Compassionate Therapy: When the Therapist Is Difficult

When Therapists Sabotage Themselves

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My most difficult client is a man about my age who initially presented many of the characteristics that I prize most in people I work with. He is fairly bright, verbal and articulate, sensitive, and apparently motivated to work on himself. About the only thing that would make me feel ill at ease is that he is significantly smarter than I am —and knows it. He is very psychologically sophisticated and has been in therapy before, several times in fact, so he knows exactly what is expected. He can talk the jargon and understands the concepts of therapy quite well.

This person is in a professional position in which he is used to getting his way and has been quite skilled throughout his life in accomplishing this goal. Because he is so articulate and persuasive, he has rarely met with any serious resistance to following his own agendas. Further, he has *extremely* unrealistic expectations for himself, perfectionistic notions that he could never be enough, never do enough. What makes him especially difficult for me to work with is that he uses his knowledge as a way to avoid real changes in his life, all the time employing his verbal skills to keep me satisfied. I find immensely frustrating the extent to which he uses his intellect to run circles around me.

One of his most pervasive qualities is his impatience. He demands instant results in his life—from himself, and I suspect from others —although he denies this vehemently. I sense his disappointment in me when I am not quite as brilliant or inventive or perceptive as he thinks I ought to be. I feel tremendous pressure to reach beyond what I am capable of understanding and doing; while I appreciate this challenge to grow and stretch myself, the constant performance anxiety takes its toll.

This guy also pushes my buttons constantly. Almost against my will I start to feel defensive or threatened in response to things he does. Even when I *know* what he is up to, I still feel powerless to stop myself from reacting negatively. It is as if he can read my mind.

And he can.

My most difficult client is *me*.

Looking Inward

In Part One we noted that "being difficult" is a judgment by one person in a position of authority about another persons failure to meet expectations. It is a label of convenience selected on the basis of one's individual subjective impressions. Therefore, we cannot consider clients to be difficult without examining our own role in formulating that label.

Much of what we experience from working with these clients comes not only from their behavior but from our own self-critical attitudes and wishful thinking (Medeiros and Prochaska, 1988). Client difficulty is not "out there," it is "in here," inside each of us where we observe, perceive, define, organize, construct, and analyze our experiences of other people. Mahrer (1984, p. 70) describes the origin of his own feelings when he encounters someone he considers abrasive: "I feel it in me. It is the experiencing of abrasiveness here in me. If someone were to ask me where it is, I would point to me, to my way of being, to feelings and experiencings in me."

Perceiving Clients Subjectively

Reporting the case of Anna O., Freud wrote about one of the first instances of a therapist's own unresolved issues making a client appear difficult to work with. Anna O. was actually a client of Joseph Breuer, Freud's collaborator in *Studies on Hysteria*. Breuer, it seems, had a tremendous fear that Anna O. might develop erotic feelings toward him. He prematurely ended their treatment together because of *his* feelings toward her, compounded by his wife's jealousy of Anna (Feiner, 1982). The interesting observation is that Breuer perceived Anna as the impediment to their therapeutic progress; he did not acknowledge his own role in creating the impasse.

Whether a client is difficult or not often depends on the therapist's perceptions as well as the client's behavior (Roth, 1990). Consider that regardless of setting or theoretical orientation, half the clients who come for a first session do not return. The prevailing wisdom has been that these are treatment failures, dropouts, or resistant clients. Because we did something wrong or were unable to build an alliance or could not sufficiently motivate the client, or because the client is so defensive and problematic, he or she elected not to return.

Then a researcher decided to investigate the reasons clients do not return after a single treatment session. Much to his surprise, Talmon (1990) discovered that in his own practice 78 percent of the clients he had seen for a single session reported improvement! In another study of two other practitioners, 88 percent of the single-session clients felt they had made definite progress. Whether or not these figures are inflated, they demonstrate quite clearly that different perceptions of the same clinical event are possible.

