, but also an impetus for the growth and development of the clinician.

Scientifically supported treatments

Currently, in many quarters there is a strong push to practice only one modality for most disorders. Of course, this means some variant of cognitive-behavioral therapy (CBT). I support CBT as a front-line approach. However, I know many seasoned psychologists and other practitioners—not only those new to the field—who disdainfully

throw up their hands and are at a total loss when the client says, “I already had CBT and it didn’t work,” or “I believe my problem resides in my unconscious, and I want therapy directed at *that*.” I had many clients who in the first few minutes said, “Please don’t ask me to list my dysfunctional thoughts; I already did that both in group and individual therapy.” So what does one do with those clients? Well, please read on.

A hands-on resource to assist with the toughest of clients

I make the assumption that you have been trained in one of the major disciplines, that maybe you are licensed, and that in your counseling or therapy practice you are guided by a generally accepted therapeutic approach. You’ve heard the saying, “When you buy a new hammer everything looks like a nail.” Well, I know clinicians whose average day consists of EMDR or hypnosis sessions, hammering one nail after another. I asked them, “What if they have acute grief or a crisis?” You guessed it, EMDR is good for everything, they know because every client looks like a nail. I’m not denigrating EMDR, as I’ve used it for many years, but almost all the time *for everyone*?

For you, perhaps you practice some version of CBT, or a mindfulness-based therapy, or maybe your theoretical orientation is psychodynamic, NLP, or some other popular approach. Perhaps you employ meditation or relaxation and stress management with your clients. If you could use an extra hand with your toughest clients, I encourage you to read on.

When first conceiving this book I thought, “What kind of resource can best assist clinicians irrespective of their approach?” As such, I intended this book to be a hands-on resource that offers you ideas, choices, and opportunities to employ as an *add-on* to your approach. I’m very familiar with clients who, early on, would set off alarm bells in my head, you know, where the hair on your neck stands up and your gut response is, “Oh, no, not another one!” With such clients, you know you have your work cut out for you and maybe you even

say to yourself, “They don’t pay me enough to try and help people like this, let me think ... hmm, how can I ensure that they WON’T return?” Believe me, I’ve thought those thoughts, but I kept them to myself, not wanting to be mean-spirited or disrespectful, and went ahead and did my best with people who were, as we say in the U.S., “a sharp stick in the eye.” Now, that type of client is an obvious example of a person whose resistance and overall presentation are worse than challenging. Even with them there are techniques that can help.

Building a foundation before advancing to corrective measures

With many people, the challenges are more subtle. You think therapy is progressing well and all of a sudden they start canceling, or just don’t show up. Something is operating beneath the surface—the issues are too dear, or you failed to put your finger on something important. In any event, you need to identify and rein in resistance so that therapy can move forward. For sure, I realize that there are some clients who simply aren’t ready to address vital issues. They bolt from therapy early, but hopefully they learned something from a session or two so that this foundation can propel them to successful therapy in the future.

One thing I emphasize in this book is how we can “till the soil before planting the seed” by building a firm base of ego-strengthening before moving on to corrective techniques. I explain this to clients as “doing a mental building up first,” likening it to a debilitated medical patient who requires major surgery (Hammond, 1990). That patient can first benefit from rest and good nutrition, strengthening her ahead of time. In psychotherapy, I believe that far too often the client comes in and says, “I need help with this problem,” and we unwittingly jump in with corrective measures. The client isn’t ready, we lose them, and once again we’re left ruminating on the old maxim, “Be careful what you ask for.” With a few sessions of ego-strengthening such treatment failures can be avoided. I always emphasized to trainees that early on they concentrate on one thing:

Ensuring that the client will return. “If they don’t come back you can’t help them,” I reminded them.

Two other major pitfalls for therapists are 1) low-grade blocks to treatment during the course of long-term therapy, and 2) therapist burnout. You’ve seen this person (or multiple persons, if it’s family therapy) for a good deal of time, progress is slow but steady, but you’ve grown weary. And if you feel weary or bored, believe me, it will show! With both these scenarios there are various techniques that you can add to both energize treatment and yourself. Doing therapy is damn hard work and you need to keep adding tools to your toolbox. Even with working part-time now I make sure my toolbox stays heavy. I keep adding tools to it and I haven’t burned out yet.

