*Compassionate Therapy: Managing Difficult Cases*

# Thinking Constructively, Feeling Compassionately


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## Thinking Constructively, Feeling Compassionately

The way we think about our clients and their concerns dictates, to a great extent, how we feel about our work and what interventions we might choose to circumvent apparent resistance. These internal formulations about our cases arise, in part, from reactions to how clients present themselves, from our own personal issues, and as a contagious effect of how others influence us.

In their classic book on burnout, Pines and Maslach (1978) noted an inverse correlation between frequency of staff meetings and therapists' negative feelings toward clients. It seems that in most agencies and institutions, case conferences and meetings offer surprisingly little encouragement while fostering terribly counterproductive attitudes toward clients. When a difficult client is brought up for discussion, rather than helping the clinician look at personal blocks that may be getting in her way, her colleagues often direct their attention to how obnoxious the client is. Often it sounds as if the clients who so crave caring and empathy are discussed in terms we would usually reserve for an enemy. These meetings, therefore, can make things considerably worse for the practitioner who still naively wants to help the person whom others find so hard to be around.

### Of Mockingbirds and Being Versatile

Versatility, flexibility, and pragmatism are the keys to working with difficult clients. And those who are most adept at working with these cases are clinicians who are able to draw on a vast reservoir of strategies and interventions, regardless of their conceptual frameworks or theoretical origins. These professionals, while they may be original and innovative in their methods, are also talented collectors and imitators of what other effective therapists can do. They are the mockingbirds of the profession in all the best sense of what it means to be a true artist.

> Mockingbirds are the true artists of the bird kingdom. Which is to say, although they are born with a song of their own, an innate riff that happens to be one of the most versatile of all ornithological expressions, mockingbirds aren't content to merely play the hand that is dealt them. Like all artists, they are out to *rearrange* reality. Innovative, willful, daring, not bound by the rules to which others may blindly adhere, the mockingbird collects snatches of birdsong from this tree and that field, appropriates them, places them in new and unexpected contexts, recreates the world from the world [Robbins, 1990, p. 6],

In these words novelist Tom Robbins describes in the mockingbird exactly what is necessary for the therapist to get through to difficult clients —the willingness and ability to do and be whatever it takes to get the job done. In a summary of all the research to date on therapy outcomes. Seligman (1990) heartily agrees that the hallmarks of clinician effectiveness are flexibility and adaptability. This means that the most successful practitioners are able to alter their levels of directiveness, treatment methods, and styles according to the client's presenting complaints, personality variables, and specific needs.

As an example, Seligman analyzes supportive versus probing forms of therapy to illustrate how both might be used by the same therapist with different kinds of difficult cases. The more confrontive, expressive methods would be recommended for those clients whose defenses will not permit nurturance as well as those who are highly motivated and psychologically minded. By contrast, supportive methods are more helpful with clients in crisis, those who are extremely vulnerable, or those who have limited goals (Wallerstein, 1986). Of course, there are also times when we may alternate between both treatment styles with the same client as therapy progresses.

## A Pragmatic Approach

Our initial clinical judgments regarding client difficulty can often create problems if these diagnostic impressions remain rigid. In a study of therapists' initial assessment of client difficulty, Rosenbaum, Horowitz, and Wilner (1986) found consistent agreement among practitioners as to which cases would present the greatest challenge; however, these predictions often turned out to be inaccurate based on what actually transpired during treatment. So many of the difficulties we initially perceive—such as a client who does not seem to be very psychologically minded or sophisticated —eventually work themselves out through the educational process that is the essence of therapeutic change. The researchers concluded from their investigations that client difficulty should not be perceived as a static and stable condition impervious to change but rather as behavior that is a reflection of pain that will be surrendered when other alternatives are developed.

The strategies that work with difficult clients are essentially the same ones that are most helpful with clients who are maximally cooperative, but they need to be applied in greater quantity and intensity. The essential element is the therapist's adaptability to changing conditions and circumstances

and his willingness to do whatever is called for in a given situation.

