Challenging and confronting clients with compassion

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Routledge Handbook of Applied Sport Psychology
A comprehensive guide for students and practitioners

Edited by Stephanie J. Hanrahan and Mark B. Andersen
From the first three chapters of this book, the importance of building a strong relationship with each client should be evident. Many things can be accomplished with clients once this foundation is built, such as taking the risk of challenging or confronting them on critical issues. Regardless of experience level or theoretical orientation, facilitating strong working alliances with clients and helping them navigate behavior change are two common threads we need to manage in most therapeutic situations. Therapists commonly serve as “agents of change” – so let’s explore how we can become highly skilled facilitators of clients’ behavior change processes by looking at our own self-awareness.

Looking inward: the therapist’s perspective

Understanding the purpose of challenging and confronting clients in therapy

One of the first steps to facilitating the process of confrontation within therapy for sport psychology practitioners is to understand why we would even want to challenge our clients. Aren’t they responsible for change? Depending on the level of direction typically provided to clients in therapy (and the therapeutic models used), we may be more or less comfortable with the idea of confronting client issues directly.

The primary purpose of challenging or confronting clients’ key issues is because one believes it will help them reach their therapeutic goals. The desired outcome, at least from the therapist’s perspective, is to keep the issue in the present moment so that it cannot be ignored (Hanna, 2002). Research has suggested that keeping clients focused in the present (i.e., how the client’s problem is being experienced right now) is a more effective method of facilitating working alliances compared to focusing on past experiences (Kivlighan & Schmitz, 1992). The process of confrontation, however, may lead to considerable distress on the part of clients because it is usually more comfortable to ignore (or deny) difficult or recurring issues. Consciously or subconsciously, clients may have developed a variety of skills or strategies to keep these issues out of their present awareness due to the distress that may be caused by bringing them to the surface.
So how should we view our roles in this process? The term *confrontation* may lead to images of the therapist in an adversarial role battling with the client and arguing for change. Most research on behavior change in therapy, however, suggests quite the opposite. Based on qualitative and quantitative studies of successful behavior change experiences, clients most often describe their therapists as warm and supportive (Hanna & Ritchie, 1995). Highly compassionate practitioners define compassion as being fully present with clients and helping clients take action to change (Vivino, Thompson, Hill, & Lanady, 2009). Pushing or pulling clients to help them alleviate suffering or grow as people may be a compassionate act when handled effectively, and may be needed for some clients to initiate change (Vivino et al., 2009).

Some clients may not be ready or motivated to change, and this lack of readiness may be the first target for confrontation in therapy. One model that can be helpful in analyzing a client’s readiness to change is the transtheoretical model (TTM; Prochaska, Norcross, & DiClemente, 1994). The five stages of the model include: (1) precontemplation (not even considering change); (2) contemplation (thinking about changing, but not ready to act); (3) preparation (making specific plans to initiate change in the next month); (4) action (the first six months of engaging in a new behavior); and (5) maintenance (more than six months of behavior change). The stages within this model, and the corresponding processes of change, can be used as guidelines to plan confrontations to help move clients from the precontemplation or contemplation stages into the preparation stage. Consciousness raising is one process that is helpful for moving clients toward contemplation. For example, if one wanted to confront an individual in precontemplation about changing a behavior, incorporating education about the benefits or consequences of change might assist the client in moving into contemplation:

**Dr. Psi:** Lee, we’ve been working together for quite some time now, and I don’t think I’ve ever seen you take a day off. I know you want to make it to the championships this year, but I’m worried that your training might be putting your health at risk. Have you noticed any negative effects over the last few weeks?

**Lee:** Well, not really. I mean, I am pretty tired, but I make do.

**Dr. Psi:** Making do doesn’t sound like the best way to be going through life. What might be some benefits of taking a day off and getting more rest?

Other processes of change can be used throughout the various stages of the TTM. Stage-matched processes of change can be incorporated at any point in the behavior change process, so we encourage practitioners to explore this work further (Prochaska et al., 1994). Many theorists and practitioners espouse the basic concept of “meeting clients where they are,” and using the TTM is only one frame of reference for helping clients achieve their therapeutic goals.

