Compassionate Therapy: Some Very Difficult Clients

Yes, No, Maybe, I Don't Know

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Among people who are not easy to work with because of their passivity and reluctance to change are those who are overly compliant. These clients are often considered difficult by their therapists as much for their interpersonal style (which may be boring and repetitive) as for their patterns of resistance. They can stay in therapy for years and years, dutifully attending sessions, performing like trained animals to do whatever we want —but only in the sessions. Outside the office, they remain just as passive and impervious to change as ever. They drive us to begin wondering whether *anyone* we are seeing is really changing anything; maybe they are all just talking a good game.

Passive, clinging, dependent clients are often unaware of their effect on their helpers. They are needy and lonely, often to excess; they perceive their doctors and therapists as an inexhaustible supply of support (Groves, 1978). They want complete and total devotion, no matter how repetitive they become and how unwilling they are to do anything to change. In fact, they do not seem to want to change at all; they like things just fine the way they are. They get to complain a lot about how helpless they feel. They can blame others for what is not working. And they can come to us week after week, tell us the same things, and know we have to listen.

Clients Who Pretend to Change Without Changing

Bonnie is just about the sweetest, kindest, most cooperative, and gentlest person I have ever had the pleasure to work with. She is attractive, articulate, and sincere. Over a period of several years she has attended her sessions religiously and always greets me with a radiant smile as I meet her at the door. Furthermore, she feels tremendously grateful for the help I have offered her and expresses unrestrained satisfaction at the progress she has made over the years. Yet Bonnie is among the most difficult clients I have ever worked with.

How, you may justifiably wonder, can such a lovely human being be such an unremitting source of frustration? What more could any therapist ask for? She is dedicated to her growth and is so responsive in her sessions she could offer workshops to other clients on the etiquette of being an ideal prospect. Yet

in spite of her smiles and contriteness, her apparent willingness to do anything to further the cause of her therapy, she harbors an especially virulent form of self-destruction resistant to any antidote I have yet devised.

All the time I have known Bonnie she has been involved in a relationship with a man she claims to love. This connection has been the source of much of her anguish —and mine as well. While not abusive in the strict sense of the word, her on-again, off-again fiancé Michael is, nevertheless, not a very nice person. He does not like women very much; although he cares for Bonnie more than anyone he has been involved with, you would never know it by observing him. Yet, he cannot seem to help himself; he has never been able to bond successfully in any intimate relationship. As hard as he tries, and sometimes he *does* try to work through his blocks to getting close to Bonnie, he ends up driving her away. Also as a footnote: he has no intention of *ever* getting into therapy himself.

Over the years, Bonnie and Michael have been engaged twice, and disengaged as many times. Just when Bonnie has finally seemed to cleanse him out of her system, she invites him back into her life to start the cycle again.

Because I have seen Bonnie over many years, she has had the opportunity to experience several different modes of treatment as I have evolved as a practitioner. We have worked together both existentially and psychodynamically, developing insights into the reasons she stays stuck in such a destructive relationship. She can vividly see how she is duplicating the same dance played out by her parents. I tried a more cognitive/behavioral approach for awhile, cuing her to think differently about her situation. And as with most of the interventions I employed, she responded brilliantly during our sessions only to contradict everything she learned by doing just the opposite in her life. “Yes, I know he is no good for me. I really do understand this relationship will never give me what I want. But I just can’t let him go, try as I might.”

Clearly this case was perfect for trying some paradoxical maneuvers. I encouraged her to see Michael *more* often, and every time she complained about his latest crime of insensitivity, I defended him. I could recite quite a list of the dozen other things we attempted together and with each one Bonnie would initially respond quite well. It was only later she would reluctantly confide she was up to her old

tricks again. At the end of my rope, at one point, I suggested she stop therapy for awhile and she readily complied with that as well.

