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Toward Engaging the Difficult Patient

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ABSTRACT: The difficult patient is here described as the one who does not readily accept the usual definitions of the treatment relationship and who tends to get the therapist to be overly-engaged in the therapeutic process. The therapist must be clear not only about his own characterological issues and countertransference predispositions, but also about the unique propensity of these patients for the enactment of conflicts. While empathy is the sine qua non of our therapeutic work, the need to set limits and to address hostility should not be underestimated if these patients are to be engaged in any meaningful psychotherapy. To maintain an empathic perspective, the therapist must appreciate the purposefulness of the patient's defensive characterological behavior and that it cannot simply be dismissed as mere pathology. Such a perspective may help the therapist to better respond to the patient's behavior as a communication about his sense of self and his concerns about relatedness. This will facilitate the engagement process.

INTRODUCTION

It is rumored today that we are seeing increasingly more "difficult" patients in the clinic setting. And it seems to be an accepted truism that these are people with fewer resources and poorer motivation than those people seen in private practice. It may be that the clinic setting and various modifications of therapeutic method are generating new clinical data echoing the beginnings of another Kuhnian revolution (Kuhn, 1962). We may indeed be in need of a new paradigm to understand the kinds of clinical experiences therapists are reporting. Therapists are talking increasingly of a sense of frustration and futility in their

Masculine pronouns in reference to the therapist or patient are understood to refer equally to the female therapist or patient.

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work with a fair percentage of the clinic patient population. In this paper, we can only take a sampling of some of the familiar clinical scenarios and interactions that therapists face regularly in their attempts to engage the patient in the treatment process. A primary focus here will be on what is considered particularly problematic in our work with people we call the "difficult patient." That is, the patient's need to *enact* and the therapist's tendency to *act*. There will also be an attempt to recast some technical aspects of our work in more subjective terms. It is hoped that by keeping some of these issues in our focal awareness, therapists will be able to maintain a perspective in their relationship with these particular patients.

It also gives a helpful perspective in our work with the difficult patient to remember that Freud began his work with the difficult patient of his day. We hear reports of some of Freud's analysands who tell us that when they faltered in the flow of their associations, he would gently kick the back of the couch (Singer, 1985). One can almost visualize the Freud of today walking around the couch and kicking the patient. While we have the advantage of Freud's genius and the work of the post-Freudians and the object-relationists, it seems that there is still a lot of kicking going around. Only it appears that a lot of concerned therapists are as likely to be kicking themselves as they are the patients.

The literature refers to these patients by various labels such as "pre-oedipal" (Balint, 1968), "regressed" (Boyer, 1983a), "character psychotics" (Frosch, 1964), "severe character disorders," people with "primitive mental states" (Giovacchini, 1979a) and "borderline personality" organizations (Kernberg, 1975). If we draw the line at overt psychosis, these patients share in common the use of splitting and projective identification (Shapiro, 1978).

In terms of a practical diagnosis, and the one that is often implicitly assumed, is that suggested by Winnicott (1954) and Boyer (1983b); "the therapeutic diagnosis." The diagnostic question then becomes: can this person benefit from our work together? Can he get himself to the sessions, and can he function adequately outside the session hour.

In terms of developmental issues, it is helpful to bear in mind the object-relational emphasis stated by Greenberg and Mitchell (1983), that these patients are "incapable of the consistent experience of themselves and others that is assumed of the classi-

cal, conflict-ridden oedipal neurotic. . . ." In these people there is a "failure to relate (even conflictually) as a whole self to a whole other" (p.384).

PRINCIPLES OF ENGAGEMENT

Here's a glimpse of a first session. The patient comes in and after a moment of silence says, "So." The therapist gives some indication that the patient should go on. The patient says, "So, you are just going to sit there like the rest of them." As the therapist thinks to himself, "so, you are going to be like one of those," he says warmly to the patient, "the rest of them?" So far so good. The patient talks animatedly about his past treatment failures. Because the therapist is now involved, he may set out to prove that he will be different, a better therapist. He may actively try to get information about what went wrong in the past therapy experiences, but may not always address the patient's sense of failure, his hopelessness and anger. The therapist may also fail to convey to the patient that he is interested in understanding how he feels now, beginning therapy again.