No longer can we afford the luxury of a parochial allegiance to a single therapeutic approach without considering the contributions from a number of competing schools of thought; there are just too many wonderful new contributions to the field from so many diverse sources to ignore what they have to offer.

Many authors such as Beutler (1983), Prochaska and DiClemente (1984), Lazarus (1986), Beitman, Goldfried, and Norcross (1989), and Mahrer (1989) have constructed integrative models of helping that combine the best features of most systems. These approaches may be likened to the effects of broad-spectrum antibiotics that are injected into the body to kill infection when we have no idea which culprit is causing the problem. If one weapon does not stop the problem, another one will. This conception is also helpful in the treatment of especially resilient client resistance. Rather than limiting the attack to a single strategy that may or may not prove effective, practitioners use a pragmatic model of functioning that allows them to draw on a variety of tools. These can target all three of the most prominent change agents: affective experiencing, cognitive mastery, and behavioral regulation (Karasu, 1986).

When clients are offered a number of conditions, interventions, and structures that seem to be universal among insight and action approaches, and cognitive and affective theories, they are more likely to find some therapeutic ingredient they can connect with. The following variables, described in a previous work (Kottler, 1991), have been found useful, regardless of a therapist's theoretical base:

**Altered States of Consciousness**

Improving the client's receptivity to influence through the use of rituals designed to maintain interest and attention.

*"When I turn my back and face you again you will notice a profound change in the way I appear and how you feel about me — even if that change is simply an awareness of how difficult it is for you to tell me what you see."*

**Placebo Effects**

Communicating our confidence and expectation that the client will eventually improve after a few setbacks.

*"I'm not all that surprised that this would be rocky for you. In fact, these difficult times are a sign that you are getting even closer to your ultimate goals."*

**Therapeutic Relationship**

Capitalizing on the difficult clients craving for intimacy and trust to override apprehensions and reluctance.

*"I want so much to get close to you and I sense that you want to trust me as well."*

**Cathartic Processes**

Facilitating the free expression of anger and frustration in more healthy and direct ways.

*"Instead of mumbling under your breath and sneering, I wonder if you might tell me to my face what you are thinking and feeling right now."*

**Consciousness Raising**

Increasing the clients awareness of patterns of resistance and the meaning this behavior has.

*"So why do you think that every time you care for someone you find a way to destroy that love?"*

**Reinforcement**

Applying basic learning principles to extinguish inappropriate behavior and reward efforts to be cooperative.

*"I am amazed that you just made it through a whole sentence without saying a single negative thing."*

**Rehearsal**

Helping the client to practice new ways of thinking, acting, and feeling.

*"Just now you attempted to tell me to back off, but you did so in a way that could be interpreted as rude and insensitive. I would like to see you try it again, but this time try to be a bit more gentle and diplomatic. "*

**Task Facilitation**

Constructing a series of therapeutic activities that counteract destructive tendencies.

*"You say that you are tired of being dependent on others, including me, for approval and validation. Let's talk about a few ways that you could deliberately do some things that YOU want to do that others would not necessarily like."*

**Major Demolition**

Shaking up the clients view of himself or herself and the world in an effort to recreate a different, healthier reality.

*"I don't think I can help you, or that anyone else can, either. I see no way out for you other than to lose everything you have. After you have lost your job, your family, and all your resources to your drug addition, THEN come back and we will talk. "*

**Modeling Effects**

Using the force of our personalities to provide a healthy model for the client to emulate.

*"Notice that I am not pleased with the way things are going, either. But rather than pouting, blaming myself or you, I would rather spend my time carefully analyzing what is going on and what it means. I am talking to you about how I feel rather than keeping everything inside. Rather than feeling helpless or immobilized or frustrated, I concentrate instead on how challenged I am to get to the bottom of this."*

**Patience**

Respecting the clients own pace in progressing at a level that is most comfortable.