A year later she returned again, doubly committed to break free once and for all. This time I made a rule that I would see her only if she agreed not to discuss Michael. We could talk about anything other than him. We tried that for awhile, and things went quite well, if only because of our conspiracy not to discuss what she most obviously needed to deal with.

I have talked about this case with many colleagues. Everyone has suggestions, and I am sure a few have occurred to you as well. Bonnie is more than content to come to therapy forever. She likes it. And she is also quite clear that there are some parts of her life she has no interest in changing. And *that* is what is so hard for me to accept and live with —to work with clients who want to talk, but not to change.

Working with the Passive Resister

The codependent model is one that would commonly be applied to Bonnie's case. There are serious problems, however, with a theory that is intended to empower helpless, passive women but instead makes all those behaviors and characteristics associated with the feminine appear to be pathological. Walters (1990) is concerned with using a medical term such as *addiction* to describe adults who choose certain patterns or kinds of relationships in their lives. By subscribing to a codependency model we reinforce the idea that the client is not responsible for her behavior, that she was born or made into "a woman who loves too much," a "woman who loves men who hate women," or who has a "doormat syndrome," or any number of other euphemisms that explain the disease invading the "codependent psyche."

Walters (1990, p. 57) suggests the best way to fight back: "In our work as therapists we can't change the larger society, but we *can* help people to feel less oppressed in their lives by knowing that they are not just passively reacting to events, but are actors whose performance will be largely shaped by the way they *understand* the drama they are enacting."

I would go further and say that while understanding these codependent patterns is certainly important, it is often not enough. Passive resisters who appear to be motivated and cooperative but never

change their behavior in any fundamental way require more direct intervention. And when a frontal assault does not work (as in the case of Bonnie), more indirect means are often helpful (Lazarus and Fay, 1982). Symptom prescription, for example, is sometimes effective; with this technique we are asking the client to do what he or she is already doing but with a small change in its context or sequence (Watzlawick, Weakland, and Fisch, 1974).

Madanes (1990a) recommends prescribing the symptoms for certain couples who attend sessions regularly, purport to want to change their ways, but continue to be critical of one another. She directs them to set aside a prescribed time each evening to criticize one another without responding or defending their positions (similar to the strategy I mentioned in Chapter Eleven in the context of combative couples). Although these paradoxical interventions are sometimes just as futile as the more direct strategies, at least they give us something to break up the monotony of doing the same things over and over.

The Lonely Client

A special case of passivity occurs with those clients who feel so vulnerable and lonely, so needy and dependent, that they appear immovable. They are indifferent to most of what is happening around them, and although they suffer from depression and melancholia, it is their utter alienation and estrangement from the human race that are most significant.

It is often hard to factor out which part of a client's distress is loneliness and which is depression, just as it is difficult to determine conclusively whether a mood disorder is biologically or situationally precipitated. We may even one day discover that there is a genetic or biochemical component to loneliness just as there is for depression (if, in fact, these are different states).

Loneliness is qualitatively different from depression in that it results primarily from a deficiency or perceived dissatisfaction in social relationships (Peplau and Perlman, 1982). It is the experience of hunger for human contact, and it is a pain felt so deeply that a person can quite literally die of love starvation.

Francine was mistakenly diagnosed by her psychiatrist as depressed. Indeed she appeared

depressed —lethargic, mournful, despondent, unresponsive. Since she was married and holding down a decent job in a large office, there was no reason to assume that a longing for human contact was the source of her pain. In fact, the condition of loneliness is not part of the usual vernacular of the therapist; it is not even listed in the index of the *Comprehensive Textbook of Psychiatry* or in the *Dictionary of Psychology*.

Francine may have looked depressed, but inside she felt incredibly lonely. That her psychiatrist kept insisting she was really depressed (and gave her medication for that condition, which could be cured) only made her feel more alone and less understood. She had lost the feeling of being connected to others. She longed for greater closeness to those around her and craved being held and communicated with intimately.

