The difficult patient in group: blendig the mayor psychoanalitic prespectives

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Abstract

As Horwitz (1977) noted, "Paradoxically, the very qualities and deficits that make the …patient a problematic group member are the same deficits that are often best treated in a group setting" (p.404). This is because group psychotherapy is the medium nonpareil for highlighting and ameliorating the associated relationship conflicts that these difficult patients have.
It has long been known that patients with chaotic, amorphous, and fragile egos are suited to group treatment because of the diminished intensity of transference compared to individual treatment and the opportunity for patients to self-titrate the intensity of their involvement (Freedman, Sweet, 1954). The group has a social reality of its own which counteracts these patients propensity to regress. Members can be quite supportive to one another. But, at the same time the group can provide vicarious gratification, as difficult patients observe others expressing feelings, self-reflecting, and attempting to work out their problems.

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They were demanding, attention-seeking, and sought immediate relief when under greater-than-usual stress. They did not seem open to meaningful communication and perceived that "the other is a target for attack or an instrument of persecution" (p. 103). Pines considered these patients to be largely borderline. However, he found both the theories of Kernberg and Kohut useful in explaining their symptoms and understanding how to treat them. Borrowing from Kernberg he noted that such patients had weak egos and used defenses of splitting and projective identification. But, in accordance with Kohut, he agreed that such patients were constantly struggling to maintain a coherent sense of self and that their resources for maintaining narcissistic equilibrium was lacking. These two theoreticians have enriched our understanding of borderline and narcissistic states, in particular, and severe character pathology, in general. Today, the term "difficult patient" has come to refer, at the very least, to those with borderline and narcissistic personality disorder (Roth, Stone, Kibel, 1990). But, often it refers to a range of severe personality disorders, including schizoid, paranoid, histrionic, avoidant, dependent, and sometimes even anti-social personalities. Many of these show elements of borderline and narcissistic pathology, including projection of blame, distrust or paranoid thinking, narcissistic rage, and have a range of narcissistic fantasies. What makes these patients "difficult" is the way they behave, particular in treatment. They are known for dichotomous, often mutually contradictory behaviors in individual psychotherapy. They have such deep-seated

conflicts in relationships that they may seek inordinate amounts of help, while rejecting what is offered. Some cannot bear to let the therapist know how much he/she is needed for fear of being overwhelmed by regressive longings. Deceptively, they can remain aloof and relatively unavailable.

Their behavior in groups is the same, but frequently exaggerated by the interpersonal nature of the group. At one extreme, they may resist engagement with others, become overly suggestible, or blatantly distrustful. At the other extreme, they may monopolize the group, act-out in self-destructive ways, or hold the group hostage with threats of suicide. However, many of these patients can be worked with in groups and some may prove to be an asset. These patients have been known to catalyze the process in several ways. Some have the ability to raise issues that others fear. They are apt to take risks more and challenge their peers. Lastly, they can be evocative when they bring up aspects of personality that others deny in themselves. In this sense, they can serve as a screen onto which group members can project unwanted aspects of themselves and disown them, but later, because the "difficult" patient continually reminds them, acknowledge those split-off parts.

Whereas Kernberg (and all theories of object relationships) emphasizes the role of aggression in severe character pathology, Kohut (self-psychology) emphasizes the fragile nature of these patients' self-esteem, or self systems. Whereas Kernberg emphasizes the use of traditional psychoanalytic techniques of clarification, confrontation, and interpretation, Kohut stresses the importance of providing soothing self-object experiences. In practice, most clinicians borrow from both and use techniques with provide support and then go on to expose and work with the aggression.

Psychodynamics

Both object relations theory and self psychology provide organized structures for understanding the psychopatholgy of these patients and dynamic vicissitudes of the personality during the course of treatment. Both focus on underdeveloped aspects of the personality. Both infer that there is an inner world of relationships, which determine both how the individual experiences him/herself and how he/she relates to others in the external world. The former postulates that the patient has a weak ego structure that is unable to defend against internal destructive processes. The latter assumes that deficiencies in the early, childhood environment left the central experience of the self in a state of insufficiency, thus producing a life-long search for substitutes. The former is a theory of conflict, the latter is one of psychic deficit (Kernberg, 1982).