Patient Description

It is the difficult patient, the one we have problems engaging, who ironically enough, is the one who gets the therapist to be overly engaged with him. This is the patient who somehow elicits the sense that there is some right thing to do or to say. The therapist feels if only he can find it or do it, the patient would be engaged in treatment, or at the very least, be less troublesome.

Persons called difficult patients are those who are undersocialized in terms of proper therapy behavior. For example, the more workable patients may make some reference cryptically or otherwise to the therapist's credentials. An intervention is made about the patient's anxiety or about his wondering if the therapist might be of help. In essence, something has been done that reassures the patient. The therapist then feels he has done the right thing. By contrast, the difficult patient wants to know where the diploma is. Those people we like to work with, the neurotics, the oedipal types, are the ones who accept the thera-

pist's definitions of the treatment relationship. In a sense, they have slept with mother culture and are blinded to the cultural glossings. They readily accept the symbolic nature of the relationship offered. The troublesome patient, however, accepts no substitutes. There is little symbolic about his demands. Paradoxically, much of what he talks about is symbolic or derivative of very archaic needs and fears. This would not be such a problem for the therapist if he could simply do supportive therapy. For these are the patients who cannot allow themselves to experience a normal dependency and they will not let the therapist be "good enough."

Sometimes the therapist must respond to the multiple phone calls, become involved with the manipulation around medication, and take seriously the threats of suicide. But these actions do not reassure these patients that the therapist cares or that he can be there for them. Sometimes by the therapist's very availability the patient experiences him as saying he cannot handle the rage or tolerate the tantrums of the patient. Finally, when the situation escalates or spirals downhill, the therapist feels set-up and emotionally drained. Feeling used-up, the therapist may have difficulty in listening to the patient express that that is how he (the patient) feels: set-up and used. By this very availability the therapist led him to believe that he would be there no matter how unrealistic his demands, no matter how inappropriately he behaved.

With the difficult patient the therapist is mobilized. Often instead of listening he is preoccupied. He may be actively thinking about the diagnosis, assessing the need for medication, or for hospitalization. He is often wondering about the risk of suicide. In those instances with the difficult patient when the therapist is not worried about these things in the immediate present, he is wondering about when they will become issues in the future.

Many of us have had the experience that if our desire to make the connection is greater than the patient's, he often responds with defensive detachment or persecutory anxiety. At times when we are "there" for a patient, he experiences us as somehow sadistic and therefore deserving of his rage, an often mystifying experience from the therapist's perspective. From the patient's vantage point, the therapist is tantalizing and ultimately withholding. He sees the therapist as titillating his insatiable demands for which he will ultimately be rejected. He vacillates between

feeling deprived of the therapist's infinite bounty and having to prove that the therapist is worthless and empty. The patient is left feeling that we withhold from him simply because he is so needy, at base, an unattractive demanding child. We as therapists become active, because doing is one way of caring and at times we become active because we do not want to be the passive recipients of a barrage of projections and projective identifications. We actively try to define ourselves as something other than what the patient would have us be. And we act, we do, to deny our own rage and reactive hate.

But some of the therapist's activity is not simply the product of an interactional process, but of something very basic that we share with our patients. Klein, Fairbairn, and Winnicott speak of *doing* instead of *being* and the manic defense. It is better to feel active, powerful and guilty, in essence oedipal, than to feel small, vulnerable and helpless (Guntrip, 1969). This is how the patient feels beneath the chaos, the impulsivity, the rage; and it is a condition with which we can easily identify. We do not want to see it in him or feel it in ourselves. Winnicott (1935) reminds us that it is "a part of one's own manic defense to be unable to give full significance to inner reality" (p.129). A simple example of the manic defense of doing versus being is when a patient becomes aware of a certain aspect of his inner world and then responds: "Okay, but what do I do now?" Here, the patient seems unable to await the natural, spontaneous *doing* that comes from within. He has little experience simply *being with* or awaiting what will emerge.

THE THERAPEUTIC INTERACTION

It is implicit in the therapeutic contract that it is basically the patient's "job" to be who he is. He cannot do otherwise. When he conveys his sense of futility and impotent rage, if these are salient issues for him, he is then doing his "job." We know how successful the patient is by the way we feel and act. Kernberg (1976b) reminds us: "the patient not only attributes a certain mental disposition to the therapist, but he also induces in him a certain emotional disposition which complements the patient's own affective state, and elicits an urge to act in a certain direction which complements the transference needs" (p.822). The

patient must create certain experiences with the therapist (Boyer, 1983c), who must accept the fact that regardless of what he does or doesn't do, he will be transformed in some way (Levenson, 1972). When the therapist accepts the fact that he can't avoid the transformation, he can begin to do his "job" of clarifying the nature and meaning of the interaction.

