Compassionate Therapy: What Makes Clients Difficult?

Profiles of Difficult Clients

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The clients whom therapists consider difficult to treat generally fall into one of two groups — those who are chronically mentally ill and those who have personality disorders. These are, of course, the client populations with the most severe disturbances, the most long-standing patterns of dysfunction, the worst prognoses for improvement, and the most irritating styles of interaction. They are usually people who have been incapable of establishing, maintaining, and nurturing healthy relationships with others. They tend toward one of two poles; either they are passive, nonresponsive, apathetic, and withdrawn or they are aggressive, manipulative, impulsive, and vengeful. In virtually all instances, they have been the way they are for a long time, and they appear, at least on some level, determined to stay that way.

Although some writers have argued that there are no difficult clients (Stieger, 1967; Altshul, 1977), only difficult therapists, Wong (1983) conducted a survey of prominent clinicians across the country to learn their views on the subject. Among these senior therapists there was a consensus regarding those most challenging to treat. Some obvious diagnostic categories immediately surfaced: borderline, paranoid, and antisocial personalities, for example. Narcissistic disorders also rose to the top of the list along with clients who are potentially violent or suicidal. Finally, among the most frequently mentioned as difficult to treat were drug and alcohol addicts, the chronically mentally ill, clients who are part of severely pathological family systems, and those hospital patients labeled "gomers" ("Get out of *my* emergency room!").

Usually elderly patients who crave attention, gomers are a heterogeneous population evenly distributed among races, sexes, and classes. What they have in common is irreversible mental deterioration, complex symptomatic patterns, an inability to resume normal adult roles, and no place to go after they are discharged from the hospital (Leiderman and Grisso, 1985).

"Gomerism" is not just a charactistic of clients, however; it represents a degree of cynicism and frustration on the part of the helper. The caregiver feels helpless and must face the limits of his or her abilities. The lonely, elderly client may even understand that there is little that can be done for him, but he feels that a little attention would be nice.

In a factor analytic study of how therapists react internally to the behavior of difficult clients, Colson and others (1986) found that among the severely disturbed population, the suicidal-depressed client evoked the strongest reactions of all. Staff members suffered most as a result of their contact with severely depressed clients who elicited a multiplicity of discrepant feelings, responding more strongly to these clients than to hospitalized borderlines or schizophrenics. On the one hand, we feel tremendous resolve to save the client's life, to rescue him or her from despair. On the other hand, we feel immobilized, frustrated, fearful, and impotent. Many of these same feelings are also elicited by difficult clients who are not so much resistant as they are uncomfortable to work with, such as victims or perpetrators of incest (McElroy and McElroy, 1991) and torture victims (Pope and Garcia-Peltoniemi, 1991).

We could certainly add several other candidates to this list, including some of those we will discuss throughout the book — seductive, dependent, manipulative, controlling, boring, or belligerent clients. Unfortunately, after we complete such a compendium of categories we are left with a population of clients who are perfectly well behaved, cooperative, motivated, and especially, grateful for our modest efforts.

Although it is true that nearly all diagnostic categories offer their own unique challenges, what makes clients difficult in therapy has less to do with their presenting problems or symptomology than with the style in which they respond to their troubles (Dowd, Milne, and Wise, 1991). Not all drug addicts or obsessive-compulsives or chronically depressed clients are especially difficult in therapy. In fact, some of our greatest satisfaction in this work comes from our interactions with those people who have quite severe disturbances.

Imagine two clients, Fran and Sasha, who are both labeled *borderline* — that miscellaneous diagnostic category used to describe people who appear extraordinarily unstable in their affect and relationships, and who are prone to self-destructive acts. Fran, however, is considerably more devious in the ways she acts out. It is as if she has a rare variety of viral infection that continually changes its form in response to any treatment introduced into the body. Whereas Sasha is somewhat predictable in her "borderlinish" ways and can be counted on to respond to vigorous limit setting, Fran has not reacted the same way twice to *any* therapeutic intervention. Fran appears more functional in the world — she has friends and a good job, unlike Sasha—but she is much more difficult for anyone to be around. Sasha is

soft-spoken; Fran is shrill. Sasha tends to blame herself when things go wrong; Fran blames you: "And unless you find a way to straighten out this mess you created, I just might sue you. Just kidding. Ha. Ha."