This client is ‘treatment resistant’

I always tired of colleagues who surrendered at the least resistance, saying they couldn’t help so-and-so because the client lacked motivation, or was “treatment-resistant.” To be sure, those are accurate terms for some clients, but certainly not all. If people say they want help, they show up and participate as best they can and nothing happens, they may indeed be resistant, but on an *unconscious* level. Consciously they’re on the same page as you, but something is holding them back. That *something* usually resides in the unconscious, and that’s where your efforts should be directed. In a workshop once someone asked, “George, does unconscious resistance mean they can’t help it?” I would argue, in effect, yes, for many, this process lies outside of awareness and thus outside of voluntary control. No, I’m not talking about secondary gain, like the auto accident victim whose PTSD or neck pain won’t improve until the lawsuit is settled. (If I were the accident victim I wouldn’t improve either!) I’m talking about the others who have average or above intelligence, no organic cognitive problems, and no apparent secondary gain. They just can’t get with the program, something is holding them back, and they simply can’t let go. It’s like any other barrier in therapy that needs to be cleared from your path so you can proceed. However, because

we're talking about the unconscious here, you need to proceed by getting in *underneath* the radar, by hitting the ball *beneath* the net.

The therapist can make something happen in the session

Jay Haley said that it was the job of the therapist to *make something happen*, and I've always taken those words to heart. We have a panoply of techniques at our disposal to help motivate and to bypass barriers in the unconscious, and many of them I'll cover in this book. You, kind reader, may already have an ample tool box. My intent in this book is to augment that tool box many-fold so you can better instigate behavior change in your clients, or at least effect a critical reframe to make life more tolerable. Most approaches to psychotherapy avoid or pay lip service to unconscious process, even though convincing psychological literature indicates that a greater portion of our mental functioning is governed by automatic or unconscious process, by forces that lie outside of voluntary control (Bargh & Chartrand, 1999; Mlodinow, 2012). Milton Erickson demonstrated the indirect approach beginning in the 1930s when psychodynamic treatment ruled the day, when the unconscious was viewed as a primordial ooze of negative impulses. Erickson showed us that the unconscious can be a highly employable resource, and in this book I try to tap into the ways we can access this vault of opportunity, the therapist's as well as the client's.

Therapy is art informed by science

I'm a strong supporter of evidence-based treatments but I also believe that in much of real-world mental health treatment we can't simply follow a manual. We must adapt treatment to the unique needs of the individual, and the more skills and tools we can bring to bear, the better for both us and our clients. I've written extensively on hypnosis—and the application of hypnotic techniques within standard talk therapy—and this book builds on that work. As such, it is a synthesis of many years of seeing difficult clients, and teaching and writing about the things we can do to amplify our skills in further

helping those clients. In this book I draw on science, but therapy is more art than science. I believe that the science informs the art rather than the other way around.

Maggie and Charles

In this book I take you on an excursion involving the treatment of two people, Maggie and Charles. Maggie suffers chronic problems, irritable bowel syndrome and PTSD, and to date she has failed all interventions. Charles' problem is acute. A clinical psychologist as well as a Vietnam veteran, he is distraught, primarily from the guilt of a romantic attachment to one of his own clients; however, as therapy goes on, something deeper and more pervasive is revealed. For both people, problem resolution resides in one place, the unconscious. Through therapy transcripts I demonstrate the range of indirect techniques that you can bring to bear on the problems of your clients. The ongoing therapy process is punctuated by chapters that further explicate these techniques. I demonstrate the use of hypnotic language and similar devices through "call-outs," where italicized principles or techniques in the text are defined in the right margin, thus providing an ongoing explanation of technique and process. At intervals in the transcript dialogue I critique both the ongoing content and process. Therefore, the reader is continuously attuned to the thoughts and reactions of the therapist. People are hard-wired to appreciate variety, and to this end I attempt to hurl at the reader a vast array indirect techniques, all employed to bypass resistance and move therapy forward.

Key components in the book

It may be intriguing to some that these "hypnotic techniques," formerly thought to reside exclusively in the sphere of formal hypnosis, can also be employed within standard talk therapy. In this book I like to think I am intentionally poking a finger into the translucent membrane separating hypnosis from not-hypnosis. In the didactic chapters that punctuate the therapy transcripts, I discuss concepts and techniques seldom addressed previously, such as the

therapist's voice, subtle vocal shift, the pause, the strategic interval of silence, and seeding, along with the use of these techniques in non-traditional settings, such as correctional facilities. The use of story and anecdote are developed, both for ego-strengthening and to initiate unconscious problem solving, along with story techniques, such as story without an ending, story within a story, and alternating stories. I discuss steps for therapists to write their own stories, and where the therapist can locate source material to this end.