One of the key purposes of looking inward is to remind ourselves why we are sitting in our offices, in locker rooms, or on the practice fields (e.g., to help our clients), and that there may come a moment when we will need to confront or challenge our clients to help them achieve their goals. Cormier and Cormier (1979) recommended that prior to implementing any helping strategy, therapists weigh their own characteristics and preferences as well as the client’s, along with any salient environmental factors. One way to begin this process is to explore how our personalities may interact with clients and the circumstances in which they are living.
How might our personalities affect our approaches to confrontation?

In our roles as counselors or therapists, we serve as facilitators of attitude and behavior change for our clients. Two important factors that will greatly affect how we facilitate change are our personalities and therapeutic styles (e.g., models of therapy we use).

Are we aware of our own dominant personality traits and how they interact with traits in others, in particular our clients? For example, a psychologist might be a highly conscientious, goal-oriented type of professional who gets frustrated with disorganized, unmotivated clients. Another could be an amenable helper who is uncomfortable with conflict and distress. Any dominant personality characteristics we possess, we bring with us into nearly every situation, including our roles as therapists. Typically, these dominant traits include functional strengths and Achilles heel-like weaknesses that we will want to be aware of in our roles as sport psychology professionals (not to mention our personal relationships!). Self-awareness of these characteristics is part of being an effective therapist, and will certainly help us understand how we may cognitively and emotionally react to the process of challenging our clients.

One useful exercise we recommend for supervision sessions is for students to discuss their personality characteristics with their supervisors, using a 1–10 scale for each bi-polar characteristic. If students have completed a personality test, then of course they can use the results as the basis for discussion, but for simplicity’s sake, let’s just use the five-factor personality model as our guide (McCrae & Costa, 2008). The characteristics within this model include: (a) open to experience–closed, (b) conscientious–disorderly, (c) extraverted–introverted, (d) agreeable–disagreeable, and (e) neurotic–calm. These five global traits don’t really do justice to the complexities of our personalities, but they may help us think about core characteristics in ourselves and our clients. The factors in this model can have a strong influence on how we approach and react to specific types of clients or clinical situations.

The purpose of this discussion with a supervisor (or colleague) would be to identify one or two dominant characteristics and then brainstorm on types of clients or specific scenarios that match, and do not match, well with the therapist’s personality. The point of the discussion is not to change dominant traits but to increase awareness of how these traits influence client interactions, the development of the therapeutic alliance, and the propensity for conflict. We believe, as Corey (1991) has articulated, that “you are your best technique” (p. 437), so it follows that we should spend considerable time studying this critical technique (ourselves) and understanding our own personalities, interpersonal skills, and therapeutic styles. Supervision is a logical place to facilitate this process because it helps sometimes to get an external view, and keep ourselves accountable and honest.

How might therapeutic style affect approaches to confrontation?

Some approaches to counseling, such as some cognitive-behavioral models, include direct confrontation as a key component of effective counseling. Rational–emotive behavior therapy, for example, includes confrontation as a critical therapist skill along with genuineness, empathy, and concreteness (Whalen, DiGiuseppe, & Dryden, 1992). This didactic approach to therapy emphasizes directly challenging clients’ dysfunctional thoughts. Training in one of the cognitive-behavioral models of therapy may result in the inclination to build effective confrontation into some sessions.

Nearly all major models of therapy outline different techniques for managing conflict within clients (Corey, 1991). Some approaches focus on exploring repressed conflicts
(psychodynamic), making choices and understanding purposeful behavior (e.g., Adlerian, existential, transactional analysis, reality therapy), or revisiting denied or repressed emotional experiences (e.g., Gestalt, person-centered therapy). Regardless of the approach or technique adopted, sport psychology professionals will need to build rapport and find positive ways to challenge and confront clients if they hope to be effective practitioners.

