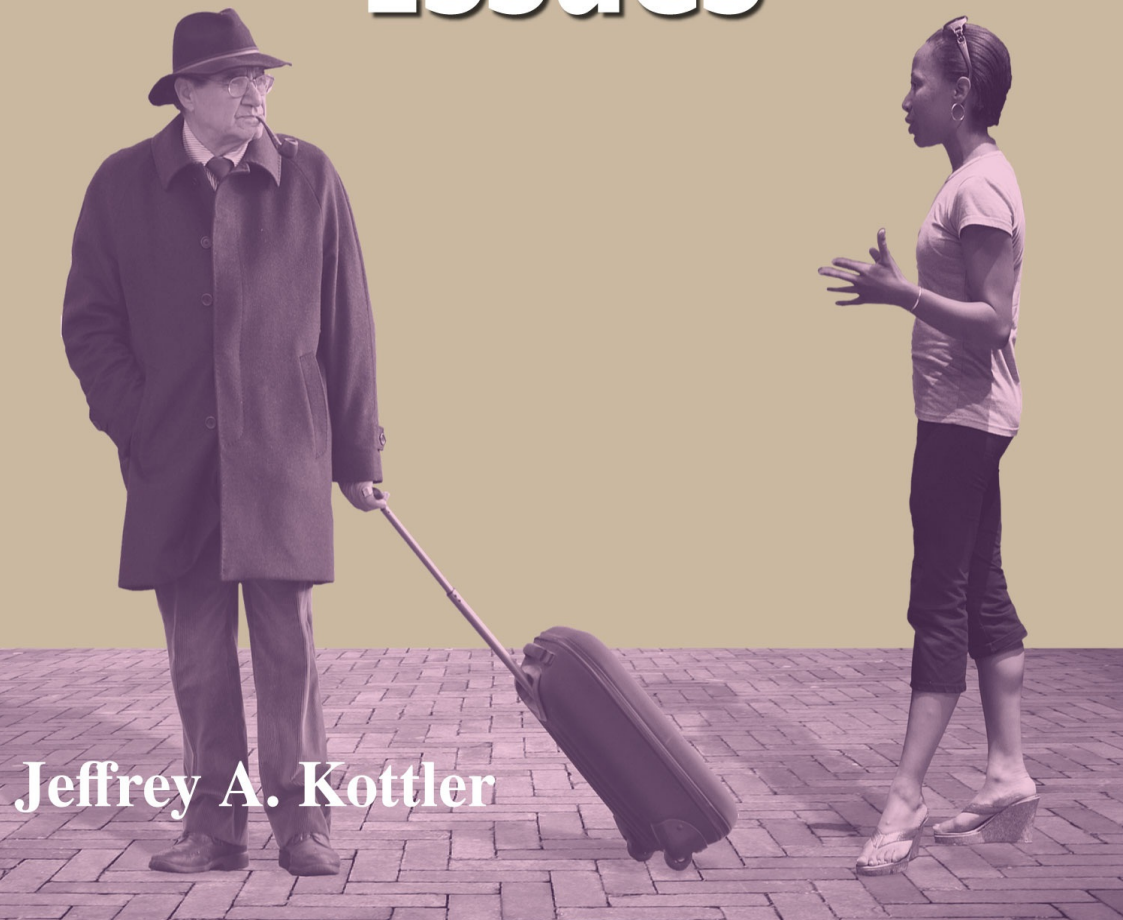
Compassionate Therapy: Managing Difficult Cases

Confronting Unresolved Issues



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Therapists are not only caring and giving; we are also *reciprocally* altruistic, that is, we expect some degree of appreciation and gratitude in return for our helping efforts. The trouble is that some clients are unable to acknowledge that they have been influenced or affected by us (or anyone), for to do so would be to dilute their own fragile power. On the other hand, if they can devise a way to make their therapist feel impotent and helpless, they raise their own sense of power.

Feeling helpless is inevitable for the therapist when working with difficult clients, as are accompanying feelings of anger, vulnerability, and sometimes even hatred. It is in exploring these countertransference feelings that we find the clues both to the most advantageous treatment plan for reaching the client and to the optimal course of growth in ourselves. Adler (1982) has suggested that many of our extreme negative feelings toward some clients has to do with our own fantasies about our omnipotence and ability to rescue. Our feelings are compounded by the regressive clients own projective fantasies in which the therapist is placed in the role of a perfect parent.

