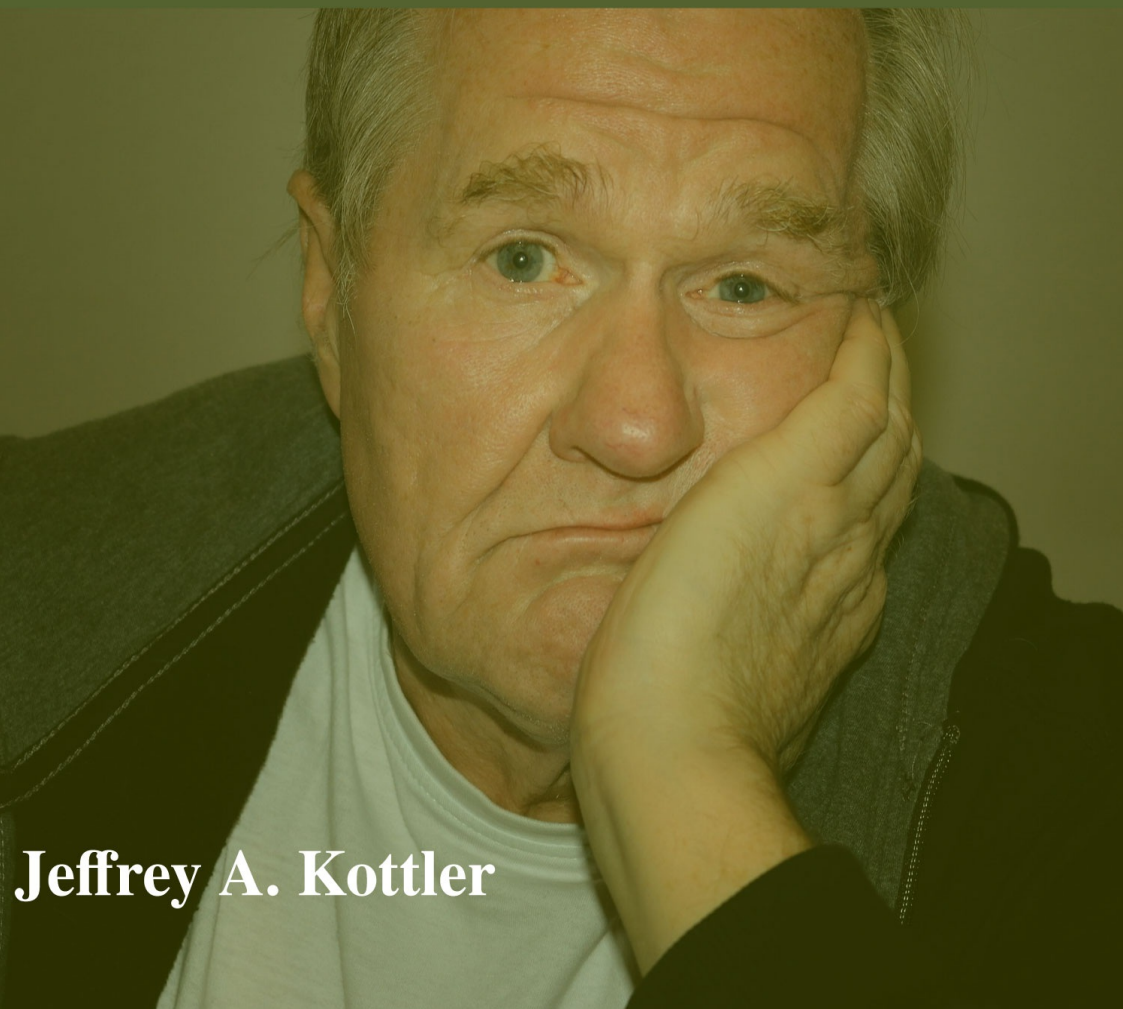
Compassionate Therapy: Some Very Difficult Clients

I Already Told You This Before?



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The first thing you would notice about Sam is how eager he is to please. He smiles nervously, with a sickly sort of expression—as if I am the doctor about to inform him he has terminal cancer. There is reason for his pessimism: although twenty-five years of age, Sam has been in therapy most of his life. He was recently "fired" by his previous therapist who said there was nothing else he could do to help.

When I asked Sam what about him was so hopeless that even his therapist gave up, he shrugged meekly and said that reaction was not so unusual — everyone gets tired of him after awhile. Intrigued, of course, by this challenge, I was eager to discover what it was about this gentle young man that drove people away.

Sam had certainly been trained well by his previous therapist in the rules and etiquette of therapy; he attended sessions religiously and had no difficulty filling the time with a running complaint of who had rejected him and how he felt about it. He was most cooperative and seemed dedicated to doing whatever was necessary to turn things around. How could any professional have a hard time with someone who is so unhappy with his life and so determined to change?