For years she had tried to talk to her spouse, but received for her efforts only ridicule and rejection. Her husband claimed to love her, and probably did, but was utterly unable or unwilling to express the slightest affection. Twice per week they had sex in which she felt mounted, violated, and discarded like an animal. She tried to talk to friends about her feelings, but they were appalled by her disloyalty and impropriety in even discussing the matter.

Her friendships were dominated by ritual and routine, but with a distinct lack of real closeness. Within them, it was acceptable to discuss clothes, jobs, and family in a general way, but off-limits were "sticky subjects"—that is, intimate feelings, fears, doubts, and innermost thoughts. She thus felt estranged from all relationships and desperately wanted to be understood by someone.

Francine had the misfortune to select a therapist who believed in the value of objectivity and passivity to foster the transference relationship. To her, he simply appeared cold, aloof, bored, and uncaring. But since she was used to such treatment from her father and husband, it never occurred to her to complain. This, after all, must be her fate in life — to be condemned to superficial, unsatisfying, withholding relationships.

Twice per week she would see her therapist, pour her heart out, and cry continuously. The good doctor would watch from behind his large desk and write copious notes. In the several months she had been seeing him, he had not offered a single comment other than to tell her she should be patient and

keep taking her antidepressant medication. When she would speak of her loneliness, he would occasionally ask a redirective question about her dreams or her family history. She felt so alone it was as if she were the only person in the world. Nobody seemed to care or understand her, even this doctor she was seeing for that very purpose.

So consumed with her loneliness and, yes, depressed that it would never end, Francine died of isolation. Of course, she did not actually fall dead off a chair one day; death by loneliness is more subtle. On a day not unlike many others, she awoke to the feel of dried semen on the bedsheets and a sense of hopelessness that anything in her life would ever change. She went into the bathroom where her husband was shaving and attempted to make contact with him: did he enjoy the lovemaking last night? What would he like for dinner? How were things going at work? To all her questions he responded gruffly and impatiently, telling her to leave him in peace. Defensively, he challenged her to tell that stuff to her shrink.

Francine left work at lunchtime for her scheduled therapy session. Throughout the interview she departed from her usual tearful monologue and attempted to engage the doctor in some sort of genuine dialogue, to get him somehow to look up from his notes and really see her as a person. She finally lost her patience and screamed at him that he was just like everybody else —that he didn't really care about her.

The doctor glanced up for a moment, actually looked as if he might say something, but then nodded slowly and asked her to continue. He wrote in his notes that the transference was proceeding quite satisfactorily. At the session's end he said, "I'll see you on Thursday, then." Francine didn't reply.

She walked out into the cold, cloudy, windy day with a tightness behind her eyes so intense she felt blinded by the meager light. Her breathing seemed labored, as if it were an effort just to stand there. She looked out at the busy street and saw hundreds of cars on their way to somewhere they had to be. She noticed a couple across the street, huddled from the cold in deep conversation. It was then that she realized there was nowhere she had to be. If she walked off the face of the earth she wondered how long it would take for somebody to notice. Although superficially connected to hundreds, perhaps thousands of people (and their faces momentarily came into view, especially the acquaintances who treated her kindly—the boy who does yard work, the woman who cuts her hair), she felt close to no one. There was

nobody to love, and nobody who loved her.

For the first time in months, something made sense. Francine began to walk purposively across the boulevard headed apparently toward a row of stores. (Afterward, the police surmised that she must have been going to the drug store because in her pocket there was a prescription for antidepressant medication.) Suddenly, she stopped in the busy street and seemed to find something that caught her attention in the grey sky just as a minivan caught her below the knees. It was then that her loneliness finally ended.

As tragic as these so-called "accidents" may be, a greater sadness is found in realizing how many walking wounded there are — those who are alive only in the token gestures they offer as they drift through life in isolation. Loneliness is *the* most prevalent problem of mental health, even if it has not yet found its way into textbooks.

