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Characterologically difficult clients in a graduate training clinic :: an exploratory investigation.

Paul N. Reid
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CHARACTEROLOGICALLY DIFFICULT CLIENTS IN A GRADUATE TRAINING CLINIC: AN EXPLORATORY INVESTIGATION

A Thesis Presented
by
PAUL N. REID

Submitted to the Graduate School of the University of Massachusetts Amherst in partial fulfillment of the requirements for the degree of Master of Science
May 1999
Psychology
CHARACTEROLOGICALLY DIFFICULT CLIENTS IN A GRADUATE TRAINING CLINIC: AN EXPLORATORY INVESTIGATION

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ACKNOWLEDGMENTS

This manuscript in its completed form represents not only the culmination of a first phase of a new research program for me, but also a significant phase in my life. Neither could have been successfully concluded without the enduring patience, the sage guidance, the ever-present encouragement, the remarkable flexibility, and the exceptional technical prowess of my treasured advisor, Dr. David M. Todd. Nor could this specific project have begun without him, for it was only under his steadfast guidance as my clinical supervisor during my first two years in this graduate program that I came to articulate the specific passions which drove this work. It would be both easy and a joy to elaborate a series of superlatives similar to those above to describe his how fundamentally influential he was in my clinical development, but the sole answer to the question of the wisdom of doings at this time would unambiguously be... it depends. Suffice it to say that I could not imagine a better first clinical mentor and I am grateful for all that he has taught me.

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ABSTRACT
CHARACTEROLOGICALLY DIFFICULT CLIENTS IN A GRADUATE
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MAY 1999
PAUL N. REID, B.A., BIOLA UNIVERSITY
M.S., UNIVERSITY OF MASSACHUSETTS AMHERST
Directed by: Professor David M. Todd

This study represents a first empirical attempt to identify and describe
characterologically difficult clients in a graduate training clinic and to explore
developing therapists' experiences with these clients. Because of the study's
exploratory nature, a hybrid quantitative-qualitative methodology was used.
This methodology included two brief questionnaires, the first asking therapists
to nominate difficult clients according to a five-point definition and the second
asking nominating therapists to evaluate the utility of the definition and to offer
open-ended comments on their experiences treating characterologically difficult
clients. Nominated and non-nominated clients were compared on
demographics, treatment characteristics drawn from a database of case
information, and on informal contextual information throughout the
investigation. Several significant differences emerged between clients
nominated as characterologically difficult and non-nominated clients on
theoretically salient but potentially correlated variables including age of clients,
clients' student status, length of treatment, and number of transfers.
Recommendations for further research, therapist training, and clinic policy and
record-keeping are offered in conclusion.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>iii</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>vi</td>
</tr>
<tr>
<td>Chapter 1. LITERATURE REVIEW AND INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Client Difficulty</td>
<td>1</td>
</tr>
<tr>
<td>Client Descriptions</td>
<td>2</td>
</tr>
<tr>
<td>Therapeutic Impasses</td>
<td>4</td>
</tr>
<tr>
<td>The Problem: Challenge to Clinicians</td>
<td>6</td>
</tr>
<tr>
<td>Working with Characterologically Difficult Clients</td>
<td>7</td>
</tr>
<tr>
<td>The Context: Clinics and Clinical Populations</td>
<td>9</td>
</tr>
<tr>
<td>Operational Definition of Characterologically Difficult Clients</td>
<td>9</td>
</tr>
<tr>
<td>The First Step: Finding What is There</td>
<td>10</td>
</tr>
<tr>
<td>Chapter 2. METHOD</td>
<td>12</td>
</tr>
<tr>
<td>Participants</td>
<td>12</td>
</tr>
<tr>
<td>Materials</td>
<td>12</td>
</tr>
<tr>
<td>Design and Procedures</td>
<td>14</td>
</tr>
<tr>
<td>Chapter 3. RESULTS AND DISCUSSION</td>
<td>18</td>
</tr>
<tr>
<td>Introductory Comments</td>
<td>18</td>
</tr>
<tr>
<td>Caveats and Descriptive Statistics</td>
<td>19</td>
</tr>
<tr>
<td>Working with a Dynamic Database</td>
<td>20</td>
</tr>
<tr>
<td>Statistical Analyses</td>
<td>21</td>
</tr>
<tr>
<td>Response Rates</td>
<td>23</td>
</tr>
<tr>
<td>Descriptive Statistics - Client Demographics</td>
<td>24</td>
</tr>
<tr>
<td>Descriptive Statistics - The &quot;Average&quot; Treatment</td>
<td>26</td>
</tr>
<tr>
<td>Inferential Analyses</td>
<td>29</td>
</tr>
<tr>
<td>Correlates of Ratings of Overall Difficulty</td>
<td>29</td>
</tr>
<tr>
<td>Defining the Groups</td>
<td>32</td>
</tr>
<tr>
<td>Comparing Nominated vs. Non-nominated Clients</td>
<td>38</td>
</tr>
<tr>
<td>The Utility of the Proposed Definition of Characterological Difficult Clients</td>
<td>46</td>
</tr>
<tr>
<td>A Comment on the Post Hoc Subgroupings</td>
<td>47</td>
</tr>
</tbody>
</table>
Explaining the Overall Pattern of Findings: Discussion and Qualitative Analyses ................................................. 49

Diversity Among Therapists ........................................ 49
The Therapist-Client Interaction ................................... 52
Potential Theoretical Limitations of the Group Comparison ............................................. 53
The Therapists' Voice -- Coming Full Circle ................... 56

4. CONCLUSIONS ........................................................................... 68

Summary of the Exploratory Findings ............................... 68
Recommendations for Further Research ............................... 69
Recommendations for the PSC ............................................... 72

APPENDICES

A. INTRODUCTORY MATERIAL AND NOMINATION ............... 77
B. PHASE TWO SURVEY .............................................................. 82

BIBLIOGRAPHY ............................................................................ 85
CHAPTER 1
LITERATURE REVIEW AND INTRODUCTION

Most psychotherapists spend a disproportionately large amount of their professional time and energy thinking about a relatively small number of their clients (Kottler and Uhlemann, 1994). These clients are the ones whom therapists perceive as particularly difficult to be with or resistant to the work of therapy. Client difficulty has been the subject of clinical literature on and off since Freud’s early writings, often written about under the rubrics of “client resistance” or “negative therapeutic reaction” (Lane, 1985). Even so, the literature on client difficulty has grown in recent years and researchers and theorists are taking renewed interest in working with difficult clients.

Client Difficulty

Clients seek therapy for a variety of different reasons, ranging from adjustment to changes in their lives to debilitating mental disorders. Some clients’ presenting problems or forms of psychopathology are inherently more difficult to treat in psychotherapy and generally have poorer prognoses than others. A therapist’s attributions of client difficulty, however, are often made independent of clients’ diagnoses, the severity of their symptoms, or the expected therapeutic outcome (Rosenbaum, Horowitz, & Wilner, 1986). In fact, some clients may present as exasperatingly difficult for the therapist yet not meet the full criteria for either an axis I or an axis II disorder. One group of researchers found that clients’ willingness and ability to engage in effective therapeutic relationships with their therapists were
associated with poorer therapeutic outcome while the severity of clients' presenting symptoms was not (Foley, O'Malley, Rounsaville, Prusoff, & Weissman, 1987).

Characterological client difficulty is most usefully understood as a feeling or judgment developed by the therapist during the course of treatment (Horowitz & Marmar, 1985). The characterologically difficult client is the client that therapists have problems engaging (Fiore, 1988), particularly because of the kind of interpersonal transactions in which the client attempts to engage the therapist (Rosenbaum, Horowitz, & Wilner, 1986). Horowitz and Marmar (1985) characterize client difficulty as the result of a composite of traits in the client that negatively affects the relationship established with the therapist. These definitions suggest that the best understanding of client difficulty involves three related issues: Who the client is, who the therapist is, and how the therapeutic relationship between the therapist and the client reaches impasses.

**Client Descriptions**

The clients that therapists perceive as difficult may have rather different presentations at first glance. Many descriptors have been applied to these clients including resistant, reactant, noncompliant, uncommitted, uncooperative, oppositional, stubborn, obstructive, and obstinate (Kottler & Uhlemann, 1994; Seligman & Gaaserud, 1994). They are often portrayed as self-sabotaging, self-defeating, or overwhelmed by feelings of helplessness and vulnerability (Kottler & Uhlemann, 1994; Silver, 1983). Difficult clients' identities are often said to be unusually tenuous or labile (Silver, 1983). They are often described as filled with rage that is expressed by making others (especially their treaters) lives as miserable as they feel is their own (Kottler & Uhlemann, 1994). They are also often are said to be undersocialized in proper
therapeutic behavior and as exceptionally adept at devaluing their therapist and therapy (Fiore, 1988). In all cases, however, the characteristics of the client that make therapy difficult are seen as integral aspects of the client’s personality (Silver, 1983).

While initial presentation of these clients may appear different on the surface, there are some client characteristics that are commonly cited in the literature on characterologically difficult clients. Chief among these is a rigid, maladaptive pattern of interpersonal relatedness (Horowitz & Marmar, 1985; Horowitz, Rosenbaum, & Wilner, 1988; Rosenbaum, Horowitz, & Wilner, 1986; Silver, 1983). While I will speak of the specific ways in which these patterns result in impasses in the therapeutic relationship in the following section, it is important to note that such disruptions of the therapy are the result of long-standing behavior patterns that have contaminated many other relationship in the client’s past. Some have spoken of these maladaptive patterns as a “hard shell” or “protective shield” that clients interpose between themselves and all other relationships in their lives (Horowitz and Marmar, 1985). These theorists assert that this “shell” is not only a part of what makes working with these clients difficult, but it is also an obstacle to working towards mediating the client’s difficulty. Above all else, however, this shell prevents these clients from developing the kind of mature dependence that lies at the core of the therapeutic alliance.

Similarly, Silver (1983) states that characterologically difficult clients share “habitually maladaptive and unsatisfying ways of perceiving, experiencing and responding to the inner stimuli and outer environment” (p. 514). He further states that this may manifest itself in many ways. Some clients’ sense of absolute entitlement may result in them adopting a demanding or insatiably needy stance. In contrast, others may adopt a cold, distant, unreachable posture, giving the therapist little to
connect with. Others may make wide-ranging attempts to control their therapist and the therapy, even resorting to threats of self-harm. Still others demonstrate a remarkable propensity for regressive behavior and may even lapse into miniature psychotic episodes. Ultimately, these clients’ persistently unsatisfying patterns of relating to themselves, others, and the world result in neither the client nor the therapist being able to be satisfied in the therapy.

**Therapeutic Impasses**

While difficult clients’ presentations may look diverse on the surface, the common dynamic of not being able to relate to themselves, others, and the world in a satisfying way will transcend their initial presentations and result in the formation of impasses in the therapeutic relationship (Rosenbaum, Horowitz, & Wilner, 1986). These impasses have three characteristics originally described by Myerson (1977), Ryle (1979) and Kiesler (1979), revisited by Horowitz, Rosenbaum, and Wilner (1988) and paraphrased below:

1. The client makes an implicit (not explicit) indication that, in order to facilitate the work of therapy, the therapist should be more active than usual.
2. The client further indicates in an expressive but barely conscious manner that a pitfall lies in the path of the very activity the client is soliciting of the therapist.
3. There is almost no zone of safe, productive activity between either responding to the provocation or ignoring it.

As Horowitz, Rosenbaum, and Wilner (1988) recapitulate the model, both the activity and the pitfall clients present to their therapist are role relationship models the client attempts to impose on the therapist. As they describe it, a role relationship model is “a schema containing the roles of self and other, and scripts of the actions of self,
responses of other, and subsequent reactions of self" (p.242). A therapeutic impasse occurs in the relationship when the client attempts to impose two or more incompatible role relationship models on the therapist simultaneously. Thus, if the therapist acts to reduce the threat the client perceives in one model the threat in the other is increased. This leaves the therapist in what the authors described in an earlier work as a "damned if you do, damned if you don't" position (Rosenbaum, Horowitz, and Wilner, 1986; p. 419).

Relationship impasses may take many forms depending on the presentation of the clients and their motivation for seeking therapy (Horowitz & Marmar, 1985). Horowitz, Rosenbaum, and Wilner (1988) have, however, utilized case studies and taped sessions to identify 12 therapy relationship impasses observed in psychotherapy, two of which follow as examples:

1. The patient is so deflated and demoralized that very little impetus for change is present, but if the therapist addresses this attitude, or encourages the patient to a more positive view, then the patient will feel that the therapist is too unempathetic and unrealistically optimistic and will feel increasingly hopeless.

2. The patient exhibits a tendency or likelihood to act-out, but if the therapist interprets this as maladaptive and needing increased control, the patient will see this as criticism and become increasingly rebellious. (p. 246)

These impasses can be dealt with by first identifying the opposing "horns" of the dilemmas and helping the client work out a safe zone in the middle that does not fully enter either of the threatening positions (Horowitz & Marmar, 1985). Attempting to negotiate such therapeutic impasses, however, can leave the therapist
feeling set-up and emotionally exhausted (Fiore, 1988). Nonetheless, as tempting as it may be to attempt to avoid such impasses in the therapeutic relationship, to do so would be to avoid the work of therapy. When therapists accept the fact that such relational crises cannot be avoided, they can get down to the work of making clear the nature and meaning of the interpersonal interactions the client creates (Fiore, 1988).

The Problem: Challenge to Clinicians

In their call for increased research attention to client difficulty, Kottler and Uhlemann (1994) suggest that most practicing therapists, even the most skilled and experienced, have relatively little formal training or clinical experience working with clients for whom resistance is the predominant theme of therapy. They stress that most therapists are taught that resistance is a normal development in therapy but that, utilizing patience and flexibility, the skilled therapist could talk the client through such barriers and usher them into a more enlightened, unfettered existence. In fact, Miller and Rollnick (1991) assert that “resistance is often the life of the play.... The true art of therapy is tested in the recognition and handling of resistance. It is on this stage that the drama of change unfolds” (p.112).

