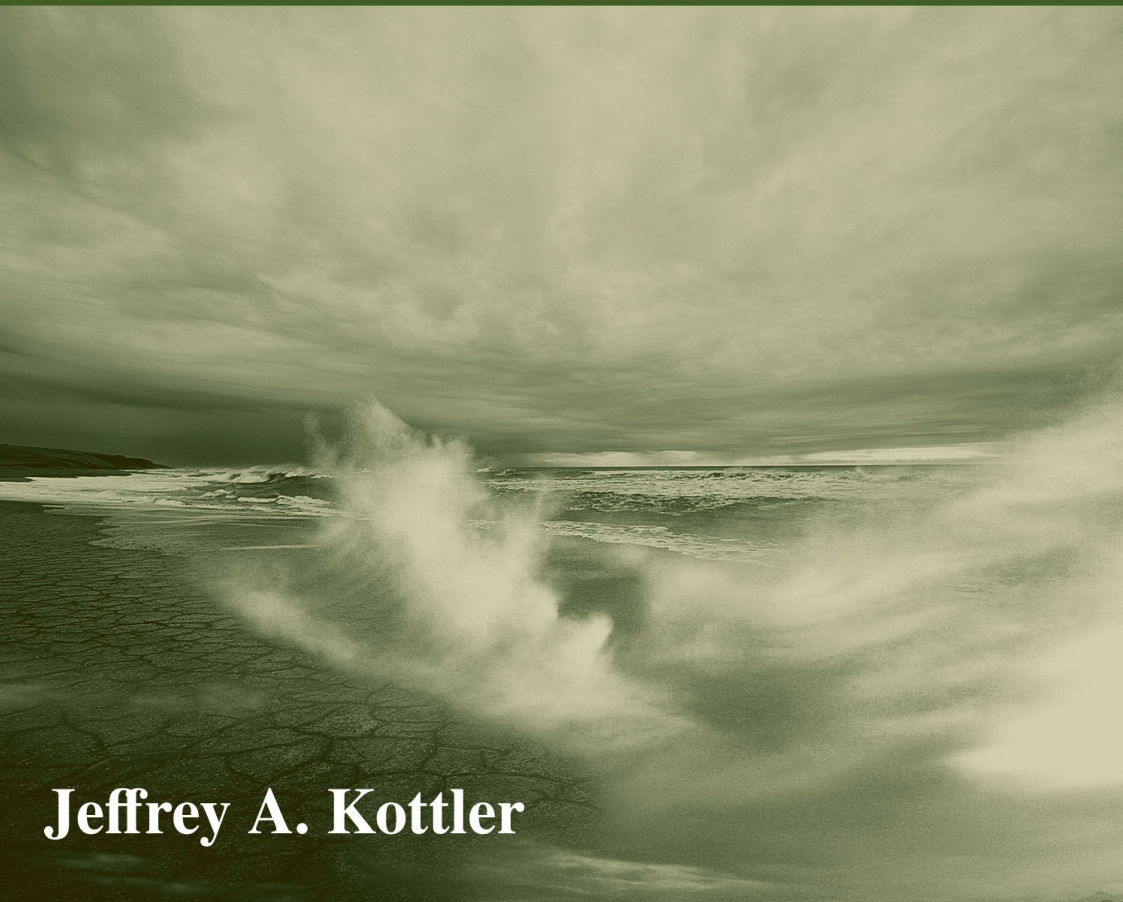
Compassionate Therapy: When the Therapist Is Difficult

Talking to the Winds



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e-Book 2016 International Psychotherapy Institute

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Talking to the Winds

Feelings of futility and frustration have been companions of therapists ever since our craft was first invented, although Freud dealt little with this subject. In his later work (Freud, [1915] 1957), he did eventually admit some of his negative feelings that cropped up during sessions with clients: "At no point in one's analytic work does one suffer more from the oppressive feeling that all one's efforts have been in vain and from suspicion that one is 'talking to the winds' than when one is trying to persuade a female patient to abandon her wish for a penis" (p. 270). Although we may not recall the last time we had a female client who wanted a penis, most of us can relate to the feeling of "talking to the winds" with those who are uncooperative.

