CHAPTER 12

The Dismissing Patient

From Isolation to Intimacy

In conventional diagnostic terms, dismissing patients can be seen to fall on a continuum with obsessives at one end and narcissists and schizoids at the other. Such patients all have enormous difficulty trusting others enough to be genuinely intimate with them, even though they may have stable long-term relationships. And they are no more intimate with themselves. Their "compulsive self-reliance" (Bowlby, 1969/1982) and defensive overestimation of their own value require that they remain remote from whatever feelings, thoughts, or desires might provoke them to seek support, connection, or care from others.

They cannot extinguish their biologically driven attachment needs, however. Dismissing adults may claim in the AAI context to feel that "all is well," but physiological measurement indicates otherwise—just as avoidant infants display little distress in the Strange Situation while elevations in their heart rate and stress hormones tell a different story (Fox & Card, 1999). Clearly our dismissing patients are reluctant to feel emotions that might spur them to connect deeply to others, and even more reluctant to express such emotions. Yet only through making an emotional connection with these patients can we actually engage them in the kind of relationship that makes change possible. The key here is to follow the affect.

We have to be keenly attuned to the dismissing patient's subtle affective cues, usually as these are communicated through the body. What do we see in the patient's eyes? (Is his gaze averted, possibly in shame, or directed

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downward, as in sadness? Do his eyes appear moist, as if he might be moved? Are his upper eyelids raised, as in an angry glare?) What do we observe in the set of the patient's jaw, mouth, or brow? What might be expressed in his posture? And what can we infer from his tone of voice?

Perhaps even more important, we need to tune in to subtle shifts in our own psychobiological state as we sit with the patient. For what patients are reluctant to feel, they will often inadvertently evoke in their therapist. Shifts in our internal experience are rarely unrelated to the emotional experience of the patient. Attention to our internal experience tends to be most fruitful when we can be at once quite deliberate about allowing ourselves to feel and not overly concerned with concealing our feelings. (Recall Ekman's research showing that adopting a poker face flattens not only the expression but also the *experience* of emotion.) Bringing our own feelings to the treatment of dismissing patients can help them to begin to integrate their own dissociated feelings.

But for psychotherapy to provide the secure base that makes such integration possible, the therapist has to matter to the patient—and allowing the therapist to matter is, of course, at odds with the deactivating strategy of the dismissing patient, which depends on diminishing the importance of others. Thus the central challenge is to enable the patient to allow the therapist to matter.

More often than not, such a patient begins treatment behaving as if the therapist either has little to offer or represents a threat that must be kept at bay. The Catch-22 here is that the patient's barriers against feeling make it impossible for him to feel much for the therapist, while the therapist's relative insignificance to the patient reinforces the barriers against feeling. Of course, this is the essence of the dismissing adult's defensive strategy in the face of his broader life problem. The patient's self-protective constriction of feeling and avoidance of closeness generate the emotional and relational difficulties that typically bring the patient to therapy.

Finding our way through that Catch-22 requires that we balance empathic attunement with confrontation. Usually patients need the former in order to feel that we understand them. Often the dismissing patient, in particular, needs the latter in order to feel that we exist—that we can have an impact upon him and that he can have an impact upon us. To really get to the dismissing patient, we may need to let the patient know how he gets to us.

EMPATHY AND CONFRONTATION

Both empathic attunement and confrontation are geared to the essential aim of opening the patient to more of his emotional experience. For with

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regard to feeling, the dismissing patient is very much a closed system, having learned that the acknowledgement and expression of distress would likely result in frustration, or worse.

Putting our empathy for the patient's experience into words may diminish the patient's fear that we are controlling or rejecting, in which case such a response will be reassuring. But it can also backfire. Dismissing patients, we may assume, knew little in the way of empathy from attachment figures when they were growing up. As a result, our empathic communication may be Greek to them; they may experience it as a lame substitute for "real" help ("Is that all you have to offer?"); or—because empathy can evoke the multiple threats associated with closeness and dependency—they may be unconsciously compelled to reject it.

