

Compassionate Therapy: Some Very Difficult Clients

In Case I Decide to Kill Myself



Jeffrey A. Kottler

In Case I Decide to Kill Myself

Jeffrey Kottler

e-Book 2016 International Psychotherapy Institute

From *Compassionate Therapy* by Jeffrey Kottler

Copyright © 1992 by Jeffrey Kottler

All Rights Reserved

Created in the United States of America

Table of Contents

[In Case I Decide to Kill Myself](#)

[Styles of Manipulative Behavior](#)

[One Case Among so Many](#)

[Greater Risks and the Ultimate Challenge](#)

In Case I Decide to Kill Myself

It is true that therapists can create difficult clients or certainly train them to be more obstinate than they are normally inclined to be. Some people, however, come to us with their manipulative skills already well honed. At times these clients, described by Kernberg (1984) as “malignant narcissists,” take sadomasochistic pleasure in triumphing over the therapist, even if it means engaging in essentially self-defeating acts. They experience a tremendous sense of power over being able to block their progress in therapy, all the while complaining bitterly of their disappointment in the way things are going. Kernberg (1984) describes one such client who repeatedly burned her arms and then hid the festering wounds under long sleeves while she reported how splendidly her life was going. What power she, and other clients like her, feel at being both victim and victimizer, able to reduce an omnipotent authority figure to an impotent and frustrated mortal!

Clients can use more benign styles of manipulation when they are committed to having their way, no matter how determined we are to follow our own agenda. Gladys began her story precisely as she crossed the threshold of my office. Out came a torrent of frustration and anger, mostly directed toward her husband who never listened to her. After forty years of marriage, Gladys and her husband had reached an uneasy truce, partitioning their home and lives into separate worlds.

Gladys spoke continuously and incessantly throughout that first session and beyond. Although I am usually quite good at ending a session precisely at the appointed time, with this particular woman, none of my usual cues made a dent in her monologue. I interrupted and politely informed her our time was up, asking when she would like to schedule her next appointment. She carried on as if I were not in the room. I stood up and walked to the door—surely a clear signal it was time to leave — but Gladys resolutely remained on the couch, continuing her litany of complaints.

I looked at this aging, forlorn, little grandmother camped out in my office, my heart aching for her. It seemed as though this was the first time in years that she had had anyone to hear her—and I had stopped listening some time earlier as I plotted ways to pry her off the couch and move on to my next client who had now been kept waiting for twenty minutes.

The problem of ending our sessions became the primary struggle of the first stage of our relationship. I tried closing the session a half-hour after we began. I would even leave the room and call to her from the hallway: "I think it's time to leave." All to no avail. The best I could do was wait for her to run down of her own accord like a wind-up toy whose energy is finally depleted. One day, in exasperation, I confided to her how abused and frustrated I felt. Her innocent response was, "Why didn't you just tell me?"

Initially, the sessions went by quickly. Gladys had many things to say, and apparently, nobody to say them to. All I had to do was sit back and let her go. She talked with great feeling about the people in her life, about her past, and about the impotence she felt to alter her marriage.

At first, I ventured a few tentative probes and questions, but since she had her own agenda to follow, I decided to wait her out before I attempted to intervene. Little did I ever imagine I would end up waiting for two years! For over 100 hours, she talked, and I listened. Any attempt I made to alter this routine was met with the same stubborn resistance she had shown earlier when I had tried unsuccessfully to end her sessions on time. Clearly she felt she was getting her money's worth and seemed delighted by the progress she was making. And indeed, her home life did improve and she became less depressed.

But what was my role in all of this? Every time I tried to say something to her —supportive, reflective, or interpretive —she would stop for a moment, regard me as she would any distraction, and then say: "Where was I? Oh yes..." continuing on with her monologue. Gladys would have been perfectly content if I had not uttered a single word in any session, but my own self-respect (and sense of challenge) urged me to insert a few feeble comments during those rare times when Gladys would draw a breath.

After rehearsing for hours in my mind, I finally decided one day to confront her about this sorry state of affairs. I felt completely useless. I wondered whether I even needed to attend the session at all. Maybe she could just borrow my office and leave a check when she was done. I told her these things. Bluntly. Decisively. Clearly.

Gladys faced me fully. She frowned as she considered what I said. Immediately I felt remorseful. This sweet little old lady is getting just what *she* wants out of therapy; who am I to argue with her? She

nodded her head. Once. Twice. Acknowledging she heard me. And then she continued right on with what she had been saying before I had interrupted her! Oh, there was a barely perceptible change in the cadence of her monologues after that; with an obvious show of great self- discipline, she would once, sometimes twice during a session, grind to a sudden halt and look at me expectantly as if to say: “OK, smartass, throw in your two cents if you think you have anything to add.”