However, not all psychotherapists share such a positive, almost playful attitude towards client resistance, reacting instead by feeling annoyed, frustrated, threatened, exasperated, resentful, and angry (Seligman & Gaaserud. 1994). Difficult clients test the limits of their therapists’ knowledge, empathy, and ability, leaving the therapists to question the wisdom of their decision to become a psychotherapist in the first place (Kottler and Uhlemann, 1994). If this is true of the seasoned therapist, how much more so would we expect it to be for the developing, neophyte therapist. In fact, anger has been found to a particularly common therapist response to client difficulty
and resistance, but it was also found to be negatively correlated with therapists' level of experience (Fremont & Anderson, 1986).

Working with Characterologically Difficult Clients

Difficult clients have been characterized as paradoxical: Much of what they bring to therapy is symbolic of long-standing or remote fears and needs, yet they are very literal and concrete in the demands they make of the therapist (Fiore, 1988). These clients often baffle therapists' attempts to talk through their "resistant" behaviors and maladaptive patterns of relating, enacting them in session instead (Fiore, 1988). Enacting, also referred to in the literature acting out or reactance (sometimes "acting in" in the psychoanalytic literature) is defined as impulsive action that precludes thought about the nature and effect of the action (Brenner, 1988). It can occur when a client either does not have the skills or language, or simply does not choose to talk about intrapersonal or interpersonal dynamics and instead recreates these dynamics within the therapy session. While reactance in therapy can be a conscious act of defiance, more often the inability to reflect verbally on a dynamic, and thus need to recreate it, is an integral part of the client's diagnosis or presenting problems. For example, Rasmussen and Angus (1997) argue that the composite traits that define Borderline Personality Disorder including difficulty regulating affect, difficulty adopting a reflexive stance in therapy, and difficulty meaningfully using the symbolic elements of therapy to gain insight compromise the client's ability to use therapeutic metaphor in a curative manner.

Because characterologically difficult clients will relate to their therapist in the session as they do to significant others in their lives, the therapist must try to maintain a transference-focused alliance (Frieswyk, Gabbard, Horowitz, Allen, Colson,
Newsome, & Coyne, 1994). While the goal of a transference-focused alliance is not unusual in psychotherapy with other clients, because characterologically difficult clients act-out the transference rather than talk about it, these clients can exert a great deal of pressure on the boundaries of the therapeutic relationship. The myriad of ways that such clients attempt to stretch and puncture the boundaries of the therapeutic relationship is a substantial part of what makes working with them difficult. No matter how much therapists may wish to avoid dealing with clients’ reactance, however, it is often the only way to engage these clients in therapy.

Contemporary researchers and theorists suggest that we must understand what purposes such reactance serves for characterologically difficult clients and what it might help us learn about our clients’ experience. Silver (1983) urges therapists to conceive of the behaviors being acted-out as not merely defenses against inner conflict but rather as a desperate attempt to maintain one’s cohesive sense of self. Fiore (1988) stresses that “much of what our difficult patients present to us is not simply crass, unadorned primitive behavior per se, but defensive and multidetermined. The chaos, rage, and meaninglessness are also purposeful” (p. 94). Furthermore, Brenner (1988) asserts that acting out is a unique opportunity to gain insight about lost or repressed memories and pre-verbal experience and behavior. He conceptualizes it as a language through which the therapist can come to know and make contact with the client. Nonetheless, therapists working with difficult clients must acknowledge and accept their own limitations and those of the treatment setting and make a conscious choice about what they will tolerate from the client in response to these limitations (Fiore, 1988).

Although therapists should expect that much of the work with characterologically difficult clients will take the form of managing these clients’
reactance within the therapy, the ultimate goal still remains to evolve the reactance into dialogue (Brenner, 1988). Dowd and Sanders (1994) suggest that this task is complicated when dealing with the most difficult to treat characterological clients not only because they are highly reactant, but also because their symptomatic behaviors are ego-syntonic. In other words, these clients see their symptoms as an integral part of who they are and even as supportive of their self-concept. Their symptoms cause them little or no distress and they see the interpersonal difficulties they experience as the fault of the other (Dowd & Sanders, 1994). For the therapist this may be one of the most difficult aspects of the client with which to work.

The Context: Clinics and Clinical Populations

Clinicians who work in psychological clinics are increasingly reporting a sense of futility and frustration in working with a growing portion of characterologically difficult clients (Fiore, 1988). Psychotherapists can encounter characterologically difficult clients in both inpatient and private practice settings, but Fiore (1988) believes that fastest growing population of difficult clients can be found in the clinic setting. He argues that clients in psychological clinics have fewer resources and poorer motivation than do most clients in private practice. While such arguments have not been empirically verified, they do have implications for graduate training clinics. This study represents a first effort to empirically explore the presence of characterologically difficult clients in such a clinic.

Operational Definition of Characterologically Difficult Clients

As the previous review of the literature has demonstrated, characterologically difficult clients may appear quite different in their superficial presentation. There are,
however, common underlying dynamics that they all share. For the purposes of this study, it is these dynamics that I will use to form the operational definition of characterologically difficult clients.

This definition has five main points as follows:

1. The clients display rigid, maladaptive patterns of interpersonal relatedness that result in relational crises or impasses in which the client feels that no satisfactory resolution is possible.

2. The clients perceive their symptoms and behaviors as consonant with their self-concept and attribute the responsibility for the relational crises or impasses they experience to others.

3. These problematic behaviors and interpersonal impasses are reproduced in the therapy.

4. The clients' behaviors evoke a strong emotional reaction in the therapist and/or cause the therapist to become confused about the course of treatment or feel incompetent as a treater.

5. The difficulty the therapist experiences is directly attributable to characterological aspects of the client's personality or way of being in the world.

The First Step: Finding What is There

The primary purpose of this study is to describe the presence of characterologically difficult clients in the graduate training clinic at the University of Massachusetts at Amherst. The secondary purposes of this research are twofold. The first is to explore the utility of the proposed operationalized definition of characterologically difficult clients. The second is to explore the utility of case file analysis in describing characterologically difficult clients and differentiating them from
other clients. Clinicians’ were asked to nominate clients that they had treated in the clinic who met any of the above definition of characterologically difficult clients. These clients’ case files were then examined and compared to clients who were not nominated.
CHAPTER 2

METHOD

Participants

With one exception, participants of this study were developing therapists who were currently enrolled in the doctoral program in clinical psychology at the University of Massachusetts at Amherst and were seeing clients at the program's Psychological Services Center (PSC) at the time of the distribution of the initial survey. There were 27 therapists actively seeing at least one client in the PSC who served as the nominating therapist pool. Eighteen of these therapists were female and nine were male. At the time of the survey there was one licensed professional psychotherapist who was seeing clients and supervising students who volunteered to participate in a special anxiety disorder training clinic. Of the graduate students, three had between three and four years of experience in the PSC, five had between two and three years, nine had between one and two years and eight had less than one year of experience. Two of those with between one and two years of PSC experience and one of those with less than one year of experience were respecialization students who already held Ph.D.’s in psychological specializations other than clinical psychology.

Materials

The data for this study were collected by means of an introductory letter, a nomination sheet, and a brief survey. The nomination sheet (prefaced by the informed consent and the introductory letter) listed by case number all of the participants a given therapist had seen during his or her tenure as a treating clinician in
the PSC (see Appendix A). This sheet also listed the opening and closing dates of the client’s therapy, the client’s age and sex, the number of weeks that the case was open, the total number of sessions, all active supervisors, and the beginning and ending dates of their supervision. Because it is notoriously difficult to remember clients by case number alone, the clients’ initials were also included in this listing. The participants were first asked to rate the over-all difficulty of each case. Then they were asked to review the five axis definition of characterologically difficult clients and to nominate clients even if they only fit a single axis by circling their entry on the nomination sheet. To protect client confidentiality, no additional identifying information was presented on the face sheet. Because the participants could not be expected to recall all of their clients by case number or even the client’s initials, however, a copy of the face sheet listing both the case identification number and the client’s full name was available in a binder located in the PSC office. These face sheets were generated by means of the clinical database described below.

The stage two survey included an additional copy of the letter defining characterologically difficult clients and the list of all of the clients that that therapist had seen in the PSC (see Appendix B). Finally, the packet contained a characterological client difficulty survey for each of the clients the participant nominated. These surveys provided an opportunity for the participants to rate the nominated client on both a single rating of overall difficulty and on Likert-type scales ranging from 1 (“not applicable to the nominated client”) to 7 (“precisely accurate description of nominated client”) on each of the definition’s axes. The participants were then asked to comment on any other descriptors that would increase the accuracy of the definition. Finally, the participants were asked to respond to two open-ended questions about their
experience treating that client. These final questions were included in the interest of generating future research questions.

The PSC maintains a rather unique clinical database under the direction of Dr. David Todd. This textual database is comprised of nearly all formal documentation in each client's case file, including the intake assessment report; the client's completed Personal History Questionnaire; The Symptom Checklist - 90--Revised (SCL-90--R; Derogatis, 1994); the treatment plan, progress notes, and psychotherapy summary of the treating clinician; and records of the client's attendance and reasons for missed sessions. This database was used to further describe the clients nominated by clinicians and the course of their treatment and to compare them to other clients treated by the same therapists in the PSC.

**Design and Procedures**

The participants' nominations of characterologically difficult clients they had treated were solicited by means of a two-step survey procedure. The first step introduced the participants to the definition of characterologically difficult clients enumerated above and asked them to nominate clients whom they would characterize as difficult to work with for any of the reasons cited in the definition. The nomination sheet was prefaced by a brief letter explaining the purpose of the research project and its application to treatment conceptualization and planning in the PSC.

The letter and nomination sheet were distributed to participants via the PSC mail systems with a request that they be completed within a week. Participants were asked to rate the difficulty of each case on a ten-point scale. Participants who felt that they could not nominate any client were asked to check a box at the end of the instructions corresponding to the statement "I have not treated any
characterologically difficult clients in the PSC. They were then asked to return the nomination sheet so as to differentiate their participation from nonresponders. When all of the nomination sheets had been returned, I put together the survey packets and again distributed them through the PSC mail system. Again, clinicians were asked to return the packets in a week.

Clients comprising the client pool for the exploratory case file analysis were all clients treated by all clinicians who completed the survey. The analysis followed several different tacks. The first strategy was to look at logistical aspects of the clients' treatments. I began with the pattern of attendance including the number of missed sessions and the reasons for these absences (i.e. client or therapist cancellation, "no shows", etc.). I suspected that attendance and "no shows" would be a fundamental means of acting out for characterologically difficult clients. I also looked at length of treatment, proportion of sessions kept and missed, and transfers. Here I hypothesized that treatment of characterologically difficult clients is typically longer, that they may require multiple session per week at time, and that they may require transfers to other therapists. I expected that the issue of transfers might be particularly salient. I suspected that these clients may be transferred either because their therapy outlasted their original therapist's graduate training, or because irresolvable impasses were reached for the client and the therapist.

At the time of my proposal, committee member Dr. Marion MacDonald, suggested that another potentially powerful indicator of client acting-out available for analysis was the clients' payment records. Because they have yet to be incorporated into the computer database, I had not considered their inclusion as a dependent variable, but the theoretical rationale for their inclusion suggested that the data were worth appending and analyzing.
The second strategy was to look at the clients' previous treatment history including previous therapies and/or hospitalizations. Here it was hypothesized that characterologically difficult clients may have histories of multiple treatments with more than one therapist. In some cases, I also expected these clients to be more likely to have been hospitalized for the their own protection or the protection of others. I suspected that a history of suicidal ideation or serious attempts may be more common in characterologically difficult clients.

A third strategy was to look at the clients' initial presentations including their symptom profiles, suicidal ideation, and, referral sources. It is also not unreasonable to assume that, if these client do have a higher incidence of suicidal ideation or suicide attempts, their referral sources would be more likely to be acute providers or “first call” crisis stabilization sources. In some cases intake workers make provisional diagnoses in their intake reports. I strongly suspected that characterologically difficult clients would receive significantly more axis two diagnoses.

Fourth, I wanted to look at the clients' early perspective of their difficulties, including their sense of the history of their difficulties and their expectations of therapy. I suspected that, because characterologically difficult clients tend to view their symptoms as ego-syntonic, they would be more likely to evaluate their problems as long-standing and integral to their personality and to attribute the responsibility for their problems to others. I also suspected that they would anticipate that their therapy would endure longer than clients who were not characterologically difficult.

Finally, where available, I looked at both therapists' and clients' retrospective evaluations of the efficacy of their therapy together. Because of the variety of clients seen in the clinic and, I suspect, because the sliding scale fee for service structure of the
clinic may affect clients' investment in the therapy, therapy termination is not always a planned event. It was not possible to look at the termination paperwork for all clients. For exploratory purposes, however, I looked at both the client’s and the therapist’s evaluation of their work together and compared the client’s SCL-90-R at termination with their scores at intake.
CHAPTER 3
RESULTS AND DISCUSSION

Because of the exploratory, descriptive, and evolving nature of this study, results and discussion are combined into one chapter, followed by a chapter entitled "Conclusions" that summarizes the findings, discusses directions for future research, and offers a few humble recommendations.

Introductory Comments

This chapter will first describe some issues that arose in conduct of the study and in the definition of groups to be compared and the variables on which to compare them. This will be followed by sections focused on the following: a description of the therapies, therapists, and clients who were included in the study; correlates of clinicians' overall ratings of client difficulty; correlates of clinician's nominations of clients as "characterologically difficult"; a brief description of additional distinctions that arose in the course of the study; a qualitative exploration of therapists' commentaries; and a comparison of the overall pattern of findings to original expectations.

As I mentioned in the introduction above, I was drawn to the phenomenon of characterologically difficult clients because of my experiences during my training in the PSC. Not only had I treated several such clients myself, but I have had innumerable conversations with classmates, supervisors, professors, and the professional therapists and doctors I have worked with in my practicum experiences. Over the course of these conversations, I found it remarkable that, in general, the majority of those involved seemed to understand, agree upon, and emotionally resonate with the descriptions of the clients and the treatment experience. While some terminology clearly made individuals from differing theoretical orientations
somewhat uncomfortable, it appeared that there was a common conceptual framework underlying the dynamics of the theoretical etiology and prognosis and the actual treatment paradigm that cut across schools of thought. I had hoped that, if I were able to find neutral language, I would be able to tap into what appeared to be a relatively ubiquitous psychotherapeutic phenomenon. This is not to say that every therapist would have seen a characterologically difficult client, but that the experience of treating such clients would be highly similar and easily recognizable. While this might have been true of a homogenous sub-set of the sample, it was not true of the sample as a whole.

