Compassionate Therapy: Some Very Difficult Clients

You Can't Make Me Talk

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You Can't Make Me Talk

Harold is extremely depressed over the breakup of his eight-year marriage. His wife says that he is impossible to live with. She claims he is neglectful, abusive, insensitive, and hostile—not a nice person at all! But Harold begs to differ: "The bitch is just ungrateful. And after everything I did for her, too. She was nothing before she met me. I introduced her to a world that was beyond her reach. And this is how she pays me back — by walking out. I say fuck her!"

I find myself liking his wife already for having the courage to walk out on this jerk. Guilt seeps through before long and I remind myself that Harold is hurting. He probably is not always this obnoxious. At least that is what I thought before he turned on *me*.

Harold was immediately suspicious and cynical about therapy. He wanted me to know that he was here under protest— only hoping to convince his soon-to-be ex-wife that he was at least trying to change. He thought this whole profession was a sham, nothing more than a form of prostitution, and furthermore, he let me know that he didn't care for me one bit!

I sputtered out some response that I appreciated his honesty and that I didn't take his attacks personally.

"You better take it personally, buddy, if you expect to get paid."

I let that one slip by and redirected things back to his miserable life. He had a long history of alienating the people in his life and claimed nobody he could call a friend. He felt completely alone. I felt bad about my cynicism and defensiveness, my need to ridicule him to diffuse his attacks. Clearly, the man was really in trouble, and in his own unique way, he was asking for my help.

The half-dozen hours that we talked together were almost nonstop struggles. Harold could be polite and cooperative one minute and incredibly hostile the next. He was seething with anger; and I was the target of his abuse. He never apologized. In his mind, I was being paid essentially to tolerate whatever abuse he felt like dishing out.

I tried to tell him how hard it was to be with him, how other people in his life must have felt the same way that I did. I explained that the pattern for all his relationships was getting people to reject him. He called me a fraud and stormed out of the office without rescheduling another appointment. His last words were that I could stick my final bill "where the sun doesn't shine." I was so glad to be rid of him I hardly cared.

Harold, and clients like him, are among the greatest challenges in our work —the hostile and aggressive person, the belligerent adolescent, and even the combative couple who turn their rage on one another. In all these cases, we are exposed to emotional upheaval in its most powerful and extreme manifestations—a cyclone of destructive energy directed toward anyone who happens to get in its path.

The Abrasive Client

Almost by definition, violent, aggressive, hostile clients who lash out at others have problems with impulse control. They feel entitled to special treatment that they believe they have been denied throughout their lives. They expect their therapists to make up for these perceived deprivations by providing instant relief of symptoms, and they become even more frustrated and angry when they are once again disappointed (Madden, 1977).

Alicia is an abrasive person who was able to penetrate the composure of a therapist who considered herself especially experienced and skilled at managing even the most belligerent and unpredictable of clients:

> I really want to forget her, just forget her. It has been four years. But I don't think she is gone. I catch myself looking twice at small green compact cars even though I remember her saying she had to get rid of her car. I think I'll hear from her again down the road. Although I have invested volumes of myself in other suicidal patients, wanting them alive, wanting them whole, wanting them to see Life's Potential, I confess I would be relieved to read or hear of Alicia's death. This is not characteristic of me. I consider myself on the end of the scale as having the widest range of tolerance for annoying, irritating behavior of any therapist I know. Hallucinations in my office are not something with which I can't cope. I have never been attacked by a patient; I think I know how to gauge rage that well. Simpler levels of obnoxious behavior seem to me to be rather clear messages of the depth of a patient's misery and I am generally able to respond therapeutically.
>
> Alicia was different [Brothers, 1984, p. 45].

What made Alicia so different for Brothers were her degrees of desperation and intensity, coupled

with a rampant unpredictability and tendency to become verbally threatening. Even the answering service complained they would no longer take messages from her because she became so abusive. While Brothers took some degree of comfort in knowing that a half- dozen other professionals were also pulling their hair out in response to their contact with Alicia, she had to conclude that ultimately she had failed: "I terminated my end with Alicia, reluctantly on the one hand and with great relief on the other. Yet, I still wonder if there were a way, which I just didn't discover, that would have led to her center and to her eventual healing" (Brothers, 1984, p. 53).