Sasha has not improved significantly faster than Fran in therapy, but most clinicians would have an easier time working with her because her style is not as overtly obstructive to the process and the alliance. It may be, however, that ultimately she will be harder to reach because she keeps so much to herself. With Fran you think you know where she stands every moment, but the process with Fran will also be more of a struggle. Thus, clients are difficult not only because of their type of presenting complaints and the severety and intensity of the symptoms, but also because of their individual interactive styles.

Many practitioners quite enjoy working with more severely disturbed clients, not because it is the mandate of their agency or because of a masochistic streak but because they thrive on the challenge of working with people who need their help the most. Such professionals report that it is not necessarily the disorder that makes treatment difficult, whether clients are schizophrenic, sex offenders, borderline, or cross-addicted substance abusers; rather, it is the unique way individual clients manifest their symptoms, express themselves, and respond to interventions.

Assessment of Client Difficulty

Any attempt to capture the tendency to resist change in a single definition of client difficulty has two immediate problems. First, as such a conception reflects what the therapist believes is resistant or obstructive, it omits interpersonal and environmental factors that may be playing a part. Second, it assumes that being difficult is a dichotomous construct that is either present or not present (Jahn and Lichstein, 1980).

Most of us understand that the question is not whether a client is difficult but the degree and intensity with which treatment problems are operative in the therapy situation. This consideration takes into account not only the clients unique personality characteristics (which may predispose him to be abrasive), but also such questions as who is working behind the scene to sabotage progress? In what ways are we exacerbating difficulties in the relationship? What is it about the clients support system,

environment, or phenomenological world that is making things difficult?

The problem of reliable assessment is made even more challenging because of the intrinsically subjective nature of this process. A half-dozen therapists who are all presented with the identical client are going to experience and interpret the situation in different ways. As an illustration, imagine that a new client walks into your office and asks:

"May I know what your qualifications and training are before I begin?"

As you think about this clients question, and formulate your response, consider how a sample of therapists might interpret this initial query:

Therapist A: Not another one of these cases again. He's going to be a tough one.

Therapist B: Sounds like a reasonable place to start. I wouldn't trust anyone with my life either unless I knew they were well trained.

Therapist C: He seems to have a need to control things from the outset. I will have to monitor that closely.

Therapist D: He seems very frightened by this unfamiliar situation and is giving himself time to get used to things.

Therapist E: As long as he can keep the focus on me he can successfully avoid dealing with his own issues.

Therapist F: Interesting that he woidd begin with that question. I wonder what that means?

Any of these assessments could be accurate. The client could very well be quite demanding to work with, but it is just as possible that he is asking a reasonable question under the circumstances. Depending on a myriad of accompanying cues — nonverbal, contextual, the referral situation —a therapist may draw a number of conclusions: that the client seems difficult (Therapists A, C, or E), that the clients question is entirely appropriate (Therapists B or D), or that judgment should be withheld until further data are available (Therapist F). The last choice is probably the most desirable posture to adopt, given the therapists neutrality and receptivity to whatever might be occurring; it is also the most difficult.

During initial encounters with clients we often feel anxious ourselves —trying to make a good impression, trying to figure out what is going on, deciding whether we can help this person, wondering how we can be of greatest assistance demonstrating our compassion and understanding. This internal stress is augmented by the direct pressure applied by (he client who is testing us, checking us out, deciding whether this is the right place to get help. Further, he wants answers: what do we see is the problem? Have we worked with this kind of situation before?

How long will it take? What will he have to do? The primary challenge is to keep our own apprehensions and performance anxieties in check long enough to get a complete and objective reading of all the nuances contained in the way the client presents himself.