Yes, his monologues on office politics were a bit tedious, and he did have a tendency to repeat himself. I could even understand how his voice, devoid of inflection, might begin to grate after a time. But how could I, or anyone else, desert a man who was trying so hard to change?

Five years elapsed before I realized that he was fundamentally no different from when I first met him. He was still complaining about the same things and still struggling with trying to make a single friend. He was still living with his parents and working in some dead-end job. And I had stopped listening to him in our sessions — the boredom and his passivity had become excruciating to tolerate. For every inventive or creative way I had tried to enliven our time together, Sam matched me with equal determination to follow his methodical formula of complaining monotonously. I might try confronting him, or acting out what he looked like to me, or even going for a walk outside, but the result was essentially the same.

It was clear to me that Sam would keep coming to my office as long as we both should live. When I asked him what he was getting out of our sessions (feeling my own need for reassurance and validation), Sam replied that he wasn't exactly sure, but therapy had always been a part of his life. I now understood what his previous therapists must have felt.

Unwilling to continue treatment in its currently impoverished form and stubbornly refusing to give up entirely, I decided to invite Sam to join an ongoing therapy group I was coleading. I hoped the feedback he would get from other group members might spark some deviation from his habitual patterns. I also thought it might be easier for me to tolerate Sam if his behavior was diluted with that of other, more vibrant people.

Perhaps I wanted to feel some comfort in knowing that I was not the only one who could barely tolerate Sam's company for more than a few minutes before feeling an uncontrollable urge to fall deeply asleep. If validation was what I wanted, I got it in the resounding chorus of unanimous opinion in that group. One by one, all the group members eventually communicated to Sam that he had exactly the same effect on them as well. When it became obvious that he was unable or unwilling to alter his style, a way of being that was so pervasive it seemed to stifle the whole group environment, several members dropped out. The group soon ended.

By this time Sam had attended a workshop offered by another therapist who had invited him to continue treatment with her, and I was more than a little relieved to offer him my best wishes. I think we ended on an optimistic note that maybe a female therapist would help him work through his intimacy problems with women. When several months later, I ran into this therapist and asked her how Sam was doing, she rolled her eyes to the sky and punched me in the arm. Hard.

The Boring Client and Bored Therapist

When therapists encounter something they do not like and cannot understand, the first thing they do is name it. *Alexithymia* is the term invented by Sifneos (1973a) to describe people who seem incapable of describing their internal states. Such people, who appear to us as extremely bland and devoid of any passion, seem to have some deficit in their brains that makes it difficult for them to process

their experiences, differentiate their emotional states, and develop insight into their existence. They are similar to surgical patients who, after having their corpus callosums severed, cannot communicate how they feel. Their fantasies and dreams lack richness. They think in the most concrete ways; their communications are devoid of imagination (Miller, 1989).

Feiner (1982) describes the client who is so concrete he (and it usually is a "he") is unable to deal with inner or outer experiences in psychological terms. Most often, he has found a line of work (accounting, computers, engineering) that allows him to relate to the world in concrete, literal ways, accessing that overdeveloped part of his brain that processes information in linear sequences.

When emotions come into play, when he experiences interpersonal difficulties, his preferred cognitive style fails him. His wife, children, and few friends (except those just like him) find him maddening: "But dear, you *said* I should loosen up around company so I thought I would do these stretching exercises."

He enters therapy completely unprepared for how to proceed. Tell him what to do and he will follow your orders to the letter. Tell you about his feelings? What feelings?

He has organized his world carefully and put everything in its proper place. But feelings? They are a nuisance, an unpredictable variable. As long as he can concretely label something, he can find a place to put it. Therapy is an enigma to him. What should we talk about? Don't you have an agenda?

Detached from life, aloof from the world of flesh things, he can hide in a world of computers where nobody will hurt him or make fun of him or reject him. If the computer does not respond correctly, it is because of something that *he* did, something he can control.

He will become impatient with you, skeptical that therapy can work. You are as alien a creature to him as he is to you. You speak a foreign language: "What are you experiencing right now?" "How did you feel after she said that?" He looks at you quizzically, eager to please, and says what he thinks you want to hear.

In addition to this inability to respond appropriately to therapeutic interventions, boring clients

also exhibit a number of other qualities described by Taylor (1984). Their speech patterns are devoid of affect and the use of metaphors, while their thinking is preoccupied with the minutiae of the external world, sometimes demonstrated by endless lists of symptomatic complaints. They are unable to recognize and describe how they are feeling. Their descriptions lack color, detail, depth, and life. In short, they seem unable to elaborate on what is going on inside them. According to psychoanalytic theory, boring clients have an arrested emotional development because of defective parent-child relationships and psychic trauma. They therefore remain in a regressed state in which a boring communication style creates protective barriers (Krystal, 1979).