Abject failures with these sorts of cases are quite common. Giovacchini (1989) described the discomfort he experienced while working with an aggressively intrusive client. The client began initially by accusing him of incompetence because he had failed to foresee a catastrophe that had occurred in the client's life. Eventually, her rage escalated to the point that she held him accountable for all the pain she had ever suffered. She became progressively angrier and more accusatory over time.

As much as he tried to understand the origins of her rage and to maintain his professional detachment, Giovacchini finally lost his temper and told her how it felt to be dumped on. She then fled treatment.

With each of these cases the therapist is confronted with someone who does not respect the usual rules of human contact that are part of therapeutic engagement. These people are abrasive, rubbing us (and others) the wrong way because of their pervasive mistrust and hostility. Nowhere is this abrasiveness more evident than in the hostile male client who, unfortunately, sometimes ends up in our office against his will.

Taffel (1990) has made a study of men who sound familiar to us, the man who is the prototype of Jackie Gleason's character in *The Honeymooners* — irritable, moody, critical, demanding, hostile, a caged animal who paces relentlessly, stomping, snarling, and sniping. He is certainly not the best candidate for therapy. But sometimes such a man does seek help, or more likely, is forced by his wife to get help under the threat that she will walk out on him if he doesn't.

This man who appears so gruff and hostile is actually masking a chronic depression, according to Taffel (1990, p. 51): "Whether the men passively disappear into the woodwork or shake the foundation

of the house with their agitation, they share one characteristic — they cannot regulate their own moods or affective states and they depend on their partners and children to do so for them."

Cast in this light, hostile men are unable to articulate what is bothering them and are completely unaware of their feelings. Their behavior is in sharp contrast to that of many hostile female clients (and also other men) who become deeply and overtly angry precisely because they are so aware of their feelings of resentment and helplessness. Taffel believes that if we would give as much attention to underlying affective states in hostile people as we do their power and self-esteem issues we could really help them deal with the feelings that are eating them alive.

This hypothesis, even if it is valid only half the time, has helped me to work with clients I find especially difficult. Hostile people frighten me —as they are supposed to. Yet once I get beyond the bluster I am able to home in on the hurt and pain that lies beneath the surface. To make that much noise one would have to be wounded deeply in some way.

I try not to see the hostile client as purposely attempting to manipulate and control; if I do, then *I* become angry. Almost against my will, I rise to the challenge of locking horns to protect the vulnerable and innocent against this big, bad monster. Alternatively, I try to look at the hostile client's underlying suffering, the desperate attempts to live up to an idealized image that is unreachable. Even if this assumption of hostility-as- masked-depression is not valid, the framework helps me to remain compassionate rather than threatened, empathic rather than defensive. Nowhere is this conceptual framework more helpful than when that most exotic, elusive, and challenging of all clients crashes through the door with a wail of defiance —the belligerent adolescent.

The Belligerent Adolescent

"Look you stupid ass, my mother made me come so I have to sit here, but you can't make me talk."

"I don't blame you for being angry when you are forced to do something you don't want to do."

He hunches deeper inside himself, crossing his arms. His scowl turns into a smirk.

"Look, this isn't exactly a lot of fun for me either. We seem to be stuck with each other for awhile. We might as well make the best of the situation. Why don't you tell me about why your mother thinks you should be here?"

"Fuck you."

"Your mother mentioned to me on the phone that unless your grades improve dramatically in the next few weeks you won't graduate from high school."

He looks up for a moment in defiance and then shrugs. I shrug back, imitating his movements. At least we are communicating on some level.

"She also said that your friends are worried about you, too. What is your best friend's name? Ronnie, isn't it? (I deliberately mispronounce it.) Anyway, Ronnie called your mom to tell her that he was real concerned about how moody you have been lately."

"Lonnie."

"Excuse me?"

"Lonnie. His name is Lonnie. Can't you even get *that* right?"

"Thanks. Lonnie, then. So what is the story?"