Saving the World, or Perhaps Ourselves

Possibly like many of you who gravitated to this field because of a drive to become more fully functioning as a person, I felt powerless and helpless throughout many of my early years. When I was about six I tied a cape (towel) over my shoulders and tried jumping off couches to fly like my superheroes Mighty Mouse and Superman. I believed the problem was that I was not trying hard enough. When I was eleven, my parents divorced because, I thought, I had failed to keep them together. My adolescence was marked by one failure after another—not being able to control my body, to date the girls I liked the best, to be part of the right group, to understand algebra or work a lathe in shop class, to win my parents' approval. Even in early adulthood, I felt out of control most of the time, unable to get what I wanted, or even to feel the way I wanted. Surely there had to be a better way.

When I first heard about the helping professions — that is, that you can get paid to show other people how to take charge of their lives —I thought to myself, "Finally, I will learn to fly!"

And I was not so far off the mark. Training to be a therapist plugged into my most grandiose fantasies of rescuing others, and myself in the process. Everyone knows that therapists can read minds, predict the future, and get people to do whatever they want. That seemed almost as interesting as x-ray vision.

So here I am, unabashedly admitting that I want to save the world, or as an alternative, at least everyone who asks for my assistance. Do I think this fantasy is a bit ridiculous if not downright psychotic? Certainly. Do I seem to be a little stuck in my egocentrism, inflating my sense of power? Assuredly so. But then, I do not tell many people about these delusions of grandeur. In fact, I hide these irrational beliefs so well that most of the time even I do not know I have not outgrown them. Time after time, I have my fantasies of omnipotence exorcised by supervision, but I never seem to get the roots out and they grow back — if not quite as lush, then more cleverly disguised. It takes a difficult client to find them again, even after months of repeating to myself and to others the mantras:

"There are limits to what I can do."

"It is up to the client to change."

"I can't help everyone all of the time."

The counterpart to these public prayers is the very private whisper that goes something like this:

"You don't believe that, do you? You are powerful. You have magic. You can talk to people; you can understand them. You have skills. You have books. You have diplomas. You can do *anything*."

I run for my cape. I tie it carefully around my neck. I climb on top of the couch. I try really, *really* hard to fly. Then I pick myself up off the floor.

Harnessing Countertransference Feelings

The reason we do this type of work is because we are both highly skilled and motivated to get through to people who have trouble communicating to others. Yes, they are boring or insensitive or hostile or manipulative: that is why they are in therapy to begin with. Either they or someone very close

to them feels that they could use some help not to be so difficult.

In spite of our training and best intentions, we find ourselves stuck in a room with someone we do not like much. We have done our best to remain attentive, compassionate, and responsive, but we can feel ourselves drifting away, leaving the session whenever possible, taking fantasy trips inside our heads, anything to escape the ordeal of being with this client.

One of the most honest portrayals of this internal struggle that goes on inside a therapists mind is described by Yalom (1980, p. 415), who offers this account of how he was able to regain contact with a difficult client:

> I listen to a woman patient. She rambles on and on. She seems unattractive in every sense of the word — physically, intellectually, emotionally. She is irritating. She has many off-putting gestures. She is not talking to me; she is talking in front of me. Yet how can she talk to me if I am not here? My thoughts wander. My head groans. What time is it? How much longer to go? I suddenly rebuke myself. I give my mind a shake. Whenever I think of how much time remains in the hour, I know I am failing my patient. I try then to touch her with my thoughts. I try to understand why I avoid her. What is her world like at this moment? How is she experiencing the hour? How is she experiencing me? I ask her these very questions. I tell her that I have felt distant from her for the last several minutes. Has she felt the same way? We talk about that together and try to figure out why we lost contact with one another. Suddenly we are very close. She is no longer unattractive. I have much compassion for her person, for what she is, for what she might yet be. The clock races; the hour ends too soon.