While I almost invariably lead with empathy, believing it provides an essential ongoing background of safety, I find with dismissing patients that in order to connect with them early in treatment something more than empathic mirroring is necessary and, for that matter, something more than interpretation. The "something more" here is the deliberate or spontaneous expression of our subjective experience of what it's like to be on the receiving end of the patient's communication. This is what I'm calling confrontation.

Letting the patient in on our experience of the relationship usually means disclosing something of what we're feeling, and our showing some emotion may be particularly important with patients who feel so little of their own. Their self-awareness is severely constricted by what they can't allow themselves to feel, think, or remember. Their preverbal experiences are lost to explicit memory and their later recollections may never have been encoded because of the deactivating in these patients of the strong emotions that ordinarily "tag" experience as worth remembering.

But what such patients lack access to in themselves may nonetheless be evoked in others, including the therapist. Thus, our subjective experience may provide a key route to their otherwise inaccessible feelings, thoughts, and memories. Moreover, since the defensive strategy of dismissing patients compromises their ability to empathize and, in turn, blocks their awareness of their impact on others, our subjective experience can be an exceptionally vital resource when it is divulged to them.

Recall the patient I discussed in Chapter 8—a forceful, rather intellectual executive—with whom I found myself anxiously "bulletproofing" my words as if I were facing the threat of prosecution. When I disclosed this experience to "Gordon," he was astonished. It seemed to him that I was giving voice to *his* experience of feeling somehow endangered—an experience for which he had previously lacked the words, but which had driven him to "goldplate" his performance at work lest he be judged or attacked. He recalled his mother, a Holocaust survivor, making the assumption that

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he was anxious at work ("You must be the only Jew there"). His feeling of being under threat seemed to be the legacy of his mother's history, the probable result of the intergenerational transmission of trauma. Confronting patients like Gordon with the therapist's experience of the relationship with them has the potential both to connect them to their own emotional experience and to illuminate something of their impact on others.

Sometimes, but by no means always, confrontation has the kind of "edge" the word brings to mind. Previously I mentioned a somewhat reluctant patient who in an early session made it clear that she was finding my every word and gesture of attuned understanding completely useless. To my empathic overtures, she responded as if I were actually an adversary toward whom she was becoming increasingly contemptuous. After 20 minutes or so of this futile and frustrating exchange, I told the patient (with a bit of an edge) that I was beginning to feel quite exasperated with her, that this was not my customary response to her, and that we needed to understand exactly what was going on here. A little taken aback, the patient collected herself, then admitted that her relationships at home and at work were regularly marred by her tendency to be contentious and, sometimes, bullying.

Such patients, especially (though not exclusively) early in treatment, have one foot in (if that) and one foot out. They can appear to be "resistant" in the old problematic sense of the term—that is, they can seem to be functioning in opposition to the therapist or the aims of therapy. But understanding the dismissing patient's apparent resistance as a *communication* is far more useful and true to the patient's experience. In being reluctant, unengaged, or controlling, these patients are conveying their fears of closeness and dependency. And as attachment research makes clear, dismissing patients have come by these fears honestly: In the context of their attachment history, acknowledging the need for help may feel like an invitation to rejection or a humiliating admission of insufficiency.

Needing help and not finding it is always a risk, but *getting* it may represent an even greater risk. To feel helped in a significant relationship is to risk destabilizing a dominant conscious working model in which the self is valued as strong and complete while the other is devalued as weak and dependent. What is likely to surface in its place is the feared unconscious model in which the self is helpless and vulnerable while the other is rejecting, controlling, or punitive; under the sway of this model, the patient is liable to feel angry as well as anxious. Moreover, experiencing the therapist as someone who is willing and able to help may evoke a terrible sadness in relation to earlier attachment figures who were unable or unwilling to do so.

Psychotherapy places dismissing patients in a bind by implicitly invit-

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ing their dependency upon a new attachment figure whose help cannot be expected to be helpful. As therapists, we may begin to disconfirm this expectation when we shift between efforts to attune to the patient's experience, on the one hand, and to recognize—and sometimes disclose—our own experience, on the other. Perhaps it should be clarified here that what can appear to be two opposing modes of responsiveness nearly always interact.

