Compassionate Therapy: What Makes Clients Difficult?

The Nature of Resistance

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The Nature of Resistance

I have long been perplexed by the differences between what I was told by supervisors, teachers, and authors about how therapy was supposed to work and how it actually plays out in my office. I feel continually assailed by the claims of numerous workshop presenters and writers who claim they have discovered the latest miracle cure that works with almost everyone. The implication is that if my clients do not improve when I use these methods, it must by *my* fault. So I find myself wondering: am I the only one who still struggles, after all these years, with difficult clients?

In beginning the research on this topic I came across a number of works on dealing with severely disturbed or resistant clients. One edited volume by Giovacchini and Boyer (1982) seemed especially promising—that is, until I read the introduction, “Most clinicians have unreasonable patients sometime during their careers, often when they are still residents or beginning practitioners” (Giovacchini, 1982, p. 19).

Great! So I am supposed to have outgrown this? By now I should not encounter difficult clients anymore? I should be able to circumvent any problem, work around any resistance, neutralize any obstruction that gets in the way of a therapeutic cure?

The author later admitted that he occasionally felt frustrated, angry, out of control, hurt, or misunderstood in response to some of his unreasonable clients. I immediately felt a sense of kinship. As I dug deeper into the volume of scholarly treatises on what to do with regressed, paranoid, or borderline clients, how they would be putty in our hands if we simply followed the analytic prescription for resolving transference neuroses, I discovered a small, comforting essay. In this chapter (Adler, 1982, p. 39), the author acknowledged the helplessness that therapists feel when confronting uncooperative clients: “I finally had to conclude that feelings of helplessness and hopelessness were part of the burden I had to bear as a therapist, and that I was not alone in experiencing them. I also began to see that these feelings tended to come up with greatest intensity with certain kinds of patients. And, in spite of my best intentions, I found myself repeatedly hopeless, helpless, and furious with those patients and fantasizing ways to get back at them or get rid of them.”

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As embarrassing as such admissions are—that certain clients really get to us in ways that disrupt our lives —I believe this circumstance is more universal than we have been led to believe. Further, by discussing openly those kinds of clients with whom we struggle the most, we put ourselves in a better position to sort out their dysfunctional behavior from our own and to formulate treatment strategies that are more likely to be successful.

Why Some Therapists Have More Difficult Clients Than Other Therapists

The whole subject of difficult clients is a bit awkward to discuss, for if we admit we have such people in our practice, we may be saying as much about ourselves as we are about them. The experts in our field have not made it easy for us to talk about our problem clients; the tendency of these experts is to publicize only those interventions that work, quietly ignoring their efforts that have failed dismally. As a result, some of us feel that we are the only ones who ever encounter difficult and resistant clients.

We often end up blaming ourselves when we cannot get through to a particular client, even though, according to Purcell and Wechsler (1991), it is the unavoidable outcome of some of our own unresolved issues that we can never hope to fully resolve. “Ignoring our personal issues reinforces the myth that as competent therapists we should be able to work effectively with all clients at all times, and under all circumstances” (p. 65).

We are further intimidated by the master therapists we see “live in concert” or on videotape who seem to handle problem clients with great deftness and ease, as if this minor glitch in the program can be easily corrected by waving a magic wand or instituting some ingenious strategy that becomes obvious only *after* they have explained it.

It is not just extraordinary charisma and skill that allow the most prominent practitioners to handle easily any difficult client who comes their way; they also have the luxury of screening prospective clients carefully and selecting only those who are most motivated and best suited to their approach. Masters and Johnson, for example, reported phenomenal success rates for their sex therapy cures in the 1970s, rates that could never be matched by other clinicians. This success is explained, in part, by their elaborate screening procedures that weeded out potentially difficult cases; also, those who were accepted in the

program were highly motivated to succeed as they had traveled hundreds of miles and paid thousands of dollars to participate. Most of us do not have an unlimited supply of clients from which we can choose our favorites, all of whom have adequate financial resources and an intense desire to change. We are thus bound to encounter a clientele different from those who journey to Mecca (Anderson and Stewart, 1983a).

The more indigent the population we are working with, the more involuntarily they are forced into treatment, and the less famous we are in clients' eyes, the more often we will encounter clients who are uncooperative. No doubt this resistance can also be a function of the therapist's age, experience level, training, skill, personality, and therapeutic approach. Given all things equal, some practitioners do encounter more clients who are difficult because of the ways the therapists work, because of their lack of flexibility, and especially as a result of how they interpret behavior and define resistance.