Caveats and Descriptive Statistics

Before proceeding, it is important to remember that this study is meant only to be an exploration of a local phenomenon that may or may not be generalizable to other training clinics or clinical populations overall. While I will be presenting a series of statistical analyses of data from clients' case files, the results of these analyses must be taken with caution. The nature of the phenomenon I wanted to explore requires, by definition, a non-random method of subject selection. Not only did I wish to explore the phenomenon of "characterological difficulty" as it occurs in a specific clinical population (i.e. clients in the PSC), but any given client's group membership is based upon his or her therapist's experience of that client in the context of all of the other clients that therapist has seen. Furthermore, each therapist brought their own intellectual and experiential perspectives to bear on these nominations. As such, I in no way wish to represent the findings of these analyses as applicable to any other population. My goal is simply to present a record of what I observed during the course of this study and to provide readers with sufficiently detailed documentation to
allow them to determine whether or not these observations might be generalizable to their own clinical context.

**Working with a Dynamic Database**

Given the product orientation of western culture it is easy to be lulled into the common misconception that scientific data collection is akin to taking a snapshot. Rarely, however, do the phenomena we observe cease developing simply as a result of our diverted attention. This is especially true of dynamic databases such as the clinical research database employed in the PSC. Information is constantly being appended or modified. So too are the instruments used to collect this information. Even the very structure of the database itself is in a constant state of development. This development is often driven by the research being conducted on its content (including this study). It is an endeavor in a constant state of evolution. This presents unique challenges to the data collection process, especially (but not exclusively) when subjects may remain under active treatment, either with the nominating therapist or with another therapist to whom they been transferred. In fact, the demands and delicacies of working with a dynamic database interact with the exploratory nature of this study. To speak of potentially theoretically salient variables such as payment history as evidence of "acting-out" behaviors is one thing, but to go to the database to ascertain a given client's payment history is another. For one thing, coding variables in a dynamic database is a developmental endeavor. Not only does it change over time, but it may gain a greater level of specificity in the space of only a few years. Trying to rework older, less specific coding systems to approximate more recent levels of specificity can be exceptionally complicated and often can yield only marginally
adequate results. In cases where it is not possible to retro-code such data, researchers may have to sacrifice specificity to maintain internal consistency.

Throughout the course of the data collection countless decisions had to be made that not only combined and recombined existing variables to create new variables specific to our questions, but even redefined existing variables with more sophisticated and informative versions of their former selves. For example, the existing formula for the variable used to determine clients' average fee was one of the many alterations made to the PSC's dynamic database during the course of data collection. In its original form, this formula determined how many different fees a client had during treatment, took the sum of these fees, and divided it by the number of fee changes plus one (for the original fee). Now the formula is based on the total amount paid by the clients during the course of their treatment and is divided by the total number of payments. As such it is now sensitive to fee changes and to the varying durations that given fees might remain in place. In the following paragraphs I will document these decisions and provide the rationale for the choices we made.

Statistical Analyses

Statistical analyses of the data were conducted on three separate levels for distinctly different exploratory reasons. The first line of analysis was not part of the original proposal, but rather it took advantage of what was originally a peripheral "manipulation check". From the outset, I was concerned that clients who were nominated as characterologically difficult were not being nominated solely because their therapist conceived of their presenting problems or symptoms in characterological terms irrespective of whether treating them was particularly difficult. To insure that these nominations were based on therapists' experience of the
treatment as difficult, before nominating clients as characterologically difficult I asked them to rate each client on an over-all measurement of general difficulty. In subsequent consultation with committee member Dr. Arnold Well, he pointed that it would be absurd to ignore this data in our analyses simply because it was not specific to characterological difficulty. He suggested that regression analysis of all major theoretically important dependent variables as a function of over-all difficulty ratings may be fruitful.

With the second line of analysis I sought to isolate the clients nominated as characterologically difficult to determine if they could be distinguished from all other clients in the clinic. The means of analysis were dependent on the scaling of the dependent variable. For those variables coded in interval or better scaling, analysis of variance was used and confidence intervals were calculated. For those variables coded in nominal scale, chi squares were calculated.

Because the response rate was initially quite slow for the relatively simple initial survey, I decided not to ask clinicians to complete the more complicated and time-consuming second phase survey on all of their clients. I did not wish to sacrifice my ability to contrast nominated clients against a control group, however, so I asked each nominating therapist to rate as many of their least difficult clients as they nominated. This was not possible in all cases, either because the therapist nominated the majority of their clients or because the therapist was unable to rate the difficulty of too many of their non-nominated clients because they felt that they had not had enough contact with these clients to rate them with confidence that the rating would be accurate.

Where further sub-groupings of the non-nominated clients was warranted either as a function of the data collection or for theoretically salient reasons, these
analyses were repeated in an attempt to yield greater detailed differentiation. All alpha levels were set at .05.

Response Rates

As is generally the case when collecting data by means of survey, the response rate was lower than I had hoped, but it was quite good with respect to social science surveys. Of the 27 acting therapists, 21 (77.78%) responded to the first phase of the survey, eleven of whom (52.38%) were able to nominate a total of 21 characterologically difficult clients. It is striking that, of the 21 respondents, nearly half were unable to nominate a characterologically difficult client, but of the 11 that did nominate clients, only three nominated a single client. Of those three, one had only one potential client to nominate. As indicated above, I will discuss this discrepancy further in the subsection on therapist diversity. All 11 nominators returned the second phase survey, yielding phase two survey data for all 21 characterologically difficult clients and for 15 non-difficult control clients. One therapist reported that she chose not to respond to the survey because she found something about the first survey discomfiting (although she was unable to recall what that was when I inquired). One responding clinician omitted data for one client because I was providing Psychotherapy for that client’s spouse. All of the nominations were made by current doctoral students. The licensed professional therapist was seeing a single client at the time of the survey and reported that this client did not meet any of the proposed criteria for nomination as a characterologically difficult client. None of the three respecialization students responded to the first phase of the survey.

When I began collecting the first survey, it became clear to me that I had overlooked some of the clients in the PSC as potential participants. I had not considered
that members of couples and parents of children who had sought treatment in the
PSC might be viewed by their therapist as characterologically difficult. Through
personal correspondence, two therapists responding to the survey communicated that
they had clients they would have nominated who had not been listed in the client list I
had provided them. The lack of anticipation of the relevance of these clients’ data was
not mine alone, however, because when I went to the database to look at their files it
became apparent that a good deal of the data that exists for individual clients did not
exist for the couples or child-parent cases. In some of these cases, for example, some
instruments such as the Personal History Questionnaire (PHQ) were not given to the
client being seen. In other cases it was not clear to which member of a couples case
specific data corresponded. One parent nominated as a characterologically difficult
client had to be dropped because insufficient information existed in the case file to be
meaningfully included in the analysis. A husband and wife in treatment together,
both of whom were nominated by their therapist, were retained in the sample.

Descriptive Statistics - Client Demographics

There were 149 clients who were potential candidates for this study. Candidate
clients merely had to have been seen for treatment at one time by one of the clinicians
who was carrying an active caseload at the time of data collection. Of these, 91 had a
therapist or therapists who responded to the initial survey and thus became a part of
the research sample. It is important to note that some of these clients will not be
represented in any other portion of this discussion. This is the case either because
their clinician’s depiction of them was not appropriate for the later analysis or their
clinician had not worked with them long enough to feel confident to evaluate them.
Unless otherwise indicated in this and the following section all of the descriptive
statistics are based on a sample size of 91. Because this is an archival study including a good deal of self-report, client-generated measures, some data may not available (or applicable) for all clients.

Although the PSC is a university training clinic, it serves members of the surrounding community as well as students. As a result, there is considerable diversity in the demographics and presenting problems of the clients in this sample. Nonetheless, students compose the bulk of the clientele in the PSC. Some 65.9% (60 clients) of the sample clients were students at the time of their treatment while 26.4% (24 clients) clearly indicated they were not students and the remaining 7 clients did not respond to the question. Of the 60 students, 43 indicated they were undergraduates and 15 reported they were graduate students. The remaining two students did not indicate their education level.

Approximately twice as many women are seen in the PSC than are men. In this sample 68.1% of the clients were female and 31.9% were male. The average age of the client sample was 27.23 years (SD = 7.84; mdn = 26; ranging from 18 to 52). Given that nearly half of the clients reported being undergraduates, this elevated average age indicates the extended range of older clients seen in the PSC. Indeed, nearly 40% of the clients in the sample were 22 years-old or younger and age 25 years capped off the 50th cumulative percentile. Ages 26 through 35 are slightly less densely populated, containing just over 36% of the sample. This may be in part due to the sizable cohort of graduate students in treatment.

Ethnicity is not formally coded in the clinical database so I cannot provide specific information about the ethnicity of the clients composing this sample. However, it is reasonable to expect that, like the University and its surrounding community, the majority of the clients are Caucasian. This cannot be verified at
present, and the creation of an ethnically sensitive measure is one of the recommendations that I will offer as a result of this study.

Similarly, assessing marital status is not a simple, straightforward matter at this point. A growing openness to non-traditional relationships has blurred the boundaries by which we traditionally have defined committed or life-long relationships. Nor has the institution of marriage fared well as a vehicle of relational commitment. Our current means of recording marriage or the equivalent is through a pair of open-ended questions on the Personal History Questionnaire. Because theory emphasizes the importance of interpersonal relatedness in the development and manifestation of characterological psychopathology, however, I felt it was important to attempt to code relationship status. Eleven subjects indicated that they were married. Six subjects reported being either divorced at some point in their life or currently irreconcilably separated and one reported being widowed. Nearly a quarter of the sample (21 clients, 23.1%) did not respond to these questions; while this may indicate that many of these clients had not had committed relationships, a more in-depth examination of their records would be required to determine whether that was the case.

Descriptive Statistics - The "Average" Treatment

While there is clearly no such thing as an "average" psychotherapy treatment, it is important to gain a sense of the general treatment context in which the clients composing this sample were seen. This is important for two reasons. First, it provides a sample-specific baseline against which to view data from theoretically salient subgroups of the sample. Second, because this is an exploratory study of a non-random sample of self-selecting subjects, I will make little or no argument for the
generalizability of any of the findings it generates. By providing descriptive data of both the subjects themselves and the treatment experience of the sample as a whole it is my intention to provide readers with as much detail as possible. In doing so, it is my hope that readers will be able to determine for themselves whether the findings generated here might be applicable to their own treatment context (Kennedy, 1979).

The mean length of treatment was 59.72 weeks (SD = 69.34; mdn = 35.3; ranging from 3.4 to 423.7 weeks). The mean number of appointments made during that period was 45.36 (SD = 55.03; mdn = 22; ranging from 3 to 324 appointments) and the mean percentage of those appointments that the clients kept was 81.6 (SD = 14.5; mdn = 86.4; ranging from 40.0 to 100.0 percent) or 38.97 sessions (from 2 to 295 sessions). The mean percentage of appointments missed by the client was 16.8 (SD = 14.5; mdn = 12.5 ranging from 0 to 60.0 percent) or a mean frequency of 5.68 sessions (ranging from 0 to 52). Of the sessions missed, a mean percentage of 50.1 (SD = 34.5; mdn = 50.0; ranging from 0 to 100 percent) were canceled, 28.3% (SD = 30.8; mdn = 20.0; ranging from 0 to 100 percent) were rescheduled for an alternate time, and 10.6% (SD = 19.3; mdn = 0; ranging from 0 to 100 percent) were the result of the client failing to show up for their appointment without contacting the PSC (typically referred to as “no shows”).

These statistics reflect the clients' entire treatments in the PSC. Of the 91 clients in the sample, 71 (78%) had seen only a single therapist in the PSC during their treatment. The remaining 20 clients had been transferred to at least one other clinician in the clinic. Seven of these had been transferred to a third therapist, and one is currently seeing her 6th therapist (which, ironically, is me). The remaining two clients were (or are) being treated by co-therapists and have
not been transferred. We do not have as much detail as easily accessible for the clients’ attendance with the therapist who nominated them as we do for their entire treatment in the PSC. We do, however, have mean percentages of scheduled sessions that these clients kept (M = 80.9; SD = 14.5; mdn = 83.3; ranging from 40.0 to 100.0) and the percentage of appointments they missed (M = 17.3; SD = 14.6; mdn = 12.5; ranging from 0 to 60.0 percent).

Despite the PSC sliding scale fee policy that starts with a minimum fee of $15.00, the average fee over the course of their treatments of clients currently being seen was $12.32, (SD = 6.29, N = 85). Only 14 of the clients in the sample had an average fee greater than $15.00, and seven of these 14 had at least one fee change during their treatment. Fee changes occurred in nearly 30% of the cases in this sample. While 65 clients (71.4%) of the PSC clients in this sample paid a single set fee throughout their treatment, 16 clients (17.6%) had their fee changed once and 7 clients (7.7%) had their fee changed a second time. Three clients had the fee changed more than two times (two had three fee changes and one had four, comprising 2.2% and 1.1% of the sample respectively).

The clinic’s intake procedure includes the administration of the SCL-90--R. This instrument measures the amount of common psychological symptoms the client has recently experienced. The Global Symptom Index (GSI) is a subscale generated in the SCL-90--R as an overall level of functioning. The average GSI t-score at the time of intake was 47.14 (SD = 9.56; mdn = 47.0; N = 90). The average GSI t-score at the termination of treatment was 37.00 (SD = 8.64; mdn = 35.0; N = 27). Note the dramatic decrease in the number of valid scores between intake and termination. This is an indication of the difficulty we have collecting termination data from clients.
Finally, nearly one-third (28.6%, 26 clients) of the clients in the sample were referred to the PSC from University Health Services. University Health Services is often the first call students make when in crisis and there is a formal arrangement in which some clients who need longer-term treatment are referred to the PSC.

**Inferential Analyses**

**Correlates of Ratings of Overall Difficulty**

As a first step, I looked at therapist's ratings of overall difficulty, which did not focus specifically on characterological difficulty. Because I had not originally considered running analyses on the measure of general difficulty, I was surprised by the number of significant correlations.

Because so many of the demographic items were of nominal scaling, only client age was available for correlational analysis. Overall client difficulty was significantly correlated with client age \( r (63) = .37, p = .002 \).