Clients like Francine are among the most challenging to treat. They do not respond to medication because, strictly speaking, they are not depressed so much as they are stuck in a passive, withdrawn mode of life. The clients sense of hopelessness often infects the mood of the therapist as well. Markowitz (1991, p. 26) describes the utter despair and sense of dread lodged in the pit of the therapists stomach when confronted by a severely depressed and lonely client: "By definition, depression attacks hopefulness, the very basis of a client's motivation to work in therapy, and depressed clients are notorious for their draining effect on the clinician's own sense of self-worth and hopefulness."

I am aware when I am working with stubbornly lonely, passive people —the ones who are not endogenously depressed, but who have chosen their life style and are determined to hold on to it no matter what I do —how relieved I am that I am I and they are they. Their attitude of total surrender to their condition is infuriating: How dare you give up when there is so much that you could do!

As to what is most likely to be helpful to the passive, lonely client, the literature suggests anything and everything! This includes helping the client to appreciate better and make more creative use of solitude (Hulme, 1977; Storr, 1988), increase her desire to change by exaggerating isolation (Reynolds, 1976; Suedfeld, 1980), become less dependent on a lover for happiness (Russianoff, 1982), talk to herself differently about her predicament (Young, 1982), use loneliness as an opportunity to love

(Moustakas, 1972), and take a more active role in life (Rosenbaum and Rosenbaum, 1973; Slater, 1976).

A number of other treatment strategies are also sometimes helpful with persistently lonely, passive clients (Kottler, 1990):

1. Facilitating greater risk taking in both reaching out to others and facing oneself without the need for distractions

2. Turning off radios, televisions, and other external entertainment/escapist media in order to deal more directly with what one is running away from

3. Understanding the significance of private time as a potentially endless source of creativity and self-expression

4. Reframing the perception of loneliness as a more active form of solitude

5. Using solitude to acknowledge more honestly ones cravings for intimacy

In summary, most therapeutic efforts are directed toward helping clients find greater meaning in their suffering, coupled with offering them support and encouragement to break out of their shells of isolation. The therapeutic relationship, of course, becomes the fulcrum by which this leverage is applied. What Francine longed for most from her therapist (and she confessed this to me the day before she died) was for him to look at her and respond to her as a person, not as a "patient," or "client," or "depressed woman," or subject to write notes about. She just wanted some compassion and understanding.

Clients Who Do Not Talk at All

Of Nordic stock, Phil embodies the essence of the word "stoic." He suffers, but oh so silently. He suffers like a man should. No tears. No feeling. No unseemly displays. Just a sad-eyed dog face and a low rumble of a voice that sounds like its battery needs replacing.

Phil is depressed and despondent because his wife left with their children. He does not much like the idea of therapy, but he thinks perhaps this gesture will convince his wife he is serious about changing. As to what it is he wants to change — that is a bit elusive. His wife, however, has stated in no uncertain terms that she can no longer live with someone who is so cold and unfeeling. Phil explains:

"She says I'm empty inside. I have no feelings, or at least none that I'm aware of. Maybe she's right." Although Phil really wants help, he does not know what to do, how to proceed, or where to go next. This uncertainty is not so unusual for a man cut off from his feelings. But Phil, not given much to introspection in any form, has no earthly idea about how to be a client in therapy. He is a man of few words and believes that talking in general is a waste of time. When queried about what is on his mind, he shrugs. When invited to bring up what is bothering him, he responds simply: "My wife left," and then looks at me expectantly as if I should go get her and bring her back.

"Your wife left you?"

"Ah, yuh."

"Can you tell me more about it?"

"Not much to tell. I came home from work last week and she was gone. So were the kids."

"Well, how do you feel about that?"

"She shouldn't have done that without at least telling me first."

"You sound pretty angry."

"Anger doesn't do a man much good. I just think that she should come home."