Ultimately, after building self-awareness of our own therapeutic foundations, which are in turn built from personal tendencies and professional training, we might ask these two questions before making a plan for confrontation:

1. How do I rate the quality of my client–therapist relationship?
2. Have I earned the right to confront this client?

By reflecting on these two questions, or discussing them in supervision, we will be able to understand if we are ready to build a specific plan for confrontation or if we need to re-invest time in our next client session to build a stronger foundation (working alliance) so we can take advantage of a challenge/confrontation later on in therapy. Now that we have discussed self-awareness by looking inward, let’s change our focus and begin to evaluate client-specific variables to come up with a plan for approaching some challenging situations.

Looking outward: the client’s perspective

Much of the literature on challenging therapy situations or confrontation focuses on specific client populations including those in prison, or clients with drug or alcohol problems. (Miller & Rollnick, 2002). In many cases, clients are “nonvolunteers,” and the context of therapy requires a strategy to help these clients achieve major outcomes in key life domains (e.g., work, relationships, jail time). Although some athletes struggle with similar concerns, many sport psychology clients don’t fit this profile because we have the luxury of working with fairly motivated individuals. There can be circumstances, however, when athletes are mandated by coaches or administrators to see a sport psychology professional (e.g., alcohol or drug violation, team suspension).

Applied sport psychology provides a different therapeutic context for understanding behavior change and confrontation because the “need” to change may not be as critical compared to other client populations. For example, if people with addictions do not find new ways to approach their disorders in a fairly quick manner, they may experience significant, meaningful, and negative consequences across many life domains (loss of work, restricted freedom, diminished social support, death). The need to change is often easy to illustrate, although not always embraced by clients in these difficult circumstances.

In contrast to the extreme examples above, a tennis player may seek sport psychology services to reduce his performance anxiety so he can serve better and play more freely in performance situations. If he doesn’t manage to change his approach in the next few weeks, it is unlikely that he will experience significant consequences outside of sport. The good news is that because many sport psychology clients voluntarily seek help, they have implicitly recognized the need for change, and they may possess stronger coping skills and support than many mental health clients. The bad news is that because the client is functioning fairly well in sport and other areas of his life, he may be ambivalent towards putting significant effort into achieving a perceived small change. To help evaluate a client’s perspective
on change, there are several useful questions to guide the process based on the motivational interviewing work of Miller and Rollnick (2002).

**Evaluating the client’s perspective on, and capability for, change**

Motivational interviewing (MI) is an approach to counseling centered on preparing people for change by helping them resolve ambivalence and low motivation (Miller & Rollnick, 2002). The interviewing nature of this client-centered approach poses clients as the experts navigating their own paths to change, with therapists holding an indirect, nonconfrontational stance. There is plenty of MI-related literature on working with difficult clients, but it is unclear how applicable this work is to sport psychology interventions, particularly for those who are oriented toward performance. Unless sessions are mandated by a coach for some violation of team rules, sport psychology practitioners may not encounter many difficult clients or those at earlier stages of readiness to change (i.e., precontemplation). There are many circumstances, however, where we may encounter athletes who are ambivalent or unmotivated toward change, so the key principles of MI can still apply to sport psychology work. Here are a few examples:

- A basketball player complains about her coach’s and teammates’ behaviors toward her but doesn’t follow through on strategies to manage her emotional reactions (i.e., she likes to complain and doesn’t accept responsibility for her role in the interpersonal conflicts).
- A cricket bowler continues to show up for psychological skills training sessions but does not complete homework assignments week after week (i.e., he doesn’t appear to want to put in extra effort to develop self-talk and imagery skills to improve performance).
- A coach refers a track athlete because of a bad attitude problem. She shows up for sessions, talks a good talk about making attitude and behavior changes related to improved work ethic at practice, but discreet observation during recent practices and competitions reveals negative attitudes and behaviors (i.e., discrepancy between session and external behavior).

MI theorists suggest that ambivalence can be expressed in two key sentiments, “I want to, but I don’t know how” or “I want to, but I’m afraid of failing again” (Miller & Rollnick, 2002, p. 12). Successful athletes are often tuned into a training–performance cycle that includes investing significant amounts of effort to achieve a stated goal (e.g., improved personal performance, individual or team outcomes). They may evaluate sport psychology interventions skeptically, and could be unsure if mental training will be worth the effort for a potential change in one of these outcomes. To help explore the potential for change in each client and how to challenge the client to pursue a different path, the “ready, willing, and able” model is useful as a guide (Miller & Rollnick, 2002).