He sinks so deeply into the couch I wonder if it will swallow him up. He is chewing on his nails now. His teeth peel off a curled strip of nail, which he casually drops off the end of the couch. He glances at me to see if I noticed.

"I want to help you. I don't work for your mother; I work for you. Neither she nor anyone else needs to know what we talk about— it's just between us. I don't expect you trust me; you don't even know me. But we have lots of time to get to know one another. Meanwhile, I have a problem that I need your help with."

He doesn't take the bait, nor even nibble. But I continue anyway.

"When this session is over, your mother is going to ask me how it went, what we talked about. What should I tell her?" Another shrug, saying he doesn't care.

"What I intend to tell her, then, is nothing. Just that what goes on here is between you and me. And that things went fine. How does that sound?"

"Look, man, I already told you I don't want to be here and I don't want your help. You guys can make me come here and make me go to school, at least until I turn eighteen next month. But you can't make me talk."

And so the battle goes between the well-meaning therapist and the surly adolescent who is hurting so much he can't ask for help. Jurich (1990) describes kids like this as the therapist's worst nightmare: defiant, obnoxious, a tough-ass who dares you to come close so he or she can eat you alive. "When they are not making our lives miserable *in* the treatment, they are making us feel worse by refusing have anything to do *with* the treatment" (Shay, 1987, p. 712).

But of course these children are hardly agents of the devil sent to torture us; they are acting out

quite honestly what they genuinely feel inside. In speaking of the younger "hateful child," Brenner (1988, p. 188) describes his or her intensely negative energy: "Sometimes there is hardly a room that can contain them. They may use the walls to climb on, the window to jump from and the closets to hide in. Their attention span is short, and they are fast going in and out of drawers and closets, with jet speed. While they continuously look for assurance and love, they are acting out of pure fury and hate. They are hungry, and their continuous movements are, like scavengers, always searching for food in the environment. They appear to be an example of pure ID impulse."

Rebellious children feel such anger and hate that they inspire similar feelings in us. Often abandoned or neglected by one or both parents, they are on a single-minded mission to make surrogates pay the price for their perceived (or actual) abuse. Their acting out, however raw and impolite, is the form of communication with which they feel most comfortable.

The days of the teenager who would act out through being promiscuous, listening to rock and roll, and smoking pot are over. Now we must contend with adolescent belligerence in nuclear proportions. Because sexual acting out is not as safe any more, there is a backlog of repressed energy that finds itself expressed in acts of violence. Who could ever have imagined that inner-city elementary schools would have guards and metal detectors, that fourth and fifth graders would control the drug trade for particular territories, that children would be murdered for their Nike Air Jordans or their leather jackets?

Among the affluent population, belligerent teenagers drive their parents crazy not with drugs or social protest, as many of us did, but with racist or anti-Semitic posturing. For a generation of parents and therapists who grew up during the turbulent sixties, when a certain amount of rebelliousness was fashionable, we are now stunned by the extremes. There are kids who act out with automatic weapons, and then there are those who swear off all drugs and alcohol and rebel against their parents by becoming neo-Nazis or materialistic wheeler-dealers.

Dismissing the Hostile Client from Treatment

One obvious solution to the problems of treating belligerent adolescents is to get rid of them altogether and work with the parents instead. Quite often their behavior is the result of dysfunctional

family structures in the first place, so it makes sense to see the people who experience the greatest difficulty and therefore should be most motivated to initiate change.

Adolescents (or anyone else for that matter) cannot be made to do anything they firmly refuse to do. The teenager who has already become entrenched in a defensive position, who has reached a point of simmering hostility, is simply not going to be budged through a frontal confrontation. Some therapists suggest that rather than targeting the child directly in such cases, the therapy should concentrate on other family members who are more cooperative and motivated. Sometimes, dismissing the belligerent adolescent from treatment even has the paradoxical effect of piquing his or her interest. In several cases described by Anderson and Stewart (1983a), the problem children were asked specifically not to participate in the therapy with the result that they became much more cooperative in their efforts to make themselves understood.