According to object relations theory, developmentally these patients have not attained the stage of object constancy where they can tolerate ambivalence which is essential to human nature. They are unable to see themselves and others as mixtures of loving

and hateful elements. The ego remains weak because those introjects dominated by the libidinal drive are split off from those dominated by the aggressive drive. That is the basis of identity impairment. Primitive splitting and its hand-maidens, primitive denial and projective identification, dominate the defensive structure (Kernberg, 1975). The major psychological problem then is the management of aggression. According to self psychology, these patients lack a coherent self system, that is, their sense of self-regard and self-sufficiency is wanting. They lack the ability to comfort themselves in the face of the normal stresses of life. Developmentally, there is a failure to establish soothing and holding introjects. Consequently, they are overly dependent on others to provide what normal individuals can give themselves. This is why they are said to need others as self-objects (Kohut, 1977), without which they feel bereft and act-out. The major psychological problem then is the need for soothing of chaotic internal states.

In practice most clinicians incorporate aspects of object relations theory and self psychology. They do so by focusing on projective identification, along with other primitive defenses, while providing a soothing treatment environment. Whiteley (1994) has noted that differences between these two perspectives can be bridged by attachment theory. Even the identity diffusion of the classic borderline patient can be seen as a consequence of a failure in early attachment, whether that failure is seen to be a product of environmental deficiency or an inability that comes from within. "Attachment gives identity through recognition and acknowledgment of one's existence" (p.367). Without that the individual goes through life unsuccessfully seeking a variety of means to create some sense of internal coherence. Whiteley terms this societal and psychic vagrancy.

One of the major contributions of self psychology is its systematic way of describing the need that these patients have for nurturance. One of the major contributions of object relations theory is its description of internal states that lie between neurotic personality organization and psychosis. Difficult patients constitute a group of personality disorders all of which have borderline personality organization (Kernberg, 1976). Currently, there is a consensus that this constitutes a spectrum of character pathology with high-functioning and low-functioning types (Horwitz et al, 1996). At the higher end are those with obsessive and masochistic traits. At the lower end are those with schizoid, paranoid, and antisocial traits. It is the combination of traits that effects prognosis.

Horwitz et al (1996) in an analysis of the literature on the treatment of borderline patients with individual psychoanalytic psychotherapy compared the indications for supportive versus expressive approaches. While they identified criteria for one approach or the other, there is one caveat that is relevant to group psychotherapy. They observed that with respect to patients' propensities for closeness or distance and their amenability for expressive work that "Patients who manifest either behavioral

extreme are not candidates for interpretation. Those who alternate between the two extremes are more ready for uncovering work" (p.304). This implies that those who are fixed in one of two alternate ego states (libidinal or aggressive), in object relations terms, and those who have an insatiable need for soothing (self-objects), in self psychology terms, are not likely to change. In contrast, those with more flexible styles of relating can make optimal use of the many facts of group psychotherapy.

Parameters for Treatment

These patients have a difficult time sharing in groups and are more apt than others to have mini-crises. Sometimes they find it difficult to function in a heterogeneous group without additional support. This is especially true for narcissistic patients and many withdrawn types. Thus, occasional prn (as needed) individual meetings are not uncommon and can often help them tolerate the frustrations of group life. There is often a serious issue as to whether the patient can "stand the group" (Wolman, 1960). Less of problem is whether the group can stand them. Whenever, a patient does not "fit in", so to speak, the group will isolate him/her. Hence, the need for additional support from the therapist.

Offering additional help outside group sessions, while necessary for many of these patients, can become a burden. In fact, there are times when it is anti-therapeutic. With demanding, stain-inducing patients, the therapist's countertransference can be put to the test. As a rule of thumb, the therapist should only offer that with which he/she feels comfortable. Beyond that, the patient will likely feel that he/she has become a burden. That will re-enforce the patient's negative self-image. In many clinical situations, it is the therapist's ability to use limit-setting that converts an extremely demanding patient who eschews group interaction into a productive group member. Knowing when to nurture and when to stop is the art of therapy, for which there does not exist any guidelines.

In general, these patients show poor frustration tolerance, do not tolerate unpleasant affects well nor the anxieties in others, have difficulty sharing attention, are anxious, self-absorbed, show poor control of their hostility, and are subject to paranoid anxieties. But, as Horwitz (1977) noted, "Paradoxically, the very qualities and deficits that make the …patient a problematic group member are the same deficits that are often best treated in a group setting" (p.404). This is because group psychotherapy is the medium nonpareil for highlighting and ameliorating the associated relationship conflicts that these patients have.