Because the participants in the therapeutic process are coequal in their subjectivity, the use of interpretation as an intervention is loaded with the clinician's own values, perceptions, personal feelings, and subjective impressions (Natterson, 1991). Therapists who are looking for evidence of resistance in their clients will find it. Shades of the Hawthorne Effect and the Pygmalion Effect! If you anticipate that a client will be difficult, he or she will probably live up to your expectations.

I recently listened to a tape of the first interview between an intern and a client I had referred to him. I had initially interviewed the client, but as she had no health insurance and could not afford even a minimal fee, I suggested she work with another therapist I was supervising. She readily agreed as she was quite motivated to make some changes in her life.

The first interview between the client and the intern began with the same cadence and rhythm that I remembered from my experience: she asked a number of rapid-fire questions. What were his qualifications? How long had he been in the field? What was his theoretical orientation? Could he see her during the evenings? When she had asked me these questions, I believed the woman was quite anxious and was giving herself some time to get used to the situation. I had therefore patiently addressed each query and then we began a delightful and productive dialogue.

I listened aghast, however, as quite another scenario unfolded from the identical beginning script. When the client asked the therapist about his therapeutic style, he became evasive, putting the focus back on her. "Why did she want to know?" he asked curtly. And anyway, before he could answer such questions, he would need to know more about her.

Just as she was about to ask another question, the therapist interrupted: "You seem to have a number of questions for me. But if you don't mind, I would like to ask you a few things first."

The client became progressively more stubborn and reticent as the interview progressed. In fact, she became downright hostile —the prototype of a difficult client—demanding, controlling, shrill, and uncooperative. As the therapist shut off the recorder, he shook his head and commented: "What a bitch, huh?" My experience with her had been quite different because my interpretation of her initial behavior was so unlike the intern's interpretation.

Encouraging Clients to Be Difficult

"At about the time I decided to quit doing therapy and go into business, I noticed *all* my clients seemed to be difficult." So spoke a burned-out professional.

It is true that therapists who feel depleted, who have lost their passion and excitement for their work, and who are tired, bored, and indifferent to what they are doing are going to encounter more clients who appear uncooperative and resistant than are those practitioners who truly love doing therapy. The depleted therapist views certain behaviors as annoying while the energized practitioner sees them as challenging. The former calls uncooperative clients "a pain in the ass" whereas the latter resonates with their pain. The burned-out clinician is impatient, frustrated, and overly demanding that clients do exactly what he expects. Any deviations from the program are labeled resistant and are dealt with accordingly.

Often the depleted therapist is actually the one who helps launch the client in a career of being difficult. Caroline walks in feeling hurt, rejected, and abused by her ex-husband. She longs for understanding, even attention from someone, especially a man. She is needy and vulnerable, and this condition becomes immediately evident as she attempts to engage her therapist in some personal interaction. She desperately wants him to see her as a person, not as an object, a client who is just paying money for his time.

The therapist is exquisitely sensitive to Caroline's neediness— or to anyone's for that matter. He is making child support payments that are more than he can afford. He is seeing many more clients than he feels comfortable with but he needs the extra money. Everyone seems to want a piece of him —his ex-wife, his children, and the thirty-some clients whom he has begun to fantasize as leeches clinging to his

body, draining his life blood. And then Caroline walks in.

The therapist puts on a mask of compassion, pretending to care. His disdain and revulsion for this dependent woman, another leech, inadvertently seep through. Caroline can sense that he does not like her; she has vast experience reading men who act as though they care about her but only tolerate her presence.

"And here is another one. I can't believe I'm paying this jerk and he still doesn't have the courtesy to be considerate. Look at him, trying not to yawn. This is humiliating. Who the hell does he think he is?"

Caroline tries harder to win her therapist's approval. As she becomes even more contrite, deferential, and clinging, the therapist withdraws further.