Some therapists conclude that almost all their clients are difficult; others hardly ever consider them so. I have mentioned that the psychoanalyst expects to see resistance in every client, sees this as normal and natural, and waits patiently for its manifestations to appear. The problem-solving therapist, on the other hand, views resistance as a label of convenience applied by practitioners who are frustrated because they do not know what else to do for the client. Client resistance, however, is an altogether different creature from client difficulty.

Resistance to change may indeed be a natural process for anyone letting go of old patterns and replacing them with new, more effective ways of functioning, but difficult clients are those who tend to resist in particularly annoying ways. We are dealing, then, with a continuum of obstruction to the therapeutic process, a level of self-defeating behavior by the client, and a degree of frustration in the therapist.

We may be uncertain of where to place the client statement that began this example on a continuum of difficulty — whether it is an appropriate question, a normal hesitance, a sign of abrasiveness, or somewhere in between —but we would have little doubt about a question posed by another client:

“What gives you the right to pry into other people’s lives? Did they teach you to ask stupid questions in graduate school, or were you always so nosy?”

In this case, there would be little disagreement among Therapists A through F (and all the way

through the alphabet) that this client has a chip on her shoulder. Regardless of the reason underlying her hostility, whether it masks deep hurt or shallow sensitivity, this is a person who will likely test the patience of even the most tolerant of clinicians.

Consensus on What Makes a Client Difficult

It is important to stress once again that some writers have argued persuasively that there are no difficult clients, only difficult therapists. Lazarus and Fay (1982) have called resistance merely a rationalization by practitioners who will not accept responsibility for their treatment failures. Although offered as a criticism of those clinicians who blame their clients every time something fails to work in therapy, this premise goes to the other extreme. Obviously treatment failures are the responsibility of *both* partners in the relationship (Golden, 1983; Kottler and Blau, 1989).

Yes, therapists *do* make mistakes and misjudgments. Yes, the way we operate, our degree of expertise and personality, our skills and style do indeed influence greatly the outcome of what occurs in therapy. Yes, there are "difficult" therapists who, because of their rigidity, are unable to help some clients and then project the blame onto them for being so inflexible. But there are also clients who display certain characteristics or behaviors that make them difficult to reach, regardless of the practitioner's level of competence. Based on research conducted by several authors (Stern, 1984; Ritchie, 1986; Robbins, Beck, Mueller, and Mizener, 1988; Leszcz, 1989) as well as my own interviews with practitioners in the field, I identify and discuss below the kinds of clients who are often described as being most difficult.

Clients with Physiological Disorders

Clients who have neurological problems or other chronic diseases that impair their ability to focus, listen, and communicate are included in the category of physiological disorders. Donald is a vigorous man in his early fifties, at least he was until he was struck down by a stroke that wiped out his right hemisphere. In addition to paralysis on his left side, he has a number of cognitive deficits that are difficult to assess because he does not want anyone to know what he cannot do. It is clear, however, that he repeats himself and has trouble focusing his attention.

Donald is intensely motivated to change some things about his life, but he misses a number of

appointments because he becomes confused about the day and time he is to come. Home visits are arranged temporarily to ensure some continuity in the effort to help him come to terms with his disabilities, his conflicted family relationships, and the financial hardships brought on by the illness. In these sessions it becomes evident that he cannot concentrate for more than a few minutes at a time. What he seems to want is an audience who will listen to the sad story of his life that he will tell again and again.

Clients with Hidden Agendas

Some people come to therapy with motives they have no intention of revealing. Sandor says that he is depressed and cannot sleep at night. This has never happened to him before; it all started with the trouble he has been having at work. His boss claims that he has not been doing his job correctly and filed a reprimand with management. Could you please help him with this problem of depression? Oh, and by the way, maybe you could talk to his lawyer who wants to know about the psychological effects of this unjust action on his mental health. How long must he come in order for you to write this letter?