Altshul (1977) attempts to address the question of what makes a client boring, and his surprising answer is that we should more accurately be asking what makes a therapist feel bored. Although he acknowledges that there are indeed some people who may be more stimulating to work with than others, Altshul submits most confidently that *all* experiences of boredom in therapy are the result of the clinician's malignant countertransference neurosis. This most often takes the form of narcissistic depletion in which the therapist's need for absorption and expectations for entertainment lead him or her to feel deprived and resentful when the client does not provide stimulation that is missing in the therapist's personal life.

There is certainly some merit to this thesis. We do tend to withdraw from those clients who do not meet our expectations. And we do have varying propensities for becoming bored, depending on whatever is going on (or not going on) outside the office. I would also mention, however, that certain clients have the capacity to drive most any therapist up the wall regardless of how patient and ego-gratified he or she might be. Some clients speak in monotones that become difficult to listen to. Others repeat themselves constantly. Often, they seem to work at developing this quality as an art form:

"... So where was I? Oh yeah. I was telling you about why I prefer to change shampoo products every few weeks. I find it makes my hair more manageable. Did I tell you about the time I was in the shower and I ran out of shampoo altogether? I did? Oh. Well, anyway. .

Sometimes such clients seem impervious to gentle or even forceful suggestions that they might use their therapy sessions more constructively by dealing with issues in their life besides their hair-washing

rituals. Nevertheless, Altshul (1977) does offer us one key to working with anyone we find boring, either as an occasional episode or a prolonged and chronic case. The first place to start should always be to ask ourselves what is significant about this client or her issues that lead us to withdraw. In what points in the session does my attention wander the most?

I think back to Sam, the young man I discussed earlier. It is certainly true that a number of other therapists (and many nontherapists) complained about how boring he was to listen to, but I exacerbated the problem in a number of ways. During the first year I worked with him, I very much looked forward to our sessions. I liked him. I felt sorry for him. I badly wanted to help him.

But Sam disappointed me. He did not move as quickly as I needed him to. Aspects of my personal life had begun to feel stale and predictable. I wanted, even needed, more diversion. I turned to Sam, and a few of my other clients, to supply the entertainment that I was missing.

I am also aware of how infuriated I felt by his helplessness and passivity. My most recurrent fantasy about him was one in which I was allowed to become Sam for a single day. During the time I lived in his body I would do everything he was reluctant to try: I would make new friends, ask several women out on dates, look for another job, move into my own apartment. I figured that in twenty-four hours I could easily turn his life around.

And if that is so, why could I not do it for myself when I was his age? At that time I felt almost as helpless as he did. And I hated reliving my own ineptitude, recalling my adolescent geekiness, watching Sam struggle so, and feeling powerless to do anything to change his life. Yes, I became bored with him. I lost interest in him because he would not follow my plan for him. I punished him by withdrawing. I protected myself from his painful issues by tuning him out. He stopped being Sam to me; he became "that boring client."

Working with the Chronically Boring Client

If it is indeed mostly the client rather than the therapist who is the problem (and such a determination is difficult considering the interactive nature of this phenomenon), confronting the issue in therapy can be a major turning point. While this did not prove to be the case with Sam, other examples

show that bringing the clients responsibility into the open can be quite useful.

Valerie spent hour after hour complaining that her husband ignored her and her friends did not seem to care about her. Even her children became impatient with her when she tried to talk to them. I knew exactly what they were going through. In fact, I felt immensely relieved every time she related the incident of another person who tuned her out; at least I knew I had company.

I invited Valerie to explore just what she might be doing to turn so many people off. Eventually, she gathered enough courage to ask me how I felt and whether I had any idea what others might be feeling. I took a deep breath and was just about to let her know that I felt much the same way when I had a flash of inspiration. I pulled out a tape player and suggested we record the last half of the session so that she could listen to herself to find some cues. I promised her that if she drew a blank, I would be happy to help at that point.

Fortunately, she was at her absolute best (or worst) during the interval we taped. Valerie began our very next session with the question: "Am I really this boring all the time?"

I looked at her sheepishly and nodded.

What Valerie finally noticed about herself in listening to the tape was that she exhibited many of the characteristics of people often described as boring— most notably a blunted communication style. She was able to learn about the ways her pattern of communication created barriers to intimacy with others, and she was able to realize what many experts consider crucial to changing this behavior—the defensive functions her boring style served (Langs, 1978; Taylor, 1984). When this strategy is combined with gradually increasing the client's tolerance for affect, she can eventually learn to show more variety in her interactions, especially to include the world of feelings, fantasies, and symbolic images (Krystal, 1982).