I try to make the case for integrating ego-strengthening into standard talk therapy. I advocate it as a “shovel-ready project,” in other words, akin to “first picking the low-hanging fruit,” as the therapist builds a firm foundation with ego-strengthening before progressing to remediative measures. These clinical accounts are true; however, I have sufficiently altered details to protect the privacy of the clients. Nevertheless, the techniques discussed, along with the incidents described—however strange they may seem—actually occurred.

I enjoyed putting this book together. I hope it can serve as a ready-to-use reference for you in your practice and help you grow in the process. Don't give up on those difficult clients, as there's always something else you can try!

CHAPTER ONE

Initial sessions with Maggie and Charles

The Case of Maggie: a referral for individual therapy

Perusing Maggie's V.A. medical record before the first session, I glimpsed a 33-year-old Mexican-American woman who had become discouraged and hardened after 12 years of treatment in the U.S. Veterans Affairs system. In the past two years she had had three brief, voluntary psychiatric hospitalizations for suicidal thought, had been tried on various SSRIs, mood stabilizers and other agents, and had been in and out of individual therapy with a series of psychology interns. She continued to decline offers to participate in the PTSD women's therapy group. Diagnostically, she was classified early on with depression and chronic PTSD, and the recent assignment of borderline personality disorder seemed to reflect staff frustration. Medically, she was followed in a primary care clinic as well as the GI Clinic for irritable bowel syndrome.

First session with Maggie

Maggie had someone with her, a short, rather shriveled up Mexican woman.

Maggie: This is my mother. I didn't have anybody to watch her. She's pretty deaf and doesn't speak much English.

Therapist: Buenos días, señora.

The woman smiled politely, sat down in a chair in the corner of the office and folded her hands on her lap.

THERAPY WITH TOUGH CLIENTS

Maggie: I have IBS and I hear you tell stories, so that's why I'm here. I know you also do hypnosis, but I don't think I need that.

She spoke in a soft but firm voice that had the huskiness of a smoker. She was tall and lanky and wore a black tank top, shorts and sandals and reeked of marijuana smoke. I could not see her eyes behind mirrored aviator glasses. Her long, black hair framed what was possibly an attractive, olive-skinned face. Actually, little of her face was visible with the sunglasses and an Arizona Diamondbacks baseball cap. The profile of her face yielded a pronounced narrow nose seen in some Mexican-Americans in the U.S. Southwest, considered by many as aristocratic or Aztec. I asked her to remove the sunglasses and when she did I observed eye contact that was steady, even intense. Her face remained expressionless as she spoke, except for a slight puffing of her lips that served as a perfunctory smile. "This woman is in control," I thought.

Therapist: So, you like stories, huh?

Maggie: Sometimes. Just so you know, I don't like to tell much about myself. I get a copy of my record every six weeks. Half of what the doctors write is all wrong.

I thought about how some clients routinely request a copy of their record. This can mean they have filed a claim for service-connected compensation and are monitoring ongoing documentation on which a determination on benefits is based.

(In the V.A., clients may be paid for any problem or condition that occurred or was exacerbated by their time in the military. From nearly 30 years in this system I knew that if a claim was extant, the "green poultice" could be at work and the client might not

make much effort to get better. If I were in their shoes I probably wouldn't get better either.) I made a mental note to ask about a claim. And then the story. She mentioned stories right at the beginning, so that's what I needed to embrace and employ right from the start and not be distracted by her problematic history and provocative presentation.

Therapist: So, Maggie, you get any money from the V.A.?

Maggie: Fifty percent for IBS.

Therapist: So, that's about 500 dollars a month.

Maggie: A bit more—and tax-free thankfully. I get by on that plus an odd job now and then. I'm not taking any classes now. My mom is taking up a lot of my time.

Therapist: So, you have IBS. Constipation-predominant? Got a claim in now?

Maggie: Constipation big time, Doc! And no, I haven't filed any claims for a long time.

Therapist: Please call me George, I'm not a doctor. And when did the gastrointestinal problem begin?