The desire to be there, to do for, or to reach, the difficult patient, is often experienced by the patient as an intrusion. The therapist's need to do or to be something, his very need to be of help, is at times felt by the patient to be at his expense. This has been the patient's experience in the past, and it is how he *needs* to experience us now. A patient who felt that I was there for him during a difficult time and that I understood him, subsequently berated me for the fact that I had taken the opportunity to prove that I was a caring person.

Limits and Structure

Because the patient often enacts rather than verbalizes, a few observations about limits and structure are in order. Extreme behavior aside, given the circumscribed nature of the therapeutic setting, the patient does not have too many variables at his disposal to test or define the relationship. The therapist, therefore, should be giving close attention to issues around time and money and the asking for advice and personal information. When there have been exceptions made around these issues, the therapist often reports feeling exploited. From a supervisory perspective, however, it is usually the patient who pays, sooner or later, in some form or another.

A mother, who was seen prior to her son's session by the same therapist (for reasons beyond the point of the example), was 20 minutes late for her session. She asked for 20 minutes of her son's time to compensate. Feeling himself to be in empathic connection with the mother's pain and desperation, the therapist went along with the request. Later in the session the mother spoke movingly about how, when she feels miserable and upset, "she drags her son down with her." The therapist saw this as an appropriate time to point out to the mother that this is what she did when she took her son's treatment time. We are not surprised that the mother was less than receptive to the interven-

tion. While a lot can be said about this interaction, it might be noted that when the boundaries of the treatment setting are not secure, *"empathy" can have hurtful consequences for the patient.*

In some instances when patients are making demands or pressing for some form of gratification in terms of time or information, there is the likelihood that, among other things, they are trying to keep us "good" or to protect an idealized view of us. At these times, it is often productive to think in terms of what negative thoughts or feelings about the therapist the patient is trying to ward off (Kernberg, 1975).

In the enactment of his sense of helplessness and futility, the patient often makes the therapist feel helpless and useless (Adler, 1982; Solomon, 1985). Because this may take a concrete form of expression, the therapist must acknowledge the *reality* limitations of what he can provide, and *choose* what he will tolerate. In working with extremely acting out and impulsive patients, it is of paramount importance that the therapist acknowledge his own limitations and those imposed by the treatment setting for certain kinds of behavior. He should also be aware of personal tendencies to be overly tolerant.

A fair percentage of premature terminations may be attributable to the therapist's tolerance of extremely provocative and often obnoxious behavior. Aside from a lesson in masochism, it may implicitly confirm for some patients a sense of their badness and leave them feeling guilty about the way they abuse the therapist and angry that he allows it. A lack of structure leaves the patient feeling fearful about what else may emerge, from himself and the therapist; he may await the therapist's vengeful retaliation.

While the therapist wants to convey his acceptance of the patient, he must also safeguard the therapeutic work. When the patient's behavior is unacceptable, he is entitled to a clear, straightforward message. The therapist must inform the patient that while his words and feelings are perfectly acceptable, certain behaviors will have to be brought under control if they are to continue to work together.

Often overlooked by the therapist is his option to unilaterally terminate treatment. In some instances the patient may have to be told that by his behavior he is letting the therapist know that he needs more than can be provided in the current setting.

Kernberg (1975) stresses the importance of getting some acknowledgment from the impulsive, acting out patient at the beginning of treatment that he is responsible for his own behavior. At those times when the patient feels he cannot control his behavior, he will make this known and go to the emergency room or accept hospitalization.

It is important to remember the indispensable perspective we find in the literature that much of what our difficult patient presents to us is not simply crass, unadorned primitive behavior per se, but defensive and multidetermined. The chaos, rage, and meaninglessness are also purposeful. In speaking of the therapist's objective hate for a patient, Winnicott (1947) tells of a patient who was "almost loathsome to him for some years." He came to realize that the patient's "unlikeableness had been an active symptom, unconsciously determined" (p.196). What could be more meaningful than the awareness that a patient actively creates meaninglessness (Kernberg, 1975). Instead of cursing the therapeutic darkness, this stance suggests alternatives for the therapist to take in communicating to his patient. For example, the therapist might say to an acting up patient, "you work very hard to show me there's no way I can understand how badly you feel." While this runs the risk of suggesting there are "right" things for the therapist to say, the intention is to show that if a therapist contains his own tendency to act, more appropriate ways of attending to the process will occur to him.