Freud ([1910] 1957) originally viewed all feelings that therapists have toward their clients, both positive and negative, as disruptive to the therapeutic process. Roth (1990) labeled this form of countertransference *totalistic*, that is, it includes all the thoughts, feelings, attitudes, and perceptions that the therapist has toward the client. This countertransference is distinguished from several other varieties, including *classical*, in which unconscious reactions develop in response to the client's transference, and the most common type described by Yalom — *interactive*. Both the therapist and client react to one another in profoundly personal ways in response to what the other is doing as well as what he or she is perceived to be doing.

As Freud originally conceived most countertransference feelings, they were labeled as evidence of the clinician's own unresolved issues, and once these were fully worked through in supervision, the therapist could again regain a state of benevolent but neutral interest. Although Freud was unable to practice what he advocated for other professionals, having analyzed many friends and even his own daughter, his cautionary advice became a mandate for a generation of practitioners who strived for this

elusive objectivity and disengagement. The paradox became this: how do I care about my clients without caring *for* them?

Natterson (1991) confronts his owns subjective contribution to conflicts with his clients, a phenomenon he considers to be much more than mere countertransference. In fact, he believes that clinicians' feelings toward their clients are the most essential ingredients of treatment. He further asserts that nobody can be truly understood without the subjectivity that is an implicit part of empathy. Even interpretations, the lifeblood of the analyst, contain the seeds of the therapist's own unconscious processes, just as they do the client's. It is senseless, therefore, to argue that we can be connected with and to a client in therapy without both of us being emotionally involved (Kottler, 1986).

Many other psychoanalysts now contend that it is not only impossible to maintain strict neutrality and impassivity in the therapeutic encounter but that it is also undesirable. Clinicians' feelings toward their clients are now a legitimate tool of assessment, one that has become the essence of the analytic interaction (Giovacchini, 1989).

Many other therapists, such as McElroy and McElroy (1991), believe that our countertransference feelings toward difficult clients are the best clues available as to how to help them. Once we become aware of what internal chords are being strummed by our interactions with a particular client—whether it is anger, frustration, anxiety, helplessness, defensiveness, revulsion, sexual attraction, or boredom — we are not only well on our way to neutralizing their negative effects but also to formulating a more effective treatment plan.

Form a mental list of your current caseload. Better yet, peruse your weekly calendar for the next several days. As you see each person's name and conjure up an image of him or her seated in your office, observe what internal reactions are going on inside you. When I complete this exercise, not without a certain amount of resistance, I feel relieved to note that I eagerly anticipate seeing most of my clients. I wonder what they are doing this moment. A smile comes to my face as I replay certain interactions or recall some conversation that was especially touching or funny or dramatic.

My breath catches, though, as a few other clients come to mind. These are people whom I absolutely dread seeing. They are demanding and obnoxious. Most of all, they don't appreciate me very much. I can

feel their disdain. Because they have not improved much, I have repeatedly asked them why they keep coming back to haunt me. Nowhere else to go, they might retort.

Manny is the most dreaded of all. I even fix myself an extra special lunch on those days I must see him. It takes me the rest of the afternoon to recover after he has come in, so I try not to schedule anyone else. Manny reminds me of fingernails scraped across the blackboard, of a mosquito bite I can't reach, of being trapped inside a room from which I can't escape.

It is no small consolation that Manny's referring physician warned me he was really ornery. That, in fact, was why he was sending him to me —because the good doctor was tired of dealing with him. There was nothing he could do to help him, medically anyway. He just needed someone to complain to.

Manny's idea of good therapy is for me to listen to him bitch about how unfair life is as he recounts all the injustices that have been heaped upon him. He has made it clear that he has no intention of changing anything about himself; it is the rest of the world that must accommodate to his needs. If I have anything that I absolutely feel I must say to him, I should be brief and not interrupt him; he will not listen, anyway.

Manny is perfectly content with the way things have been proceeding in our sessions together. He intends to keep coming forever, or until one of us dies or has a nervous breakdown. I think he will outlast me.

Now why, I ask myself, does Manny get to me so thoroughly? I can understand feeling mildly irritated and impatient; he is, after all, unwilling to play by the rules: he will not listen, respond, or change. But why do I dread his appointments with such intensity?