Perspectives on Change and Resistance

The subject of difficult clients is treated by almost every existing therapeutic model, beginning with Freud's original conceptions of the client's efforts to repress threatening material unconsciously ([1914] 1957). In addition to this psychodynamic formulation of client reluctance, the phenomenon has also been defined as (1) an unwillingness to disclose (Rogers, 1958), (2) noncompliance with prescribed assignments (Shelton and Levy, 1981), (3) a struggle for interpersonal dominance (Watzlawick, Weakland, and Fisch, 1974), (4) nonacceptance of the therapist's legitimacy as a source of influence (Strong and Matross, 1973), or (5) a specialized form of communication (Erickson, 1964). Most simply, resistance can be defined as whatever the client does, deliberately or unconsciously, to prevent, circumvent, or otherwise block the progress of therapy (Puntil, 1991).

Developing a taxonomic classification of the twenty-two most common forms of client resistance, Otani (1989a) divided them into several basic categories that include withholding communication through silence, restricting meaningful content, engaging in a manipulative style of responding, or violating the basic rules of therapy. These kinds of resistance, with examples of characteristic behavior for each, are shown below:

Withholding Communication
Being silent
Making infrequent responses
Making minimal responses
Engaging in incessant rambling

Restricting Content
Making small talk
Intellectualizing
Asking rhetorical questions
Engaging in obsessive rambling

Being Manipulative
Discounting
Being seductive
Externalizing
Forgetting

Violating Rules
Missing appointments
Delaying payment
Making improper requests
Displaying inappropriate behaviors

The way therapists interpret these various client behaviors depends on their operating theory of how and why people change. Resistance can be viewed as an inevitable and natural component of change or as a signal that therapy is headed in the right direction. The gestalt therapist, for example, defines resistance as the clients avoidance of expressing genuine feelings. The behavior therapist labels clients difficult if they do not follow through with assigned tasks. And the client who follows therapeutic directives, but uses denial or repression to avoid dealing with other issues, will be seen by the psychoanalyst as defensive and resistant (Anderson and Stewart, 1983b).

Some of the more common theoretical views of resistance are also described by Dowd and Seibel (1990). A review of these interpretations of client behavior shows that some practitioners do not equate resistance with being difficult; they see in the client's obstructive actions a potential for progress if used effectively. Other therapeutic approaches view client resistance as an enemy that must be overcome if the client is to make any lasting changes. I have organized these various perspectives on a continuum from viewing resistance as the therapist's enemy to seeing resistance as a friend:

Resistance as Enemy

Problem Solving: Resistance is the enemy and must be overcome

Psychoanalytic: Resistance must be interpreted and counteracted

Behavioral: Resistance is annoying noncompliance with assigned tasks

Social Influence: Resistance is viewed neutrally as a form of communication

Cognitive Behavioral: Resistance is a natural component the change process

Systemic: Resistance is a way to maintain the structural integrity of the family

Existential: Resistance is a means of legitimate self- expression

Strategic: Resistance is embraced and paradoxically prescribed

Resistance as Friend

The continuum, of course, is a simplification of some very complex and varied perspectives. It is not meant to pigeonhole a theoretical orientation into a particular slot; rather, it allows practitioners to classify their ideas about client behavior as primarily negative, positive, or neutral. This evaluation will determine, in part, how the therapist interprets and subsequently responds to resistant behavior.

Some Types of Resistance and What They Mean

A therapists treatment of a difficult client depends not only on his or her general theoretical orientation but also on the particular meaning a certain client behavior has at a given moment in time. Resistance can be a normal and healthy way for clients to stall action until they have had the opportunity to explore thoroughly the consequences of changing. In other cases it can stem from more severe underlying character disorders. It can be used to avoid discomfort; it may arise from the fear of success. Resistance can be motivated by self-punishment or reflect a rebellious disposition. It can even be caused by neurological disease or meddling family members.

In the context of sexual dysfunctions, Munjack and Oziel (1978) classified various types of resistance according to their underlying causes. If we adapt their schema to a more universal client population, we can identify five discrete types of resistance, all motivated by different origins and thereby treated by different methods.

In *Type I* resistance clients simply do not understand what the therapist wants or expects. They may be relatively unsophisticated about how therapy works or may be very concrete thinkers. When requested to explain how he happened to arrive in therapy, one client says that he took the bus. He is not trying to be sarcastic or avoidant; he just does not understand the intent of the question. The source of the client’s difficult behavior in Type I resistance can be the clients naiveté, the therapist’s incomplete

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communication, or a combination of both factors. Once the source of misunderstanding is identified, the therapist is able to clarify the expectations, roles, and objectives of therapy while concentrating on being very precise in future communications with the client.