Clients Who Ignore Appropriate Boundaries

Because of feelings of entitlement or a lack of awareness about rules, these clients invade our personal domain. "What's the big deal if I leave my children in your waiting room while I run a few errands? I mean, hardly anyone ever comes in. I'm sorry if they got a little loud, but if you didn't want them to write on the walls, maybe you shouldn't leave those pens in here where anyone can get to them. Next time I come you should put those things away."

Clients Who Refuse Responsibility

Some clients are perpetually negative, critical, and demanding, always blaming others for their problems. "I can't believe how stupid those teachers are at my son's school. No wonder he has trouble; who wouldn't with those idiots in charge? And that means that I have to clean up the mess that they create. It's the same thing over and over again. I was telling you before about the people at work.. . . Hey, are you listening to me? Well, if you are, why did you look up at the clock.. . . What do you mean, our time

is up? What kind of crap is that? You are just like those people I was telling you about; all you care about is yourself. ... All right, I'll leave. But next time I expect you to do more than just sit on your butt and tell me that *I* have to change. Listen, buster, other people have got a lot of things *they* have to do differently if they think that I'm going to change."

Clients with an Argumentative Attitude

Certain clients enjoy verbal combat as a form of entertainment or a test of will. Onie is an elder on the Indian reservation's council. The nature of her work requires her to be able to compromise with others to take care of necessary business, but she is always at odds with everyone. She seems to take delight in stirring things up, provoking fights with the other tribal leaders, usually sabotaging whatever program is being developed.

In therapy she is similarly provocative. She challenges with a frightening ferocity everything that is offered. Onie says she genuinely likes the therapist and respects what he is trying to do to help her, but she disagrees with almost everything he says. Whenever the therapist attempts to agree with something Onie says, she will change her position and take the opposite point of view.

Clients with a Fear of Intimacy

Clients who desperately crave being close to others but are terrified of being vulnerable have a fear of intimacy. Crane has been rejected throughout his life, first by his parents who were alcoholics, next by his older sisters who considered him a burden they had to take care of, and finally by childhood friends who treated him like a leper (or so he recalls). He is close to nobody right now, except for you, of course, his therapist. Oddly, you do not feel close to him at all.

When you try to get close to him, or invite him to share something personal with you, he finds some way to push you away. At times, he will be sarcastic or ridiculing or withholding. During those rare instances when some minimal degree of intimacy does begin to develop, he will "forget" to come to his next appointment. If by some miracle you do manage to bridge the distance between you, you fear he will flee. You recall that you are the fourth therapist he has seen in as many years.

Mismatch of Client and Therapist

The client presents issues or a personal style that is not generally responsive to what the therapist does and the way the therapist does it. Maurie is angry. He looks angry. He acts angry. In the very first encounter he makes it quite clear he has a problem with anger.

Maurie has suffered silently for many years at the hands of an abusive spouse. His wife is a state-certified schizophrenic; therefore, he has found it difficult to hold her accountable for her crazy behavior. If he is not angry with her, he is certainly angry with himself for putting up with her abuse for so long. He wants help expressing his anger.

I suggest to him that perhaps an even more desirable goal would be to harness the energy of his anger in more productive directions. He becomes angry with me because I am contradicting him. It is apparent to both of us that something is not clicking between us; some dynamic irritant is impeding our making contact.

Countertransference issues

Some clients bring intense issues to therapy that the client and therapist cannot fully work through. Only after I referred Maurie to a colleague, at his request (and my relief), did I begin to explore what in our interaction was so irritating. I had already been alerted years ago to monitor myself carefully whenever I worked with clients who were struggling with fears of death or fears of failure, but my response to Maurie seemed to be something new

I eventually reached the conclusion that I have problems dealing with anger — my own as well as that of other people who are in the throes of an outburst. I reflected over the years at how often I had tried to talk people out of being angry; if that did not work, I had concentrated on other areas that were more comfortable for me.

Clients as Countertransference Objects

Certain clients remind us of others we have struggled with in the past. My first grade teacher called

herself "Eagle Eye Silver" because she claimed she could read our minds and see *everything* we were doing. Once when her back was turned I tested her and put gum on my nose. She saw me through the back of her head and made me stand in front of the class for the rest of the morning with the gum still perched on my nose. I have had a problem with authority figures ever since.