It has long been known that patients with chaotic, amorphous, and fragile egos are suited to group treatment because of the diminished intensity of transference compared to individual treatment and the opportunity for patients to self-titrate the intensity of their involvement (Freedman, Sweet, 1954). The group has a social reality of its own which counteracts these patients propensity to regress. Members

can be quite supportive to one another. But, at the same time the group can provide vicarious gratification, as difficult patients observe others expressing feelings, self-reflecting, and attempting to work out their problems. Horwitz (1977) noted that many inhibited patients identify with both aggressor and victim during hostile interchanges that occur. One cannot overemphasize the benefits of vicarious experience in the group, to involve the patient while providing a cloak of anonymity.

Difficult patients can be an asset to a psychotherapy group in several ways. Because of their interpersonal sensitivity, they can respond to subliminal affects in others and bring them to the fore. In this way they can serve as a conduit for affects that are not yet accessible to others. Likewise, this same attribute enables them to contain affects for others and then explore deep realms of emotional experience from which their peers shy away. Their interpersonal sensitivity, which makes them prone to serve as repositories for projective identification from the rest of the group, can make them vulnerable to scapegoating but, at the same time, enables them to be an asset. Because they may serve as a kind-of barometer of the group, they can help the leader recognize hidden, unarticulated experience in the group (Schlachet, 1998). In fact, sometimes the leader's examination of his/her own countertransference to the difficult patient can give invaluable insight into what is going on in the group-as-a-whole.

These patients have great difficulty forming a therapeutic alliance. Consequently, the drop-out rate is high compared to patients with less severe character pathology (Skodol et al, 1982). The situation is compounded by the fact that it is generally impossible to tell beforehand which patient will remain in treatment and which will drop-out (Conelly et al, 1986; Stiwne, 1994). After ruling out obvious factors, such as lack of commitment, an inability to form even a fragmented alliance, impulsiveness, and a history of serious acting-out behavior, the clinician can only guess who will remain and who will leave prematurely.

The narcissistic element in all severe character pathology posses special challenges in the long run. This is because of the tendency to fluctuate between states of idealizing the group and devaluing it. Narcissistic patients who remain in treatment for extended periods of time may still drop-out when the core of their narcissism is challenged.

A rather dependent, narcissistic woman entered treatment because of a history of failed relationships with unreliable men and inability to finish schooling. Over several years of treatment she made considerable progress. She graduated college with a degree in a skilled profession, terminated a long-standing destructive relationship, and finally married a stable, if somewhat obsessive, withdrawn man. During the course of treatment, she had had a dependent relationship on the group. The members had given her advice as she often asked them how she "should think and act." She was often challenged on her behavior and had seemed to profit from confrontations, although complaining about them. The group had become a strong,

protective object for her, one that tempered her affective instability and restrained acting out. The members had challenged her inability to be intimate with men. After marriage, her relationship with the group changed. She withdrew and experienced the group as a critical, rejecting mother. She began to act-out. She had found it difficult to be intimate with her husband, promptly had an affair with a married man, complained about her husband, but resisted his efforts to involve her in marital therapy. When confronted by the group on her behavior, she impulsively quit treatment.

While narcissistic patients are difficult to manage in group, those with paranoid and antisocial traits often do poorly. While paranoid patients are distrustful in individual treatment, in group their paranoia is magnified; in group there are many more people to watch and against whom to be on guard. Antisocial traits are associated with a poor treatment outcome. In a study of borderline patients without co-morbid antisocial personality disorder, but with antisocial traits, Clarkin et al (1994) found "that antisocial behavior is the most important component of …..pathology in predicting treatment course" (p.311). Kernberg (1989) has alerted us to a continuum in severe character pathology of narcissism, antisocial traits, and paranoia. The further to the right the patient falls on this spectrum, the worse the prognosis. In this regard, there are no differences with respect to the treatment modality. The exception here may be groups specifically designed to treat these more malignant character traits.

Group Atmosphere

These patients have chaotic experiences of themselves and others. That is the consequence of identity diffusion. In treatment they unwittingly try to induce chaos in others, thereby reassuring themselves that confusion, callousness, and other undesirable traits emanate from others, not themselves. To counteract this effort, the group must be resilient. Obviously, its tone will be set by the leader. Stability and consistency are essential to minimize these patients' anxiety. However, it is not possible for groups to have an absolutely benign atmosphere. First, the members themselves create tensions. Second, circumstances always occur to cause disruptions in treatment. These patients are more apt than most to react adversely whenever there are interruptions in the therapeutic process, such as during vacation breaks, the entrance of new members, the departure of long-time ones, and during periods of group instability. In this regard, there is some evidence to suggest that a uniform, consistent leadership style is more important than his/her theoretic orientation, regardless of whether the approach is more or less probing or structured (Luboshitzky, Sachs, 1996). An atmosphere of constancy and predictability helps these patients to feel safe so that they can relate to one other.