In one of the first documented cases of the profound effect a difficult client can have on a therapist, Sigmund Freud and Carl Jung commiserated with one another over their mutual exasperation with a client named Otto Gross (McGuire, 1974). Gross, it seems, was causing Freud some degree of frustration and anxiety because of his severe narcissistic pathology, a situation aggravated by Freud's own self-admitted "egoism" and feelings of countertransference. Freud found a way to pawn his patient off on Jung for the summer. With great optimism, Jung proceeded to treat Gross, only to find that all his empathy, good intentions, and brilliant interpretations were virtually useless; the patient hooked him as well. In a letter dated June 19, 1908, Jung complained to Freud about Herr Gross: "He is now living under the delusion that I have cured him and has already written me a letter overflowing with gratitude. . . . For me this experience is one of the harshest of my life." Jung then expressed his sincere desire, tinged with guilt, that although he would not wish to inflict this patient on anyone else, not the least back to Freud who originally referred him, he had had quite enough of him —and so pronounced him cured (Liebenberg, 1990).

When Clients Push Our Buttons

Clients seem much more difficult to us when we are feeling dissatisfied with some aspect of our personal and professional lives. One therapist recently described to me quite poignantly the effects one

particular case had on him during a time in his career when he was suffering from burnout.

My most difficult client was not challenging because of his diagnosis or his treatment requirements. He wasn't very interesting or colorful or dynamic. What made this case so trying for me was the emotional reactions that I developed in response to working with him.

I was working as a therapist in a mental health center where I had been for the past four years. I was frazzled. I was burned out. I was emotionally exhausted. I had no sense of personal accomplishment. And I was depersonalizing everything and dehumanizing my clients, or I should say "patients" since about 90 percent of my caseload were chronically mentally ill. My job was primarily case management, putting out fires for over ninety patients in my caseload. That's an important job, but not the job I wanted to do.

This particular client was a 70-year-old black male just released from the Mississippi State Hospital after a stay of fifty years. He had been there all his adult life, since he had first been diagnosed as schizophrenic. He seemed to respond to gestures better than words, so I motioned for him to follow me to my office, which he proceeded to do in the sporadic shuffle that is so frequent among patients who have been on psychotropic medication for long periods.

I tried to talk to him, but really didn't put much effort into it. He was like so many other patients I had seen — mute and dead to the world. To every question I asked, he responded with a grunt. So I set him up in a boarding house and arranged to see him again in three months. Then I proceeded to fill out the thirty-three different forms that were required to process his case.

I had spent a total of twenty minutes with the guy, and the only thing I knew about him was that he had cut out the backs of his shoes — a brand new pair of shoes with the heels missing. I had several other no-shows and cancellations that morning so I had plenty of time to think about this man, and there was something about him that was bugging me. Something about him or his name seemed familiar to me, but I figured maybe he had killed somebody or escaped from the state hospital at one time and his name or face had been in the papers.

I was leafing through his file when it finally hit me: he had the same name and was born on almost the same day as my grandfather, who had died seven months before. And I had not yet fully worked this through. I was the strong person in my family and I had to take care of everybody else, never giving myself time to grieve.

So then I became absorbed in his records, and the more I read, the more indignant and disgusted I became. At age twenty he had been seen by a doctor for some brief psychotic episode, and by a series of mishaps and incompetencies that are typical of state hospital systems, this man had been condemned to a life in a warehouse doing the "Thorazine shuffle." Four months after his original admission, they wanted to release him, but because his family didn't want him and there was no place else for him to go, they just put him on a shelf and forgot about him. Another iatrogenic psychosis, created by the doctor.

I was furious at the mental health system for how they had victimized this man, and then I realized that I had done the same thing. I, too, had refused to treat him as a person; he was just another schizophrenic, another hopeless case. I was no better than everything I despised.