One operant in our work with clients who show restricted communication styles is our attempt to make up for the lack of stimulation provided by the client by creating our own. We often give ourselves permission to be more lively, dramatic, and engaged in an attempt to draw the client out of a shell as well as to keep ourselves awake. The following dialogue shows one possibility for helping a boring client to experiment with being more dynamic and lively in his communication style:

Therapist: Sorry I yawned just a moment ago. Sometimes it is hard for me to focus on what you are saying.

Client: That's all right.

Therapist: That's all right? It is all right with you if I fell asleep while you are talking?

Client: No, I mean that. . . I just mean I'm used to it.

Therapist: I noticed that you seemed taken aback just a moment ago when I implied that you were sometimes boring to listen to.

Client: Well, yes, it did surprise me. I didn't expect that from you.

Therapist: Go on.

Client: No, that's all.

Therapist: That's all? There seems to be quite a bit more that you would like to say.

Client: Not really.

Therapist: You know, for just a moment I saw a flicker of life in you. Your eyes smoldered. I really started to perk up. I thought, aha, there is some energy! But now you are dead again. So polite. So constricted. You are looking at me with that corpse-like expression. What is going inside you?

Client: I don't know. Nothing much. I'm just listening.

Therapist: This time I don't buy that. You seem angry. I called you a name. I told you that I found you boring. And you are going to tell me that's all right with you?

Client: Maybe I'm a bit perturbed with you. I thought you liked me. You told me you liked me.

Therapist: It is because I care so much about you that I am willing to be utterly truthful with you. But it is hard to get close to you when you don't tell me what is going on inside.

Client: Well, I do feel hurt. A little anyway.

Therapist: And angry?

Client: Yes, that too.

Therapist: Say it.

Client: I'm angry.

Therapist: That's the best you can do? No, don't look that way. Look at me.

Client: I am angry. And I do feel hurt. And I'm scared. I don't know if I can trust you if you think I'm boring. It just

seems so hopeless!

Therapist: Thank you. Thank you for finally telling me some of what you feel. What was that like for you?

And so continues the dialogue, slowly, laboriously, haltingly playing itself out as the client struggles with trying to express himself in ways that he has never been able (or willing) to before. Obviously this kind of interaction is not right for everyone. It does illustrate, however, the importance of not colluding with the client and his dysfunctional behavior while helping him to access his affective dimensions. It also shows how within the context of a trusting relationship it is not only possible but desirable to use self-disclosure as the primary bridge by which to confront his most obvious problem. Most of his other issues related to poor self-esteem, depression, and isolation would vastly improve if he were able to enliven the way in which he relates to the world.

The Challenge to Stay Attentive

Morrant (1984) has stated that the reason some clients come to us in the first place is because they are so boring that they cannot find anyone else to listen to them. When we consider that the therapeutic situation itself is even predisposed to be boring, considering that everything is deliberately structured to remain the same — the room, the regularly scheduled appointments, the seating arrangement, the rituals for beginning and ending— the therapist is constantly challenged to remain attentive and responsive (Esman, 1979).

About the only things that change in therapy are what the client brings to the session and how we decide to react to what we have experienced. If a particular client is repetitious or limited in the stimuli that he or she presents, the clinician is tested to maintain requisite mental activity and focused concentration in order to remain interested and respond empathically.

Clients who are most restricted, inhibited, and monotonous in their communication styles are precisely those individuals who most need the very best that we can give. They believe themselves to be essentially unlovable and use their boringness as a defense against being hurt. That is why our essential mission, beyond all else, is to teach such people that they are indeed worthy of love and caring.

In order truly to love such clients who make themselves unlovable, we must separate our own

narcissistic demands for stimulation from what the client is prepared to offer. To do this requires us to make a number of cognitive adjustments by which we challenge ourselves to stay attentive —much the same way that all meditative activities are practiced. Csikszentmihalyi (1990) prescribes the antidote to boredom which he calls flow, the optimal experience of life in which the mind is stretched to its limits in ones voluntary effort to accomplish something worthwhile.

In the context of therapy, clinicians practice flow when we are able to immerse ourselves totally in the experience of what is occurring and focus our concentration on the innumerable nuances that are visible only during an altered state of consciousness:

"What is he saying?. . . Where have I been?. . . What triggered this lapse?. . . Got to concentrate. . . . Take a deep breath. . . . Focus. Focus. . . . What am I missing?. . . Look! There! His eyes. . . . Look at his eyes. The way he breathes. His face is flushed. . . . Why is my heart beating so hard?. . . Gosh, I never noticed his eyes before. . . . Wait, I am starting to leave again. Got to stay here and stop drifting. ... I am inside him now. ... I think I can really feel it. . . . How could I have ever been bored?. . . There is so much to hear, to see, to say, to sense, to feel..."

Boredom is a state of mind, not of circumstances. The boring client ceases to be tedious once we are able to invest even more energy and concentration in our interaction. It is from such encounters that we learn to stretch our own limits of patience, concentration, creativity—and compassion.