As noted earlier, rage and chaos may be purposive, rather than only derivative. And knowing that these are not the totality of who the patient is, helps the therapist venture statements such as, "as angry as you are with me right now, there is another part of you that hopes I can put up with this." And sometimes when acting out gets intense, the therapist may have to make a direct appeal to the patient. For example, "I know that you feel that there is no other way you can be right now. But I do need some sign or indication from you that you understand what's going on" (or "that you are not going to kill yourself.")

The patient often struggles with ways of conveying his sense of desperation and terror. His provocative behavior, seen in the context of the therapist's readiness to act, highlights the tendency to respond to the content of a problem or crisis. This often gets in the way of the patient's fuller or more adequate

expression of his feelings. When a patient is talking about suicide or the fear of another hospitalization, it may be his way of saying that he feels *like* he cannot handle it, he feels *like* he cannot go on. Admittedly, one of the therapist's most difficult tasks is to know when to act and when to translate and listen. But when the patient is definitely in need of hospitalization or some form of constraint, this is a difficult situation, and not a difficult patient in terms of our discussion.

THE CONTAINER CONTINUUM

The Therapist's Containing Function

To be able to hear the message, to listen, is to be able to contain a great deal of anxiety. Each therapist has his own unique tolerance for anxiety. In terms of the patients we are considering, much of it has to do with experience. Therapists often assume that there is a definitive way of dealing with crisis situations with difficult patients. However, in many of the troublesome instances, there is no objective right or wrong. What to do, or how to be, and in some cases, what will be, evolves out of the interaction. Often, supervisors or administrators make a decision on the basis of how much anxiety they can help contain in the therapist and in themselves rather than on the basis of any objective set of criteria. If the therapist's anxiety is contained, he can stay in contact with the patient and be receptive to what emerges. When the therapist's anxiety gets in the way, it may obscure the process and enhance the patient's sense of futility and confirm his worst fear: it is as bad as he thought it was—even the therapist thinks so.

The Role of Supervision in Containing Function

For the therapist to be able to tolerate and contain the chaos, the rage, and the projective identifications, he often needs to know in advance that there is someone there for him, a supervisory container, if you will, and that the agency is supportive and willing to listen.

The supervisor knows that it is a difficult case when he

suggests an intervention to the therapist who responds, "I tried that already." The supervisor then offers what he considers to be a "megaintervention," to which the therapist then responds, "Yes, I have been doing that for the past 3 months." At this point therapist and supervisor usually obsess about an appropriate diagnosis for the patient. In those instances in which the supervisor senses that nothing he says can help, he may realize that what the therapist needs most is simply for him to listen. He may then ask the therapist to talk about his feelings about the patient or their work together. Although nothing objectively has changed, the therapist may now feel reassured and freed-up in his work with the patient. From another perspective, the therapist has the experience, the reminder, that relatedness is meaningful. This kind of supervisory process can be an indispensable validating experience for the therapist. One of the things that makes the difficult patient difficult is that he implicitly and often consistently questions the meaning of life and the value of relatedness. Because of the patient's affective intensity, and the therapist's empathic linkage, the therapist may lose sight of the fact that he is functioning at a different level. The patient's questioning and forelornness challenge the therapist's beliefs about life generally and his capacity to care specifically. What he must remember is that for the patient, these expressions are not existential questions but are object-relational laments.

Supervision gives the therapist a perspective, a place to step back; a reentry to the world of secondary process with solid boundaries, a reassuring hierarchy, a world where symbolic expression is valued. The difficult patient shows us how fragile and capricious our man-made world is in the face of the primitive. The therapist's meaning system is under assault and to maintain perspective he must have some viable way of comprehending his experiences and processing rapidly shifting, overly determined complex data. Our meaning systems are our transitional objects when we are alone with the patient's frightening productions. One aspect of a larger meaning system is the concept of transference. Whatever its unique meanings and universal applicability, in essence it allows the clinician to say at the worst of therapeutic times: "it's not me he is talking about." At the supervisory level we have a variation of this, the *parallel process* (Bromberg, 1982; Caligor, 1981; Ekstein & Wallerstein, 1958; Gediman & Wolkenfeld, 1980). It allows the supervisor to

say: "this really doesn't have anything to do with me; he is just showing me what the patient did to him."