Working on a cognitive level, naturally, appeared more comfortable for him. And that is just where we stayed for awhile, each of our sessions seeming to last for hours of awkward silence: talking about the mechanics of living alone, what he should tell friends and family, ways he could fall asleep at night. He would begin each session with a single question and then fully expect me to talk the whole hour. Phil remained mute during our sessions; he claimed he had nothing to say.

"Fine," I said in relief, hoping to get rid of him. "Then I see no reason for us to reschedule."

But if Phil quit therapy he could lose the last chance he had to get his wife to come home, or so he believed. No, he was going to keep coming until his wife decided what she was going to do. But meantime, what were we to do with our time?

Each session was excruciating. Even if Phil wanted to talk, he did not know how. That left me with

more than my share of the responsibility for what we did, unless I wanted to continue rambling, trying to fill up forty-five minutes with an answer to his initial question. I jabbered on, giving pep talks, trying to engage a flicker of interest in something. We tried fishing and hunting (subjects I know nothing about); sometimes we attempted to talk about what he feels or thinks inside (subjects he knew little about). Somehow we would get through the hour and then he would straighten his back as if preparing himself for the next dose of foul-tasting medicine and schedule another appointment.

I would like to think that Phil got something out of our time together, even if his wife never did return. After six months he did become a little less reticent. And I learned a lot about hunting and fishing. He eventually normalized his life once again, decided he would find another wife who could love him the way he was, or barring that, at least agree to live with him.

Phil was different from most clients who don't talk in therapy as he was not being the least resistant. He was trying to cooperate; he just did not know how. There are, of course, other clients we see who do not talk because they refuse to play by our rules.

Clients may remain silent for a number of reasons. Some resent intrusions into their privacy and the only way they can retain an illusion of autonomy is by controlling the flow of what comes out of them (verbally, anyway). Other clients appear quiet because they do not know what to say or what is expected of them; they wait until they can figure out how to provide what the therapist wants. Still others are expressing passive-aggression, withholding themselves in an effort to be punitive or controlling (Harris and Watkins, 1987).

Working with the Silent Client

Children and adolescents are among the most proficient at employing silence as a weapon in therapy. Marshall (1982) collaborated with one ten-year-old client who was especially skilled at avoiding any interaction whatsoever through a variety of means —detachment, indifference, disengagement from anything the therapist might try. Because this child was so brilliantly adept at ignoring questions, he was recruited to help write a list of what it takes to be the most difficult client possible. Marshall therefore suggested that if other children want to be like him and frustrate their

therapists, they should say *only* the following in response to any question:

"I don't know."

"Sometimes."

"It doesn't matter."

"I guess so."

"That's about it."

"I don't care."

"I forget."

"Yes."

"No."

"Sort of."

"I don't remember."

"It doesn't make any difference."

Of course, once the therapist and client had made a game out of their rigid patterns of communication, making the rules explicit, they could laugh at themselves and thereby remove some of the barriers preventing them from exploring other areas.

Of all the responses we get from the silent client, "I don't know" may be the most difficult of all. Sack (1988) has catalogued several of the most common ways a therapist might respond to a client who says "I don't know" to any query that is initiated. I have presented the therapeutic options in progressive order of how intrusive they might be. My assumption is that we try to do as little as possible to produce the greatest impact. Only when our most benign interventions fall on deaf ears should we resort to more potent strategies.

Therapist's Response Options to the Client Response of "I don't know."

1. *Silence*. Respond to silence with silence.

2. *Reflection of content*. "It is difficult for you to articulate what is going on for you."

3. *Reflection of feeling*. "You really feel resentful that you have to be here to answer these questions."

4. *Probe*. "What is it like for you not to know?"

5. *Labeling of behavior*. "I've noticed that you say 'I don't know' a lot."

6. *Invitation to pretend*. "Imagine that you did know. Take a wild guess as to what form it would take."