The strange thing is that I liked Gladys a heck of a lot. I *enjoyed* listening to her even as I resented not being allowed to respond to her (just as her husband felt shut out). Yet there are few clients with whom I have ever worked so hard. I became a therapist because I *like* to talk; I like to be actively engaged in animated conversation, to share and exchange ideas. But Gladys seemed to know what she needed, and that was an audience — one she could pay not to interrupt her.

Gladys represents those clients who come to therapy with their own skewed plan for what they want from us. It makes little difference to them how we prefer to work best, or what we think they need. They will interview a dozen prospects, if necessary, to find a cooperative therapist whom they can manipulate to do their bidding.

Styles of Manipulative Behavior

Manipulation can be defined as “deliberately influencing or controlling the behavior of others to one’s own advantage by using charm, persuasion, seduction, deceit, guilt, induction, or coercion” (Hamilton, Decker, and Rumbaut, 1986, p. 191). The term is almost always used to describe the client’s attempt to control the relationship; if the therapist tries the same thing, it is called “artful management of client behavior.”

For this reason Hamilton and his coauthors prefer to speak of “manipulative behavior” rather than “manipulative clients,” since they are talking not so much about a stable disorder as a situational strategy to gain control. This conception also helps us to focus on aspects of the client that need to be altered rather than considering the client an enemy who is challenging our turf.

Clients can be manipulative in many different ways, both directly and indirectly, consciously and unconsciously. In the direct mode they will attempt to set the conditions of therapy, solicit promises, or

ask for reassurances; in the indirect style, which is even more difficult to recognize and manage, they can be very creative. Murphy and Guze (1960) have described some of the more common forms of manipulation. I have summarized these below with representative examples:

Unreasonable Demands: "I'm sorry to bother you at home, but I can't sleep. Isn't there something that you can do to help me?"

Controlling the Conditions of Therapy: "You never told me I had to give twenty-four hours' notice to cancel an appointment if I didn't feel well. I thought you meant only if I didn't want to come back. And I *do* want to schedule another appointment, that is, if you intend to be reasonable about this misunderstanding."

Soliciting Promises: "You said I could call you if I felt worse. I was wondering if my headache could be part of my symptoms also?"

Special Attention: "I know you don't usually work on Wednesday evenings, but just this once couldn't you see me?"

Self-deprecation: "I don't know why you are so nice to a person like me. I really don't deserve such attention."

Expressing Dissatisfaction: "And I thought you were different from all those other doctors I've seen. But you can be so cruel."

Threatening Self-Destructive Behavior: "I'll probably be all right this week. But in case I do decide to kill myself, I want to thank you for everything you tried to do to help."

One Case Among so Many

Many of these examples of manipulative behavior make up the repertoire of the most dreaded of clients, the most difficult people to deal with because of their tendencies to resort to extreme measures to bend us to do their bidding. I am speaking, of course, about the Borderline.

The beginning usually seems innocent enough. In one case, Maybelle asked me if I would read a brief letter she had written me during the previous week. "Now?" I asked. "No," she said sweetly. "You can read it later."

We began our second session and Maybelle continued the narrative from the first time we met. She recited some of the more despicable experiences she suffered at the hands of parents who were both wretched: neglect, verbal abuse, overtones of sexual molestation, endless mind games. She looked so incredibly vulnerable I could hardly stop myself from reassuring her over and over that everything would be all right, that she had come to the right place and I would help her.

Soon after Maybelle left, I unfolded the two-page letter. In the writing she essentially demonstrated how well she had been listening during our first session. She repeated the themes we had discussed, even quoted me verbatim in places. I was impressed and a little flattered. I was further moved by the pain she was living with and the intense desire she had to live a normal existence, once and for all free of her parents' poisonous influence. I jotted a few notes to her in the margin and mailed the letter back to her.

Just prior to the next session, our third, she handed me another letter—this one quite bulky. I began to get the first glimmers that things were not all they appeared. But by then I was hooked.

The phone calls during the week began soon thereafter. At first, they seemed harmless enough. Might she reschedule her appointment? She lost her reminder card; was her appointment at 3:00 or 4:00?

Over the course of a few months the calls escalated until I began to expect them at regular intervals. I had not, as yet, had the heart to cut her off; I was, after all, the only close relationship in her life. And she did seem to be improving.

It was a colleague who first cued me or at least labeled what might be going on. Furthermore, this friend gave me the permission I felt I needed to start setting limits with her. At the very next session, I informed Maybelle I would no longer accept her calls during the week unless she had a genuine emergency (what an invitation to disaster!). It was then that the calls at home began.

I picked up the phone very late one evening to hear the sounds of sobbing on the other end of the line — gut-wrenching, pitiful sobs. I knew instantly who it was. After many fruitless minutes of trying to calm her down, my own voice took on some of the hysteria she had been demonstrating. *I just know she is going to kill herself. And it's all my fault because I cruelly rejected her just like her parents* (she may even

have spoken those very lines).