**Question 1: Is your client ready to change?**

One factor to consider is whether the client feels that the potential behavior change is important enough at this specific moment in time to invest the necessary effort. If the client is ready for change, then think clearly about whether she has the motivation and skills to navigate the path ahead.
Question 2: Is the client willing to change?

Typically, athletes don’t lack willpower or motivation to achieve their goals, but in some cases their understanding of how to go about correcting long-term problems or repeated failures may be limited and lead to low motivation. Attempting to change, therefore, may disrupt a comfortable state of persistent unsatisfactoriness. One of the key issues involves understanding if clients are willing to experience additional failures along the way for the potential of increasing the consistency or level of performance in the future.

Question 3: Is the client able to change?

Elite athletes are often creatures of habit. They manage their food intake, sleep, hydration, training, and recovery often with military precision so they can achieve predictable and consistent levels of performance. Taking on the challenge of changing most, or part, of this routine may result in significant distress and frustration. So, does the client have the coping skills to overcome the negative mood commonly experienced during change? If not, time may be needed to help them build up critical coping skills to manage the stress response likely to be experienced.

The game plan for confrontation

Timing

We should allow plenty of time within a session for confrontation, because we may need to attend to clients’ feelings before they leave our presence. For example, some clients may bring up a sensitive issue towards the end of a session to present material that is “therapy-worthy” without actually having to discuss it. Although it is important to confront clients who repeat this pattern, it is rarely a good idea to broach the topic with only a few minutes left in a session. Instead, consider approaching the client at the start of the next meeting so that there is ample time to discuss both the issue at hand and the client’s motivation for avoiding “doing the work.”

Direct or indirect?

When formulating game plans, consultants should consider whether a direct or indirect approach is best for confrontation. The approach that one decides to take will ultimately depend on a combination of factors, including personal therapeutic style, the client, and the specific scenario. It is important to have a clear sense of the clients’ worlds and to be able to anticipate how they will react to particular challenges. It might be helpful to think of planning for confrontation as an imagined chess match, thinking several steps ahead before acting. If I say “x,” how might the client respond? If the client reacts with “y,” what would I do next? Thinking about the “what ifs” might help determine which approach will work best for the client in that situation; as well, this thinking ahead can allay anxiety and ready the therapist for the various reactions the client might exhibit. It is useful to imagine both positive and negative outcomes to be optimally prepared.

If one is not comfortable openly challenging a client, or if the client exhibits characteristics such as anxiousness or defensiveness, an indirect approach may work best. Indirect approaches that are often effective include the use of humor, identifying discrepancies in behavior, and
other techniques found in motivational interviewing (Miller & Rollnick, 2002). The following is an example of a confrontation using an indirect approach with a client:

Amy was referred to Dr. Psi by her swimming coach because her competitive times have continually increased throughout the season, and she seems totally unmotivated. Amy has been to see Dr. Psi twice already, and has expressed a desire to “do whatever it takes” to get back to her previous levels of performance. Nevertheless, Amy has agreed during both previous sessions to complete a practice journal for homework, but arrives for the third session without having completed the log.

Dr. Psi: So Amy, do you have the journal that we agreed you would complete for this week?

Amy: No Doc, I’m sorry I don’t have it.

Dr. Psi: Well, I was never a big fan of homework assignments either, so I can appreciate where you’re coming from (stated in a humorous tone). However, you’ve said a number of times to me already that you want to do everything that you can to get back to your previous performance, so I can’t figure out why else you would agree to keep the journal and then not follow through on it (identifying discrepancies).

Amy: I know Doc, and I really do want to improve, I do!

Dr. Psi: Okay, so what gives? Help me understand why you haven’t completed something that could help us get you back to those faster swimming times (clarify motivation).