*"I hear what you are saying— that you can't stand it any longer. But apparently you CAN stand it a little longer or you would let go of what is holding you back. I can wait for you as long as it takes."*

When we review these variables, which operate as part of most effective therapies, it isn't necessary for us to choose which ones to use and which to ignore. They can all be valuable on some level. In fact, when working with clients who do not respond to our preferred method of operation, we must be even more pragmatic than usual. The only way we can ever hope to get through is by capitalizing on as many of these factors as possible to increase the pressure on the client to stop being so difficult with himself or herself and with others.

## The Dangers of Rigidity

A major source of resistance in therapy that stems directly from the clinician is a posture of certainty whereby the therapist communicates absolute parameters of right and wrong, good and bad, to the client (Bauer and Mills, 1989). These rigid beliefs regarding what constitutes reality or what clients *really* mean when they act in certain ways are bound to stir up rebelliousness in many otherwise cooperative clients. Not only does such an attitude communicate disrespect for the client's capacity to determine for herself what is best, but it also implies that there is a single reality to which everyone must swear allegiance.

Confronted by a client who suddenly becomes stubborn, it is often helpful to ask ourselves in what ways we are being overly rigid. As a beginner in this field, I looked with awe on those supervisors and mentors who always seemed to know the right thing to say or do, no matter what circumstances arose in a session. During an encounter with one supervisor, he informed me that while he might *appear* to know what he was doing most of the time, often he felt confused and uncertain. Furthermore, he claimed, he was very suspicious of any therapist who *did* claim to know what was happening in any moment. "Worry not when you don't know what to do with a client," he cautioned, "but when you think you do."

I have always taken this advice to heart, and I have found that of the dangerous traits with which a therapist can hurt people, rigidity can be the most lethal. I have learned to be suspicious of therapists who believe they have found truth, not only for themselves but also for the rest of the world. Further, I have discovered that when I face a client who seems to be digging in for a fight, I look first to myself to see what trenches I have dug for myself. Quite often, I find that I have been spouting some variation of "I-know-what-is-best-for-you-damn-it! Just-do-what-I say!"

## A Mental Checklist

A comprehensive and accurate assessment of client and therapist contributions to therapeutic impasses is crucial to formulating successful treatment strategies. These contributions would also include, of course, interactional effects as well as external influences that often sabotage progress—meddling family members, impoverished environments, and the like.

When clients are resistant, it is important to examine carefully the positive adaptive functions of their symptoms. Because causality is so hard to ascertain — that is, who is creating the problems by doing what — the remedy is to examine all four possible factors that could be contributing influences: *interpersonal issues*, which help to show how the resistant behavior aids in maintaining the client's stability; *individual issues*, which provide clues to the intrapsychic and psychodynamic values of the symptoms; *family history data*, which can reveal cultural and ethnic factors and codependency issues; and *external factors*, which are operant reinforcers in the client's environment that discourage change.

A more specific approach to assessment is offered by Dyer and Vriend (1973), who tackle the problem of reluctant clients by running through a mental checklist much the way a pilot does before beginning any takeoff. They recommend that when therapists feel stuck, they ask themselves a series of questions such as the following:

Who is the *real* client who needs help?

Which negative attitudes and self-defeating beliefs does the client subscribe to that are interfering with his or her ability to change?

What payoffs is the client enjoying as a result of his or her behavior?

What meaning does the resistance have for the client?

What expectations do I have that the client is unwilling or unable to meet?

How is my own impatience becoming an obstacle?

How am I personalizing the difficulties in such a way that I feel like a target?

Focusing this assessment process to even greater specificity, it is desirable to follow a similar pattern every time we encounter trouble. For example, one of the most common ways that clients become uncooperative is to fail to complete homework assignments —either those prescribed by their therapist or those tasks that they initiate on their own. A therapist's mental checklist might then proceed as follows: were the instructions clear? Was the task beyond the client's capabilities at this time? Was the assignment irrelevant to the client's needs? What is the client communicating by his or her noncompliance? Who is working behind the scenes to sabotage progress? What appears to be most threatening to the client if he or she completed the task? "By exploring the possibilities raised by each of these alternatives," Lazarus and Fay (1982, p. 119) explain, "it is often possible to reframe the assignments, reeducate the patient, and, if necessary, reexamine the therapeutic relationship and reevaluate the patient's family system or social network."