When the grey-haired lady first walked into my office, I felt there was indeed some redemption in life. She was better than a first grade teacher—she was an elementary school *principal*. She carried herself with an air of great authority, even royalty. Worse yet, she addressed me as "young man." It was payback time.

Fortunately, I was under supervision at the time and my supervisor quickly helped me realize that this case of a difficult client was, in actuality, a therapist who was being difficult.

Impatient Clients

Some clients persist with unrealistic expectations regarding what therapy can do, how it works, and how long it takes. Sung was an engineering student who came to the counseling center because of an inability to concentrate on his studies. He missed his family who lived very far away, he had very few friends, and he was experiencing a number of problems adjusting to a new culture and climate. His one solace was in the purity of solving engineering problems: with the right tools and resources at his disposal, he felt that he could build or fix almost anything.

Sung had similar expectations for how therapy would operate. He would tell the therapist what the problem was and then this expert problem solver would design the best remedy. Sung was adamant that this procedure not take longer than one or two meetings. Also, the nature of his pain was such that he insisted he could survive for only a few days without giving up completely.

Inarticulate Clients

Clients who lack verbal skills or the capacity to describe what they think and feel are often reported by therapists as being especially challenging to help.

Therapist: What can I do for you?

Client: I don't know.

Therapist: You don't know why you are here?

Client: Yes. I mean no. I mean I know why I am here —I want help and stuff — but I don't know what is wrong or what you can do.

Therapist: Tell me something about yourself.

Client: There is not much to tell. I've lived here all my life. I work just down the street. What is it that you want to know?

Therapist: Why don't you start with how you are feeling right now?

Client: I'm not feeling anything at all.

Literal, or Concrete, Clients

Some people are unable to tolerate ambiguity and lack the capacity for abstract reasoning. Stephen is an accountant — and a good one, he is quick to explain. He has a clipboard on his lap and in his breast pocket he has an assortment of different color pens. Right now he is taking notes on what is being said and highlighting something important in yellow. He reads from his paper: "So what you are saying is that you are my consultant, sort of like my mental accountant, ha ha, but I have to do most of the work? I assume you will be giving me reading assignments and homework to do?"

Empty Clients

Some clients lack the capacity for self-reflection and have no interest in self-awareness. "I would certainly like to accommodate you, but the truth of the matter is that I don't really think about this stuff at all between sessions."

Clients Who Feel Hopeless

Among the most difficult of clients are those who are utterly despondent, seriously suicidal, and without the slightest hope that anything will ever be any better. Karyn is diagnosed with major depression that has been unresponsive to a half-dozen different medications. She cries constantly, great sobs of excruciating anguish, and looks at you with eyes that plead: "Please do something! How can you

sit there and see me literally dying inside and not do anything?"

Compliant Clients

There are clients who pretend to cooperate with therapy by being overly solicitous and complimentary, but they do not ever change. Frieda has been appearing at her appointments for years. In fact, she has been at the agency longer than most of the staff, having seen four different therapists who have now moved on to other jobs. Although each of the clinicians followed a somewhat different therapeutic approach, the progress notes are remarkably similar: Frieda is a quite pleasant and cooperative client. She will do whatever the therapist asks and seems grateful for whatever assistance is offered. However, after many years and four therapists she is still living in a dysfunctional marriage, still working at the same dead-end job, and still seeing the same friends who ridicule her. But she sure looks forward to her weekly sessions!

Clients Who Attack the Therapist

Some clients seek to intimidate and control the relationship by attacking the therapist's credibility, or even physical health. "Look, I have explained to you what I need you to do. I want you to call my wife and tell her to come home. She trusts you. In fact, you are probably the one who put the idea in her head to leave in the first place. Either you straighten out this mess that *you* created, or I'm going to straighten you out. I know where you live. And if you don't hear from me real soon, you will be hearing from the state licensing board and my attorney."

