Compassionate Therapy: Managing Difficult Cases

Solidifying Therapeutic Alliances

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There are as many different ways to treat difficult clients as there are approaches to any other aspect of therapy. Each strategy appears to be enticing. "I must learn to do that," I say to myself, only to find another, sometimes conflicting, strategy that also has tremendous appeal.

I have been ruminating about a case I cannot make much headway with. I have tried everything I can think of — both with the client and with myself—so I don't become even more frustrated. Nothing yet seems to be getting through to her. I feel more than ready to get out of my comfort zone and try something new.

I reacquaint myself with paradoxical interventions suggested by Madanes (1990a) in which I can prescribe resistance, because that is what the client is determined to do anyway. I am both intrigued with and amused by a case Madanes describes in which a series of four different directives are offered to an anorectic girl and her alcoholic father. Their symptoms are linked by a contract in which each becomes responsible for the other's life: if the father stops drinking, the daughter must start eating. And vice versa.

Brilliant, I think, and start searching for a way I can apply a strategic approach to my own case. I am convinced now that this is the key. While Madanes and her colleagues can explain only superficially why such a strategy works —disrupting patterns and such —they claim that it doesn't really matter. What counts is fixing the problem. Makes sense, I reason; after all, it is the client who wants satisfaction, not me. If I must live with the uncertainty of not knowing how I was helpful or understanding the exact mechanisms by which change took place, so be it.

Before I ever had the opportunity to put this approach into practice, I came across another conception of working with difficult clients that seemed diametrically opposed to what I was about to try. In a case with a young man who had been unable to engage with any of several reputable therapists over a problem related to a writing block, Basch (1982, p. 15) described what to him made the biggest difference: "A turning point in the therapy came when I found myself unable to follow the patient in something he was saying about his work in one particular session. He casually mentioned a book that

gave a nontechnical overview for the interested layman of the particular subject we were discussing. Some weeks later when the topic came up again I was able to understand what he was saying, which surprised him. When I said that I had read the book he recommended and had enjoyed it, he burst out sobbing: 'You really do care,' he said."

How compelling that anecdote sounded! But should I concentrate on the conflicts in our relationship, or forget that stuff and go after the presenting problem? This very dilemma is what makes our work so deliciously complex. There is an infinite number of ways to facilitate change, depending on the situation or even our mood at the time. The important point in this instance is that I have options, lots of options, too many options. I can pick one of these strategies, or a dozen others, and will never feel stuck as long as I remember that all clients are difficult, life is difficult, and the reason I chose this line of work is because it is challenging.

Therapeutic Alliances

One interpretation of the behavior of clients who are being difficult is that they have been unable to bond with the therapist in a constructive alliance. Rogers (1980), in looking over his life's work, found that again and again he made the greatest impact on people and circumvented their reluctance to change through the authenticity of his personal encounters. Bugental (1990) also believes that clients *become* difficult when we are unable to reach them.

According to the bulk of empirical research, there is greater likelihood that a therapeutic effort will be successful when a relationship has been established that is mutually interactive, includes collaboratively structured roles, and is characterized by openness, acceptance, and empathy on the part of the clinician (Sexton and Whiston, 1990). More specific to severely disturbed clients, Campbell (1982) examined the texture and structure of the therapeutic relationship. After reviewing the positions of the major theorists who focus on treating borderline personality disorders, including the work of Kernberg (1975), Blanck and Blanck (1974), Masterson (1976), and Giovacchini (1982), she identified a consensus regarding the optimal therapeutic alliance.

The majority of writers agree that borderline disorders are characterized by both developmental

arrest and inadequate separation/individuation issues. Thus it is crucial to construct a vehicle that permits further growth in these areas to occur. This plan would involve a long-term commitment to a relationship that permits the client to work through primitive dependency and aggressive needs without pushing the therapist to relinquish a position of technical neutrality. Campbell (1982) further emphasizes the inevitability that countertransference issues will arise and notes the importance of using these feelings to promote greater developmental maturity in the client.

A warning to therapists about disclosing their feelings to the client is certainly in order. Tansey and Burke (1989) caution practitioners to be careful when sharing their feelings to clients, especially when these reactions may be the result of countertransference processes.