The rationale is clear: take somebody who is a world-class expert at rebellion and defiance and then ask him to do what he does best. Even if this isn't immediately effective in eliciting the sullen teenager's cooperation, you have at least eliminated the major impediment to the therapeutic process. The client is now facing the consequences of his belligerence—that is, he is not permitted to participate as an adult in the attempt to find a solution to the problem. If he decides to continue pouting he will at least not disrupt the therapy the way he has stirred up the family. Meanwhile, there is plenty of work that can be done with the parents to help them understand their child and deal with the conflicts more effectively.

It is also quite helpful for the child to get the clear message from his parents: "We want to help you. We will do anything within our power and resources to be of assistance. If you do not want our help, we have no alternative but to respect your choice. However, we have decided to get help for ourselves. And we have definitely decided to try doing some things differently. With the support and expertise of our therapist, we are optimistic that needed changes can be made."

A great number of the times that belligerent teenagers are dragged into treatment they are acting out the problems manifested in their parents' relationship. The message above lets the child know that the parents are getting help for themselves. It is no longer necessary for the child to act as a scapegoat or

distractor.

Parents are often urged to come in for the first session on behalf of their child, ostensibly to provide needed background information. At least half the time, once we get into the family history and dynamics of the couple's relationship, we end up starting there first. If the parents are going to be at all effective in helping their child, they have to be reasonably cooperative with one another first. In an amazing number of times, when we start working on the marital relationship, the hostile child's behavior miraculously improves.

A plan devised by Roberts (1982) helps the parents of acting-out adolescents to create a more mature and satisfying relationship with their child. The change is accomplished through a sequential process beginning with the *preparatory phase*. The object of this stage of the therapeutic relationship is to instill positive expectations, raise morale, and recruit support. We are also gathering specific information regarding what the adolescent does and what effects such behavior has on others.

In the *rethinking phase* no effort is made to explore the marital relationship; rather, the focus is exclusively on the angry adolescent and the parents' relationship to him or her. Roberts (1982, pp. 20-21) has observed that "while a few families can meaningfully begin quickly to broaden the context of therapy to include their personal lives, the great majority are unable to, and premature termination is likely to occur if the therapist gets fooled into pushing such areas too soon."

The principal goals are thus to help the parents become more reflective about their child's behavior, to understand better what he or she is going through, and what is being communicated through the acting-out behaviors. Madanes (1990a) described the helpfulness of such awarenesses to the parents of a young girl who was especially difficult to deal with. The parents claimed they could tell immediately on awakening whether the girl was going to be in a good or a bad mood throughout the whole day.

> "And if you believed it was going to be a bad day, how would you greet your daughter?" Madanes inquired.
>
> "Well, we would usually go in her room and ask her to get ready for school. It was all business. We knew we were in for a fight."
>
> "And what if you anticipated she was in a good mood?" "Oh, then I would sing to her and play games."

The parents believed the child was dictating to them what life would be like; in fact, they were unconsciously cuing their child as to what *their* mood was, based on reading (or misreading) her behavior.

Understanding communication patterns and relationship structures is the bread and butter of the family therapist. In this specialized form of treatment, attention is concentrated primarily on the parental dyad in relationship to the hostile child. Efforts are made to strengthen the parental bond through joint problem solving. The therapist gives the couple permission to do what they need to do to protect and take care of themselves. Finally, rethinking is initiated in areas of defining responsibility—who is in charge of what, and what realistically is within their power to influence. The general emphasis is in training the parents to be more objective and less emotionally vulnerable to the whims of their irresponsible child.

This strategy proved to be especially helpful to the parents of Clem, a young man who had been dragged to therapy but refused to participate. The parents were at the end of their rope. Once they came in for sessions they sent a clear message to their son: "We may not be able to stop you or get you to act more civilized, but we're damned if we will let you control our lives anymore!"

Understanding why Clem was so difficult was quite an interesting exercise for the parents but less useful than their resolve to take better care of themselves. As happens so often in such cases, Clem considerably reduced his acting-out behavior once his parents stopped overreacting. Further, he seemed less angry when his parents began operating with cooler heads.