In this scenario, the counselor challenged the client about discrepancies between her words and her actions, but did so indirectly by refocusing attention on the counselor’s empathy for the client and her situation. The end goal to confront Amy about her not completing a homework assignment was attained, but was done so without provoking defensiveness or placing blame on the client.

At times, a direct approach to challenging a client may be more helpful than an indirect one. Being direct with a client does not mean being combative or attacking. Instead, it is helpful to think of direct confrontation as an invitation to clients to examine their own behaviors, thoughts, and attitudes, with the intention of cooperation toward behavior change. In addition, confrontation does not necessarily have to emphasize negatives, but can instead be reframed in such a way as to challenge clients to stop blocking their strengths and to live to their potential. When the working alliance is strong, or the client has the perceived skills to handle open confrontation, then a directive stance may be useful. An assessment of the level and severity of the issue that needs confrontation may also help dictate whether a direct or indirect approach is warranted. When the consequences of an issue are high, such as if a client is abusing substances or self-harming, then a direct approach may be warranted. Strategies that are often helpful in direct confrontation include the use of visual aids, asking for evidence, and various Gestalt techniques (Hanna, 2002). The following is an example of a direct approach to confrontation:

Troy has been seeing Dr. Chi for several weeks regarding his anger management and mood issues. Troy reports experiencing conflicts with his girlfriend, his teammates, his coach, and several friends that are causing him stress. Troy, however, refuses to take
any responsibility for his own actions or role in the problems that he is having, instead placing all blame on external factors.

Troy: None of them ever call or text me back. I'm always the one who has to make plans or get in touch. If I don't do it, I won't hear from them. It's so unfair.

Dr. Chi: Well Troy, can you think of any reasons why your friends might not call or text you? (Trying to hint at several recent arguments Troy has started with the same friends.)

Troy: No. Because they aren't really my friends. My teammates are the same way. I'm always the one doing all the work, and they just act like they do as much as me. Then when I try to help them or tell them how to do something, they get all mad! That's why when I get home I'm in a bad mood. Then instead of making me feel better, my girl will pick a fight!

Dr. Chi: Troy, I want to stop you right there. I want you to take a look at something for me, ok? (goes to a whiteboard). Over the last couple of weeks I've listened to you talk about how much drama and conflict you have to put up with, and how it's coming from all different fronts. (draws “what if” Figure 4.1) But what I'm not hearing from you is your role in all this. Look at all those parts of your life. There's conflict in each area (draws harsh lines in each bubble to represent conflict; Figure 4.2). Now tell me, the conflict experienced by your teammates, your friends, your girlfriend. What do they all have in common in this scenario?

Figure 4.1 Areas of conflict for Troy.

Figure 4.2 What do these conflicts have in common?
Troy: Me.

Dr. Chi: That’s right, you’re the thing that all those pieces have in common (draws Figure 4.3). You and conflict. Don’t you think it’s time you own up to your responsibility in the drama? I know you want to mend these relationships, and I think we can make them better. But you have to be willing to look a little more at yourself and less at the people around you. It might be hard, but you’re a strong guy, and I know you have what it takes to improve yourself. What are your thoughts Troy?

In this scenario, the counselor confronted Troy directly about his external blame and used diagrams to help illustrate that it was time for Troy to take responsibility for his own actions. Although the counselor was direct in his challenge to Troy, he was respectful, encouraging, and, above all, compassionate. By pushing or placing demands on clients you are showing them that you care, and that you believe that they can change. What’s important to remember though, is that ultimately the decision to make that change lies with the clients.

**Conclusions**

Ultimately, as sport psychology practitioners our job is to work ourselves out of a job. One of the ways to ensure this outcome occurs is to help clients confront persistent barriers to achieving their therapeutic goals. If we have confronted our clients effectively and helped plan a successful course of change, the clients will have gained the autonomy, competence, and motivation necessary to maintain these changes on their own, and we will no longer be needed.

**Box 4.1**

*Practical take-home messages about challenging and confronting clients*

- Effective confrontation is a compassionate act meant to help clients grow – when done well, it is not bullying or attacking a client and may actually improve the therapeutic alliance.
That’s a good result. See Box 4.1 for a summary of the take-home messages from this chapter.

References