Clients with Little Impulse Control

Clients lacking impulse control may be the most difficult of all. These are people who have a hair-trigger temper and are prone to violent outbursts; also in this category are often substance abusers. Nate has four convictions for driving under the influence of alcohol and other miscellaneous substances. He has been referred to therapy by the court as an alternative to serving jail time and has been ordered to attend sessions until *you*, the therapist, release him.

In addition to his chronic alcohol abuse, he also has a history of losing his temper and getting into

fights. The last episode, the one that led him to your office, occurred on an expressway when Nate believed he was cut off by someone driving into his lane. He forced the person off the road, kicked in his window, yanked him out of the car, and "persuaded" him to apologize. Nate explains, "It was no big deal; I wasn't really going to hurt the guy; I just wanted to teach him a lesson."

A review of the categories that therapists report as most difficult to treat shows that the most dominant characteristic of difficult clients seems to be their demanding behavior. Regardless of their diagnosis (paranoid, narcissistic, or borderline), regardless of their primary traits (stubborn, manipulative, or complaining), regardless of their behavior (rejecting help, failing to cooperate, acting dangerously), difficult clients feel entitled to more than their fair share of attention. In several studies of what makes clients most difficult to their therapists, the most recurring themes are centered around the demand for extra time and attention (Rosenbaum, Horowitz, and Wilner, 1986; Robbins, Beck, Mueller, and Mizener, 1988).

A second theme equal in importance to the demanding nature of difficult clients is their need for control. Any client can become resistant when experiencing a sense of helplessness and seek to restore a sense of personal power by attempting to control the therapy and the therapist. The truly difficult client, however, is one who is not only situationally resistant but characterologically reactant as well (Brehm and Brehm, 1981). Such an individual responds to threat (which is perceived to be everywhere) by attempting to dominate and control all encounters in his or her life (Dowd and Seibel, 1990).

A third factor that easily distinguishes difficult from more cooperative clients is the nature of their defensive organization. Higher-order defenses like repression, intellectualization, and rationalization are relatively easy to deal with compared with the more primitive mechanisms described by Kernberg (1984) as splitting—which involves the actual dissociation of unacceptable impulses often seen in borderline personalities. These defenses are quite effective at protecting the disturbed client from intrapsychic conflict, but they have side effects that reduce the client's flexibility and adaptability.

A fourth theme is the tendency of difficult clients to externalize problems. These are people who wage war against the human race. They are in such pain that they have become vengeful and retaliatory for past injustices that were inflicted upon them. "Rather than the problem being lodged in themselves,

in such a way that it might be possible to reach and help them, it becomes lodged in the outside world. It is 'other people' who are seen as disliking them, preventing them from living their lives, making them worried and anxious, and depriving them of their rights" (Davis, 1984, p. 30). Thus they devote all their energy and attention to righting perceived injustices, complaining about how unfairly they are being treated, and guarding against being hurt by attacking those to whom they are closest.

We can therefore conclude that most therapists agree about which clients are the most difficult. They tend to demand more from us than we are willing or able to give. They fight us every step of the way for control and attempt to manipulate us to do their bidding. They do not admit they have the same problems we think they have. And when they do acknowledge that they have some deficits, they refuse to do what we want them to do to resolve them.

We might then justifiably wonder: if this is only a *partial* list of what therapists experience as their most difficult clients, is there anyone left to treat who may be described as cooperative?

The Ideal Client

You are waiting in your office for your next client, a new referral about whom you know nothing. You hear the door open and someone enters the waiting area. Whom do you hope it will be? Construct an image of your ideal client, the one perfectly suited for the way you prefer to work. Is it a man or a woman, boy or girl? Is the client old, young, or middle aged? What does he or she look like? What does this person do for a living? What is the presenting complaint?

My client is definitely a she. She is in her forties, about my age, attractive, but not distracting. She is in good shape physically. She is a movie producer. No, make that a photographer (more reliable in showing up for appointments). She is self-assured and poised, though she is not afraid to show her vulnerability. She has come to therapy not because of any debilitating problem but for growth and self-understanding. She wants to learn about herself, and while she is already quite effective in her life, she would like to become even more so.