Just when my own patience reached the limit, Maybelle miraculously regained control. She thanked me profusely for being there when she needed me the most. I probably saved her life, she repeated over and over. When I hung up the phone, I felt as though I was still dangling on the end of the line.

She was most cooperative during the following sessions, a model client—grateful, eager, and fully in control of herself. In much the same way a person in the eye of a hurricane tells himself that maybe the storm is over—after all, everything seems calm—I blithely proceeded along, intensely proud of myself and progress we were making.

When the calls at home began in earnest, I should have been better prepared to expect them. They were, after all, the next logical step. But by then I was in way over my head. Desperate to find some way to extricate myself from her manipulative ploys, I suggested that a psychiatric consultation might be in order. Wails of protest: “You’re just trying to get rid of me.” *Right you are*, I thought, but said instead: “We need to check out the possibility of medication for your depression.”

The psychiatrist was most sympathetic. To me, not to her. “Yes, you’ve got yourself a full-fledged borderline all right. I’d be careful if I were you.”

“Borderline” sounds so dismal, so hopeless and frightening. It conjures up images of someone walking a thin line he or she can never quite cross, postponing the inevitable fall into the abyss below. Yet Maybelle made unsteady but consistent progress over several years, eventually stabilizing herself in a good job and support system up to the time I moved out of state.

A year later, her letter found me:

Let me tell you: I am in big-time trouble and things don't seem to be getting better. I am very withdrawn. I haven't shown up to work or called them. I am drinking a lot and taking all kinds of different drugs. I stay in my room, will not answer the phone, and have no contact with my family or friends. Things are going downhill very quickly and I have no desire to do anything to stop myself.

I have been irritable and I have raging outbursts for no reason. I wake up screaming in the middle of the night. I am injuring myself in the hope that I might do some damage or make the right cut so I can bleed to death. I

don't know what is happening to me or what to do about it. I have all but given up.

I feel like some strange person has control over my body and there is nothing that I can do to stop it from destroying me. You would not believe that I am the same person who you worked with for two years and did so well.

Please send me some magical words to help me think more clearly and get back on track or I know I will never live to see my twenty-fifth birthday next week. Take care, and maybe you will hear from me again.

The depth and intensity of Maybelles pain are so profound I can hardly read her words without feeling scalded. She is not deliberately trying to cause me anguish or punish me for deserting her; that is just part of the “natural” way in which she functions. She has learned to survive, however tenuously, by drawing people in and then keeping them where she wants them.

What I find so remarkable about Maybelle and her strange behavior is that almost every therapist I have ever met— whether working in a university counseling center, mental health center, hospital, private practice, rehabilitation center, crisis center, or school — has had a similar case. Some therapists thrive on the challenge of dueling with manipulative clients like Maybelle. Others of us lose a part of ourselves in each exchange, lick our wounds, and jump back into the arena for more. One thing is clear to me: the pathologically manipulative borderline is the ultimate test for any therapists compassion, skills, and expertise.

Greater Risks and the Ultimate Challenge

The emotional strains we suffer as a result of interaction with severely disturbed clients is not the only hazard of our work; even greater are the legal risks. Filled with so much rage and schooled in sophisticated methods of manipulation, some clients are willing to inflict as much damage as possible on those who are close to them. Therapists often become targets of retribution in the court system, not only because they commit some professional transgression but because a difficult client wants to get even with them for some imagined offense.

Even when clients refuse to pay their bills or fail to cooperate with treatment, we become liable for malpractice suits if we attempt to terminate the relationship without ensuring that they receive continued care (Vandecreek, Knapp, and Herzog, 1987). Some clients may feel abandoned at the

slightest provocation, and those who wish to inflict the greatest damage can initiate nuisance legal action. Given the climate of the times, in which insurance companies prefer to settle claims as quickly as possible, we may never have a chance to tell our side of the story.

Practicing our profession with the people who need our services the most presents real obstacles and dangers. An analogous issue is being debated by surgeons, deciding when and if they should jeopardize their safety by conducting elective operations on patients with auto immune deficiency syndrome (AIDS). The main differences are that our most difficult and manipulative clients are suffering spiritually, not physically. And although we cannot become infected by their disease, we can and do become affected by their toxic behavior.

The manipulative client described in this chapter and the controlling client discussed in the next chapter present the practitioner with the ultimate professional challenges and also the greatest satisfaction. Working with severely disturbed and/or resistant clients requires incredible patience, high frustration tolerance, realistic expectations, excellent diagnostic and clinical skills, and the guidance and support of a group of experienced colleagues and supervisors. Such clients may change more slowly than we would prefer. They may test us in devious ways. They may get under our skins and force us to look at our own unresolved issues. But they also need us the most. And when, sometimes after years of hard work, they do lead more productive and satisfying lives, we realize that there are few accomplishments about which we can feel more proud.