"Why do these people find ME? Look at her—hanging on every word I say. I suppose I should confront this dependency stuff or she will never let go."

He does so. Caroline explodes. For the first time in her life, she tells somebody, a male somebody, to go screw himself. She storms out of the office in tears.

The therapist shakes his head. He can't wait to tell a colleague about this latest wacko. He wonders why they always end up on *his* doorstep.

Two years pass before Caroline builds the confidence to see another therapist. This time it is a woman. But before Caroline even begins, she lets the new therapist know her terms and expectations. The therapist sighs to herself: *"Another difficult client."*

Feeling Threatened

One of the premises of this book is that clients' negative responses to therapy are not necessarily results of their resistance or tendency to be difficult. Often they are defending themselves against perceived attacks by clinicians who have been insensitive or clumsy in their interpretation or confrontation (Strupp, 1989).

Contrast, for example, how two therapists might offer different responses to the following client statement:

> Client: I'm not sure that I am ready to get into that yet.
>
> Therapist A: I notice you seem very defensive when I probe in that area.
>
> Therapist B: You're not sure that you can trust me yet and I can understand how you would prefer to wait until we get to know each other a little better.

Although we cannot necessarily conclude that one response is more effective than the other, it seems clear that the more provocative intervention of Therapist A is likely to spark entrenched resistance in the client. As so often occurs, we become the catalyst for creating monsters of our clients by not respecting their pace or needs at a given moment in time. We may feel as though we are only trying to be helpful, but the clients feel that we are trying to nail them to the wall. The only possible responses a client can make to such a perceived attack are a strategic withdrawal, an unrestrained retreat, or a vehement counterattack.

In the *strategic withdrawal*, clients tell themselves that therapy is apparently not a very safe place. They begin to feel that any vulnerability they expose will be exploited, any weakness they show will be jumped on. They fail to see that we are only trying to identify their self-defeating behaviors and increase their awareness of their dysfunctional patterns. Instead, they devise ways to get through the sessions without sustaining too much damage. They throw up a smoke screen to cover their retreat, using rambling, distractions, overcompliance, anything to buy enough time to bow out without getting shot in the back.

An *unrestrained retreat* is a considerably more direct response to perceived attack: "Goodbye. I'm not coming back. But I will be sure to call you when I am ready." The message is clear that therapy does not feel safe to the client and it is time to leave the scene.

The *vehement counterattack* may actually be the healthiest response of all, even if the therapist must expend considerable trouble to neutralize it. The client feels hurt, rejected, and belittled; like most wounded creatures, he or she is a formidable foe when cornered. Either as a reflex action or a deliberate choice to do battle, the wounded client begins a war of attrition. He or she has now determined that we

are indeed like other sadistic authorities who have wielded unrestrained power in the past. But since we are being paid to be helpful, we are certainly fair game from whom the client will exact retribution. Payback is a bitch.

Difficult clients threaten us in ways we would prefer to ignore and avoid. They challenge our expertise ("*I'm too perceptive for him and he just can't handle it*"). They test our patience ("*She just doesn't seem to have the motivation it takes to get anything out of therapy*"). They threaten our very sense of competence as professionals ("*Who is HE to talk about being a fraud*?"). It is for these very reasons that we prefer to keep potential failures at a distance, disown them whenever possible, and blame the client as being difficult whenever we feel threatened (Kottler and Blau, 1989).

Making Excuses

Certain qualities predispose a therapist to encounter more than his or her fair share of difficult clients. Smith and Steindler (1983, p. 110) believe that clinicians who are most vulnerable are those who have developed "therapeutic zeal"—"a kind of misguided conviction that they must provide treatment literally at all costs."

This idealism, unrealistic expectations, and search for perfectionism lead the therapist to experience much disappointment. Clients are not sufficiently grateful for all the effort that has been expended on them. They fail to live up to the therapist's expectations for where they should be. Further, the therapist feels disappointed in his or her own performance when a client is not cooperating: "I must be doing something wrong." "If only I were more skilled/intelligent/creative, surely I could solve this problem."