Our meaning systems, metapsychologies, theories of human development, and the language we use are our attempts to codify our clinical experience. And while they are a means of understanding the patient they can also get in the way of knowing the person and staying in contact; dynamics and diagnosis not only lend clarification and enhance empathy, but can also demean and distance. It is often pointed out that when we break down behavior into its component parts we lose sight of the individual. While we decry an atomistic approach to patients theoretically, we often reveal an atomistic attitude in some of our complaints about the difficult patient. We expect them to have acquired certain functions intact, ignoring the larger context of their developmental difficulties. We would like them to have the cognitive ability to benefit from our insights, an adequate observing ego to inhibit acting out, and enough object constancy to be glad to see us from session to session. What we expect is what they complain they lack.

FROM THE TECHNICAL TO THE PERSONAL

As noted earlier, the use of splitting and projective identification is the hallmark of the difficult patient. As these are technical concepts it might be helpful to reframe them in more colloquial language and see if it brings us closer to the patient's experience and suggests ways of responding.

Splitting

Splitting, a means the infant used to organize his world before he had more sophisticated means, later comes to be overused defensively (Jacobson, 1964; Kernberg, 1976a). Splitting was the way the infant sorted out his world, and a simple means of keeping pleasant and unpleasant experiences and sensations in separate categories in order to control them better. Fleeting impressions of the self and the other could be sorted according to "pleasant-unpleasant;" later, good-bad became the category. Possibly the person who was supposed to be helping this child

negotiate his world was not up to the task. Perhaps in addition, the child tended to have very intense feelings or other mediating abilities weren't developing fast enough to make sense of a fast moving world. In any case, the child kept things separate because they seemed more manageable. This process also kept bad feelings and images from contaminating the good.

The difficult patient is the one who has continued to use this way of organizing his world into adulthood. It is this tendency to a binary, dichotomizing management of feelings and impressions of himself and others that we find so maddening in our work with these patients. It is either good or bad, all or none, me or you; if something isn't right, it has to be someone's fault. A common example of splitting is that of the patient treating one person as if he were all good and another as if all bad. It is easy to point this out in inpatient settings or when our patient is talking about two people outside the treatment setting. We are often less prone to see it when the patient is treating us well at the expense of some other significant person in his life.

Splitting has been given a variety of meanings in the literature. Kernberg (1975) refers to splitting in relation to contradictory ego states. Significantly, Fairbairn and Guntrip speak of splitting of the self: "a splitting of the unitary, pristine ego into a part dealing with the outer world and a part that has withdrawn into the inner mental world" (Guntrip 1969, p. 70).

Patients also split feelings from content and the therapist may have to peruse the material to find the affect, and then often only in disguised form. In addition to keeping contradictory feelings toward the same person separate, patients may split off contradictory issues or opinions over time or may present them only in parable form.

If we could construct an ideal form of splitting, it would be one in which the patient could split himself into an experiencing part and a part that could observe and report what was going on. Whatever primitive material he wanted to report would then be quite manageable for the therapist. Our hypothetical patient might explain splitting to us this way: "It's important for me to keep things neat and separate. I wish I were an obsessive; but it's like my life depended on it. I have to keep my good feelings and thoughts separate from the bad ones. Sometimes the only way I can feel good about myself is to feel bad about somebody else. If

things get a little gray I get scared—like the bad in me is going to take over or hurt the people I care about." Remembering that our patients use techniques that are holdovers from infancy, we are not surprised that he has a concrete sense of inside and outside and some interesting theories about how things shift back and forth. One of his dilemmas is how to get the bad (angry) stuff out of him without losing the people he needs.

Projective Identification

If our insightful patient were also to describe projective identification, he might use Langs' (1975) word, "dumping." Langs' more technical phrase for the process is interactional projection. The patient conceivably would say:

> When I get close to somebody I start dumping all this negative stuff on them. Even though I know it's my stuff, sometimes I think they're doing it to me. Sometimes it shifts back and forth so much I lose track of who is doing what to whom. Then I really start feeling crazy. Now you can point this out to me, and I can know it intellectually, but it doesn't seem to make any difference. One of the things that really bugs people about me is that I am so controlling. That's because when I dump this stuff out there, it feels like the other guy is out to get me so I really have to stay in control of things.