Overall difficulty was also highly correlated with several of the logistical aspects of the clients' treatments. Both length of treatment (number of weeks in treatment across all treaters, \( r (63) = .47, p = .0001 \), and number of appointments with all treating therapists \( r (63) = .47, p = .0001 \), were correlated with client difficulty. While it may appear that if either length or number of appointments is correlated with difficulty the other would also be correlated by necessity, such a conclusion is not automatically true. It is generally the case that both length of treatment and number of appointments are extremely highly correlated, but there are some circumstances where this is not necessarily the case. For example, I saw a client who went without a
scheduled appointment for nearly 5 months in a 12 month period, but her case remained open throughout her absences.

Because the PSC is a training clinic and therapists leave for internships every spring, it is not unusual for clients to have worked with more than one therapist during their treatment. This is especially true of difficult clients, as overall difficulty is highly correlated with the number of clinicians a client has seen in the PSC, \( r(63) = .43, p = .0003 \). As such, total appointments and length of treatment may not reflect the specific treatment experience of the nominating clinician. However, overall client difficulty was also correlated with the number of appointments with the surveyed therapist, \( r(63) = .25, p = .05 \). I was rather surprised not to find a correlation between overall difficulty and missed sessions for either the nominating therapist or the client's entire treatment. There was, however, a significant positive correlation between overall client difficulty and the proportion of missed sessions that were specifically due to client cancellations with all treating therapists \( r(63) = .33, p = .007 \). The same was not true for the proportion of missed session due to either rescheduling or client "no-shows".

Because the payment records have not been computerized, I was not able to tease out the surveyed clinician's data from the entire treatment data. Looking at the data for the entire treatment, however, I did find a correlation between overall difficulty and proportion of kept sessions for which payments were missed \( r(62) = .31, p = .01 \). There was also a significant positive relationship between client difficulty and the number of times the client's fee had been changed \( r(63) = .40, p = .001 \). This finding is of particular interest as it may be an often overlooked avenue of acting-out around issues of payment.
As was true of the client demographics, most of the data for clients' previous treatment history and clients' early perspective of their difficulties were recorded in nominal scale and could not be analyzed using regression. This was also true with most of the variables measuring the clients' initial presentations, with the exception of the SCL-90-R.

Surprisingly, there was no evidence of a relationship between over-all ratings of difficulty and a subset of items of the SCL-90-R which is believed to represent characterological symptoms, $r (63) = -.07$, $p = .59$. One possible explanation for these observations may be that symptom-oriented evaluations may be less sensitive to characterological psychopathology than are interpersonal relatedness-oriented assessments. It would be interesting to compare such assessment results and also to compare them with the therapists' evaluation of characterologically difficulty in their clients.

Despite the greatly reduced amount of data available at termination, the data that we do have proved a fruitful source for analysis. I first looked at the clients' self-report data and found a negative relationship between therapists' rating of client difficulty and the extent to which clients evaluated positive change at the end of treatment (i.e. the difference between the evaluation of their own functioning before treatment and this evaluation after treatment), $r (17) = -.56$, $p = .01$. Interestingly, there was a small, non-significant positive correlation between difficulty ratings and clients' evaluation of their functioning before treatment, but a negative correlation between difficulty ratings and clients' evaluation of their functioning after treatment, $r (17) = -.63$, $p = .004$. Overall difficulty was also correlated with extent to which clients report the need for further treatment at the time of termination, $r (17) = .47$, $p = .04$. It is important to note the dramatic decrease in degrees of freedom due to the
notoriously low rate of client responses to requests to complete termination paperwork.

Turning to the therapists' termination data I found that the therapists' evaluation of their clients' need for further treatment was significantly correlated with client difficulty, \( r(1, 40) = .35, p = .02 \). Similarly, the therapists' assessment of the success of the work with their clients was negatively correlated with client difficulty, \( r(1, 40) = .45, p = .003 \).

At this phase of the survey the therapists had not yet been instructed to use the five-axis definition of a characterologically difficult client. The instructions were quite clear that the overall rating of difficulty was simply a general sense of difficulty during the client's treatment. Nonetheless, the overall ratings of client difficulty correlated highly with all five axes of the definition. The correlations were as follows: axis 1, \( r(33) = .77, p = .000 \); axis 2, \( r(33) = .76, p = .000 \); axis 3, \( r(33) = .75, p = .000 \); axis 4, \( r(33) = .84, p = .000 \); axis 5, \( r(33) = .81, p = .000 \).

Defining the Groups

Unlike the overall ratings of difficulty, nominations were specific to characterological difficulty. Participating clinicians were asked to indicate which of their clients, if any, they would consider to be characterologically difficult, given the definition that was used in this study. Before I begin to present the results of the analyses, it is important to discuss the manner in which the subjects were grouped.

Any researcher who invests the energy and time to endeavor to empirically explore a phenomenon that has previously been the subject of much speculation, discourse, and theory seeks above all else to bring clarity and understanding. The history of science, however, is replete with examples of the damage that the much
more complex and sometimes chaotic realities can do to our elegantly parsimonious, compellingly logical, and intellectually satisfying theories. This, for better or worse, was the case with the data in my study. Rather than simplifying and clarifying matters, my data call forth a complex and complicated state of affairs.

During the course of both the theoretical discourse between myself and my advisor prior to proposing my hypotheses and the actual data collection, it became clear that the groupings would be more complicated than I had first expected. A simple dichotomous grouping of subjects would clearly be an oversimplification of the actual experiences of the therapists in the PSC. I originally anticipated that the issue of client grouping would be settled by the therapists themselves by means of the nomination process. As a developing psychotherapist myself, I should have remembered that things are always more complicated than they appear.

Even before I put the surveys in the hands of the clinicians I had recognized it was going to be necessary to provide therapists with two additional group options for theoretically salient reasons. I became aware of the first when I looked at my own client list. I did not recognize the very first client listed. I had to go back nearly two years to recall that the very first client assigned to me left town between intake and my first telephone call and was not expected to return for over six months. Clearly there were going to be some clients with whom the therapists would not have had enough contact to accurately assess these clients' difficulty. The therapists were instructed to mark these clients' entries with an “X”.

Nonetheless, several clinicians rated clients they had not seen as “0’s”. When I contacted the one’s I could reach, they confirmed that they had never met with the clients in question and had not noticed the instructions to not rate them. In other cases where I was not able to reach the therapist who rated clients “0” the records indicated
that they had seen once or twice or had never seen. Because the payment records were not computerized and had to be tallied by hand, I had an opportunity to cross check the computer records (which occasionally lag behind the paper records). On one occasion a therapist had started seeing a client shortly before the survey was distributed (at which time the client lists were approximately a week old) and continued to see the client into summer. I let this therapist's rating stand. In every other case, the payment record confirmed the computer record and a total of 26 clients were excluded on this basis.

The second group arose as a result of my concern that, should a clinician be sufficiently frustrated with a client who was difficult, but not characterologically difficult, the clinician might errantly nominate the client. Therapists' reactions to difficult clients can be extreme and are as vulnerable to unconscious expression as are anyone's strong emotional responses. In order to avoid this, I instructed therapists to indicate clients who were difficult for reasons other than those listed in the five axis definition of characterologically difficult clients as distinct from those nominated on the basis of the definition. Clinicians identified 11 such clients.

A third theoretically relevant group arose from the data collection process itself. Two therapists provided feedback on their surveys that they had seen clients who had characterological symptoms or presentations with whom they did not find it difficult to work. As one clinician elaborated on in a note on her survey, the characterological presentation of these clients was "mitigated" by other factors in their work together. The term stuck. This "mitigated" group is somewhat problematic because its post hoc nature denied other therapists the opportunity to distinguish such clients in their own surveys. Nonetheless, I wanted to respect this distinction made by two skilled clinicians independently. There were four clients nominated as "mitigated".
This latter characterization is further complicated by the fact that several of the clients nominated as characterologically difficult where later described as no longer characterologically difficult at the point of the termination of the therapy. What distinguishes the latter clients from the mitigated clients in general remains unclear. It is my speculation that therapists recognize mitigated clients' characterological presentation early in the therapy, but there is some aspect of the clients' presentation, personality, or style of interaction that prevents the therapy from ever becoming difficult. As a developing therapist who has worked with a number of characterological and difficult clients, I am consistently amazed at the facility with which an important characteristic like a sense of humor or a powerful intellect can take the edge off of a tense moment in therapy. Unlike mitigated clients, the difficult clients identified in this study clearly made it distinctly difficult for their therapists to work with them early in their therapy, even if this difficulty was resolved by the termination of therapy.

The final theoretical group I have already mentioned. The “non-difficult controls” group was created for the second survey that was used to evaluate the five axis definition of characterologically difficult clients. It was arbitrarily derived by selecting any client a nominating therapist had rated a three or less on the ratings of overall difficulty. This group is used only in the analysis of that definition. There were 15 clients designated as “non-difficult controls”.

Two additional groups were also created. The creation of these groups, however, had nothing to do with theory, but rather were the result of data collection irregularity. The first was the result of therapists who did not respond to the first survey. The 30 clients of these therapists were coded as missing values and excluded from all analyses.
The second group was a little more troublesome. The clients in the second group had therapists who responded to the first questionnaire but failed to rate their clients. The instructions clearly asked respondents to rate all clients first and then to read the definitions and make the nominations. I provided a box at the end of the instructions to check if they had not seen a characterologically difficult client in the PSC. This item provided therapists with a way of confirming that they were not making a nomination. However it appears that some therapists simply checked the box and skipped the step of rating each of their clients. In addition, two nominating therapists substituted their own coding instructions for mine and also did not rate their clients on overall difficulty. A total of 22 clients were left unrated.

Were it not for the inclusion of the “difficult other” and “mitigated” groups, this lack of rating would not present a major problem. While these two categories were ostensibly designations made by the nominating therapist, so few therapists followed the instructions correctly that my advisor and I were faced with some decisions when we looked at the data. For example, some therapists rated clients as “8’s” and “9’s” on overall difficulty but neither nominated them nor indicated that they were difficult for other reasons. We felt that these clients could reasonably be designated difficult for other reasons and did so. When I began looking at comparing groups more decisions had to be made. For example, should the two additional theoretical groups “difficult other” and “mitigated” be treated as independent groups? Should they be grouped together with either the nominated or non-nominated clients? Should one be grouped with nominated clients and the other grouped with non-nominated clients? These questions were examined both theoretically and practically, as every one of these combinations were coded and used in the data analysis. The results were sometimes markedly different and not necessarily theoretically consistent. In the end
we decided that we did not know exactly what to do with these two groups, but that they should not be treated as either nominated or non-nominated. We decided to exclude these groups from the comparison analysis and to do exploratory descriptive analyses on them instead.

This, however, left another question. If I was going to exclude some cases on the basis of their ratings, what should I do with the clients who were never rated? An examination of the data suggested that, with some exceptions, the findings were quite similar whether non-rated cases were included (as "non-nominated") or whether they were excluded from the analysis. Since there were some discrepancies, however, I decided to emphasize the more conservative analysis that excluded non-rated clients. Where there are contradictory and conceptually interesting findings from the analysis that included non-rated clients, I have included those analyses as well.

In summary, a total of 4 theoretically relevant groups were defined among the clients of clinicians who either nominated at least one characterologically difficult client or who returned the survey indicating explicitly that they had not seen any characterologically difficult clients. Two of these groups ("difficult for other reasons" and "mitigated") were excluded because there was insufficient theoretical evidence that these groups were independent of the a priori nominated and non-nominated groups. The nominated group was comprised only of those 21 clients specifically nominated by their therapist as characterologically difficult clients. Non-nominated clients were defined as those who not nominated as characterologically difficult (nor as difficult for other reasons, or "mitigated") and who were rated less than 7 on overall difficulty. There were 34 clients in this group.
Comparing Nominated vs. Non-nominated Clients

As I have documented in the preceding discussion, the process of determining the clients to be included in analyses comparing characterologically difficult clients to other PSC clients was more complex than I had anticipated. As it turns out, a full third (11 of 32) of those clients clearly rated as difficult were not nominated as characterologically difficult clients. Several of the following statistics will look quite similar to the results of the correlational analyses of overall difficulty with the variables of interest delineated in the methods chapter. It important to note, however, that the analyses that follow compare clients overtly nominated as characterologically difficult clients with those clients who were not indicated as being substantively difficult or presenting any characterological symptomatology. The 11 client composing the "difficult for other reasons" group and the four clients composing the "mitigated" group are not included in these analyses.

When I began thinking about how characterologically difficult clients might be different from their counterparts in the clinic, not once did it occur to me that some of these differences might appear in the demographics of the groups. However, analysis yielded several significant differences in the demographics of each group. Just as age was correlated with overall difficulty, nominated clients were significantly older than non-nominated clients, F (1, 53) = 16.56, p = .000). The average age of the nominated clients was 32.48 years and that of the non-nominated clients was 24.41 years.

While the overwhelming majority of non-nominated clients were students, which is typical of the population seen in the PSC, the majority of characterologically difficult clients were not students, X² (1) = 5.12, p = .02. Of those clients who were students, twice as many characterologically difficult clients were graduate students as
were undergraduates (three undergraduates and six graduate students), while only four of 25 non-nominated clients were graduate students, $X^2 (1) \, 8.18, \, p = .004$.

There was no difference between groups in marital status. Very few of PSC clients, including the characterologically difficult, are married. There were, however, a significantly greater proportion of characterologically difficult clients who were either divorced or separated with the expectation of divorce, $X^2 (1) \, 4.85, \, p = .03$.

Of all the major demographic variables, gender alone did not differ across group. For most types of psychopathology this would not be a notable surprise. For characterologically difficult clients, however, it is a bit unexpected. The types of clients with characterological psychopathology that typically seek therapy voluntarily are predominantly women. Regardless of all of the speculative arguments of potential societal influences producing such gender differences, females are more often diagnosed with personality disorders such as borderline, dependent, and histrionic personality disorders (which can produce rather dramatic symptomatology) as opposed to schizoid, paranoid, and antisocial (the later seen in treatment most often because of court compulsion) which are most often diagnosed in men and rarely found in voluntarily treatment. Nor was there a difference in the gender pairings between client and therapist. That is to say that opposite gender pairings were as common in non-nominated clients’ treatments as they were in nominated clients’ treatments.