After all, I am able to understand and empathize with the patient largely through, and on the basis of, my own experience. In this connection, I'll occasionally preface my words to the patient by saying that my understanding of him derives from experiences of mine that may (or may not) turn out to be relevant to his. Additionally, in the process of deliberate self-disclosure, I usually find myself feeling more attuned, as well as closer, to the patient. Conversely, the experience of empathizing with the patient, and sometimes expressing that empathy directly, often leads me to feel more self-knowledgeable and more connected to myself.

THERAPEUTIC INTERACTION AND THE DISMISSING PATIENT

An authentic expression of the therapist's subjectivity may be necessary in order for the dismissing patient to *feel* the therapist's presence as a separate person. This is especially true when the patient has experienced his parents as rejecting or emotionally absent, in which case the therapist's affective responses may be bracing, but also reassuring. Even when the patient has felt overly controlled by his parents and has consequently drawn inward, it may be important to hear from the therapist, as a sometimes vulnerable human being with the ability to feel and express feelings.

Particularly when dismissing patients are more remote, they may need the stimulus or encouragement to be present that an affectively substantial expression of the therapist's subjectivity can provide; when patients are more emotionally engaged and available, on the other hand, they may simply need the therapist to stand beside them, as it were, to help them feel more deeply and understand their experience. The risks of the therapist's self-disclosure are real, but so are the risks of his appearing overly controlled or reserved—a blank screen. Stereotypically neutral or "objective" therapists (especially those with a dismissing attachment style) may wind up colluding with the defenses of the dismissing patient, inadvertently reinforcing the emotional isolation that has hobbled the patient's development.

The point, of course, is not to deliver a barrage of honesty but, rather, to communicate our experience in a form the patient can make use of. Nat-

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urally, this can be quite challenging at times. While the dismissing patient may succeed in remaining out of touch with many feelings, anger is not inaccessible: Unlike sadness, say, anger helps make for distance. And, as expressed through the overt (or covert) devaluation intrinsic to the patient's deactivating strategy, that anger often winds up provoking strong feelings in the therapist.

Exactly what feelings and how they are expressed will depend largely on our own attachment pattern(s). Therapists who lean in the dismissing direction may become cold or withdrawn. Or, they may become controlling. Or, they may interpret, adding insight to injury, so to speak. Preoccupied therapists with powerful fears of abandonment may find it impossible not to show how crushed they feel or they may fly into a rage.

Ideally, we are secure enough to convey something of our feeling, with just enough affect to reach the patient at an emotional level. Obviously, we are not (nor should we be) entirely in charge of the emotions that unfold in our interaction with the patient. Sometimes we overshoot and sometimes our responses mirror the patient's withdrawal or overcontrol. To be able to recognize and understand the characteristic patterns of transference/countertransference that are likely to arise with our dismissing patients is no guarantee of optimal responsiveness, but it can help.

Three such patterns stand out, and each seems to be associated with a somewhat different history of avoidant attachment. One pattern is played out with patients whose first line of defense is devaluation, a second with patients who (initially) idealize, and a third for whom control is the watchword. Usually we experience more than a single pattern with the same patient, but early in treatment one tends to predominate; because it represent the patient's first line of defense, it often reemerges during times of difficulty both inside and outside therapy. And because the therapeutic relationship is co-created, our own attachment characteristics inevitably have an impact on the patient. If we have a need to be idealized, for example, the patient may be more likely to lead by idealizing us.

The Devaluing Pattern

Dismissing adults in couples have been described (Goldbart & Wallin, 1996) as "merger wary," and those among them who devalue as "the merger wary who sabotage love" (p. 93). In conventional diagnostic terms, these patients tend to be labeled "narcissists." Frequently the children of deprived and narcissistically devaluing parents, they have grown up in an emotional desert. Borrowing their parents' defenses, they have learned to shield themselves from their unmet needs and angry frustration by thinking too well of themselves and too badly of others.