I then started to run this guilt trip on myself. I started to become obsessed with his case. I decided I was going to cure him. I got him in to see the psychiatrist the next day and insisted we change his medication. I started to see the man three to four times per week. We went for walks. I bought him a new pair of shoes without the backs cut out of them. I even altered my own shoes to resemble his.

We sat on the porch and I tried to talk to him. I used everything that I knew how to do. After four months I never got the slightest response from him, or even an indication that he knew I was there, before he died in his sleep.

Of course, I now realize that I wasn't so much trying to treat him as I was myself. But then I think that most of the clients I find difficult are those who plug into my own issues. I also realized that I was going up against my limits, and that is something that I don't take very easily. For five to six months after this experience I was an emotional wreck. If I had been burned out before I met this man, by this time I was toast. I needed a month's leave of absence to recover.

Taking Matters Personally

Therapists enjoy helping people and expect in return some degree of appreciation. When clients respond instead with hostility, disrespect, or indifference, it is difficult for the therapist not to take these reactions personally. In the case of the hospitalized schizophrenic described in the previous section, the therapist became emotionally overinvolved, not only because his own personal issues were intertwined with those of his patient but because he needed and demanded some success from his treatment. He could not save his own grandfather, but he was determined to make this patient's life a little easier, regardless of whether the man wanted or was able to respond to the therapists intervention.

In many similar situations, we often feel frustrated, insecure, and hopeless when the client does not respond as we wish. We communicate our dissatisfaction directly or through withdrawal. In response, the client feels even more rejected and devalued, and the resistant behavior intensifies. Thus the endless spiral of hurt and retaliation continues until each participant views the other as uncooperative.

In a study of patients who were generally resistant to medical intervention and noncompliant with treatment recommendations, Martin (1979) found several common characteristics. These patients tended to conform less to suggestions and to show less deference to doctors than did the general population. They used denial as a defense against acknowledging their problems. They also manifested high degrees of anxiety.

Although the subjects of these studies were patients with tuberculosis and diabetes, those suffering from other chronic illnesses, and patients with unusually difficult dental problems, results can be instructive for therapists. The most common characteristic of all these resistant patients is "the fundamental importance of anxiety in determining individual reactions to illness, to preventive

campaigns and to treatment situations" (Martin, 1979, p. 5).

Deep down inside, the difficult client is a very anxious person who is trying to cope with a painful and vulnerable existence. This observation is so obvious and such a basic part of therapeutic lore that we hardly ever mention it. However, we must not forget that the difficult client is just trying to get along as well as he or she can. When this client attacks us, withdraws from us, plays games with us, our first instinctive reaction is take the gesture personally: "Why are you making *my* life so unnecessarily difficult?" It is only after stepping back from the situation that we eventually realize: "No, you are not doing this to me; you are doing it to yourself. I am the designated target for your wrath. I am the one person you feel safe enough with to let all the demons out. Lucky me."

Similarities Between Difficult Clients and Their Therapists

As much as we may dread or even despise certain clients because of traits or behaviors that we find especially annoying, we may be more like these individuals than we would care to admit. In a comparison of the most common characteristics of physicians and features of their most difficult patients, Ford (1981) discovered a fascinating but disturbing parallel. Most doctors would identify those patients who consistently give them the most trouble as the ones with chronic somatizing disorders who have made illness a way of life. These are patients with chronic pain who relish a sick role, or chronic complainers about symptoms that the doctor can do nothing for. They are the patients with hysterical or hypochondriacal tendencies, the malingerers, and those with factitious disorders, disability claims, or conversion reactions.

All these patients share some common features, a finding that is hardly surprising. For example, somatizing patients often come from childhood homes that left them with unmet dependency needs. They often have had experiences with illness or death as children. They exhibit marked depression, excessive use of medication, and emotional constriction. The surprise came when Ford (1981) compared these qualities to the most common characteristics of the doctors and found that doctors and patients exhibited many of the same characteristics.