Validation of the disclosure is the most important problem. If the therapist is feeling bored or frustrated, this condition is not necessarily because of what the client is doing. Second, even if the therapist's perceptions are accurate, sharing them with the client can do as much harm as good, especially considering the power that some clients attribute to therapists, seeing them as omniscient authorities.

The authors also note that how the disclosure is presented is just as important as what is said. Consider the difference between these two efforts:

1. (Said with an irritated, impatient, and sarcastic tone of voice): "Do you realize how long you have been talking about this? Sometimes I find it very hard to listen to you."

2. (Said softly and tentatively): "I notice you feel the need to spend a lot of time on this subject. My attention is moving on to other things you mentioned earlier, which could mean that you have exhausted this topic. Then again, perhaps we could look at it from a different angle. How do you react to what I just said?"

The first disclosure sounds punishing whereas the second is offered with caring and sensitivity. We can make certain the first situation is avoided if we ask ourselves (a) what am I trying to accomplish? (b) What is the evidence that my perceptions are accurate? (c) How can I say this in a way that it will be well received?

The essence of therapy with difficult clients —or any clients for that matter —is the quality of the

therapeutic relationship. Once the clinician allows this alliance to become polluted by the clients manipulation or hostile traits, disengagement often follows. Every client wants to feel valued and understood by us; it is when we trade our compassion for cynicism that we loose the opportunity to be helpful.

Feeling Understood

In a qualitative research study on the experience of feeling understood, Dickson (1991) interviewed a number of people to get at the essence of significant personal transformation. Several of the people he interviewed described their experiences as similar to the following:

> The instant after you conveyed your understanding, I experienced a full pause. The frame froze. My feeling of urgency dissipated. For that moment, I had nothing to do and nowhere to go. What I had been struggling with seemed settled and resolved. I felt no urge to try to convince anyone of anything. I did not want to fight or bang pots. I felt like a person who found water after nearly dying of thirst in the desert. It was enough. Nothing else mattered. The craving had been fulfilled and the next concern was still down the road. When the time would come, I would be able to leave that moment and engage fully in the next. The issue felt complete [p. 86].

I think all people, whether perceived as difficult or not, respond more cooperatively to someone if they believe that person understands them. A client who has previously felt raw or vulnerable will sometimes let go of defenses designed to keep others away once he or she feels understood: "I have experienced a soothing quality to it, like warm oil. The oil is also protective. It adds freshness, healing in a sense. One is not so harshly exposed to the cruel elements. There is a renewal. It is really nurturing" (Dickson, 1991, p. 123).

Understanding someone, especially a person who is throwing up obstacles, smoke screens, and diversions, and who is changing forms so as to remain disguised, is an awesome, even an overwhelming task. Yet as Bugental (1990, p. 321) discloses, "The gift above all else that my clients have given me is the conviction that there is always more; that courage, persistence, and determination can always open possibilities where none has seemed to exist.

"We cannot do everything, but we can do so much more than we usually do. It is tragic how little we recognize this. It is breathtaking to recognize how much more is possible."

Empathy and compassion are the keys to helping clients feel understood and nurtured. These elements are crucial to any therapeutic relationship because they allow us to access the client's inner world and remind us we are dealing with real, live human beings—not just objects to be treated. Perhaps most important, empathy and compassion reduce our tendencies to view difficult clients as bad and evil (Book, 1991).

Family Relationships

Sometimes clients become difficult in therapy, not because it is their choice but because someone else is actively sabotaging treatment. A young wife, for example, starts out highly motivated to work on several issues. . . until her husband begins ridiculing her as weak and spineless because she is always running to her shrink for support. An adolescent would very much like to open up and deal with some things that are bothering him, but he is teased mercilessly by his brothers for attending sessions. A middle-aged man has been quite cooperative in the first session, but then things turn ugly thereafter; you learn that his mother is working behind the scenes to undermine his resolve because of her own fears that certain family secrets will come out into the open. In each of these cases, the client initially wants to be as cooperative as possible —that is, until an influential relative or friend seeks to destroy the therapeutic connection.

Once the source of the resistance is identified, recruiting that person into the treatment is often helpful. The husband is asked to come in to help the therapist understand the situation better. The siblings of the adolescent are invited in so that now the whole family is the "client" rather than the one child stigmatized as the problem. And in the last example, the mother can be called to let her know how important she is and how valuable her help could be.