The Function of Primitive Defenses

Obviously, the clinical situation is more complicated than is being conveyed here. According to Kernberg (1975; 1976a) ego states, comprised of specific self and object representations with a particular affective tone, are split off and projected. One ego state can now be used defensively against another. But the purpose here is to maintain a subjective sense of the interaction and a perspective that will help us maintain a therapeutic connection while also providing an appropriate clinical distance. As therapists we cannot technically, nor personally for that matter, ignore some of the terrible things our patients say or enact with us. We can however try to understand some of the various purposes that mechanisms like splitting and projective identification serve as aspects of the difficult patient's way of being in the world (Grotstein, 1981; Kernberg, 1976a; Malin & Grotstein,

1966; Segal, 1964). To that end, the following examples are given:

1. While making contact so difficult, the patient is paradoxically maintaining a very intense, if not intimate contact.
2. The patient is protecting the relationship by avoiding some very intense conflicts. In Kernberg's terms, he is trying to prevent the activation of primitive transference paradigms.
3. The patient is trying to externalize his conflict, that is, get it outside, where it began, between him and his world. (These are the people who have been the repository or container of their parents' inadequacies or dissociated negative aspects).
4. The patient is still identified with what he ostensibly disowns by putting it "out there." Relatedly he can vicariously enjoy what he is renouncing via projection.
5. The patient is repeating old issues, old battles, in an attempt to master them. Unfortunately he is also using the old techniques to master the current situation.
6. He is enacting issues that give him so much trouble to see how we deal with them; a chance to learn by example.
7. The patient is looking for feedback as to how he is experienced and what will be tolerated.
8. He is giving himself another chance to take in something new.
9. Lastly, and by way of summary, the patient is implicitly asking to use us as a container.

For the therapist, containment means allowing the patient to enact his troubling issues without our attack, withdrawal, or collapse. As this occurs over time the patient may learn that something other than rage passes back and forth between people and he may be freed up for new experiences and to find new ways of relating.

A provocative and tangible example of the container function is cited by Boyer (1983c, p.193), although he uses the term repository. As an army psychiatrist Boyer saw a psychotic young man who was delusional and hallucinating. In lieu of therapy the patient was told to keep a log of his experiences. A week later the young man presented Boyer with a two volume diary. Several months later, Boyer had a chance to speak with the young man who seemed fully compensated. The patient told him that

he had put all his bad feelings and thoughts into the books that he gave to Boyer. He then watched him closely for the next few months and was reassured that Boyer had not been damaged or contaminated.

Winnicott's (1960) concept of the "holding environment" and Bion's (1962) concept of the "container" function (see also Modell, 1979) are important. Kernberg (1980) conceptually integrates these concepts. He uses the phrase "affective holding and cognitive containing" (p.188) to describe the therapist's "holding action" in maintaining an empathic attitude in the face of regressive behavior, while attempting to cognitively integrate (or contain) the fragmentarily expressed transferences (both are important components of technical neutrality). Grotstein (1979, p.176) refers to the "nonanalytic caretaking" aspects of the work of Winnicott, Balint and Kohut. Obviously the capacity to absorb emotionally charged material and to maintain an empathic connection, especially with those aspects of the patient that he needs to dissociate or disown, is an important on-going function of our clinical work. However, I think that aspect of the work usually referred to by the "holding environment" is more appropriately applied to a later phase of treatment, at least with the population of patients under discussion. I am referring to the time when the patient is no longer actively defending against the relationship and his pain and yearning, yet still hasn't the words to express it. That is when our work at *being with* rather than *doing for*, takes on a cogent meaning. Whatever we may say basically takes the form: "yes, I'm here."

Although a vast literature (e.g., Epstein & Feiner, 1979; Heiman, 1950; Little, 1951; Racker, 1953, 1957) has shown that an understanding and use of the therapist's feelings and reactions is a sine qua non of our work with the difficult patient, we also know that the conduct of therapy is not all empathy and countertransference. But as this is an introductory paper, I can only offer a perspective, suggest an attitude of receptivity, and hint at some general directions.

THE ENGAGEMENT PROCESS

In reflecting upon the significance of the first session, it would be difficult to overemphasize the importance of getting a

sense of what it is like for the patient to be beginning therapy. This may be more meaningful than exploring why he is there or what his expectations are. Conveying our interest in understanding his experience is a very basic but often neglected means of engaging the new patient.