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Over time, however, the illusions of specialness that protect and comfort these patients can prove an increasingly hollow substitute for love. Yet genuine intimacy risks exposing the feelings of dependent longing and anger which their parents could not tolerate. Consequently, their response to a potentially intimate relationship is akin to that of a starving man at a banquet who tells himself the food just isn't good enough and therefore refuses to eat.

What we need to keep in mind about our dismissing patients is that the self-generated propaganda about *their* perfection and—still more so—*our* imperfection provides them with (a very prickly kind of) protection from shame. As vital as this protection may feel at an unconscious level, it is also self-defeating and, as such, requires therapeutic attention.

More effective than a direct focus on the patients' protective hostility, however, are comments that highlight their difficulty in letting others matter. In therapy, that difficulty is reflected in the patient's (often unconscious) efforts to make sure the therapist does not become too important to him. Faced with an impending interruption in the treatment, for example, the patient may cancel sessions or comment on the money he'll save in the therapist's absence, as if to reassure himself about how little the therapist will be missed.

> A year or more into the relationship with one such patient, I finally commented on his rather striking way of beginning and ending our sessions. Upon entering the office, he would stride by me, handing me his check without a look in my direction, and often, in fact, briefly shutting his eyes. When parting, he would stride out, silently showing me his back in response to my usual "take care" or "see you next time."
>
> Without mentioning that I often felt shut out and slighted by his behavior, I simply described it to him and suggested that it probably had some meaning. On hearing what I had to say, he initially seemed to try to normalize his behavior, observing that a kind of "military crispness" marked most of his professional relationships. As we explored his experience, however, it became clear that he was uncomfortable with the "personal" dimension of these relationships.
>
> Therapy, for example, was bound to end, he pointed out, so why would he allow himself to get too personal or close here? He admitted that trust was an issue and went on to elaborate that his mother probably provided the model for his behavior as well as the reason for it. She would regularly withdraw into her bedroom without the slightest gesture or word of parting. Nor would there be any sign of acknowledgment, much less welcome, from her when he arrived home from school: She would remain sequestered in her bedroom, silent; it felt, he said, like coming home to an empty house.

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With patients who are defensively devaluing, either implicitly (like this one) or explicitly, we may find ourselves enacting a couple of different responses. In a dismissing state of mind, we may respond to the patient's devaluing transference with a devaluing or angry countertransference. When in a preoccupied state of mind, by contrast, we may feel all too vulnerable and respond as if the patient's devaluation were warranted by our insufficiency: If the patient won't let us matter, maybe that's because we have nothing of importance to offer him. In either case, if we are able to bear both our own discomfort at the potential for further devaluation and the patient's discomfort at feeling "exposed," we have the opportunity to explore an important *relationship* pattern (as well as a defensive one) that may shape the patient's interactions not only with the therapist but also with others.

The Idealizing Pattern

Dismissing patients who idealize, like those who devalue, have often grown up with overtly self-absorbed, covertly insecure parents. Sensing that their parents' narcissistic needs would always come first, such patients as children came to realize that they could find an oasis in the emotional desert by satisfying these needs. Through helping their parents to feel special, they could feel special themselves—while avoiding the risk of being dependent or angry.

Knowing this pattern of childhood adaptation gives us a way to understand the tendency of some of our dismissing patients to idealize us. What is crucial to keep in mind is that the admiration of these patients is overdone because it is overdetermined. No matter how terrific we are, patients at some level usually feel that their admiration for us is obligatory. They "know" that in order to maintain the relationship they must prop up what they imagine—or perceive—to be our shaky narcissistic equilibrium. Generally such patients keep to themselves (and sometimes from themselves) the implicit assumption that the therapist has feet of clay and requires reassurance. Unspoken, this assumption gives their relationship with the therapist an "as if" quality and preserves distance. Seen from this angle, idealizing patients, while *appearing* significantly more engaged than their devaluing counterparts, may actually be no less avoidant.