A therapist obviously must use a great degree of tact and skill to involve the disruptive person in the treatment without aggravating the situation even more. Nevertheless, when there are systemic dysfunctions in a client's family, especially the kind that are working actively to resist change, the whole family must be involved in the treatment. In these cases, the difficult client is simply acting out the ambivalence toward change manifested in the system or in coalitions of the family structure.

Stanton and Todd (1981), specialists in the treatment of difficult clients, believe that attempting to treat these clients without including their families is foolish. The authors find this especially true with drug addicts; not only are they the scapegoats of their families, delegated to act out on behalf of others, but they are sabotaged unconsciously if not overtly by those they love most.

In researching the techniques with greatest promise for engaging the most difficult of client populations—resistant heroin addicts and their families — Stanton and Todd found that the absolutely essential step is to identify the family members most capable of sabotaging or encouraging progress and to insist that they attend sessions, even if they or the client seems reticent about their involvement.

In other research on treating resistant families, Anderson and Stewart (1983a) suggest a number of guidelines that should be followed:

Create an alliance. Join the family as a supportive and compassionate member.

Realize all families resist therapy. Any system works actively to maintain its constancy and resist change of any kind.

Establish an alliance with the person who holds the power. Without the support of the family power hierarchy, any change is doomed.

Accept the family's view of the problem. Initially, it is best not to challenge the family member's perception of their problem. Slowly, it can be reframed.

Start where the family is. Do not ask them to do anything they are not ready for.

Take the road of least resistance. Avoid power struggles and concentrate on the areas that are initially most responsive.

Relabel resistance as helpful. Rather than seeing uncooperative behavior as oppositional, view it instead as feedback.

Establish contracts. Help members set goals that are realistic and complete tasks that are within their grasp.

All this advice has one central theme: stay loose and flexible. Put your own agenda aside. Rather than searching for something that is not there, or demanding something that the client(s) are not ready

for, go with what they are giving you. Of utmost importance, concentrate your efforts on establishing the most constructive alliances possible with those in positions of influence.

Group Relationships

Most group therapy practitioners screen out difficult clients because of their disruptive influence on others and their potential to destroy the cohesive elements in a group. Leszcz (1989), however, believes that groups are ideal settings to help such people alter their maladaptive styles. When groups are structured to include not more than one or two character-disordered clients, these individuals are provided the opportunity to experience stable, affirming relationships under the tutelage of an empathic leader. This therapeutic experience can be invaluable for the difficult client who so needs opportunities for healthy interaction; it can also allow more normal-functioning clients to work on issues related to confrontation and conflict management.

I applaud the effort of any therapist who takes on the challenge of including difficult clients in group settings. My own experiences have been somewhat less than successful in this arena because of my inability to neutralize the negative effects of the difficult one on other group members. I am convinced, however, that this treatment modality is the ideal setting to alter dysfunctional interaction styles, *if it can be done without diminishing the therapeutic experience of other group members*. That is a tall order, indeed!

Assessment, naturally, is the key. In deciding whether a difficult client (especially one manifesting classical symptoms of borderline or narcissistic disturbance) is appropriate for group treatment, Powles (1990) recommends that the therapist make a series of clinical decisions, based on these questions:

> How severe is the psychopathology?
>
> Is the client amenable to treatment at all?
>
> What is the best indicated treatment modality? Intensive versus supportive versus behavioral? Individual therapy? Family therapy? Group therapy?
>
> If so indicated, what kind of group therapy is likely to be most beneficial? Group guidance versus group counseling versus group therapy? Heterogeneous versus homogeneous group composition? Insight versus action- oriented approaches? Group-centered versus

leader- centered formats?

Some difficult clients are accepted much more easily than others into group environments. They are potentially more responsive to confrontation and better able to adapt to group norms. Sam, the "boring client" of Chapter Twelve, was able to respond no better in a group than in individual sessions, but another client with similar problems did marvelously well in group therapy. Every time he began to ramble, to drone on about meaningless details, he was vigorously but lovingly confronted by others. He felt accepted by the group, so he did not pout too much when others told him to shut up. And when he would withdraw and feel rejected, the other members would draw him out and encourage him to share his deeper-level feelings.

Gradually, this client did learn to alter his communication style. But just as important, for the first time in his isolated life he had access to the personal world of others (something that had been available to him previously only through television). He was fascinated and greatly entertained by the more dynamic members of the group. Even though some of their behaviors were self-defeating, he began to model himself after their more engaging styles of expression. For the first time, he felt part of a group who cared for him.