There are other ways that difficult patients and their doctors are often linked. The patient is

hypochondriacal; the doctor is counterphobic in regard to disease and death. The patient exhibits blatant dependency needs; the doctor develops a reaction formation to defend against dependency wishes. The patient has a desire for protection while the doctor entertains fantasies of omnipotence. After reviewing this pattern, Ford (1981, p. 255) concludes: "Because of the psychological similarities shared with physicians, somatizing patients have the capacity to tap into the physicians own intrapsychic conflicts."

It would be interesting to extrapolate Ford's findings to the therapeutic encounter: what are the similarities between ourselves and those clients we despise the most? What are the common features of difficult clients and our own backgrounds, personalities, and unresolved issues?

Therapists often come from homes characterized by a high level of conflict, just as their clients do. We also share a number of other qualities such as the ability to influence others, a highly developed sensitivity to what others are feeling, overreactions to themes of dependency, and a need for power and control in relationships. This comparison leads us to the inescapable conclusion that the clients with whom we have the most trouble are those who are like us in ways we find most distasteful; but in a positive light, our own emotional reactions to our clients can give us the most valuable clues for how to treat them.

Who Gets to You and Why

Because difficult clients are often defined in terms of their effects on their therapists —their ability to induce anger, irritation, anxiety, or oversolicitousness—it is important for us to look at our own arousal potential. Which kinds of clients, diagnoses, behavior patterns, and interactions do you consistently find upsetting? At the very least, even if you cannot agree that your own biases, perceptions, and issues make clients difficult, you must certainly acknowledge the interactive effect of both client and therapist contributions to the problem.

When we encounter obstructions to progress in therapy, the *first* place we should look is toward ourselves:

- What am I doing to create or exacerbate problems in the therapeutic alliance? *Isn't it interesting that I talk to this client so differently on the phone than in person? I seem to feel some need*

when he is in my space to let him know firmly who is in charge.

- What unresolved personal issues are being triggered by the conflict I am experiencing? *I am definitely not doing enough for this lady. No, maybe I am trying to do too much for her, and am taking too much responsibility for how this turns out. No, I mean, I don't know what I am trying to do. I get frustrated and confused when I don't know where I stand with someone, whether she likes me, whether she thinks I am doing a good job. This woman gives me no clues so I end up being caustic and sarcastic with her to provoke some reaction, and then I don't like what I get.*

- Who does the client remind me of? *My Uncle Matt. Definitely Matt. They both have the same manipulative way that they get other people to eat out of their hands. I remember all those times Matt sweet-talked me into. . .*

- In what ways am I acting out my frustration and impatience with the client's progress? *She just asked me when we can reschedule her next appointment since she can't seem to make it here on time in the mornings. Why did I give her such a hard time? I am not usually so inflexible about things like that.*

- What expectations am I demanding of this client? *This guy is really hurting because his father is in the hospital. I tell him about my own father, that I know how he feels, and he blows me off as if I am a servant who has spoken out of line. Come to think of it, maybe my disclosure was inappropriate.*

- What needs of mine are not being met in this relationship? *I expect—no, demand—that people show me a degree of gratitude when I put myself out to help them. Even though lam paid to deliver a professional service, I do this type of work primarily for the kick I get in seeing others grow. OK, it even makes me feel powerful to think that I helped in some way. When a client doesn't acknowledge that my efforts have been appreciated, I start to feel cheated.*

You may think of other questions as you try to figure out why a certain client is disturbing to you, or why you are being considerably less effective than you could be: what information am I missing that would help me understand better what is happening? In what ways have I mismanaged this case? How have I been unduly manipulative and controlling? How are my operating assumptions getting in the way of my understanding and dealing with the client? And probably the most important self-query of all: what is keeping me from being more caring and compassionate with this person?

By going through this checklist of questions when we find ourselves having trouble with a case, we

are able to identify our role in exacerbating the problems before we heap accusations on the client that he or she is being obstructive, resistant, and uncooperative. When clients are difficult, it is usually for one of two reasons: (1) they are not feeling accepted or understood by the therapist, or (2) they are fearful of allowing the therapist to get too close. In either of these scenarios, the therapist's own feelings of anger and frustration as well as his or her ongoing personal issues become a fulcrum by which resistance can be understood and worked through.