Probably we need to be as respectful of such a patient's need for idealization as we are of another's need to devalue—and just as committed, ultimately, to addressing the defense in a way that will be helpful to the patient. Many years ago, I had a powerful and regrettable lesson about the perils of failing to do so:

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> After a long, seemingly successful therapy, a patient I'll call Andrew experienced a profound and embittering awareness that his relationship with me had reproduced his compulsorily idealizing relationship to his narcissistic mother—a formidable, and only superficially available, woman who seemed to have required and received the admiration of all around her.
>
> This patient abruptly and angrily concluded treatment, accusing me of being blind to this dimension of our relationship (presumably on account of my own need to be idealized) and the limitations it had imposed on his treatment. Years later, I crossed paths with Andrew, and told him what I had been thinking for quite some time, namely, that he was right: I had been blind to the enactment and deaf to his earlier words entreating me to be more emotionally involved with him, more self-revealing, and more self-reflective.[1]

Like devaluation, idealization can be driven by a more or less unconscious sense of necessity. But whereas devaluation is mainly motivated by the need to avoid dependency, idealization may largely serve the patient's need to maintain the two-person mutual admiration society that he has learned to use to reinforce his sense of specialness. This understanding suggests that rather than challenge the patient's idealization, we ought to focus on the patient's worry about our vulnerability and his conclusion that we need to be propped up and shielded from his doubts that we are really so "idealizable" after all.

Preoccupied therapists may be uncomfortable with their patients' idealization and, consequently, they may feel compelled to puncture the balloon the patient has inflated to keep them both aloft. Dismissing therapists, in contrast, may take their patients' idealization of them too much at face value or enjoy it too much to recognize its role as part of a defensive pattern of relating. Noticing either our discomfort or pleasure at the patient's admiration can often be a clue to the presence of idealization.

The Pattern of Control

Some dismissing patients can be counted on to turn their relationship with the therapist (and others) into a power struggle. Often labeled "obsessive personalities," these patients seem obsessed with control and the fear of being controlled. Unsurprisingly, such patients often grew up with controlling, brusque, and fastidious parents who suppressed their own anger and appeared uncomfortable with close physical contact. Probably these were parents with little tolerance for their children's distress, messiness, or temper tantrums. But unlike the parents of devaluing and idealizing patients,

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these responded less with angry rejection or withdrawal than with intrusive control. As children, these future patients coped in two ways. First, like all who adopt dismissing defenses, they became as remote from their feelings as possible. Second, they (often covertly) resisted their parents' control as if turning away from the hazardous pursuit of comfort and connection to a preoccupation with the struggle against powerlessness.

In the psychotherapy of such patients, issues of power and control may seem to pop up with exasperating frequency. We may be drawn into struggles around the fee, the schedule, or the way we choose to work with the patient. Meanwhile, the patient often sees the therapist (who may actually be feeling quite beleaguered) as a controlling figure intent on imposing her will. The key is to identify the meaning to the patient of all these struggles. Frequently, they turn out to represent a rematch with the parents, so to speak, as well as an avoidance of the underlying attachment issues: People generally don't wish to be close to those with whom they feel embattled.

The challenge with these patients is neither to avoid the control struggles through submission nor to attempt simply to dominate them. Enacting the first is likely to leave us feeling resentful. Enacting the second may lead us to feel guilty. Neither alternative looks particularly therapeutic on its face—yet, assuming we're aware of our role in the enactment, both may open up meaningful exploration of the control struggle, as the following clinical summary illustrates:

> "Selena" was a patient for whom the fee was a very contentious issue. A businesswoman fallen on lean times, she was determined, as she put it, not to be screwed. Wanting to make therapy possible and having arrived at a sense of what she could actually afford, I proposed a reduced fee. From her side, it wasn't reduced enough. She made a counteroffer. I agreed to it.
>
> Some time later, however, I learned of some rather considerable financial assets the patient had not disclosed. In this context, I suggested that we probably ought to revisit the issue of the reduced fee. My suggestion left the patient feeling betrayed, exploited, and vulnerable. Complaining bitterly that I was taking advantage of her candor, she added that she should have known better than to trust a therapist who had already evidenced an overinterest in money. Shortly thereafter she interrupted treatment. A couple of years later, however, she returned, and though her personal economy was somewhat improved, I nonetheless agreed to a reduced fee (though not so reduced as before). Then her business took off spectacularly.
>
> For more than year, I said nothing about the fee, nor did she. It seemed to me that her acute vulnerability to feeling exploited was reason enough to set the issue aside. Finally, I realized that my reticence

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was also driven by my fear of reigniting her anger and suspiciousness—and that in keeping silent I was experiencing a toned-down version of Selena's own feelings of anger, distance, and vulnerability at being taken advantage of. It took me another month to brace myself and tell her that I was raising her fee.