Maggie: It started in 1991 when I was in Kuwait in Desert Storm, we were huddled behind a berm with our gas masks on and a SCUD missile zoomed over my head and it literally scared the shit out of me.

Therapist: So, you *do* talk about yourself sometimes.

Maggie: Yeah, when I feel like it.

THERAPY WITH TOUGH CLIENTS

I could see this might be a fairly brief session, which I didn't mind, as I appreciate any extra time for the paperwork. I verified a bit more of her history. Early on, I never ask about substance abuse. If they bring it up, fine. If I act interested in that at the start they sometimes don't return.

Therapist: Okay, now is the best part, my story for you today. You can sit back in that recliner, close your eyes or keep them open, whatever feels better ... (in a slightly lower volume) as I've learned over the years that a person doesn't even have to pay attention because the unconscious mind can glean anything important, as you *slow down your mind, or your body*, become *absorbed* on the outside, become attuned to the inside, *amuse* yourself inwardly, or simply *experience* relaxation and comfort in your own unique way, as I tell you a little story.

Suggestion covering all possibilities

The story is about Pandora and her box, have you heard it before?

Maggie: Ancient Greece is all Greek to me.

She elevated the recliner's foot rest and sat back. She crossed her arms on her chest and let the sunglasses fall to the floor. Her mother remained impassive but had now closed her eyes.

Pandora's Box

Therapist: This story was first heard around an olive press ...

Maggie: Olive oil makes me itch.

Therapist: ... or maybe at bedtime, who can know for sure?

Maggie: Bedtime for sure. Pandora is her name, right?

WHETHER YOU'RE FAIRLY NEW TO THERAPY OR YOU'VE PRACTICED FOR MANY YEARS, NO DOUBT AT TIMES YOU'VE FOUND YOURSELF STUMPED WITH CERTAIN CLIENTS WHO LEAVE YOU FEELING PERPLEXED AND DISCOURAGED WITH THAT "I-JUST-DON'T-KNOW-WHAT-TO-DO-NEXT" FEELING.

This volume by George Gafner revolves around two such fascinating cases, Maggie and Charles. Maggie is a Gulf War veteran and suffers from chronic problems, including irritable bowel syndrome and PTSD. Charles's problem is acute. A clinical psychologist as well as a Vietnam veteran he is distraught, primarily from the guilt of a romantic attachment to one of his clients; however, as therapy goes on, something deeper and more pervasive is revealed. For both individuals, problem resolution resides in one place, the unconscious. Following how these cases unfold offers a unique, revealing insight into how a master therapist deals with and confronts his clients from whatever direction best suits the client's psyche. Through the use of transcripts the author demonstrates the panoply of indirect techniques that a therapist can bring to bear on a client's problems as he feels that all therapists must adapt treatment to the unique needs of the individual, and the more skills and tools that can be brought to bear, the better for both client and therapist.

"This book is intended as a hands-on resource and is replete with clinical wisdom. Wonderful-Serious-Wise, this is the work of a true master, and it should be required reading for all entry level therapists and most seasoned therapists as well."

STEPHEN R. LANKTON, MSW, AUTHOR OF *TOOLS OF INTENTION*

"George Gafner challenges us to recognize and transcend our own limitations, encouraging a personal growth that will no doubt spill into performing more creative and effective psychotherapies. Read this book and you will be better in more ways than one!"

**MICHAEL D. YAPKO, PH.D.,
AUTHOR OF *TRANCEWORK AND DEPRESSION IS CONTAGIOUS***

"Gaffner is an expert in therapeutic story telling and this book is unashamedly based around metaphor. With therapists from every background in mind, he discusses how approaches can be applied both hypnotically and non-hypnotically and also explores their application in a diverse range of settings, from couples therapy to those working with people held in correctional facilities. A well-rounded book that holds something for everyone, irrespective of their therapeutic background."

**PETER MABBUTT, FBSCH, CEO/DIRECTOR OF STUDIES
LONDON COLLEGE OF CLINICAL HYPNOSIS**

About the Author: **George Gafner, MSW, LCSW** recently retired from the Southern Arizona Veterans Affairs Medical Center where he was Director of Family Therapy and Hypnosis Training. For the past two years he has worked part-time as a mental health counselor at a local jail which holds 2,000 inmates. He is the author of five previous books on clinical hypnosis as well as numerous journal articles.

Psychotherapy

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