Several of the logistical aspects of the clients’ treatments were also significantly different between groups. The first dramatic difference was in the length of treatment, $F (1, 53) \, 15.36, \, p = .000$. Characterologically difficult clients’ treatments lasted on average 113.86 weeks (mdn = 81.6 weeks, ranging from 6.7 to 423.7 weeks) while non-
nominated clients' treatment lasted an average of 39.77 weeks (mdn = 23.9 weeks, ranging from 3.7 to 138.4 weeks). While this is a huge difference, the fact that the average non-nominated client's treatment lasts nearly nine months in the age of managed care treatment limitations is itself amazing.

A second finding that conformed to my hypotheses was the dramatic difference in the rate of transfers. Significantly more characterologically difficult clients were transferred at least once during their treatment in the PSC, $X^2 (1) = 10.83$, $p = .001$. Correspondingly, characterologically difficult clients had seen significantly more therapists in the PSC than had non-nominated clients, $F (1, 53) = 15.15$, $p = .000$. This is not surprising because characterological psychopathology or symptomatology has been found to be fairly intractable.

Perhaps one of the most interesting logistical aspects of treatment in the PSC to explore is treatment fee and client payment history. A large part of what makes this aspect of treatment so interesting is that the treating therapist does not see any financial profit from the clients' payments. Because it is a training clinic, the experience and the supervision is the reimbursement the developing clinician receives. All of the client's fee goes to the operations budget for the clinic itself.

The interesting aspect of this is that there is considerable emphasis in supervision on maintaining the "frame" in therapy. This means that the logistical aspects of the therapy and the relational role of the therapist are held constant as much as possible to continually reinforce the boundaries of the therapy. The payment of the fee, however, often falls between the cracks, mostly I suspect because the developing therapists are not dependent on the payment of the fee as they would be were they no longer in training. Often, usually unless it is required by their supervisor, the therapists-in-training let the front office staff handle all of the financial
transactions. I believe that this allows the client to “act-out” though their payment activity without much of a response from their therapist. I had little appreciation of how powerful this could be until I was forced to tally the entire sample’s payment histories by hand.

One variable that I looked at that is closely tied to the concept of the therapeutic “frame” was the payment history. Contrary to my expectations, there was no difference between characterologically difficult clients and non-nominated clients. What surprised me, however, was that the reason why there was no difference was because missing payments and carrying a balance is a ubiquitous PSC phenomenon. Of 34 non-nominated clients only five had never missed a payment. Of the 21 characterologically difficult clients only a single client had never missed a payment. Four clients in each group carried balances for periods longer than their treatment lasted. Because of the influence of outliers on calculation of the mean (and there are a couple of distant outliers here - one characterologically difficult client carried a balance almost twenty times as long as the client was in treatment) I will report that the median percentage of the clients’ treatment for which they carried a balance was 16.67 for non-nominated clients and 31.81 for the characterologically difficult clients. As I stated above, none of this of statistical interest, but from a clinical perspective this represents a considerable amount of torque being applied to the therapeutic frame. I also wonder if the state of affairs would be the same if the clinician’s not only handled the financial affairs with their clients, but depended on the clients' payments for their services as they will as professional psychotherapists.

As I alluded to in the overall difficulty regressions, another potential means of financial “acting-out” that is not often talked about is multiple client requests to reduce their fee. The number of fee changes differed significantly between nominated and
non-nominated clients, $F(1, 53) = 10.07, p = .003$. Of 34 non-nominated clients, 27 paid a single rate throughout their therapy and only 7 had their fee changed once. Out of 21 nominated clients 11 paid the same fee throughout their treatment. Four had, however, their fee changed once, 4 more had their fee changed twice, and the remain two had their fees change three and four times, respectively. While variables such as this one may vary as a function of variables other than the clients' nomination status, one variable that is of particular importance in a clinical study such as this is the duration of treatment. There is good reason to expect that there is a great deal of interdependence of many of the variables in this study. While a multivariate analysis is beyond the scope of this exploratory work, little can be said about the independence and interdependence of these individual variables until such an analysis is run.

Finally, I was quite surprised that there was no difference in the proportion of missed session either throughout the clients' treatment or with the nominating therapist. In fact, the only aspect of the clients' attendance records that approached significance was the proportion of missed sessions due specifically to client cancellation, $F(1, 53) = 3.39, p = .07$. When non-rated clients were included in the analysis the results inched into the significant range, $F(1, 74) = 4.32, p = .04$. While I expected attendance to be a significant means of acting-out, there is a logical reason to suspect that this would not be the case. Very often clients within a characterological presentation seek treatment because of a lack of satisfactory relationship in their lives. Characterological symptoms are notorious for alienating others and it is not uncommon for clients with characterological presentations to end up in relationships with others with similar presentations. As such, the relationship they establish in therapy may be the only consistent, reliable relationship they have and may depend on it too much to miss sessions. We do not keep records of late arrivals, but I have
spoken with several other developing therapists who have recounted many tales of characterologically difficult clients' repeated late arrivals. It would be an interesting avenue of exploration.

Turning to the clients' previous treatment history, the analysis revealed two additional differences that approached significance. First, only 2 of 21 characterologically difficult clients had not been treated before their current treatment while nearly one third (11 of 34) of the non-nominated clients had never been in treatment before coming to the PSC, $X^2 (1) = 3.75$ $p = .06$. Second, although there was no difference in the number of clients in each group that reported considering suicide, more characterologically difficult clients reported attempting suicide, $X^2 (1) = 3.58$, $p = .06$. This difference became significant when the non-rated clients were included in the sample $X^2 (1) = 6.70$, $p = .01$. Oddly, there was no difference in the number of clients in each group who had previously been hospitalized, considering that most serious suicide attempts result in mandatory temporary hospitalizations.

The analysis of data on the clients' initial presentations (e.g. provisional diagnosis at intake and SCL-90–R GSI at intake) and their early perspective of their difficulties (e.g. long-standing nature of their presenting problems and expected length of treatment) yielded no significant findings. One reason for this is that some of the data available in these variables are not easily coded or analyzed. Analysis did reveal, however, that more non-nominated clients came to the PSC with transferable free sessions, $X^2 (1) = 4.81$, $p = .03$, meaning that they were formally referred from the University Health Services, typically for longer-term treatment. This difference, however, is most likely an artifact reflecting the previously cited finding that the proportion of students in the characterologically difficult group is significantly lower than the non-nominated group.
I did complete a rough review of the text of reports that contained the terms “Axis 2" and “Personality Disorder" to little avail. I suspect this is because there is no formal policy on using diagnoses in reports. In fact, there is considerable disagreement among the faculty about the use of diagnoses and some supervisors explicitly discourage their use.

One of the aspects of the clients’ early perspectives of their difficulties that I expected to see in characterologically difficult clients was ego-syntonic symptoms. I expected that characterologically difficult clients would view their characterological symptoms as a part of themselves, not as symptoms that needed to be changed. One of my own difficult clients viewed her characterological symptoms as a big part of what made her “special”. While I had no direct measure of this, axis two of the definition of characterologically difficult clients taps this construct. It reads “the clients perceive their symptoms and behaviors as consonant with their self-concept and attribute the responsibility for the relational crises or impasses they experience to others.” As I will present shortly, this and all four of the other axes were far more applicable to the nominated clients than to their non-difficult counterparts. A second possibility would be that these clients could have potentially lower SCL-90–R scores. For this to be true, however, these clients would have to read a symptom description and explicitly not endorse it not because it was not true, but because it is a “personality trait” rather than a “symptom”. While such behavior would not be uncharacteristic of characterologically difficult clients, we have no way of detecting it at present.

Despite the decreased data available in the termination paperwork, the analysis yielded several significant differences between the nominated and the non-nominated groups. The clients' evaluations of how helpful therapy had been for them indicated that characterologically difficult clients found therapy to have been significantly less
helpful, \( F(1, 16) = 4.76, p = .04 \). Similarly, therapists of characterologically difficult clients rated the success of treatment far less favorably than they did their other clients, \( F(1, 36) = 9.86, p = .003 \). Therapists also assessed their characterologically difficult clients’ need for further treatment as far greater than their other clients did, \( F(1, 36) = 7.18, p = .01 \). The characterologically difficult clients did not rate their own need for further treatment any differently than did their non-nominated counterparts, which is consistent with an ego-syntonic view of symptoms.

Finally, using a slightly different tack in the analysis (thanks directly to the advice, once again, of Dr. Well), I used repeated measures ANOVA to look at three combinations of termination data. To create a measure of the therapy’s success, I used the clients’ assessment of the helpfulness of the therapy and the therapists’ assessment of the treatment’s success. To create a measure of the need for further treatment I combined both the clients’ and the therapists’ assessment of the need for further treatment. To create a measure of client change I combined the clients’ termination assessment of how they were doing when therapy began and the termination assessment of how they were doing at the time of termination. All of these variables were measured on seven-point Likert-type scales. Of these three analyses, only the measure of client change produced an interaction between group membership and change that approached significance, \( F(1, 16) = 2.99, p = .10 \). While both non-nominated and characterologically difficult clients assessed their level of functioning at the time of termination at nearly six on average (5.9 and 5.7 respectively), non-nominated clients had assessed their initial level of functioning at 2.5 on average and characterologically difficult clients assessed their initial level of functioning at 1.4 on average. Again, this is interesting when viewed in the light of their therapists’ assessment of the characterologically difficult clients’ need for further treatment.
The Utility of the Proposed Definition of Characterological Difficult Clients

The question of the utility of each of the five axes of the definition of a characterologically difficult client is complex and difficult. While all five axes were significantly useful in delineating characterologically difficult clients from their non-difficult counterparts (Axis 1, F (1, 33) = 67.63, p = .000; Axis 2, F (1, 33) = 51.75, p = .000; Axis 3, F (1, 33) = 48.04, p = .000; Axis 4, F (1, 33) = 62.57, p = .000; and Axis 5, F (1, 33) = 69.54, p = .000), this is not entirely surprising since these were, to a large part, the criterion used to distinguish characterologically difficult clients from other clients. It is important to note, however, that the therapists were asked to nominate clients as characterologically difficult if any of the five axes were important in understanding and working with a given client. There was no stipulation that more than one axis needed to apply to a given client in order for them to be nominated.

In addition to the evaluation of the proposed definition, the second survey also asked two open-ended questions about the therapists' experience with the clients they nominated and the non-difficult comparison group. I will discuss the therapists' responses to these questions in depth under a subsequent heading. However, one therapist's responses was particularly salient to present at this time because of its relevance to axes one and three of the definition of characterologically difficult clients I proposed. I labored long and hard to find an example that would illustrate the kind of rigid, maladaptive patterns of interpersonal relatedness that result in relational crises or impasses in which the client feels that no satisfactory resolution is possible (Axis 1 of the definition). This therapist provided a true-to-life example of such an Axis 1 impasse as it
was reproduced in the therapy (thus satisfying Axis 3 of the definition). The passage follows:

"She would constantly barrage me with questions like: ‘Have you ever been depressed?’ and ‘don’t you ever feel like throwing yourself on the floor and crying?’ Interestingly she constantly referred to this discomfort of talking about personal issues ‘to a stranger’ whom she knows nothing about (i.e. martial status, age, upbringing). This was a constant theme that occurred throughout the year-and-a-half treatment. Even when I did offer information about myself she said “actually I don’t really want to know, stop”.

A Comment on the Post Hoc Subgroupings

While it would be gratifying to complete a thorough analysis of the data pertaining to the post hoc subgroupings I have referred to as “different for other reasons” and “mitigated”, I have chosen not to do so. My reason for this is two-fold. First, as I have stated, I have found no compelling theoretical reasons for considering these groups as completely orthogonal from the non-nominated or characterologically difficult groups. This does not mean that none exists. But it is beyond the purview of this study to search for such reasons. Second, with group sizes of eleven clients in the “difficult for other reasons” and four clients in the “mitigated” group, any statistical analysis I might run would be speculative at best. That these additional groupings are significant enough to the clinicians themselves to have had them nominate clients in what externally looks to be a meaningful manner, however, I respect. I, too, find that these categories prompt a great deal of thought when I reflect
on my own clients. Future investigators of client difficulty would likely benefit from including these distinction in their a priori design.
Explaining the Overall Pattern of Findings: Discussion and Qualitative Analyses

What is the overall pattern of findings in relation to the expectations enumerated in the methods chapter? This question will be addressed in terms of the following four topics: diversity among therapists, the therapist-client interaction, potential theoretical limitations of the group comparison, the therapists' voice (a qualitative analysis).