One other assessment procedure a therapist can use when encountering resistance is the differentiation between normal versus characterologically reluctant clients. Dowd and Seibel (1990) make the following distinctions between the two:

| ***Normally Resistant*** | ***Characterologically Reactant*** |
|---|---|
| Situationally ignited behaviors | Chronic interpersonal style |
| Overt oppositional behaviors | Subtle manipulative ploys |
| Adaptive functions | Maladaptive functions |
| Healthy expression of autonomy | Destructive expression of need for control |
| Protection against rapid changes | Protection against any changes |
| Reponsiveness to direct intervention | Responsiveness to indirect intervention |
| Desire for a resolution of conflict | Preference for oppositional position |

Dowd and Siebel (1990) find it extremely valuable when interpreting the behavior of difficult

clients to determine whether the interactive problem is unique to the therapeutic encounter, or whether these clients find themselves constantly in conflict with others. One person may experience trouble in virtually all his relationships, in which he is seen as inflexible, controlling, and caustic. Another person may generally get along with most of his peers but seem to have consistent trouble only with those in positions of power. Still another possibility is the client who has difficulty only in therapy because of unique factors inherent in that encounter. It is important to determine which of these situations we are dealing with before we construct an appropriate response.

The client who is difficult with the therapist but no one else will profit from an intensive examination of transference-countertransference dynamics as well as the personal meaning this encounter has for her. As I have mentioned before, it would also be helpful for the therapist in this circumstance to consider her own contributions to the problem because of the unique interactive effect.

The client who is generally oppositional to authority figures will find it quite helpful to reach an accommodation with the therapist as a representative authority figure who can be trusted. The client thus learns to create a new conceptual schema for power figures: those who are exploitive versus those who are benevolent. This is an intermediary step before such clients learn eventually to empower themselves.

The client who is difficult with almost everyone requires quite a different strategy, one that seeks a major reorganization of the client's perceptual and interactive systems. With this person we tend to work more cautiously and in smaller increments. Although we may exhibit greater patience for the progress of the characterologically reactant clients than we would for those who are situationally resistant, we will tolerate a lot less acting out from the former and feel the need to establish firmer boundaries with them.

## A Behavioral Profile

One way the therapist's assessment process is applied to these temperamentally difficult clients is through attention to those specific behaviors that are most obstructive. In their book on chronically difficult children, Turecki and Tonner (1985) offer advice to parents that is equally appropriate for therapists who are struggling with clients who are uncooperative. They recommend constructing a

profile of exactly those types of behavior that are viewed as disruptive or counterproductive, including specific examples, the situations in which they occur, and what usually results from these actions. They feel that we must have a thorough understanding of exactly what it is about a difficult client that we find troublesome before we can ever hope to break the destructive cycle.

One of the hardest things for therapists to do is to resist simplifying complex clients into simple diagnostic categories; this simplification is often more important for our own need for structure than it is for treatment planning. Emily, for example, has been a continual challenge for me over a period of many years. She has so many problems, that may or may not be psychosomatic in origin, that I never really have had a handle on what I am helping her with. She was originally referred by her physician because of suspected self-mutilation of her vagina. While she vehemently denied touching herself in any way, she offered no other explanation for the vaginal bleeding that never seemed to diminish. When one time she was caught by a nurse trying to raise the thermometer temperature artificially with a match, I decided to do away with a "borderline" diagnosis. She seemed to be exhibiting a rare Munchausen syndrome in which she continuously found ways to seek medical attention for apparently fake maladies. But her situation was a lot more complicated than that.

