Compassionate Therapy: What Makes Clients Difficult?

Calling Clients Names

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Table of Contents

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Traditionally, in medicine, education, and the social sciences, when we do not understand something very well we give it a fancy label. It seems that if we can name a complex phenomenon, we can harness it. Thus diagnostic systems based on the medical model equate complex psychological processes with discrete categories. In theory, this is a wonderful idea; in practice, however, difficult clients are often shuffled into boxes called "borderline," "narcissistic," and "histrionic," even though they often fit the criteria of all or none of them (Kroll, 1988).

Our diagnostic systems are also unacceptably unreliable. They stigmatize people for life and substitute their uniqueness and individuality for labels that are both ambiguous and confusing (Boy, 1989). They also emphasize, disproportionately, what is wrong with people — their psychopathology rather than their resources and strengths (Kottler and Brown, 1992).

Difficult clients have been given a number of different descriptors: character disordered (Leszcz, 1989), stressful (Medeiros and Prochaska, 1988), bogeyman-like (O'Connor and Hoorwitz, 1984), obnoxious (Martin, 1975), hateful (Groves, 1978), help-rejecting (Lipsitt, 1970), manipulative (Hamilton, Decker, and Rumbaut, 1986), impossible (Davis, 1984), entitled (Boulanger, 1988), and abrasive (Greenberg, 1984) as well as the more benign labels of reluctant (Dyer and Vriend, 1973), resistant (Hartman and Reynolds, 1987), and unmotivated (West, 1975).

The major thrust of most literature on this subject is that some clients, for a variety of reasons that may or may not be their fault, have a need to *enact* while their therapists have a need to act (Fiore, 1988). Therein lies the struggle: we feel a strong drive to do something, to fix what we find broken, whereas the difficult client feels compelled to behave in ways that are beyond our comprehension. He or she operates under different rules from those we are used to. Whether these are forms of resistance is beside the point; these unusual ways of acting in therapy (to use neutral language) are disorienting and often frustrating as we try to make sense of and respond to clients' behaviors without escalating their intensity.

Although labeling our problem clients provides us with some relief initially (sort of like making up

an explanation for a mysterious sound in the middle of the night so we can go back to sleep), ultimately these labels can prevent us from seeing the people we help as unique individuals. Once we start thinking of our clients as borderlines, hypochondriacs, or narcissists, we sometimes sacrifice much of our compassion and caring. These labels do not quite elicit the same sympathy as other medical terms such as cerebral palsy or multiple sclerosis.

If we are to be of much use to clients who are already mistrustful and cautious, who already feel weird and unfairly judged by others, we should not confuse the labels we insert on treatment plans or insurance forms with the actual people we are seeing. It is often in anger and exasperation that we use psychiatric labels to refer to clients in our own minds or when we talk to colleagues: "You wouldn't believe the borderline I saw today. . .," "I've got this obsessive. . .," "Time to gear up and see Mr. Narcissism and Mrs. Hysteria. .

The cynicism implied in these statements illustrates the disdain (and fear) that we sometimes feel in response to clients who give us a hard time. The first step to being able truly to help them is to regain the caring, compassion, and empathy that we once felt while protecting ourselves from further abuse. Sometimes we can accomplish this by substituting more behaviorally based labels that do not reduce the whole person to a dysfunctional entity. Thus, if we say or think that a client is engaging in "borderlinish" or "narcissistic" behavior, we describe what might be occurring while we still recognize that this phenomenon could be situational and certainly is not the sum total of what this person is like. Even the *Diagnostic and Statistical Manual* of the American Psychiatric Association (1987) is moving away from labeling people and is instead, in its subsequent revisions, describing disorders.

It is a sign of maturity in our profession that we are ready to confront the difficult client; more and more, books, workshops, symposia, panel discussions, and special journal issues are appearing on the subject. In a parallel process, increasing attention is being directed toward the therapists own countertransference reactions to difficult clients and his or her contributions to the conflicts (Slakter, 1987; Wolstein, 1988; Tansey and Burke, 1989; McElroy and McElroy, 1991; Natterson, 1991).

Feiner (1982) views the broadened attention to difficult clients and their impact on therapists as a healthy attempt to extend our influence to those who need us the most but who do not conform to the

rules we consider sacred. The main problem, however, is that by confronting the difficult client as an issue, we negate a particular persons autonomy and uniqueness. We take people we consider hard to deal with, even a little frightening, and we use labels to smother the life out of them.

Sometimes Ignorance Can Help

Not everyone is a suitable candidate for psychotherapy. Some clients do not work well with particular therapists but would do just fine with others. Other clients cannot respond to what anyone does to try to help them. They are either unwilling or unable to make substantial changes in their lives. These forms of resistance are so virulent they could defeat Carl Rogers, Albert Ellis, Sigmund Freud, and Virginia Satir before lunch and still have time for Milton Erickson for a little afternoon diversion. These clients, in short, are difficult people to be around.

We are speaking of those who fit mostly in the personality disorder categories of the *Diagnostic and Statistical Manual* (American Psychiatric Association, 1987). It is just this classification, however, that sometimes gets us in trouble, even though we find it helpful to diagnose accurately the disorder a particular client is manifesting. The labeling process helps us to get a handle, or at least a starting point, on what we are dealing with —the etiology, symptom clusters, prognosis, and the like. It is also very comforting to see in black and white a description of what we are encountering in the office.