Diversity Among Therapists

As mentioned previously, it is remarkable that, while half of respondents nominated a characterologically difficult client, the other half (10 of the 21) were unable to nominate a characterologically difficult client. This distribution has only a .01 probability of occurrence by chance. Moreover, of the 11 who did nominate clients, 8 out of the 10 who had more than one potential client to nominate did so. While it is certainly possible that the disparity between nominating and non-nominating therapists is merely an artifact of this sample there are other possibilities that should be considered. One such possibility is that theoretical orientation may play a more important role in affecting clinicians' conceptualization of characterologically difficult clients than I had anticipated. This would be most likely when theoretically exclusive terminology is used to characterize the phenomenon in question. With the exception of the literature on Borderline Personality Disorder (which has as many behavioral as psychodynamic writers) the literature on characterological difficulty is almost entirely psychodynamically oriented. Despite my efforts to utilize neutral language, I may have failed to achieve a level of neutrality that would not evoke orientation-specific responses.
The issue of finding neutral language may have implications beyond the boundaries of theoretical orientation. Therapist’s personal values and their fundamental world views serve as filters through which they understand their clients and their work. Therapists vary dramatically in their comfort with terminology which might imply “labeling” which could be interpreted as demeaning clients or even representing a depiction of these clients as unchangeable. Characterological symptoms and disorders have long been represented and notoriously intractable. At the very least, clinical change has ubiquitously been portrayed as possible only after considerable time and investment. While it could be argued that such representations are only problematic to the extent that they are inaccurate others would argue that these representations themselves may be responsible, in part, for the difficulty in effecting clinical change. As in most matters involving personal values, objective evaluations is difficult if not impossible. My intention in raising the issue is only to illuminate another potential source of therapist bias which may have limited therapists’ willingness to employ this particular terminology to describe their clients and thus skew the overall pattern of response to this survey. Case in point: During the course of an academic discussion in which I was a participant, two of the therapists who indicated that they had never treated any characterologically difficult clients in the PSC voiced their disapproval of “characterological” or “personality disordered” conceptualizations of clients, rejecting them as overly pessimistic and implying the futility of treating these clients. Their antipathy was validated by the professor moderating the discussion. It remains unclear whether these therapists’ responses to the survey reflected their discomfort with terminology I utilized to frame the construct I intended to explore.
Another, and somewhat more compelling, potential explanation for the disparity between nominating and non-nominating therapist that has been suggested by several clinical faculty is that there is a clinical tradition (though not a formal clinic policy) of pairing such characterologically difficult clients to a certain sub-set of clinical trainees. As I have mentioned in the introduction, most therapists find working with characterologically difficult clients an exasperating experience that often leaves them emotionally drained and often confused about the course of treatment. While nearly all graduate students in the program start seeing clients at approximately the same time (usually towards the end of their first year or the beginning of their second year), each student enters the program with distinctly different experiences, both in their own development and in their experience with mental health and related fields. When the intake team feels that the client they are about to assign to a clinical trainee might be a characterologically difficult client to treat, the trainee's experience, both in the program and prior to his or her acceptance, becomes an assignment criterion. So also does the team's perception of the trainee's personal characteristics and clinical maturity. This introduces a selection bias into the assignment process at two levels. First, whether inherently or simply as a result of the team's perceptions of the trainees, clinicians assigned characterologically difficult clients are far more likely to be similar to one another in several salient ways. Second, those clinicians to whom characterologically difficult clients are not assigned are not exposed to this type of psychopathology and may lack the experience and the conceptualization of the work to recognize it as a clinically salient variable.
The Therapist-Client Interaction

The characterologically difficult client as defined above is a paradoxical entity. By definition, the characterological nature of these clients' presentations that makes them difficult is an inherent aspect of their personalities and long-standing styles of interpersonal interaction. It may have both genetic and environmental underpinnings and is developed over the clients' lifespan in the context of a myriad of interpersonal relationships. In the case of characterologically difficult clients, is not unusual for them to have experienced a significant proportion of these relationships as traumatic or troubled in some way. Nonetheless, it is the therapist who makes the clinical determination that a particular client is characterologically difficult. The difficulty itself can only exist within the context of the therapist-client relationship. As such, the therapist cannot be assumed to be absolutely neutral in the development and determination of such difficulty. As I will demonstrate below, not every client deemed characterologically difficult by one therapist may be so designated by another clinician. Furthermore, there may be factors within the client, the therapist, and the relationship between them that can either mitigate or exacerbate the client's characterologically difficult symptoms or presentations.

One specific example of this interaction can be seen in one particular transfer case. The therapist to whom this particular client was transferred had not only been on the previous therapist's supervision team (as had I), but had also been observing the client's sessions extensively from behind the one-way mirror. The unanimous consensus among the team, the supervisor, the observing therapist and, most of all, the treating therapist that this client was the quintessential characterologically difficult client. Convinced of this client's characterologically difficult presentation, the observing therapist anxiously anticipated her initial session with intense trepidation.
for weeks before the transfer. Nonetheless, she reports a virtual epiphany when she opened the waiting room and saw the dreaded client sitting in wait for her. She reports that, in that instant, she intuitively knew that her being female would ameliorate the difficulty that the client had presented to her predecessor. At the time of the data collection she had been seeing the client in treatment for nearly a year and had not experienced any of the interpersonal behavior that had caused her predecessor immense stress.

Potential Theoretical Limitations of the Group Comparison

While my analysis revealed a number of significant differences between characterologically difficult clients and non-nominated clients in the directions I expected, the state of affairs was nothing like I had anticipated. The literature paints a much more gothic picture. The clients often portrayed in the literature clearly stand out as quite different from the “typical client” seen in outpatient psychotherapy. Nor did the clients described in this study look like the harrowing characters of the many stories I have heard in break-rooms and group supervision.

The term "characterologically difficult client" begs the question “are these clients different?” Is, then, the term a valid and meaningful clinical entity. If all observations are created equal, then I must give credence to the articles, the anecdotes, the group and supervisory discussion, and my own (albeit quite limited) experience and suggest that we not discard the term as a spurious distinction just yet. So the ancillary question arises “why were so few of the expected differences significant?” In response to this question I would like to offer three brief possibilities and one conclusion, the latter of which will follow under its own heading.
The first possibility is probably the most obvious: I am asking the wrong questions. Perhaps Freud was right and “acting out” is ubiquitous. This is not to say that “acting out” does not distinguish characterologically difficult clients from clients who would not be nominated so. Rather it is to say that my original hypotheses about the “acting out” behaviors that might distinguish characterologically difficult clients from their counterparts (or their operationalization) were inaccurate. It could also be true that the measures I used to gauge such behavior were insensitive enough to detect them. To extend an idea I began developing earlier, perhaps missed sessions without advance notice does not reflect the salient message being acted out or is simply too blunt an instrument to detect group differences. For example, perhaps missing a session is too much of a relational sacrifice to a client whose characterological style prevents the development of satisfying relationships outside of therapy. Perhaps showing up a half-hour late is a more effective way of “punishing” the therapist. It is conceivable that being late would allow the client to be gratified both by making the therapist wait and wonder and by reassuring the client that the therapist will be faithful enough to wait so long, yet still leaving the client twenty minutes of satisfying relationship with the therapist that week. Such behavior would be remain unaccounted for by using so crude a measure as “missed sessions”.

The second possibility is suggested by one of the reasons I set out to explore this phenomenon—the changing face of clinical populations in clinic settings such as the PSC as noted by Fiore (1988). As developing professionals this is a novel experience for most of us. Those of us who have had experience prior to our training here most likely gained that experience working with a similar population (if not more disturbed) in a much different relationship with the clients. By the nature of the discipline, without a masters degree at minimum and, at the least, licensed supervision
we would not be allowed to enter into the kind of psychotherapeutic relationships we do here. Furthermore, this limit on the kind of experience we might have had often limits the populations with whom we worked. All of this is to say that few of us have any "normal" or "average" experience to compare our current experience with. If, in fact, the proportion of characterologically difficult client (and clients difficult for other reasons) of clients in clinic settings such as the PSC has been increasing in response to managed care, in our naivété, we may only be nominating the extreme cases because we do not know any better. Here the question is not "are nominated clients different than non-nominated clients?" but rather are PSC clients different than other outpatients.

The third possibility I would like to raise is a lack of clarity compounded by developmentally appropriate limits of understanding. Regardless of experience and theoretical understanding, every clinician I have spoken to has had some difficulty expressing what is meant by characterological difficulty. They have had perhaps even greater difficulty quantifying the experience of recognizing and working with characterologically difficult client. In an era where attentions to theory, both classical and contemporary, is rapidly giving way to empirically verified treatments and bureaucratic limits on length of treatment, t would be unreasonable to expect graduate students who are in their professional infancy to be any clearer. Constructs such as "characterological difficulty", "acting out", and even "personality" do not share the same definition, implications, and acceptance across varying theoretical orientations.

While reviewing the literature and constructing the definition of difficulty and the survey in which I used it, I was completing a practicum placement with two classmates, whom I had the good fortune dine with often at lunch. Prior experience
had taught me that survey material can ignite passionate debate along theoretical lines. I wanted very much to avoid including terminology or conceptualization that clinicians of any theoretical orientation might find objectionable. In my efforts to remain “orientation neutral” I ran my thinking past them often during our regular lunches. Both had theoretical orientations somewhat different from my own (and very different from each others’) and I had been in team supervision with each of them separately during the preceding several academic years. As such, I knew each of their caseloads reasonably well. Every time I had the occasion to discuss the development of my thinking they both stated they understood and both stated that the material applied to at least one of their own clients. Nonetheless, between our last discussion and the final draft of the survey, something changed just enough in the wording to cause one of them to recant and check the space indicating that none of the axes of the definition applied to any of that classmates clients.

In addition to this incident, several other clinicians sought me out during the survey to ask clarifying questions. For the most part, nearly all of the inaccurate interpretations of survey content that I heard were logical, defensible, and they all came down to conceptual definitions. Whether the fault was my presentation of the construct, whether it is inherent in the current conceptualization of the phenomenon of characterologically difficult clients, or whether it is a conceptual rift between differing theoretical orientations, there is sufficient evidence of confusion to suggest that the nomination process itself may be unreliable.

The Therapists’ Voice -- Coming Full Circle

In the preceding discussion I began to ask the question, “are characterologically difficult clients no different than their non-nominated counterparts?” My answer: The
exploration has only begun. Psychotherapy is a complex, multi-layered endeavor, and, in a manner, its complexity is but a pale shadow of the complexity of all other interpersonal relationships. The conclusion that I would offer is that characterological client difficulty is, above all else, about interpersonal relationships. As I have discussed, without a therapist who is subjectively experiencing the work with the client as difficult, the clinical entity “the characterologically difficult client” does not exist. The statistical evidence produced by the analysis of the hypothesized variables presented herein, however, does not argue overwhelming that such clients exist. To rediscover the phenomenon I set out to explore I had to turn full circle and listen again to the frustrated voices of therapists who had come to feel profoundly derailed in their efforts to reach and heal these clients’ distress. I found these voices in the lone pair of open-ended questions at the end of the second survey. In the responses to these questions I began to hear what had been muffled in the mathematical analysis of logistics and the quantification and indexing of symptoms: the real and reciprocal relationship between therapist and client.

The first of these two questions was very specific. From my own experience, both outpatient and inpatient, and from my experiences on treatment teams with other therapists who nominated or spoke of characterologically difficult clients, I had the impression that these clients were more likely to request their therapist’s attention outside of their regular session. Often such requests for contact outside of regular sessions are in response to what the client is experiencing as a crisis. Because clients in crisis are often quite emotional and because typically the goal of the contact for both client and therapist is to reduce the clients’ distress to a level that they feel they can manage until the next regular session, such crisis contacts do not often result in an additional session and are rarely brief. The PSC currently has no overt policy about
crisis telephone calls and there is a range of opinion of how to handle them among both faculty and clinicians. Whether the duration of such calls should be limited, under what circumstances should the clients be charged, should telephone charges be seat at a different rate than regular session charges and when, if ever, do “crisis calls” cease being crisis call and become violations of the therapy boundaries--none of these issues currently have set, uniform answers. But the phenomenon appeared to be quite real and relevant to the developing clinician's experience, and I felt that assessing therapists’ experience could have decidedly practical applications. As a result, the first question I asked the therapists was to estimate how often the client in question attempted to engage them outside of their regular sessions.

Of 21 characterologically difficult clients, 14 (66.67%) were reported to have sought contact outside of sessions. Only two of these clients were reported to have sought contact for reasons other than crises, but even these two were strange in their own right. The first one phoned several times to rearrange scheduled meetings, but did so not to the clinic but phoned her therapist directly at home. Where the client got the therapists home number remains a mystery. The other client’s attempts to engage the therapist were not in the form of telephone calls at all. Rather the client would reportedly angrily leave the session in the middle and then attempt to confront the therapist publicly in the clinic. While this is not particularly what I had in mind when I asked the question, it does speak to threat to the boundaries of the therapeutic relationship that such clients can present and the frustration and emotional strain the therapist can experience in attempting to conduct even the logistic of a session.

Of the remaining 12 who called in crises, two clients are reported to have called only once, a third client was reported to have called once or twice, three more were reported to have called in twice, two more were said to have called three or four time
across their treatment, and the remaining four were reported to call in on a regular basis (e.g. “once a month on average” and “three - four times each semester”). One of these four was also noted to have surreptitiously obtained the treating clinician’s number and attempted to call the clinician at home. I also found it particularly interesting that three therapists explicitly noted having addressed the issue of contact outside of sessions during their regular sessions and two of these indicated that they believed these discussions facilitated work around issue including availability, alliance, communication, and disclosure.

Of the 15 non-difficult controls (I remind the reader that this group is subset of the non-nominated group whose overall difficulty was rated at three or less and is used only in the analysis of this second survey) only one client was said to have called in crisis “once or twice”. Nothing else was said about the reported contacts. This is by no means a definitive analysis. I believe, however, that it suggests that there is at least sufficient effect on both the clients’ and therapists’ experience of treatment to enter a formal dialogue about the merits of a clinic policy on contact outside of the regular therapy session.

While this first question had decidedly practical implications, it was the therapists’ responses to the second question that made all of the effort feel worth while. Here was the real phenomenon that first captured my attention. While I had a host of questions I wanted to ask, I decided that, in the interest of not overwhelming the responding therapists with onerous questions that I found interesting and relevant I would allow them to select the aspects if the treatment they most willing to talk about. I asked them to comment on how the work with this client was different from their work with non-difficult clients. I then suggested that they consider any of the following five areas: the development of their theory, their understanding of
psychotherapy, their supervision, their confidence as a therapist, or their emotional resources. Much to my gratification, therapists spoke at some level to most of these aspects of treatment. I will share with you some of what they had to say.

The first two aspects of treatment—the development of theory and of an understanding of psychotherapy—can be difficult to distinguish. While both speak of intellectual aspects of the work of the therapist, the construct of the therapist's theory is broader and more far reaching. Psychological theory informs and guides the psychologists understanding of all aspects of human functioning. It includes human development, anatomical functioning, patterns of interpersonal relatedness, the existential need (or lack thereof) to make meaning of their life, and the development of psychopathology, to name but a few. It also provides the foundation of their understanding of psychotherapy. A therapist's understanding of psychotherapy goes much beyond his or her theoretical framework, for psychotherapy is a dynamic, constantly developing relationship of knowing another and being known by them (for both the therapist and the client). Understanding psychotherapy is to understanding psychological theory what an improvisational "jam session" is to music theory; pure musical academics can be very adept at explaining polytonal scaling and return only a blank stare if you place a saxophone in their hands. Echoing a similar sentiment, one therapist wrote, “this case reminded me that you can have strong theories about an individual’s functioning, but they can be of no use in treatment. The theoretical approach that you use with a client [like this] simply has to reflect what the client is willing to do in therapy.”

Had I the opportunity to interview these therapists rather than collect a survey from them I might have been able to tease out other such distinctions between these two constructs. I did not interview participants systematically, however, so for all
practical purposes I will admit to having made too fine a distinction for too insensitive a measure to detect. In the following discussion, then, I will treat these two constructs as a single entity.