Emily was also very depressed, sometimes suicidal. She had a number of learning disabilities, and although she refused to talk much during sessions, I strongly suspected there had been some severe sexual abuse in her family. Only after several years of therapy did she finally confess that her older brother had been coming into her room at night since she was five years old (she refused to elaborate). Contributing to her problems, she was going nowhere vocationally and she was socially isolated; she had never dated a boy during the twenty-five years of her life. But regardless of the diagnosis I could select—borderline, hysterical, Munchausen syndrome —Emily was a chore to be with. She could be alternately withdrawn, petulant, or entertaining, depending on her mood and perhaps how far she believed she could push me on any given day.

And yes, I *was* taking this case very personally; I felt as if she were playing with me. I tried many different strategies during our tenure together. On occasion I would try waiting out her silences; once we managed a whole session in which neither one of us said a single word for forty-five minutes until I broke the spell by asking her if she wanted to reschedule. Of course she said yes. At times I confronted

her, interpreted her behavior, shared my frustrations, provoked her, supported her, mimicked her. All these worked. And at times, nothing did. Yet whatever I did with Emily, however much I was frustrated, there was no doubt she was improving consistently. I was completely at a loss to explain how and why.

I knew that behavioral profiles can sometimes be helpful in planning treatment. We use them to target interventions that are likely to be more successful than what we are already doing. So I tried constructing a behavioral profile describing the aspects of her that I found most difficult (see Table 15.1).

From this exercise I learned that there was a pattern operating (a brilliant conclusion), but I could not see what it was. I studied all the evidence for a while and finally, the answer hit me: the pattern was that there was *no* pattern! Emily was an expert at change, a virtual chameleon who could change her colors of camouflage as the situation required. She may have been learning disabled in math or reading, but she was one awfully smart lady. I told her so. I even showed her my chart (I was so proud of it I *had* to show it to someone).

*Table 15.1. Profile of a Difficult Client.*

| Type of Behavior | Behavioral Example | Situation | Consequences |
|---|---|---|---|
| Defiant | I mention that now she has enough money to move out of her parents' house, so she quits her job. | When her life is changing too quickly. | Lets me know I must respect her. |
| Withdrawn | She sits down and does not say a word; answers questions with monosyllables | When she has me on a variable interval schedule. | Frustrates the heck out of me. |
| Obstructive | She cancels appointment at the last minute. | Usually after an intense session the week before. | Thinks she is punishing me for getting too close. |
| Manipulative | She tells me she might not see me next week because she may decide to kill herself. | After I have been aloof from her games. | Hooks me into threatening hospitalization. |
| Complaining | She whines and complains that nothing will ever change. | After she has made some dramatic change. | Denies responsibility for progress. |
| Stubborn | She refuses to see a doctor for a chronic health problem. | After I contact her doctors. | Establishes limits regarding what she considers safe to discuss. |
| Helpless | She expresses her hopelessness that she could ever be different | In reaction to any therapeutic task that requires effort. | Avoids taking risks or increasing her vulnerability. |

Source: Adapted from Turecki and Tonner, 1985.

Emily smiled enigmatically, but furiously denied that my theory had any merit. If nothing else, she seemed appreciative that I had devoted so much time to thinking about her. And I noticed, immediately, that she became more cooperative in the sessions that followed. Oh, she still kept me on my toes with new twists, but I could tell her heart was not in it. Even if doing this behavioral profile did not help her, it definitely helped me get a handle on the chaos I was trying to organize without resorting to writing her off as "another crazy borderline." Sometimes it is better if I just let go of that need for order I find so important. Once I realize I am in the vortex of a cyclone and I cannot do much about it, I might as well enjoy the ride. And while I can truthfully say that I never enjoyed much of our time together, I believe Emily improved most significantly once I was able to appease my own anxiety about the case by attempting to create some semblance of structure.