Manny, I come to realize, is my worst nightmare. It is not that he is so difficult to be with; in some ways he is quite interesting and entertaining. It is that he is the embodiment of everything I have learned to fear. He is so externally controlled, so unwilling to accept *any* responsibility for his life, that he is a professional victim. And if there is one thing I cannot stomach for even a few minutes, it is having someone else pulling the strings of my life. Flashback—to adolescence when my moods were completely under the spell of half a dozen girls I was in love with; to my mother, whose life was completely dictated

by other people's whims; to my father, who left without asking my permission; to my first supervisor, who listened to my sessions through the wall and rapped hard whenever I said something she did not like.

Yes, Manny had become the monster I feared the most— the helpless, embittered victim. And on some level, I wondered if it might be contagious.

I found the clue to helping him in my irrational fears of becoming like him. I could not allow him to be the way he was; he had to change, to be more independent, more internally controlled and more compulsive. Just like me. Yet once I uncovered the principal source of my own discomfort, I realized that he could stay essentially the way he was and still get something out of therapy, even if it was just having a person who would listen to him without interrupting. Now this certainly was not the way I prefer to do therapy, but Manny is utterly convinced that he is getting his money's worth.

Incidentally, things did become more relaxed and fluid between us after I stopped trying to convince him to be different. And he actually started to change, a very little bit at a time. As for me, separating Manny's issues from my own is only the first step in working them through. In the rest of this chapter, we consider some of the other ways that therapists attempt to resolve countertransference issues and protect themselves from psychic damage in this line of work.

Not Taking It Personally

The single best way to protect oneself against the onslaught of difficult clients is to apply Freud's most basic dictum of professionalism: detachment. By maintaining appropriate distance from clients — close enough to be empathic, yet far enough away to avoid becoming overly emotionally involved —we are able to stay more objective, tough-minded, and clearly focused (Smith and Steindler, 1983). For example, in a study of burned-out mental health professionals, Pines and Maslach (1978) concluded that the most helpful strategy for preventing deterioration is adopting a stance of "detached concern" in which our feelings of compassion and caring are tempered with a degree of psychological withdrawal.

Basch (1982) has observed that while this detachment is easier said than done with obstructive clients, one of the most important things we can do is to remind ourselves that they are doing more to themselves than they are to us. "Resistance is a much more frustrating phenomenon if we believe on

some level that the patient is willfully opposing us and could, if he were only a nicer person and less bent on making our life miserable, do something about it" (p. 4).

This belief, that clients are being difficult with us rather than with themselves, is easy to understand; it certainly seems as if they are out to get us. One of the prerequisites, however, to working through the resistance is to separate out our own unresolved issues. This is especially true with regard to wanting others to meet our expectations and imposing on our defensive clients the images of other people from our past who have given us a hard time.

Trying to Do Too Much

Strean (1985) catalogues the mistakes that therapists make while working with resistant clients, the most common of which he believes is trying too hard to resolve the presenting problems. When clinicians become overzealous, overactive, and overly committed to making things work single-handedly, clients who are already skittish may back off further. Although coming from a conventional psychoanalytic perspective that stresses detachment, Strean nevertheless reminds practitioners of all orientations to remember the limits of what can be done without the clients active participation.

Sometimes we have no choice but to accept the limits of what we can do for people who are determined to stay miserable. I recall how helpless I felt with my most difficult client— *anyone's* most difficult client—my own child. My son was suffering terribly after we relocated to a new state. He missed his friends. He felt lonely and lost. And worse, from his nine-year-old perspective, he could not imagine there would ever be a time when he would be happy again.

As I watched tears rolling down his cheeks and listened to him talk about how awful he felt, I mentally checked off the therapeutic options I might have chosen if he were my client. (What good is it to be a therapist, I reasoned, if I can't help my own son during his time of need?) I tried reflecting his feelings regarding his loneliness and pain, demonstrating that I understood what he was going through; he sobbed even more uncontrollably. Next, I tried self-disclosure: I told him about my own feelings of estrangement, how hard it was for me to make new friends, and that I, too, missed people we had left behind. "So what," he countered, "this was *your* decision to come here. Nobody gave me a choice." He had

a point there. So much for his feeling we were in the same boat.

I tried reasoning with him next, helping him to recall that once before we had moved and he had had to make new friends. It had taken awhile, but eventually he was even better off than before. While this argument made perfect sense to me, he quickly dispensed with it by insisting that the circumstances of this situation were not the same.