Much has been written about the need to attend to one's countertransference when working with such patients. At times they can be trying for the therapist; at times they can be trying for both the therapist and the group members. Then there is the danger that feed-back and confrontation will be used to excess. The result may be scapegoating. On the other hand, when these (or any) patients act-out, limit-setting needs to be considered. The therapist often hoes a fine line between exerting effective control, which can comfort the patient, and acting-out his/her own countertransference.

Narcissistic patients are the most difficult to engage in treatment. They tend to have blatant disregard for group norms. Their self-centeredness is dominant. Alonso (1992) conducted a group made up entirely of narcissistic patients. For the first three sessions no one showed interest in learning another's name. Early in treatment these patients require special acknowledgment of their neediness, while expecting little from them. A mature group can handle such patients. However, a group in earlier phases of development cannot. Then, the therapist must play an active role and support the narcissist. But of course, even the most astute therapist and the most mature group cannot help "failing" the patient at times. The crucial viable here is the patient's ability to tolerate his/her own narcissistic injuries in a supportive group. Neither the therapist nor the group should be faulted for empathic failures. After all, some of these patient's neediness is insatiable.

When group psychotherapy works for narcissistic patients it does so because of aspects of the treatment that favor the amelioration of a faulty self-esteem and that whittle away at narcissistic defenses. A cohesive group can function as a protective cocoon that keeps at bay profound internal sadness and emptiness, until the patient is ready to bear these to others. The sense of belonging to a cohesive group, one that feels larger than oneself, provides support for a fragile ego; the group can then function as sort of a nurturing self-object, in the Kohutian sense. There are, in most groups, a wide range of empathic but also non-empathic responses from which the patient can avail him/herself. The former provides psychological nurturance; the later provide the opportunity for narcissistic fantasies to yield to interpersonal reality. In other words, the group provides support while affording the opportunity of learning frustration tolerance as self-centeredness is challenged, merely by the process. The latter includes sharing with others and facing the fact that no one can always resonate with one's emotional needs. Lastly, patients can learn to tolerate humiliation and not avoid criticism as they gradually expose shame-ridden experiences.

There is a consensus that in groups with difficult patients the therapist must be supportive and take active steps to counteract the patient's propensity to feel unaccepted, rejected, and even persecuted. Empathic responses and demonstrating interest in the patient goes a long way to counteract these tendencies. At the same time, noting similarities amongst group members and promoting caring attitudes help

to facilitate the development of cohesion, provide a sense of belonging, and diminish feelings of alienation. The therapist is invariable a model of identification in the group. He/she promotes the development of a therapeutic attitude amongst the members. This includes one of inquiry, interest and curiosity. But, foremost is an empathic attitude. At first, the therapist may chose to provide empathic responses him/herself. But, that is only a preliminary step to facilitate the development of empathy between members. Working diligently to promote the therapeutic alliance is so important that Stone and Gustafson (1982) claimed this to be "a goal, rather than an intermediary step in" (p.45) treatment.

A group atmosphere that is consistent and predictable gives the patient a sense of safety, so that he/she can reveal the inner most parts of self and put them into that social sphere. When disruptions in the treatment process occur, the patient withdraws, at the very least. During those times whenever there is a disturbance, the group leader must work toward rebuilding attachments. During times of cohesion, the therapeutic progress can function. Winnicott's (1971) description of play is relevant here. The group becomes a potential space in which the patient "plays", that is, reveals and works on the disruptive aspects of his/her own personality. Like the toddler, the patient has the illusion that an all-powerful, protective, and providing object (mother or group) stands nearby to rescue him/her if chaos emerges. Gradually, as these noxious aspects of personality are revealed, understood, and tolerated, the patient, like the toddler, can separate, that is, the shielding quality of the group is no longer needed. This is the very meaning of Winnicott's term, transitional space.