In the *directed action* phase, the meat (or "potatoes" for vegetarian readers) of therapy is accomplished. Insight and understanding are useless unless they are translated into action. This transition occurs when any number of strategic, structural, or behavioral interventions are implemented, depending on one's theoretical preferences. There is no doubt, however, that some action is required to alter the parents' responses to the belligerent adolescent. The action plan can run the gamut from being more supportive to kicking the young adult out of the house. In any case, the parents are likely to be more successful in their efforts than they would have been without their newfound alliance, their objective problem-solving attitude, and their detachment from the bonds to their child that previously held them immobile.

Neutralizing Hostility

According to Bowlby's "attachment theory" (1973), hostile clients are expressing their frustration toward authority figures who have been continuously nonresponsive. As the hostile activity is based on a lack of trust, the object of therapy is to work on establishing an affectionate attachment with the person who is rebellious.

In an unusual application of Bowlby's theory, Nelson (1984) suggests that the best way to treat disruptive and hostile adolescents is through abrupt shifts in emotion to create bonding and trust. Dysfunctional or inappropriate behavior is confronted for a few seconds, after which it is juxtaposed with support and affection. The "scolding" initially creates anxiety, followed by the reassurance that produces relief and eventually trust.

Hartman and Reynolds (1987) provide a partial list of resistant behaviors that should be confronted within this context, such as a client's showing disrespect to authority figures or becoming obstinate. According to the authors, these behaviors, and hundreds of others like them, should be confronted vigorously and then immediately followed by caring reassurance. This paradigm counters resistance by working on both process and content levels. It creates a safe atmosphere in which the therapist can let the child know that what he or she is doing is not acceptable, without breaching the trust that has been established between them.

When I read about models such as this I usually shake my head. Slowly. I think to myself: that's all very fine, and what the authors are saying surely sounds good on the drawing board, but what about when some kid is trying to take my head off? I smile as I try to imagine some belligerent adolescents I have known sitting still while I "juxtapose confrontation with caring." Most difficult clients I have worked with are difficult precisely because they see through attempts to control them or modify their behavior. Yes, they need firm boundaries, but not within the context of a game called "good cop, bad cop" where I alternate scolding with a sappy smile.

One of the major points we gleaned from Sigmund Freud, Erik Erikson, Jean Piaget, Lawrence Kohlberg, and the other developmental theorists is that adolescence is a time for testing limits. It is the period in which the half-adult-half-child seeks to exercise autonomy and to test himself in combat against

established authorities. In fact, being resistant and rebellious is part of the job description of a teenager and a component of many relationships teens have with their parents and other authorities. Novelist Len Deighton once wryly observed that the universal conflicts between adolescents and their families is necessary for the very survival of the planet: if kids did not fight with their parents, they would never leave home. And then the world would end.

While adolescents may indeed be sullen, secretive, self- absorbed, and sometimes rude, most have not developed rebelliousness to an art form. A number of studies have indicated that adolescent belligerence is overstated and that most arguments that take place are over relatively inane issues — whether to take out the garbage and how one's hair should be cut (Gelman, 1990).

McHolland (1985) cautions that adolescent resistance must be looked at in terms of the system it serves; quite often the acting-out behaviors serve a protective function in the family. He also notes that in many cases the therapist, by her attitude, expectations, and labeling, can create resistance where little or none exists. McHolland, therefore, offers several guidelines for avoiding the manufacture or stimulation of adolescent hostility in the early sessions:

1. Establish general rapport before beginning any attempt to get into the presenting problems. Start with basic interests in music, sports, school, and other activities.

2. Keep the pace moving. Do not let silences last too long. Engage the client in interactions.

3. Do not interrupt the client while he or she is talking. Do not offer advice or judgments.

4. Use self-disclosure to build trust. Stay within appropriate boundaries while sharing one's own feelings and experiences.

5. Do not expect or demand that the client do something that he or she cannot do. Learn about present levels of functioning-cognitive, affective, interpersonal, verbal, and developmental—and stay within them.

6. Use humor whenever possible to diffuse tension. For example, one especially potent technique most adolescents cannot resist is to ask them: "Would you like to see me imitate the way you look? Now, how would you like to imitate the way I look to you?"