My gosh, this exercise is revolting! This is the last person on earth who needs my help, and yet she is my ideal client. When I examine my attitudes more closely, however, I realize that I get considerably

less satisfaction from this type of "easy" work than from working with so-called difficult clients who force me to go beyond what I already know and can do.

Most professionals can do quite easily what I just did: create a portrait of their ideal client. The perfect client is trusting and disclosing, has realistic and positive expectations for what therapy can do, has acute rather than chronic problems, and is willing to accept major responsibility for progress in sessions (Stiles, Shapiro, and Elliot, 1986). When asked to compare the easiest client in their caseload with their most difficult, therapists were able to distinguish consistently among several characteristics: their ideal clients were more attractive, less pathological, and had a better prognosis for improving than did their difficult clients. They were also less likely to be labeled a personality disorder. Overriding every other consideration, including the therapist's level of experience and theoretical orientation, was the universal conclusion that the best clients are highly likable and have good relationship skills (Merbaum and Butcher, 1982).

In a review of client characteristics most often associated with positive outcomes, Sexton and Whiston (1990) concluded that the best candidates for therapy (at least in terms of measurement criteria used in empirical research) tend to be those who are more intelligent, better educated, members of higher socioeconomic groups, Caucasian, emotionally healthy, and experiencing acute problems. The authors also refuted a number of myths regarding client characteristics. For example, the sex of the client is unrelated to outcome (Jones and Zoppel, 1982) as is age (Luborsky, Crits-Christoph, Mintz, and Auerbach, 1988) or race when the client is in the upper socioeconomic stratum (Jones, 1982).

The clients who are usually most desirable, whom psychiatrists, psychologists, family therapists, social workers, and counselors compete for in the marketplace, fit a definite profile. They are bright, vibrant, and interesting people. They are professionals. They are reasonably healthy, have no underlying personality disorder, and present symptomology that is easy to treat. They are highly motivated to change, yet are patient enough to wait for results. They have a great capacity for developing insight, can tolerate ambiguity, and have a high threshold for dealing with uncertainty. They are verbally expressive, creative thinkers who present vivid material rich in detail and symbolism. They are socially skilled and responsible. They show up on time, pay their bills promptly, and offer to pay for cancellations. They would never call therapists at home or bother us between sessions unless they had a

genuine emergency. They are appropriately deferential toward and respectful of our position. They are also very grateful for our help.

A discussion of cultural issues is also in order here, for if some therapists were to make a list of clients they would rather not work with, these people would likely be poor, disadvantaged, and members of minority groups. These clients are generally perceived to have poor motivation to change, to be members of dysfunctional families likely to sabotage treatment, and to present disorders that are generally not amenable to psychotherapy—child abuse, alcohol and substance abuse, abject poverty, and chronic hopelessness (Larke, 1985). I should note, however, that many of us in the field prefer to work with people who are disadvantaged or culturally different because we are forced to stretch our values and skills to reach those who need us the most; often such clients are not difficult so much as they are different and thus more challenging than people who are most similar to us in background and life experiences.

Although we would be quick to point out that it is not racism, cultural insensitivity, or biases that lead many of us to prefer a young, attractive, verbal, and intelligent clientele, this would be a feeble protest, indeed. The truth is that, more often than not, difficult clients are difficult because they are not like us. They operate under rules and values different from ours. Often, they have not been prepared to get the most from a therapeutic experience. They may be mistrustful of authority and reluctant to talk about what is bothering them.

It is easier to communicate with someone with whom we share the same background, language, and customs. The degree to which these life experiences differ determines the amount of time and energy we must invest in finding common ground.

It is ironic that the people who most need the services of an advocate or confidante are those who are least likely to get one, and to keep one for any length of time. Clients are difficult not only because of what they do and how they do it but also because of how they are perceived and labeled by their therapists.