## Reframing Resistance

One of the most helpful ways to circumvent impasses with difficult clients is to change the way we think about them, to alter our diagnoses to those that may be more useful. A useful diagnosis, according to Weltner (1988), is one that suggests a treatment plan that is easy, efficient, and effective. Such a diagnosis of the problem would meet the following criteria:

1. It is acceptable to the client and everyone else involved in the treatment.

2. It identifies something the client truly wishes to change, something she has demonstrated *behaviorally* that she has the power and willingness to change.

3. It involves a problem that is generally resolvable within the time parameters and resources that are available.

I know of no metaphor more applicable than *reframing* to describe how therapists reconceptualize client problems in order to deal with them more easily. Originally coined by Watzlawick, Weakland, and Fisch (1974) in their work on formulating client issues, the term *reframing* is discussed in different forms by a number of writers including Haley (1967), Palazzoli, Selvini, Cecchin, and Prata (1978), Madanes (1981), and Bergman (1985).

In this internal strategy we seek to take the work of art that the client creates and presents to us, retain its essence, and change its form to something the client will still recognize as his but which we can feel more comfortable dealing with. When reframing works well, the client's perceptions of his problems are forever altered in a way that feels more hopeful.

By illustration, the behavior of an angry adolescent can be recast as a "helpful" way to get attention for a problem that has been ignored. Then, the whole concept of "resistance" can be looked at in a different light.

Some clinicians believe there is no such thing as resistance, that the client is simply educating the therapist through a unique form of cooperation. Reframed in this way, the difficult client's behavior dictates the most appropriate way to respond. O'Hanlon and Weiner-Davis (1989) describe, for example, the four possible ways a client could respond to a homework assignment and offer appropriate therapist actions:

If the client completes the task, give another one.

If the client modifies the task, offer easily changeable assignments that are ambiguous.

If the client does not do the homework at all, do not give any more.

If the client does the opposite of what is suggested, give a paradoxical directive.

From this perspective, clients are never resistant, oppositional, or difficult; we have just been unable to decode the ways they are trying to cooperate. In advising therapists who work with difficult clients, Erickson (1980, p. 213) reminds us that behavior we might find obstructive or unreasonable is "part of the problem that brought [the client] into the office; it constitutes the personal environment within which the therapy must take effect; it may constitute the dominant force in the total patient-doctor relationship."

One of the major contributions of Ericksonian therapy is the novel and indulgent view that client behavior, no matter how bizarre, is a legitimate form of communication. This perspective requires the clinician to show a high degree of acceptance and flexibility in order to treat resistant behavior, paradoxically, as a valuable resource (Dolan, 1985).

## Changing Our Expectations

The principal assumption that gets in the way of therapists as they work with difficult clients is the notion that resistance is an inevitable part of treatment and that people do not want to change (O'Hanlon and Weiner-Davis, 1989). Our expectations of what we will find most definitely influence what we actually observe; that is why we go to such lengths in conducting research to minimize "subjective pollutants." If we expect a client to be difficult or anticipate that we will encounter resistance, we are most likely to find what we are looking for—trouble.

An extreme position regarding this subject is advocated by deShazer (1984), who has declared resistance to be a figment of the imagination. He further insists that when clients do not cooperate with their therapists, it is not at all because they are resisting; rather, they are teaching their therapists how to be most helpful, and also showing them the behavior they do not especially appreciate. If a client does not comply with a task, complete an assignment, or cooperate the way the therapist thinks she should, the problem is not with the client but with the therapist.

I get a kick out of this unusual perspective, as I do with any creative innovation; however, I do believe that resistance exists. I also find it helpful, in some circumstances, to expect a hard time; then I am able to be more understanding and patient, and I am willing not to take the reluctance personally. I also see the value of monitoring carefully what I am thinking, feeling, observing, and anticipating as I begin working with a new client. Whenever my gut-level internal voice is saying something like, *"Oh no, not another one of these!"* or "*What am I ever going to do with this one?*" I know it is time to stop, take a deep breath, clear my head of these negative thoughts, and start over again. DeShazer is indeed right on one score: every client has a unique way of communicating and cooperating in therapy; it is our job to discover what that way is and to make the best use of it.