What jumped immediately to my attention in reading therapists' responses was what I had not heard since I had first turned to the data analysis: the subjective distress of therapists who have lost their way. I began hearing statements like, "I was confused about where to go clinically", and "the lack of progress was frustrating, I no longer knew how to plan the client's treatment." These are voices of intellectuals and developing professionals beginning to recognize and admit their own confusion and frustration. These are voices acknowledging that, despite their new role as psychotherapist, they still retain the limits of humanity.

Then the focus shifts from their own limits to the effect these limits might have on the client and their impact on the relationship. "I think my strong negative reaction towards her caused me to be less available in the room in therapy" reflects therapists' attempt to begin to measure the relational effects of their own reactions on the client. They also begin to acknowledge that they are as much an active participant in this relationship as the clients, and, as such, bring some of their own needs into the relationship. Statements like, "I often felt invisible in the room" indicate an awareness that the therapeutic alliance has broken down and the therapy has ceased to be a relationship.

Ostensibly, the client does not pay us to be passive objects to "vent" to; in fact, Kottler (1986) has suggested that, "we are specifically paid to say the things to the client that no one else has the courage or finesse to say" (p. 12). As in any relationship, the movement away from the relationship can be initiated from either side of the dyad. This is particularly salient in the treatment of characterologically
difficult clients. Characterologically difficult clients typically exhibit a pattern of interpersonal behavior that serves to alienate others and prevents the facilitation of satisfying levels intimacy. Furthermore, these clients are usually either unaware that their behavior drives others away (or at least unaware of why it drives them away) or they simply have no other styles of relating in their repertoire to substitute. As such, it is incumbent on therapists to be acutely attuned to the clients pattern of relating to them and to be aware of the strong currents that will both pull them away from the client or unconsciously entice them to push the client away themselves. This often means that therapists must be far more proactive with characterologically difficult clients. As one therapist attested, “my understanding of therapy has changed quite a bit with this client. I have broadened my understanding of ‘neutrality’ as this included being more active and engaging with the client rather than a blank sheet of projection.”

Even hypervigilance on the therapist’s part may not be sufficient to keep such relationship-crippling behavior at bay. As one therapist remarks, “In this work I learned that not all client-therapist alliances can be rebuilt once they are damaged.” Some would argue that the rebuilding of broken relationships is the very thing characterologically difficult clients have been unable to do in significant relationships outside of therapy. It is in the experience of rebuilding the relationship with the therapist after it has somehow become damaged is the curative work of the therapy. This work, however requires the cooperation of both the therapist and the client; neither one can do it alone.

No matter how adverse the circumstances become, there is always something to be learned for the mind that remains receptive. One therapist attested, “I learned a lot about the purpose of psychological defense mechanisms and how to (and not to)
address and challenge them in therapy”. Another noted, “I learned the difficulty of treating someone who knows the therapy lingo too well. [I] also learned about clients’ resistance as a major focus in some therapies.” Some of the lessons are hard won, as reflected in the comment, “this client taught me that the process of change in therapy can be very slow, subtle, yet powerful.” Still others are deeply human: “I became extremely frustrated with what I saw as our lack of progress and felt it was important to make some changes in therapy. In supervision we discussed this and I changed my stance as a therapist and began to try and meet the client where she was at that time.” Sometimes the lessons learned under difficult circumstances are the ones that change you most deeply.

Supervision is essential to developing psychotherapists’ learning process. The most amazing insights can come in supervision if developing clinicians can leave their pride on the other side of the consultation room door and take only their honesty with them. If this is done and the supervisor is open, supportive, and equally (but gently) honest, the processing of developing therapists’ work with characterologically difficult clients through supervision can become a refuge and an apprenticeship in one.

Unfortunately, this is not the case for all developing clinicians. I had anticipated that nearly all nominating therapists would cite supervision as a resource they perhaps over-utilized with their characterologically difficult clients to the exclusion of other, less difficult clients. While this was the case for many of these therapists, for two therapists it was not. Three of the first therapist’s nominated clients proved to present difficulties for her in supervision. Of the first she simply wrote, “I didn’t even like talking about [this client] in supervision.” Of the second client she reported, “Supervision around this client was very difficult because I disliked working with her; I didn’t like working with her and did not enjoy exploring her case.” In her
supervision for the third case she stated, "[the client] would often be left until last in supervision, and it was difficult to find ways to discuss [the client's] difficulties in supervision."

The second therapist echoed similar sentiments about her supervision experience for the work with her nominated client: "Discussing this client for an hour in supervision was extremely draining and exhausting compared to other cases. I often asked that supervision end early or simply be canceled". She expanded on this stating the following:

Working with this client created more friction in supervision. I was frustrated by suggestions to try new approached, ideas, etc., that I had already tried to no avail or that I was quite certain would be unsuccessful due to my earlier interactions with the client I felt 'forced' (though somewhat subtly) to continue working with a client who refused to engage in any goal directed behavior or interaction. She notes several lines later that that she felt the supervision of her work with this client should have been more supportive.

While not always pleasant, the remainder of the clinicians seemed to find supervision useful and supportive. In fact, some reported feeling like they over-utilized supervision to talk about their characterologically difficult clients. For example, one therapist noted, "this client often required the full supervision hour, sometimes for consecutive weeks in a row - not to mention an occasional full clinic team meeting." Another reported that "[this client] took up more supervision time and the time in supervision was spent on my reactions to [the client]."

Therapists reporting that time was spent in supervision dealing with their reactions to these clients often seemed to indicate in their wording that this was somehow not what was supposed to happen in supervision. I imagine that that the
The most common conception of supervision is that of a place where grand theories are consulted, sage advice is bestowed, and abstract clinical strategies are staged and choreographed. In my own supervision, however, my supervisors have always stressed that it is often the reactions that I experience during the sessions that prove most fruitful in directing the clinical work (only, of course, after they have helped me make sense of those reactions). When the communication in therapy is honest, the therapists' reactions are often similar to the reactions of clients' significant others outside the therapy experience. They can also inform therapists about clients own reactions to other significant people in their lives and their expectations of such interpersonal relationships.

This and the reports cited above suggest that the match between the therapist and supervisor is equally as important as that between the therapist and clinician. As the following clinician's statement reveals, different supervisors can conceptualize the same case in dramatically different terms. "[My] supervisors had very different reactions to [the client], more so than with other clients where I've switched supervisors. I think they were responding to [the client's] characterological presentation (i.e. some were strict limit-setters, others were more 'sympathetic' to [the client's] wants)." For a new clinician, such disparate conceptualizations of the same case by two mentoring figures who do not have to sit across from the client being conceptualized the following week, can be an overwhelming. When the match is right, however, the entire process can produce therapeutic change for therapist as well as the client. As one therapist attested, "in supervision it has been important to get a clearer sense of my own emotional life as it gets translated in session." Also when the match is right, genuine affect, brutal honesty, and humor can coexist. In the words of another therapist, "I think this was the first client I felt I did not want to work with - I
recall confronting that sense in supervision, discussing how the client needed case management rather than psychotherapy and that's not what I went to graduate school for!"

The fourth subject I asked nominating therapists to comment on was how working with this client effected their confidence as a therapist. Common among the clinicians' responses were statements such as "working with [this client] lessened my confidence as a therapist; it made me feel inexperienced and unprepared", and "working with her impacted my confidence negatively. I felt guilty for not liking her, and I felt unable to help her." One therapist wrote that trying to steel herself in advance to receive a transfer case whom she knew to have been difficult for the preceding therapist still was not enough to keep her from being vulnerable. She wrote, "even though I knew this client had a history of denigrating therapists, refusing to set goals, etc., I still felt drained by the sessions and began second guessing myself and questioning my competence". Perhaps the most effective and compelling statement about one therapist's confidence used absolutely no words. She simply wrote "confidence as a therapist:" followed by three downward facing arrows and a hastily drawn sad face. The one ray of hope, however, came from this therapist: "My confidence as a therapist is a struggle to maintain through out treatment with this client. However, it has grown more solid in my two-years of treating her."

Finally I asked therapists to comment on how the work with their clients affected them emotionally. Responses ranged from "I often felt bored and frustrated by the client" to one therapist's description of the increase in stress and strain she would experience when her client would become suicidal. Another described her sense of personal responsibility for the client's safety and well being: "She was a draining case and when in crisis she felt and stated that I was her only support."
Some therapists’ subjective experience of their clients was so dramatic that they described aspects of their work with these clients in distinctly traumatic terminology. One described the work as “very taxing emotionally [because the client launched] lots of direct attacks [at the therapist]”. Another stated that, “[the client] would monopolize sessions and in some sense ‘verbally bully me’ by not allowing me ‘space’ in the therapy. I felt like I was afraid and reluctant to address all the [client’s] reactions”. Two other therapists chose wording that held over-tones most often associated with the phenomenon of “burn-out”. The first stated that, “working with [this client] opened my eyes to how (over) involving this work can be.” The second admitted “I felt pretty demoralized about doing therapy after this client.”

Above all else, I was struck most by the depth of the descriptive language that cut across the aspects of these clients’ therapies. In addition to what has been presented thus far, some of the other comments that leapt off the survey pages included, “I dreaded this client”, and “I became ‘shell shocked’ at times.” These therapists clearly felt that their emotions had taken a toll during the treatment of their clients. Another somewhat more vague comment offered by another therapist, “working with this client profoundly affected me”, may not specify how he had been affected, but leaves little doubt that he is a different person than he had been before working with this client. For this, all of these clinicians have my respect, for it is a testament to their honesty and their willingness to endure great distress to enter into a real, honest and curative relationship with their clients.
CHAPTER 4
CONCLUSIONS

Summary of the Exploratory Findings

The results yielded by this first effort to empirically explore the presence of characterologically difficult clients in an outpatient psychological treatment clinic are decidedly mixed. While it appears to be a difficult task to identify characterologically difficult clients on the basis of their case files alone, they appear to be a very real phenomenon to therapists who treat them. What remains unclear, however, is how to reliably define such clients in a way that all therapists would agree upon. Despite an attempt to provide a clear, detailed definition, the data collected indicated that participating clinicians applied this definition in fairly diverse ways. This fact, combined with a relatively small sample, leaves it unclear whether there was sufficient statistical power to detect important differences that might have existed in the population that was sampled. The large number of variables examined also makes it difficult to know how much confidence to place in the differences that were found. For those therapists who found the definition of characterologically difficult clients useful, all elements of the definition seemed to have value in identifying these clients.

On a more descriptive level, however, the ratings of difficulty and the nominations based on characterological difficulty did show interesting relationships with case characteristics and behaviors that might be thought of as "acting out", such as cancellation of appointments and suicidal gestures. There are compelling theoretical considerations that suggest that several of the measures of variables used in this study may not be sensitive enough to detect the other kinds of acting out in which characterologically difficult clients might engage.
Perhaps the most interesting differences found between characterologically
difficult clients and other clients are those that are associated with extended experience
in mental health care treatment. These clients are older, have been in treatment
longer, and have had multiple therapists. They also report less improvement as a
result of therapy and evaluate the therapy as less helpful than do their counterparts.
Their therapists also evaluate their therapies as less successful and evaluate these
clients’ need for further treatment as greater than the other clients they have treated.

The more anecdotal data from the open-ended questions provides compelling
evidence that the expected impact of characterological difficulty is in fact present for
some therapists in some cases, and provides good examples of how therapists-in-
training may experience, understand, and cope with that impact.

Recommendations for Further Research

As the title suggests, this study was meant to be only a first step in the
exploration of characterological client difficulty. To those who would extend this line
of research I would offer several suggestions. First, as I have already mentioned, the a
priori inclusion of the two additional groups “difficult for other or non-
characterological reasons” and “characterological but not difficult” (previously
referred to as “mitigated”) may prove beneficial. Not only would the inclusion of
these groups prevent therapists from feeling that they must “force” a client into one
of two dichotomous groups, but would also increase the sample size by including
rather than excluding these subjects.

A second recommendation I would make is actually a piece of the original
methodology for this study that I abandoned relatively early in the data collection. It
was my original intent to survey treating clinicians and their supervisors. Perhaps it
was an artifact of timing, but, as spring segued into summer and clinicians began to return the nominations sheets the question of which supervisor to survey for any given clinician began to look like an extraordinarily daunting task. Because the PSC is a graduate training clinic, supervisors are typically changed twice a year: Once between spring and summer and again between summer and fall. Over the space of an average four to five year graduate training career, and even when allowing for some repetition, this results in a considerable number of supervisors with whom any given therapist has worked. Furthermore, in addition to regular faculty members, professional therapists from the community and some advanced graduate students are invited to supervise every year. This adds to the complexity of the selection process the issue of supervisor attrition. Having not given the selection of supervisors sufficient thought prior to the data collection, I ultimately dropped this convoluted piece of the method from the study. I must point out, however, that this was an omission of convenience, not a decision made for any compelling theoretical reason. I was quite disappointed to have to let this piece go and strongly believe it would have added a great deal to this investigation. I strongly suggest other investigators consider adding supervisors to their samples as well.

A third suggestion I would offer would be to develop a more sensitive, finer-grained measurement of “acting out” behaviors. One possibility along this line would be to try to develop a composite measure across various forms of acting out. Another possibility (although an admittedly daunting one) would be to code and track acting out behaviors as they occur within the session. Above all, I would suggest interviewing therapists and using their experiences to guide the development of measures of acting out.
A fourth recommendation I would offer would be to use multivariate analysis to explore the interdependence of treatment variables with treatment length. I only explored individual differences between clients on one aspect of treatment at a time. Many of the differences that did emerge could well be correlates of length of treatment. While this does not necessarily imply that these differences are spurious, the question of the relationship of the overall pattern of these differences to treatment length remains open. It would be important to determine what differences are a function of the clients themselves and which are merely correlated with the length of treatment. It is possible that a composite or index of several individual variables may be useful in distinguishing characterologically difficult clients from their peers.

I would also recommend that further attempts be made to rid the definition of language or conceptualizations of difficulty that might be objectionable to therapists of differing theoretical orientations. I believe that, had I found more neutral language in which to frame the survey, some of the clinicians who chose not to nominate a client would have made nominations. Ironically, this might mean the elimination of the term “characterological” from the label, as this might be identified as objectionable to those clinicians who are not of the psychodynamic orientation. It is perhaps a further irony that I would also recommend that researchers give thought to the measurement of ego-syntonic symptomatology. This is also a very psychodynamic concept, though it need not be, but it may be an important discriminator of characterologically difficult clients.