Promoting Insight Within Therapeutic Relationships

Assuming that the source of greatest impediment to progress in therapy lies in the client's behavior rather than our own, Golden (1983) recommends a problem-solving approach to identify contributing factors and to neutralize them. Often the most advantageous place to start this analysis is with a thorough exploration of those secondary gains or payoffs the client is receiving as a result of engaging in difficult behavior.

Applying a model suggested by Dyer and Vriend (1973), the therapist examines all behavior in terms of its helpfulness, even the most self-defeating acts imaginable. He also examines the payoffs that accrue to the hostile client. Anger is seen as a way of dominating and controlling others, instilling fear, keeping people on the defensive. This style of interaction holds people at a distance and protects the client against vulnerability and rejection. It gives her license to be abusive to others, and then to have a ready excuse: "I'm sorry about my outburst earlier, but you know I have a bad temper." It also allows the

person to act out freely any residual anger and frustration that she has accumulated throughout her life.

Once we, and later the client, understand what she gets out of the difficult behavior, it is harder for her to continue it. I have seen this technique work quite effectively in a number of different settings, including a therapy group.

Patrick was Irish and damn proud of it. His flaming red hair and lilt were dead giveaways of his ethnic origin. Patrick announced to the group during this first introduction that he had been pressured into getting help for his bad temper, but he saw it as a hopeless cause: he had Irish genes that predisposed him to lose control sometimes. Everyone laughed nervously.

Soon Patrick showed us what he meant. His temper could be ignited without warning. His face would turn the color of his hair, his eyes would smolder, and he would virtually explode with anger over some imagined injustice —usually a feeling that he was slighted or ignored. Needless to say, Patrick demanded and got a *lot* of attention.

Eventually, one courageous group member decided to broach the subject during one of Patrick's calmer moments when he had announced that he was in a good mood. She very softly yet directly told him she did not feel safe with him in the group. She was tired of his ranting and raving and insisted that it would have to stop or she would leave the group. She had already endured enough from an abusive husband similar to Patrick and she did not intend ever again to subject herself to that sort of psychological torture. The group broke out into spontaneous applause.

Much to everyone's surprise, tears started to run down Patrick's face. He said that he wanted to change so badly but that he just could not, no matter what he tried. It was just part of his blood.

He was then challenged to consider whether that assumption was indeed true and what satisfaction he got from believing it. Patrick could think of absolutely nothing. "I hate being like this. It is awful being so out of control."

The leader asked him and other group members to consider that everyone gets *something* out of a particular behavior; if they did not the behavior would stop. Patrick agreed with that assumption, but

could still not think of any payoffs to being so belligerent and hostile. “After all, I just end up alienating everyone.”

“And what is the benefit of that?” one group member asked, picking up the cue.

The next half-hour was spent helping Patrick list all the “wonderful” things he got out of being the way he was —the attention he received, the power he wielded, the barriers he erected to protect himself. If ever insight can be an impetus to lasting change, it is in understanding the hidden secondary gains from self-defeating behaviors. No longer can you pretend you do not know what you are doing and why. Henceforth, every time Patrick began to erupt, before anyone else would say a word, a small smile would cross his face. He would shake his head, once, twice, take a deep breath and continue. Sometimes he would even giggle when he caught himself engaging in previous maladaptive patterns.

This model for looking at difficult client behavior in terms of the helpful functions it serves accomplishes a number of therapeutic tasks: (1) it focuses on the existence of values in even self-destructive acts, (2) it unveils the hidden motives behind behavior, (3) it makes clients assume responsibility for even their unconscious behavior, (4) it teaches clients a way to think about and to make sense of what they are doing, (5) it labels in concrete ways the meaning and purpose of even the most destructive acts, (6) it gives the therapist the leverage to confront the difficult client by labeling what he or she is doing and why, and (7) it takes destructive behavior out of the realm of the pathological and explains it as a legitimate coping mechanism that just has unfortunate side effects.

Models for facilitating insight are only as effective as the quality of the therapeutic relationship that has been established. Whether we are working in the context of individual, group, or family sessions, any interventions we try have a greater likelihood of success once the difficult client feels secure enough to risk experimenting with new ways of interacting with others.