"OK," I said, "then let's accept the fact that you are here, there is nothing you can do about that; but how are you going to make the most of a difficult situation?"

He had an answer for that one, too.

I tried reassurance, problem solving, and everything else I could think of until I finally admitted to him that no matter what I said or did he seemed determined to feel sorry for himself.

His lip quivered. He looked at me with accusing eyes. And then he burst into tears once again.

All I could do was hold him.

There are times when clients (or family members) are determined to keep their pain, no matter what we (or perhaps anyone else) might do or say. At least they are not operating on the same time schedule that we are. They seem difficult to us because they are not as ready as we are for them to change. It is during such times that all we can do is offer comfort, to sit patiently until they finally become sick of themselves the way they are. Certainly there are things we can do to accelerate this process, but only within certain parameters. The strongest antibiotics or antidepressants still take a number of days to make a difference. Among the most challenging things that we are required to do is to wait and try not to do too much or take too much responsibility for the client's decisions. Sometimes, all we can do is to offer support.

Getting Support

Just as our most difficult clients need support, so do we. Those therapists who are least well equipped to withstand the pressures of difficult clients feel isolated and cut off from their peers. They

have no support system for talking about their cases, their frustrations, and their problems. They are no longer certain about the meaning their work holds for them.

Other specialists who are in the same situation and experience similar feelings of stress and impairment when subjected to difficult clientele include dentists, dermatologists, and ophthalmologists (Smith and Steindler, 1983). Yet among all these professionals who work in an isolated environment, therapists are subjected to the most intense degree of interpersonal bombardment. This is why building a network of supportive and caring friends and colleagues is so crucial to working through the pressures that we experience.

Practitioners in private practice are the most notorious for neglecting their own needs for interpersonal nourishment. Most of their schedules are individually designed according to the major criteria of bunching clients together so as to maximize production per day. Because time to the private practitioner is measured in hourly rates, it is not unusual for the clinician to reason as follows:

"Well, I could meet some friends for a leisurely lunch. But can I really afford to give up two billable hours, plus the cost of a meal, just to sit around and swap a few stories? And if I do meet them and talk about one of my cases, all they will point out are things that I have already tried anyway."

Fiore (1988) believes the greatest need of therapists who are struggling with difficult clients is not further insulation or more treatment suggestions from colleagues. So often the response to supervision advice is "I already tried that" or "I have been doing that for awhile." No, what therapists need most is the opportunity to talk about their feelings, to feel validated and supported, to dissipate energy that builds up from stressful encounters. "One of the things that makes the difficult patient difficult is that he implicitly and often consistently questions the meaning of life and the value of relatedness. Because of the patient's affective intensity, and therapist's empathic linkage, the therapist may lose sight of the fact that he is functioning at a different level. The patient's questioning and forlornness challenge the therapist's beliefs about life generally and his capacity to care specifically" (Fiore, 1988, p. 96).

This is said so well! We do reach an altered state of consciousness or enter a different realm of awareness when we are engaged with a difficult client. We think about the person at odd moments. We feel powerless. The texture of our fantasies changes. We start questioning whether we want to continue

doing this kind of work. The last thing in the world we need at that moment are more treatment options that we may have missed.

Our initial belief when we consult with peers is that they can see something that perhaps we have missed or know something that we do not. And, of course, while this is usually true, it is mostly irrelevant. I have noticed that when I tell friends in the profession about a case I am struggling with, the first thing they do (which is also what I do when I am called upon to respond) is to try to find the brilliant strategy that I have missed. Because I am smart enough to consult with colleagues who I believe are cleverer than I, I am rarely disappointed. I often get some wonderful ideas about how to proceed with the client that I never would have considered. I even write them down.

I rarely use the suggestion, however. By the time I get back into the session, somehow the idea does not fit quite so clearly as it did over lunch. What does linger is the renewed strength I feel from friends who have listened to me and supported me. I do not feel so alone. I feel I have been given permission not to know what to do; I've been told it is all right to struggle with a client. I am reminded that with sufficient patience and caring and clarity, I usually do help the client to get through the impasse. I also especially appreciate my colleagues' sympathy, their telling me that they also would feel frustrated, that anyone would. Yes, what helps most is hearing them say that I am not incompetent or stupid (as I sometimes tell myself) because I feel like I am completely blocked with a particular client. I need to let off steam, to be nurtured and taken care of for just a few minutes. And then I feel clear again, ready to resume the engagement, even eager to get back to the work at hand.