In *Type II* resistance the client does not comply with assigned tasks because she lacks the skill or knowledge necessary to do so. The client is not being obstinate; she just cannot do what the therapist is asking. “How are you feeling right now?” the therapist asks a young woman who seems upset. She repeatedly replies, “I don’t know,” with increasing exasperation because she really does not know; at that moment she cannot put her feelings into words. The solution to this form of client difficulty is also relatively straightforward: ask clients to do only what they are able to do at the time, at least until they are able to develop new options.

Type III resistance involves a lack of motivation; clients show marked apathy and indifference in response to whatever the therapist does. This behavior can be the result of previous failures in therapy or a self-defeating belief system. Ellis (1985) has postulated that most forms of client reluctance result from the clients unrealistic demands that the world be a certain way (“It’s not fair that people treat me this way”) and self-sabotaging internal statements (“My situation is hopeless and I will never improve”). Some clients are especially difficult, not just because of the presence of these dysfunctional thoughts but because the clients resist any challenge to consider their validity.

Type III resistance also results when the client does not perceive any incentives to cooperate: “Why should I get all worked up over talking with you? Nothing will change anyway. Whether I get my act together or not, my wife is still going to leave me. At least I get time off as long as I stay depressed.”

The intervention strategy for this type of resistance also logically flows from its source; the therapist should concentrate on instilling hope and positive expectations in the client as well as identifying possible sources of motivation and reinforcement for him. For this unmotivated man, he was helped to realize that even if he had no urge to improve his mood for himself or to save his marriage, he had to consider the effect of his behavior on his children. It made sense for him to lighten his mood and try to get on with his life for the sake of his children, who were suffering because of his neglect.

Type IV resistance is the “traditional” guilt- or anxiety-induced variety recognized most often by

psychoanalysts. Defense mechanisms are no longer working effectively. The client starts to back off as repressed feelings begin to surface. Work can be proceeding smoothly and consistently until a nerve is struck, and then sometimes deliberately, but often unconsciously, the client does everything possible to sabotage further progress. Fear is often the overriding force — fear of embarrassment when revealing personal material to a stranger, fear of the unknown, fears that are triggered by prior experiences with well-meaning helpers, fear of being judged, fear of the anticipated pain that will accompany facing one's problems (Kushner and Sher, 1991). The antidote for these types of resistance is the bread and butter of insight-oriented psychodynamic treatment: offer support, work on trust in the relationship, facilitate greater client self acceptance, and interpret what is occurring.

Type V resistance results from secondary gains the client receives as a result of his symptoms. In general, most examples of self-defeating behaviors that we see in clients (or ourselves) follow several basic themes (Dyer, 1976; Ford, 1981). Look, for example, at a client with a chronic somatizing disorder that is resistant to any and all interventions. Whether he has a complex factitious disease, a Munchausen syndrome, or a more pedestrian form of hypochondriasis, the client enjoys a number of benefits that make change especially difficult.

Whether we are speaking of symptoms as diverse as guilt, obsessive rumination, or temper tantrums, secondary gains usually provide the following cushion:

1. They allow the client to procrastinate and put off action. As long as clients have distracted us (and themselves) to focus on their favorite method of acting out, they do not have to take risks that are part of growth and change.

2. They aid the client in avoiding responsibility. "It's not my fault" and "I can't help it" are favorite laments of difficult clients who externalize problems. Because they blame others for their suffering and seek to punish perceived enemies, they never have to look at their own role in creating their suffering.

3. They help the client to maintain the status quo. As long as we look at the past, there is no opportunity to examine the present or future. The client remains safe and secure in a familiar existence (however miserable it might be), rather than having to do all the hard work that is involved in changing lifelong patterns.

One client who had remained impervious to every effort aimed at confronting his need to destroy

all his intimate relationships finally started to come around after generating a list of his favorite payoffs:

- "I get to feel sorry for myself that I'm so alone. It is other people's fault that they don't understand me."
- "I get lots of sympathy from others; they feel sorry for me."
- "I prefer to call myself 'complex' rather than 'difficult.' I like being so different from your other clients. That way you really have to pay attention to me."
- "As long as I can drive someone away before he or she gets too close, I don't have to grow up and learn to carry on more mature, adult relationships. I am able to remain selfish and indulgent."
- "I get a lot of mileage out of the excuse that I have this problem — *that* is why I am not more successful in my life. I am afraid that once I resolve this I might have to face the fact that I can't reach my goals. This way, at least, I can pretend I could have what I want if only I tried."
- "I like the idea that I am destroying my relationships on *my* terms, before anyone has the chance to reject me. As long as I am in control of the way things end, it doesn't hurt half as much as it would otherwise."