Over the course of treatment, clarification of both individual and group issues is vital. The group leader must attend to group processes, to ensure that negativistic, pessimistic, and paranoid attitudes do not inhibit the treatment. Confrontation occurs more readily in groups than in individual treatment because it is intrinsic to the feedback that patients give one another. Even ordinary feedback in group can be quite confrontive at times and stress-inducing. Yet, confrontation can be traumatic. The individual being confronted tends to feels exposed and become defensive or withdraws. Therefore, it is important that the target member receive support. Patients often find support in some corner. When that is not forthcoming from members, then the therapist must intervene. In contrast, confrontation of individuals by the group leader should be avoided. The leader more than any single person in the group can leave someone exposed and feeling either attacked or mortified, something that these patients find intolerable. However, confrontations may be necessary to prevent scapegoating and to counter intractable resistances, particularly group-wide resistances.

Process of Treatment:
Group psychotherapy is potentially suited to providing both the elements of support and confrontation, which these patients need. In their study of individual,

psychoanalytic treatment, Horwitz et al (1996) found that both were necessary. They note, in fact, that all supportive treatments provide insight and all expressive treatments provide support. The psychotherapy group, with its admixture of containment and feedback, is an arena in which both abound. Its very nature lends itself to, what has been referred to for individual treatment (Pine, 1984) as, "interpretation within the context of support."

The view that these patients need support and cannot tolerate regression is found with practitioners of psychoanalytic treatments, to be sure, but is also evident in cognitive, interpersonal, and behavior approaches. All assume that pathological behavior patterns are sometimes induced by, but invariably fostered, in a reciprocal and complementary fashion, by contemporary responses of the patient's social system (Allen, 1997). In fact, all seem to suggest that the therapeutic interaction serves as a kind of corrective emotional experience. Only psychoanalytic treatments have honed theory to where it is possible to offer a comprehensive view of this process.

Psychoanalytic theories view severe character pathology as an ego defect, whatever its alleged etiology. This deficiency is expressed as a faulty "self-system" or, in other words, a pathological identity. That is precisely what psychotherapeutic groups address. They do so via three dimensions of the group: the member's relationship with other members, with the leader, and with the group-as-a-whole. The commonality of experience in the group promotes universalization, namely, the sense of being the same as others in the same environment. In groups with difficult patients, the leader assumes special importance, since he/she controls the atmosphere of the group by moderating disruptive behavior, promoting cohesion, and fostering the therapeutic attitude. The latter includes encouragement for the expression of intrapsychic turmoil (and its attendant behavior) and its translation into verbalization (as opposed to action), tolerance for intragroup conflict and demeanors that are consumed by aggression, the conviction that these will be worked out, and the attitude of self-investigation. By molding the group, fostering certain attitudes, encouraging interaction, and stressing commonality of experience, the leader promotes mutual identifications between the members, with the therapeutic attitude, and finally with the group itself.

The latter is most important. The attachment to the group entity gives the individual a sense of being intimately associated with something larger than oneself. That connection is the basis for incorporation of experiences from group life. As noted above, group interactions function in a way that is analogous to play (Kosseff, 1989). Like a play group conducted for toddlers under the protective aegis of a mother-surrogate, members can make trial relationships in an atmosphere where there is relatively little concern for consequence. This is because the group leader assumes ultimate responsibility. Play allows one to selectively place parts of oneself into the immediate world and then recover them at will. This is the basis of trial

identifications. For this reason, group psychotherapy has been said to fall in the area of transitional phenomena (Kosseff, 1989).

Within a psychoanalytic frame-work, the therapeutic process can be conceived in terms of projective identification. Disruptive aspects of personality are re-enacted in the group. This is followed by salutary re-introjection, once they become association with the therapeutic attitude. This association means that attitudes of tolerance, containment, inquiry, and reflection are incorporated into the group's response to projected material. As noted, the therapist is instrumental here. This process was described for individual treatment by Ogden (1981), but can readily be extrapolated to the group. Projective-reintrojective relatedness is a psychoanalytic concept that describes the psychological process associated with member-to-member interaction and ordinary feedback in a group (Kibel, 1991).

Over time, the experience of acceptance in the group, of tolerance for the more disruptive aspects of one's personality, and adoption of the therapeutic attitude itself, allow the patient to view him/herself in more benign ways. That constitutes internalization. In other words, the group experience affords the patient the opportunity to develop new partial identifications by incorporating, at first, and then internalizing elements of the group alliance (Kibel, 1991). These, in turn, can modify or even displace former pathological identifications.

Once change begins to occur in the group, new behaviors emerge which are socially accepted. They act in a reciprocally enhancing manner, at least within the group, to enhance self-esteem, acceptance, and interpersonal effectiveness. In short, more adaptive behavior is rewarded. The new experience of oneself in the group functions as a remedial self-object relationship, which is available to be internalized. This process is at the heart of the corrective emotional experience.

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