7. *Confrontation*. "I sense that you may know a whole lot more than you have decided to share with me right now."

8. *Self-disclosure*. "I'm having a hard time working with you when you answer 'I don't know' so often. It is as if you expect me to know what is going on inside you without your offering much help."

These are just some of the response options that are available to us when we are confronted with one common ploy passive resisters use to keep us at bay. On a larger scale, there are even more interventions that are sometimes effective in counteracting exaggerated silence or extreme passivity:

9. *Relabel the behavior*. "You seem to be quite good at staying within yourself. Most people can't stay quiet as long as you can.

10. *Schedule a silent session*. Continued silence now becomes a cooperative response.

11. *Prescribe the silence*. "I appreciate your keeping so quiet. That will make it so much easier when I discuss the problems with your parents. I'd like you to stay silent so I don't become confused by hearing your side of things."

12. *Provide structure*. "You don't seem to know what to do with our time together. I wonder if it would be easier for you if I asked you a series of questions?"

13. *Provide freedom*. "I respect your desire not to talk right now. I am willing to wait as long as it takes for you to open up."

14. *Create a game*. I'll ask you a series of questions in which you won't have to say a word. Just nod your head when I ask you a question or shrug if you don't know."

15. *Use nonverbal sources*. "As it seems difficult for you to communicate verbally, maybe you could draw a picture describing how you feel." Other variations include bringing in photos, playing favorite music, playing a game, or going for a walk.

Doing More by Doing Less

I have read so many books and articles, attended so many workshops, consulted with so many colleagues about child and adolescent therapy that I can easily spout the party line. Provide a sanctuary of trust for the child. Communicate with the child on his or her own level. As play is the primary form of expression, do a lot of play therapy.

Well, even with all the training I have had and permission I have been given from supervisors I admire, I still feel the need to *do* something in my work. Cases in point: I am seeing three adolescents right now whom I would describe as difficult because they refuse to talk. Their parents insist they get help, feeling guilty about the monsters they believe they have created, so they drop them off at my office once a week for some brainwashing.

All three boys are defiant and surly. They have declared to me that they may have to come but they don't have to talk. "Fine," I tell them, "what, then, would you like to do with the time we have together?" I feel proud of myself. I am being supportive, concentrating on being with them on any level at which they can function. With one boy, we play cards —poker and gin rummy. He is not interested in learning any other games, and he will not respond to any question if it does not relate to the game. Another boy brings a ball and we play catch outside. He will not talk either, but I convince myself that on a metaphoric plane we are communicating on a deep level. The third boy walks with me to a drugstore where I buy him some chips and a Coke. He mumbles thank you and then promptly ignores me.

I have been seeing each of these boys for a period of months. I cannot see that their behavior when they are with me has changed at all. We have settled into a routine in which we know what is expected. The real surprise is that the parents of two of the boys claim there has been substantial improvement in their demeanor and school performance. Sometimes they are even nice to their sisters. The parents think

I am some kind of magician and ask me what I've been doing. Trade secrets, I tell them. But I think to myself, *This is ridiculous. No fancy confrontations or brilliant interpretations. I just play cards and go for walks. I can't believe I get paid for this*!

So why are these kids possibly improving? It must be that they sense I really do care, that I *am* trying to help them. I try to be completely honest, and they know I will not tolerate any crap. I suppose they also realize that I am in a position to get them into even more trouble if they do not cooperate minimally. Maybe I will even be able to do them a favor someday.

The act of *not* doing psychotherapy is difficult for those of us who are so attracted to progress and change. Yet passively resistant clients do not respond too well to direct intervention. And sometimes with adolescents, the best therapy is to suspend any therapeutic activity temporarily so they do not feel so cornered (Anthony, 1976). I suppose it is awfully arrogant of us to believe that nothing much happens in therapy unless we make it happen; some of our best work comes from allowing resistant clients to move along at their own pace and speed without having to cater to our expectations.