For the many months of the waxing and waning of the engagement process, we are not trying to change anything, or to get the patient to see anything. It is we who want to learn how this person lives his life, how he keeps himself from being aware of it, and what sustains this person.

During the early months of shifting connectedness, the therapist constantly monitors how the patient is hearing what he is saying (Frosch, 1971). "What are you doing with that?" is one form this inquiry takes. It suggests that there is an active process going on within the patient.

Kernberg (1975) addresses this issue in discussing the value of interpretation with severe character disorders, and makes the point that these patients can understand and integrate interpretive comments, particularly if the patient's understanding of the therapist's interpretations are examined and interpreted in turn. He tells us that clarification takes precedence over interpretation and this technical demand creates quantitative differences between psychoanalytically-oriented psychotherapy and psychoanalysis.

Many accounts in the literature on the difficult patient do not give examples of interpretations per se, but the therapist's attempt to address the patient's ego state, and to convey not only understanding but to impart the message that the patient's behavior itself is a communication. An example of this is Giovacchini (1979b) saying to his patient that her reactions, especially "the most distressing ones, were designed to prove to me how miserably helpless she felt" (p.235). Likewise, Rey (1979) accepts his patient's distress about what might come out of her and her wanting to leave treatment. While encouraging her to verbally venture on, Rey tells her that of course she can leave treatment if she so desires, but that if she is willing "to say what thought is making her so uncomfortable that she wants to leave," it might save her time and misery (p.475). The issue for these patients is how to show the therapist how badly they feel or how crazy they fear they are. In the first instance, it was the "patient's" task to

convey her helplessness without saying it per se. It was the therapist's task to make the inference and communicate it.

What if the issue or task for a patient is to try and get what he needs from a therapist without being rejected for being bad, or destroying the therapist with his rage? He may resort to presenting material in a chaotic, elusive, seemingly meaningless way. Kernberg (1976b) accepts the importance of the content of the material while pointing out the process in terms of its defensive use. Kernberg says that "I told him he was trying to bring up a number of matters that were meaningful, indeed, but that now served the purpose of preventing the emergence of a more dreaded emotional experience regarding me" (p. 803).

While in this example Kernberg is preparing to address the negative transference, we must also be sensitive to hostility in its more subtle characterological forms of put-downs, disguised contempt and sarcasm. For example, several years ago I began working at the clinic with a patient whose therapist had left abruptly. Whenever this man would refer to his previous therapist, it was as "that other yoyo." To which I would often respond, "as opposed to this yoyo." Needless to say, the patient found numerous opportunities to recall his former therapist.

One reason hostility often goes unaddressed, aside from characterological or countertransferential reasons, is that clinicians sometimes see it as something to be either tolerated or gotten around rather than as a central part of the work. This suggests that they may be operating from the assumption that repression is at work with these patients and that there is a specific nuclear conflict to be reached. What we are dealing with in our work with the difficult patient is what in fact makes them difficult. It is work that entails some undoing of their way of organizing experience and their defensive way of being in the world.

CONCLUSION

And finally, a brief note on a common complaint of the difficult patient that stirs a lingering apprehension in the therapist and induces pessimism about engagement. I am referring to the patient's feelings of emptiness. We learn of emptiness due to the

gross projection of inner contents, loss of self and object constancy, the emptiness due to turning rage against the self, the narcissist's emptiness due to never having cathected objects, or schizoid emptiness due to withdrawal. We see it as both a symptom and something to be defended against.

A number of years ago, I went to a supervisor feeling a sense of futility in working with several patients who were complaining that they were "empty." In essence, the supervisor's response was that I was acting as if I really believed the patient was empty. Since then, patients have shown me how much empty can contain. Our work with this aspect of our patient's experience should focus on what emptiness means to him subjectively rather than accepting it as an objective fact. We explore what it expresses, and what purpose it serves intrapsychically and interpersonally. And by maintaining the conviction that there is something there in the patient, we will be ready to learn about the uniqueness of his inner world.

In conclusion, just as the supervisor sees the potential for excellence in the neophyte therapist, so the therapist sees the potential for relatedness and change in the difficult patient, and, like the good-enough mother, allows himself moments of empathic failure. Our work, at various levels, is reminiscent of the mother who can tolerate the eruptions and shortcomings of her child because she has confidence that change and growth will occur.

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