7. Avoid taking sides with the adolescent or the parents.

I find this last guideline the most challenging of all. If the adolescent perceives we owe loyalty to her parents, there is no way she will ever trust the relationship. And if the parents believe we are too closely aligned with their child against them, they will yank her out of treatment. I have often found it helpful to recruit the child's assistance in this matter:

"Look, I need your help with a problem. Your folks will want to know what we talked about in this session. If I don't tell them, they probably won't let you come back —and that means they may find someone else you would like even less than you like me. So let's agree on what is OK for me to say to them, and what you would prefer that I not tell them."

Even the most obstinate of adolescents can recognize a good deal when he hears one. We are now coconspirators in a plan to help him attain autonomy and maintain dignity, and to do so without alienating other family members.

Confronting the Hostile Client

One of the most trying aspects of working with hostile clients is that their anger often elicits anger in us as well. We feel abused and attacked. No matter how much we reassure ourselves that this hostility is part of the client's pathology, we find it hard not to take the attacks personally—especially with clients who deliberately try to provoke us. These individuals are often exquisitely sensitive to vulnerability. If attacking our competence fails to strike a spark of indignation in us, they will try a host of other ploys to elicit a reaction —make a lot of noise, complain to others behind our backs, and even threaten physical violence. We then seek to retaliate under the guise of confrontation (Youngren, 1991).

Fremont and Anderson (1986) analyzed the client behaviors that provoke anger and suggested that in dealing with these, our first step should be to determine whether the anger or frustration we feel is indeed appropriate or whether it is a f unction of our own personal issues. The authors recommend that we next examine the hostile incident to learn whether it reflects the problem that brought the client to get help in the first place or represents an interpersonal dynamic in us. Then, and only then, should therapists talk about the feelings they are experiencing, although fully 90 percent have some reservations about sharing these reactions aloud (Fremont and Anderson, 1986). The principal criterion

for determining the appropriateness of voicing these reactions is the same one that should be used before any self-disclosure: will hearing what I am about to reveal be helpful for the client, or am I doing this just to meet my own needs?

We must be sure that we are not disclosing our feelings to let off steam, to inflate our own egos, to put the client down, or to strike back. If we genuinely desire to give feedback that can be helpful to the client, however, such interventions can be a tremendous turning point in treatment.

One reason that hostile clients employ their abusive style of communication is because they have been allowed to get away with it. Other people feel so intimidated by hostile clients that they will not challenge them, nor will they risk greater vulnerability by revealing how the hostile behavior has affected them. The therapist, however, is in an ideal position to force the hostile client to accept responsibility for the negative impact he or she has on others.

"I am sitting here thinking to myself that if I were not paid to listen to you, I would never put up with your antics. In fact, I am wondering if I am paid enough. No wonder your wife left, your children are afraid of you, and you have no friends. Why would anyone subject himself to your childish outbursts? Now, you can storm out of here if that is what you want to do; it's what you have done every other time somebody has tried to help you; but if you do leave, you are going to stay a very unhappy human being. I want to help you, but you make it very difficult for me to like you, to be with you."

A brilliant speech, I thought. But he did leave. And he did not come back. I reassured myself that even if he had stayed, I could not have helped him much, anyway. I did know that before I told him how I felt, I was absolutely positive I was doing it to help him (although I certainly felt some small satisfaction as well). If I had been more compassionate or softer, could he have heard me without feeling so threatened? I doubt it. Why should he give up a lifetime strategy of intimidation just because I did not like it?

There are other possible benefits of confronting hostile clients with the therapist's own feelings. For one, it helps them to distinguish between anger and hostility, to learn the benefits of expressing feelings without inflicting damage on others (Cahill, 1981). It also opens up avenues for exploring interpersonal conflicts in healthy ways and helps clients to learn they can have intense feelings and can express them with consideration for who is listening (Welpton, 1973).

Regardless of the preferred interventions, the hostile client must be taught that while it is indeed legitimate to feel hurt and angry, there are appropriate ways to express these feelings. The best place to practice these more effective ways of communicating is in the therapy itself, with the clinician taking the lead by modeling assertive responses in a compassionate and sensitive manner.