But these labels occasionally do us, and our clients, a disservice. Early in my career a young man came to see me complaining of irresistible urges to dress up in his wife's underwear and run out in the street for all his neighbors to see. His compulsion had escalated to the point that now he would sit by the door wearing a favorite negligee, just on the verge of bolting out the door. In my naiveté and inexperience I simply offered the explanation that all of us do things we are ashamed of. So what? But it is the *guilt* that destroys us.

He seemed especially relieved to hear that, and I could see he felt much better. Before I saw him the next week I met with my supervisor who expressed astonishment at my innocence and stupidity. The client was clearly exhibiting a problem of impulse control and sexual deviance; it would be very difficult to treat and take years to resolve successfully. I was suitably chastised and adequately prepared for next

time in which I would take a thorough history and begin the lengthy process of whatever is involved in working with sexual deviates.

The client entered my office with a bright smile on his face and a hearty handshake. “Thanks for your help. You were certainly right. When I left you I decided it was the shame and guilt that were eating me up. I decided to tell my best friend about my compulsion, and rather than fleeing from me he told me his own kinky preferences. Then when I got home, I tearfully confessed to my wife, convinced she would want to institutionalize me, or at least divorce me. But to my astonishment, she asked me to dress up in her underclothes and we had the wildest sex of our lives! Thanks a lot. I feel just great. And no more impulses to run outside.”

It would be easy to say that obviously this was not a true sexual deviate (because by definition he could not be cured in a single session), but I would like to think (and please indulge me for the moment) that it was my inexperience, ignorance, and lack of sophistication that allowed me to label this case not an “impulse disorder” but a “man-who-does-strange-things-and- feels-guilty-because-he-can’t-accept-himself.” I have never forgotten the lesson of this case (nor did my supervisor who wanted to transfer me to someone else). Many times since then I have worked with other so-called impulse disorders, personality disorders, and the like, and while a part of my brain automatically supplies a label, I stubbornly refuse to use it in my thinking about the case.

Diagnostic labels depress me. Once I read how morbid the prognosis is for a particular label, I lose my hope and faith that I can be helpful. (I also do not feel so bad when the client fails to improve.) Many of the clients we will discuss in this book are frustrating, even infuriating, to work with. They easily provoke our anger and lead us to compromise our compassion. They get under our skin and sometimes even try to hurt us deliberately, to knock us off our high horse. Therefore, some form of counteraction is needed to keep us from losing our composure and our caring. Ifind it helpful in talking about and working with difficult clients to remind myself, constantly, that this is a human being in pain who is doing the best he or she can.

Clients Are Not the Enemy and Therapy Is Not War

Some practitioners think of their difficult clients as lethal, dangerous, ferocious barracudas who engage us in a contest of wills. In his book *Fishing for Barracuda*, Bergman (1985, p. 3) describes this point of view, noting that clients do their best to defeat mental health professionals any way they can: "Once I learn from the initial telephone conversation about this impressive history of treatment failure, I immediately begin thinking in my 'resistance mode' and seeing the family differently from the way I would see a less resistant family."

Bergman (1985) measures the degree of client difficulty by several factors: (1) the client's previous history in defeating other therapists, (2) the chronicity of the present symptoms, (3) the level to which the underlying issue is covert and hidden, (4) the number of other helpers involved in the case, and (5) the context in which the referral was made. He claims that he can easily determine whether he is dealing with a "barracuda" in the very first telephone contact with the client. Those who call from phone booths, ask questions about his credentials, communicate that they feel little anxiety, or believe someone other than themselves is the source of their problems are immediately diagnosed as resistant and needing unusual forms of treatment.

Concluding after only one brief phone conversation that a client will be difficult sets into motion a series of actions that are irrevocable. Yet there is no dishonor for a client in being resistant, no reason to be called names just because he or she wishes to avoid pain. As Breuer and Freud (1893) originally conceived their term in *Studies of Hysteria*, resistance was meant to describe the client's attempt to avoid real or imagined pain. Milman and Goldman (1987) recount the startling event in which Freud first stumbled on what could be causing his twenty-four-year-old client, Fraulein Elizabeth von R., to be unable or unwilling to remember certain thoughts and memories from her past. After repeatedly admonishing her to continue her associations, and still feeling frustrated in his efforts to enlist Elizabeth's cooperation, Freud excitedly concluded: "A new understanding seemed to open before my eyes when it occurred to me that this must no doubt be the same psychical force that had played a part in the generating of the hysterical symptoms and had at that time prevented the pathogenic idea from becoming conscious" (Breuer and Freud, 1893, p. 268).

Freud, of course, spent the rest of his life searching for why certain clients resist and become

difficult, discovering in the process the heart of his theories of repression, defense mechanisms, and transference. Understanding what makes clients uncooperative thus became the cornerstone of all psychoanalytic thought.

Subsequent generations of analysts attempted to expand Freud's notions on resistance; these included such writers as Wilhelm Reich, Heinz Kohut, Robert Langs, Jacques Lacan, James Masterson, Anna Freud, Peter Giovacchini, and Otto Kernberg. The principal value of this attention to the subject, regardless of whether the clinician is sympathetic to psychodynamic theory, is the central premise that a clients obstructive behavior should be respected as a source of valuable information about what clients fear, what they are avoiding, and what this warding off means.

Difficult clients are frightened. Their behavior, which we call resistance, is normally something that we try to prevent or circumvent—an enemy to be defeated. These people are certainly not ferocious barracudas seeking to eat us alive. Difficult clients are often just people with problems that are more complex than those we usually confront, and with an interactive style that is different from what we might prefer. Calling them names only disguises the reality that resistant clients are attempting to tell us about their pain, even if their method of communication is sometimes indirect and annoying.