Remembering That Two Heads Are Better Than One

Sometimes support is not enough. Getting a hug from a loved one, a few encouraging words from a friend, a pat on the back from a colleague feels great, but many times it is not nearly enough. There are times when we do miss obvious or subtle clues, when we are doing things that are not working, but we cannot figure out why or think of anything else to do. It is during such times that consulting with a colleague or supervisor for input is crucial.

The days of the eccentric but brilliant genius, working in isolation, are over. Once the Edisons,

Fords, Bells, Freuds, and Einsteins could labor in relative obscurity, creating revolutionary models of space, time, matter, or mind when left to their own devices. We have even come to associate innovation with the single-minded effort of a lone scientist or thinker.

In contrast, Diebold (1990) describes the development at Bell Laboratories of the transistor, an invention that has perhaps changed modern life more than any other, and observes that one-person accomplishment is now a rarity. Modern problems are so complex and multifaceted that they virtually demand collaborative efforts in order for researchers to unravel all their components and find an innovative solution. Three scientists were awarded the Nobel Prize for developing the transistor, but they were supported by dozens of physicists, chemists, engineers, metallurgists, and managers who pooled their expertise in solving technical problems.

The collaborative model has now become commonplace in several mental health training centers, especially those that specialize in family therapy. Recognizing the complexity of some families that manifest extreme interactive pathology and resistance, practitioners work as teams with some behind one way mirrors monitoring carefully what goes on during sessions and offering input as needed. Although this arrangement is not practical for those who operate in solo practices or who do not have access to the resources available in these training centers, it does illustrate the value of collaboration when we are working with clients who are especially troublesome.

Above all, Saretsky (1981, p. 247) believes that getting good supervision and peer consultation is the key to resolving therapeutic impasses with difficult clients. He comments that in "narcissistically threatening predicaments" even the best clinicians "are temporarily deprived of their ordinary good sense and adaptive capacities." The regressive tendencies that manifest themselves in therapists during these times — extreme emotional reactions, feeling bored or restless, trying too hard to be liked, being abrupt, soliciting praise, ruminating about sessions—can all be worked through with the help of an able consultant. Process-oriented supervisory sessions as well as creative brainstorming often help us to regain our compassion and empathy while surrendering omnipotent authority roles.

Certainly seeking supervision when we feel stuck or when countertransference issues get the best of us is not a novel idea, but too often supervision is considered only for beginning practitioners who are

still satisfying licensing requirements or for more experienced therapists who are meeting the standards for continuing education. It is too often thought of as something we have to participate in because it is mandated rather than as a process that we willingly undergo during times of need.

Stop Complaining

Much of the activity that takes place during supervision and peer consultations involves a litany of complaints about how awful some of our clients are to work with. During staff meetings, discussions can escalate to the point that people try to outdo one another with stories of who has the most difficult caseload or the nuttiest, most obstructive client. We hear ourselves and our colleagues say over and over that we can't believe the latest indignity heaped on us. Complaining about our difficult clients to a sympathetic audience does feel cathartic, but it also seems to legitimize that activity as appropriate. We must remember that complaining only begets further misery and gives us permission to continue feeling like victims.

When a therapist complains about a clients abrasiveness, Greenberg (1984) wonders what motives are operating. In his experience, labeling people as difficult is more a statement about the therapist than the client. "The longer I am in practice the more tolerant I find I have become of patients' communicative styles. I now no longer find a patient's communicative style irritating or offensive when I have the option to be curious or find it interesting instead" (p. 57).

Robbins, Beck, Mueller, and Mizener (1988) remind us that although we would much prefer to work with clients who are cooperative and appreciative, the mandate of our profession is to understand, accept, and manage those who are often bizarre, maladjusted, and obnoxious. In other words, it is senseless to complain about what we are being subjected to; such is the nature of this work. We would be better advised to look at our own unresolved countertransference issues, let go of excessive responsibility for therapy outcomes, and concentrate not on our frustrations but rather on what we can do within the circumstances.