Confronting these ploys and forcing clients to identify the games they are playing in order to avoid change is an important step in creating more self-responsibility. Secondary gains work best only when clients are not aware of what they are doing; once these self-defeating behaviors become explicit, it is much harder for clients to engage in them without laughing at themselves. When the confrontation strategy is combined with attempts to alter the systemic forces that are reinforcing the secondary gains, many types of client resistance can be significantly reduced.

Homeostasis and the Meanings of Resistance

We in the helping professions are quite fond of borrowing instructive concepts from the sciences and adapting them to explain complex psychological phenomena. Maybe we are attracted to these concrete physical realities because the subject of our own study is so abstract and elusive. Perhaps we are imitating Freud, who liked to "neurologize" psychotherapy. Maybe we are frustrated doctors who envy

those who are able to fix problems with a pill, a scalpel, or a laser beam. Or maybe there is just a lot of intuitive sense in assuming that human behavior, both internal and external, obeys laws similar to those of the physical world.

One of the more common ways we tend to conceptualize the behavior of difficult clients is with the process of homeostasis, the body's strong determination to maintain equilibrium throughout every system. Turn up the heat and the sweat glands will kick in to cool the surface temperature of the skin. Invade any part of the body's environment in such a way as to disrupt the precisely calibrated temperature, pressure, and fluid balance, and defenses will work to repel perceived threats and restore a stable cellular state.

We often observe this same process in some clients who will attempt to thwart our goodwill, as well as their own efforts to make needed changes, in order to maintain the homeostatic balance of even a dysfunctional organism. According to this functional model of client obstruction, most forms of client resistance and difficulty are efforts to avoid change that may threaten existing conditions.

People tend to become difficult when they are expected or required to change something they are already doing. "Unless people are immediately persuaded by overwhelming evidence that a change in their behavior is necessary or beneficial, such as responding to a fire by exiting from a building, they will resist change in the status quo" (Anderson and Stewart, 1983a).

Clients play games to keep us from getting too close, to protect themselves from perceived attacks. Of course, clients do not participate in this process consciously, any more than they deliberately order their sweat glands to activate; the responses are automatic and therefore need to be recalibrated — the essential process of psychotherapy.

The homeostasis model allows us to view difficult clients in such a way that we do not take their behavior personally, nor are we shocked when they use manipulative games to sabotage progress. We fully expect almost all clients to be difficult on some level, and when they are not, we are pleasantly surprised. (Some practitioners would even insist that *apparent* cooperation is, in itself, a sneaky form of resistance, but that is another story.)

Lest we get carried away with the metaphor of homeostasis, we should note that some writers offer the compelling argument that human behavior is not subject to the same laws as biochemical or intercellular events. Haley (1989), for one, believes the whole debate about client resistance is ridiculous: clients want to change; they just do not know how. Nevertheless, the family therapists have been most passionately committed to the homeostasis metaphor in explaining family dynamics of power and control.

It may be sheer egocentricity on our part to assume that human beings are exempt from the laws of the universe that apply to everything else. Eastern religions, Native Americans, even physicists have been saying for some time that *all* events and actions, however localized, are connected and influenced by energy in other parts of the universe. This is the root of the most basic theorem in quantum mechanics (Zukav, 1979).

My assumption throughout this book is that when clients are difficult it is because they are trying desperately to maintain homeostasis in their lives. Through their behavior they are trying to get along as well as they can and keep their lives on as even a keel as possible. If that effort means that the therapist must be inconvenienced or aggravated along the way, so be it.

Most people in general, most clients in particular, and difficult clients most of all are trying their best to get through hard times by resorting to the strategies that have worked for them before, however dysfunctional these may be. They seek to control as much of their environment as possible and are in turn influenced by the events and people who populate their world. They are not deliberately trying to make our lives miserable nor do they stay up late at night plotting ways to get to us; they just want to be understood.

Difficult clients are difficult precisely because they are not always aware of what they are doing. Our job is to help them in this endeavor of self-revelation and personal change without being made to suffer ourselves during the process. To accomplish this mission requires us to have a thorough understanding of the exact circumstances and variables that make some people so challenging to work with. This knowledge allows us to increase our sensitivity to what clients are experiencing and permits us to respond to them compassionately and effectively.

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