Finally, I would simply recommend to researchers who are interested in characterologically difficult clients to pursue this research by all means. The impact that these clients have on the therapists who work with them can be profound and the course of their treatment can be long and difficult. Both the therapists treating these
clients and the clients themselves stand to benefit from a greater understanding of the dynamics of their treatment.

**Recommendations for the PSC**

In addition to the general recommendations for further research above, I would also like to offer several very practical recommendation for the PSC that arose directly from my experience conducting this study. All of the following recommendations have implications for the operation of the clinic, the treatment of the clients, or the facilitation of clinical research. With the exception of the first (and possibly the most fundamental) recommendations, I will present the simplest and least time or effort intensive first and then progressively move through the more involved, long-range recommendations.

First, I would encourage all supervisors and developing therapists whose experience is touched by such clients, either directly or through discourse or the literature, to enter into dialogue about these treatments. The literature is still in its relative infancy and the current context of psychological treatment is in such flux as the politics of managed care evolve. What it means to treat characterologically difficult clients in the realities of current treatment climate is dramatically different than it was when psychoanalysis was the predominant treatment for such clients, yet much of the existing literature is founded in the psychoanalytic tradition. There is still a great deal to learn about working with these clients, and an open dialogue can only facilitate such learning. What the existing literature clearly underscores is the potential stress and distress even the most seasoned and skillful therapist can experience when working with characterologically difficult clients. There is no place that should be
more concerned with preparing therapists to work with such clients than a graduate training clinic such as the PSC.

Second, I would nominate several new demographic variables to be included in the database (and, by extension, the data collection forms). Perhaps it would be more accurate to say that I would nominate a greater level of specificity to our existing method of collecting these demographics. Currently, many of the demographics of our clients are collected by means of open-ended questions in the Personal History Questionnaire (PHQ). I do not advocate that we cease using such open-ended questions. To do so would be to sacrifice valuable information that so many clients inevitably volunteer. Rather what I suggest is to include very brief categorical questions that would reduce the amount of interpretation and coding that therapists and (more importantly) researchers have to do. Strategically located categorical questions would greatly facilitate determining clients ethnicity, marital status, current education level (e.g. graduate vs. undergraduate), and other demographic material. Even clinical data (e.g. duration of presenting problems) could benefit from added categorical questions.

Closely related to the issue of additional categorical questions on the PHQ is the recommendation that a committee or consulting group be formed to evaluate the research value of our current data collection techniques. The PHQ would be a good starting point and an excellent example of the potential benefits of reevaluation. The PHQ is an excellent tool for collecting clinical data. It is an excellent tool, in part, because the open-ended questions provide for rich data to be volunteered by the clients. As a researcher, however, I spent a considerable amount of time trying to interpret and code many of these open-ended question into variables which could then be analyzed statistically. The PSC provides an exceptional opportunity to
conduct clinical research. To take this potential seriously, however, some additional thought must be invested in how to facilitate data collection for both quantitative and qualitative analysis.

One of the possible changes that I would recommend such a committee or consulting group to consider would be the formal implementation of a provisional diagnosis policy for intake workers and clinicians. While the issue of the value of diagnoses and stigma of labeling are complex and contentious, the continued growth of the medical model and managed care argue strongly that psychologists will be expected to be competent diagnosticians in the foreseeable future. This being the case, clinical training in the PSC is a logical venue in which to receive such training. Having said this, I want to be clear that my recommendation stipulates that these diagnoses be treated only as a training experience and their status always be acknowledge as provisional at most.

Another example of how additional thought would facilitate research can be seen in the client payment records. Going through the payment records by hand was not only an arduous, time-consuming task, but it yielded only very crude data. This was the case for several reasons the most significant of which was the absence of the raw data to manipulate. What ended up being the "raw" data in my data set were each themselves the result of much manipulation and multiple calculations. My recommendation, then, is to computerize the payment records beginning with the clients currently being seen and working back when possible. Doing so not only would make this data available for research use, but as I mentioned in the discussion of the subgrouping of the sample, I used my manual data collection of the clients' payment histories to cross-check therapists' mistaken ratings of clients that they saw
for two or less sessions (in some cases never saw). Such cross-checking of effectively redundant data would be so much easier if these records were computerized.

Another recommendation related to attendance and payment histories arises from the need for greater specificity. In the payment records, attendance and payment are coded separately and, in some places, are incomplete. Currently, the therapist is the one who decides (often in consultation with the case supervisor) whether a client pays for a missed session. Because clients are not automatically charged, knowing that a client missed a session tells clinicians and researcher nothing about whether or not the client was charged for that session. Similarly, knowing that a client was charged does not convey any information about that clients attendance. Because both attendance and payment were important measures of “acting out” in this study, it would have been nice to look at the possible interaction of the two. It would be a relatively simple matter to either code both fee charge and attendance information on a single code or on two separate variables that could be easily recoded into a single variable.

My last two recommendations I make from an admittedly naive perspective. From a clinical perspective, I would strongly recommend that the clinical faculty consider the need for establishing or clarifying overt clinic policy on the financial and “frame” aspects of telephone contact (i.e. crisis contact, telephone check-ins, etc.) and on fees, missed payments, and account balances. While I have no doubt that these issues have been explored and discussed in depth and that there are more than likely already policies in place, in the course of this investigation, it became clear to me that a considerable number of clients (and, presumably by extension, their therapists) who are unclear enough about what constitutes appropriate behavior in these areas. By making this recommendation, I am acknowledging my own ignorance and admitting
that my lack of understanding caused me to, for example, have telephone consultations with clients in crises that have exceeded a normal 50 minute session without charging the clients. This is potentially a serious breach of the therapeutic “frame”.

My final recommendation specific to the PSC I make with immense respect for my advisor, Dr. David Todd. He has, with unwavering dedication and resolution, constructed, maintained and administrated a singularly unique clinical database. Without his commitment at a “nuts and bolts” level, this investigation would not have existed. For these reasons, I feel oddly disloyal recommending that the clinical faculty, led by Dr. Todd’s expertise, open a dialogue exploring how to make this unique asset less dependent on his lone administration. This could mean updating the software to a more modern, less esoteric database package, or it could mean finding another faculty member or employee to learn the existing software. It could easily mean some alternative solution that I cannot conceive of at present. Nonetheless, I maintain that this database is a unique and immensely valuable resource that should be proactively protected. It is a digital testament to the lives and work of all who have passed through the PSC, client and developing therapist alike.
APPENDIX A

INTRODUCTORY MATERIAL AND NOMINATION

Informed Consent

By signing below I am giving my consent to use my responses to the following questions for the purpose of the current research being conducted by Paul Reid. I understand that I may withdraw my participation at any time. I also understand that I will receive, at my request, a summary of the research findings when it has been completed. Furthermore, I understand that the information I provide will remain confidential and neither my name nor the names of my clients will be revealed in the report of the study.

Signature

Date
Characterological Client Difficulty

Through conversations occurring in clinic teams, individual supervision, and in personal conversations, it has become clear that some of the clients seen in the PSC present unique and formidable challenges to their therapists. There is an aspect of these clients’ personalities or ways of being in the world which makes them particularly difficult to work with, even for the most skilled and seasoned clinician. The effect of treating a characterologically difficult client can cause the most competent and well-intentioned therapist to experience a great deal of frustration and even question the very nature of psychotherapy and their desire to practice it.

I am asking you to participate in an exploratory research project with decidedly practical application. Several of the clinical faculty have recognized that these clients have a profound effect on the clinical trainees they supervise and that the work of therapy with these clients is significantly different from work with the other clients seen in the clinic. The literature on difficult clients has also suggested recently that community clinics such as the PSC may begin to see an increase in such clients as the health care system continues to change and resources become increasingly limited (Fiore, 1988). Little is systematically known, however, about the current number of characterologically difficult clients seen in the PSC or their effect on their therapists.

Once you have completed this survey, I will be looking at PSC database information on a subset of your clients. I will compare the “difficult” clients to a control group on a number of theoretically relevant variables such as previous treatment history, number of transfers (hypothetically because their therapies outlive their original therapist), and missed sessions.

This project represents the first attempt to explore the effect such clients are having in the PSC. It is also an opportunity to begin to think how clinical trainees can be better prepared to help these clients and to manage the feelings that these clients elicit in their therapists. As such, your help in getting an accurate idea of what is happening in the clinic is greatly appreciated.

It is important to note that the phenomenon I am attempting to explore is not a reflection of the competence and skill of the therapist. The term “characterologically difficult” explicitly identifies the difficulty as within the clients themselves. My interest in this question, in part, arises from my own experience treating characterologically difficult clients in both in- and outpatient settings and discussing them with supervisors and experienced clinicians. I am inviting you to join me in thoughtful exploration of this phenomenon which affects all of our training experience in the PSC.

Thank you for your participation. Paul N. Reid
Clinical Survey of Characterological Client Difficulty

Attached is a list of all of the individual adult therapy clients you have seen as a therapist in the PSC. They are listed by case number, the “unit” of therapy (i.e. ‘I’ = individual), the opening and closing dates of the client’s therapy, the client’s initials, age, and sex, the number of weeks that the case was assigned to you, the total number of sessions you had with the client, all of your supervisors and the beginning and ending dates of their supervision. If you do not remember a client or cannot connect a case number or initials with a name, there is a notebook in the PSC office which has a sheet similar to your own, but with the clients’ full names as well. That notebook cannot leave the clinic, but the personalized sheet attached here may. **Please do not detach your client list. It must be returned with this sheet.** If you want a copy, note this on your client list and I will gladly print you a new one.

Please read the proposed definition of characterologically difficult clients that follows:

1. The clients display rigid, maladaptive patterns in their interpersonal relationships which result in relational crises or impasses. The client feels that satisfactory resolution of these impasses is not possible. In these relational impasses, the client makes known to the other that they want something specific in the relationship. The client further communicates that not getting what they want is intolerable. When the other attempts to provide what the client wants, however, the client’s reaction is dramatically negative (a clinical example will follow).
2. The clients perceive their symptoms and behaviors as consonant with their self-concept and attribute the responsibility for these relational crises or impasses to others.
3. These problematic behaviors and interpersonal impasses are reproduced in the therapy (see reverse side for example).
4. The clients’ behaviors evoke a strong emotional reaction in the therapist and/or causes the therapist to become confused about the course of treatment or feel unsure of his or her competence as a treater.
5. The difficulty the therapist experiences is directly attributable to characterological aspects of the client’s personality or way of being in the world.

(over for special conditions and additional information)
After carefully thinking about each clients treatment, I ask you to do two things.

1. Please first **rate each client** on how difficult overall it was for you to conduct their therapy by entering a number from “0” (not at all difficult) to “9” (extremely difficult) on the line to the left of their entry on your client list.

2. *Because individuals may vary in their use of rating scales and because I am concerned that arbitrary cut-offs may not be meaningful, I would like you to decide which clients you would describe as difficult. If any of your clients could be characterized as difficult to work with at any time during treatment for any of the reasons cited in the definition (regardless of your overall rating), please circle their entry on your client list.* Please feel free to nominate as many clients as feels appropriate.

**NOTES:**

1. If a client has been difficult to work with for reasons other than those listed in the definition, please circle their entry and place an **asterisk** next to their case number.

2. If you feel that you do not have enough information to rate a given client, please place an ‘X’ on the line to the left of their entry.

3. If you do not feel that any of your clients should be nominated, please check the statement below. **Do not, however, detach your client list from this form.**

   ___ I have not treated any characterologically difficult clients in the PSC.

4. If you do not feel that you can participate in this research at this time please check the statement below and return the form to my box.

   ___ I decline to participate in this research project.

*Please* : return this packet to my box by **Thursday, May 7th**. I will ask you to do additional ratings on a small subset of your clients on a subsequent survey after I have collected your initial rating sheets.
An example of such an impasse may prove to clarify the position in which therapists find themselves.

The client presents as so deflated and demoralized that there is very little impetus for change. The client overtly communicates that he or she want to feel better. However, every time therapist addresses this attitude or encourages the client to adopt a more positive view, the client feels that the therapist is unempathetic and unrealistically optimistic. As a result the client feel increasingly hopeless and becomes angry that they are not feeling any better.

Modified from Horowitz, Rosenbaum, and Wilner (1988)
Clinical Survey of Characterological Client Difficulty

Please find attached the follow-up Survey of Characterological Client Difficulty materials for you to fill out on either the client(s) you nominated last week or one of the clients whom you indicated was rather easy with whom to work which will become the comparison group.

Please rate each of the components of the definition of characterologically difficult clients and then respond to the two open-ended questions as they apply.

For the survey for control client (the non-difficult comparison group) please also rate each of the components of the definition for the control client and respond to the two open-ended questions if they apply.

Please: return this packet to my box As soon as conveniently possible.

If you are going to be leaving for the summer or moving out of the area and would want a pre-addressed, postage-paid envelope to return these materials, please check the following space and indicate the date by which you need the envelope and return this cover sheet to my box:

Check here I need the envelope by: __/__/1998

Thank you once again.
1. The clients display rigid, maladaptive patterns in their interpersonal relationships which result in relational crises or impasses. The client feels that satisfactory resolution of these impasses is not possible. In these relational impasses, the client makes known to the other that they want something specific in the relationship. The client further communicates that not getting what they want is intolerable. When the other attempts to provide what the client wants, however, the client’s reaction is dramatically negative.

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2. The clients perceive their symptoms and behaviors as consonant with their self-concept and attribute the responsibility for these relational crises or impasses to others.

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3. These problematic behaviors and interpersonal impasses are reproduced in the therapy.

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4. The clients’ behaviors evoke a strong emotional reaction in the therapist and/or causes the therapist to become confused about the course of treatment or feel unsure of their competence as a treater.

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5. The difficulty the therapist experiences is directly attributable to characterological aspects of the client's personality or way of being in the world.

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6. Please estimate how often this client attempted to engage you outside of the sessions (e.g. call the PSC in crisis, require phone sessions or 'check-ins', etc.)?

7. Please comment on how the work with this client was different from your work with non-difficult clients in any of the following areas: your supervision, the development of your theory, your understanding of psychotherapy, your emotional resources, or your confidence as a therapist.

Would you be willing to meet with me to discuss your experience treating this client in the future? Yes ____ No ____.

Would you be willing to fill out additional ratings of the clients not covered in this packet? Yes ____ No ____.
BIBLIOGRAPHY