His analysis of resistance in therapy led Ellis (1985) to believe that the most difficult client of all is the therapist, especially when he or she stubbornly holds onto beliefs such as the following:

- "I must be successful with all my clients all the time."
- "When things don't progress in therapy the way I believe they should, it's because of my essential incompetence."

- "My clients must cooperate with me at all times, and love and appreciate everything I do for them."

- "Therapy should flow smoothly and easily and I should enjoy every minute of it."

These internal assumptions operate in those therapists who are most prone to the deleterious effects of working with difficult clients. Such clinicians assume too much responsibility for therapy outcomes, believing they are at fault when the client's problems are not resolved positively. One successful defense against the temptation to accept responsibility for negative results is to take the opposite tack: blame the client for being difficult.

Therapists generally make two types of excuses to account for the client's obstructiveness: one is the tendency for the therapist to be a perfectionist and to blame herself when therapy does not proceed according to plan. The second is to be defensive and disown any responsibility for negative outcomes. These extreme points of view are shown below by a description of the internal dialogue of the Perfectionistic Therapist and the Defensive Therapist in response to several difficult client behaviors.

Client: I'm sorry I missed my last appointment.

Perfectionistic Therapist: *If only I could be more engaging and firmer in setting limits, this kind of thing wouldn't happen to me.*

Defensive Therapist: *I'm obviously getting close to something that the client cannot handle.*

Client: I really don't appreciate what you just said.

Perfectionistic Therapist: *Oops. I really blew that one. Why can't I be more patient? I can't seem to find the right way to get through.*

Defensive Therapist: *He's just trying to distract me from the point I made. Boy, has he got a thin skin!*

Client: I think one day I'll just decide to kill myself.

Perfectionistic Therapist: *After all this time I still haven't been able to reach him. There must be something else I can do.*

Defensive Therapist: *Hey, that's his choice. If that is what he decides to do, I can't do much to prevent it.*

Client: You're a fraud. You just sit there each week pretending you know what you're doing, but you don't have any earthly idea how to help me.

Perfectionistic Therapist: *Got me!*

Defensive Therapist: *It's not MY job to fix his problem. He is just angry because I'm so calm and composed when things get a little bumpy.*

Client: I don't know how I will survive when you go on vacation.

Perfectionistic Therapist: *Maybe I shouldn't be away so long. I seem to have allowed too much dependency to develop, and now I'm cutting him off abruptly.*

Defensive Therapist: *He is just playing mind games with me. He will do just fine. And if he has a hard time with me away, it will be a good lesson for him not to become so dependent on me in the future.*

Client: I've decided not to come back.

Perfectionistic Therapist: *Where did I fail? I thought I did everything right. Yet here is another one I lost because I just can't adapt quickly enough. Maybe if I offered to lower my fee. . .*

Defensive Therapist: *It's probably for the best. She is just not ready to change. Now, who can I put into that time slot?*

At the heart of any answers we might formulate in response to the client statements listed above are our own inclinations toward being perfectionistic or defensive. Our core issues remain ever-sensitive to the buttons that are triggered by work in sessions every day. The more difficult and challenging the client, the more we must resort to our own self-protective defenses.

Centered between these two perspectives is a position that allows us to be realistic about what we can and cannot do. On the one hand, it is important not to fall victim to the client's attempts to draw us into a dysfunctional system; maintaining emotional distance is helpful in this regard, as is having reasonable expectations for our clients and ourselves. Yet hiding behind a thick mask of clinical detachment is ultimately not useful, either. It makes us appear withholding and cold to people who so strongly crave a little caring and cuts us off from our personal issues that are ignited by therapeutic interactions. If we are not willing to admit the extent to which we are affected by certain kinds of clients and incidents, we can never attempt to loosen their stranglehold.