With a slightly guilty smile, she said she'd been wondering when I was going to do so. She asked if I was raising her fee only, or that of my other patients as well. I answered that I'd raised my fees with other patients some time ago, but that I'd hesitated to hike hers because of how deeply troubling it had been for her when I had brought up the issue of the fee in the first round of our therapy. She said she was moved that I was taking her feelings so much into account.

Tempted to leave my newly burnished image intact, I nonetheless pushed on, telling her that, in fact, what had kept me quiet was my fear of arousing her feelings of anger and betrayal—feelings so intense that they had previously made it impossible for her to stay in therapy. However, I added, keeping quiet also kept me more distant from her than I wanted to be.

I asked what it was like for her to hear what I was saying. She said she was still grateful that I hadn't brought the fee up earlier, before she felt as trusting as she did now. But she was also both intrigued and disturbed to learn that her anger and potential for suspicion could have such a problematic impact on me, and, by extension, on her relationships with others. Interestingly, she had completely forgotten that her flight from therapy had been precipitated by the issue of the fee.

The struggle for control has different meaning to different patients. The loss of control can be equated with a threat to the patient's identity, or self-sufficiency, or autonomy. Giving up (or even sharing) control can feel like surrender or submission. For Selena—especially early in therapy—feeling subject to the perceived control of the other in a relationship was to feel endangered. As the treatment progressed, she could begin to consider that her sense of danger was less real than her worry about being close, vulnerable, and dependent. In short, while the issue of control here has importance in its own right as it does with many dismissing patients, it is at the same time also a refuge from the risks associated with intimacy and attachment. Often as psychotherapy proceeds and our relationship with the patient deepens, the focus shifts from aggression to love—from the risks of being controlled or controlling to the risks of loving and being loved.

Concluding on a Neurobiological Note

The right hemisphere has been described as *the social–emotional brain*. Ideally, the therapist's relationship with the dismissing patient nurtures the

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development and integration of the "right mind" (Ornstein, 1997) in ways that the patient's original attachment relationships did not.

The *relational* connections that normally nurture the *neural* connections of thinking with feeling, language with experience, and the sense of the self in relation to others may have been largely absent for such a patient, growing up as an avoidant child with dismissing parents. Remember that attachment and caregiving behavior, face recognition, and the reading of nonverbal, bodily cues in oneself and others are all functions of the right hemisphere. In avoiding closeness and feeling—activities largely mediated by the right brain—the dismissing patient may have learned to dwell mainly in a left-hemisphere world organized by linear logic and language.

Coaxing the patient's "right mind" into the relationship with the therapist depends on *right-brain-to-right-brain communication* (Schore, 2003) that is largely nonverbal and implicit but can also arise through the exchange of words that embody and evoke emotion. Certainly a (dismissing) therapist who deals exclusively from the left hemisphere is unlikely to activate the patient's undeveloped capacities to relate intimately and to feel. On the other hand, a (preoccupied) therapist who has trouble harnessing the left brain's linguistic and interpretive resources may be unable to speak in a language to which the patient can respond. Depending on our own psychological organization, we may need to still our mind enough either to inform our thoughts with feeling or to let our feelings be effectively translated into thoughts.

The ability to enter a mindful state may be particularly helpful when working with dismissing patients because mindfulness fosters in the therapist the sort of open and integrated experience we are hoping to encourage in our patients. A mindful stance enhances our capacity to both sense and articulate the nonverbal and emotional undercurrents in our relationship with the patient. Not unimportantly, facilitating the development of the *patient's* capacity for mindfulness may also be very helpful. Dismissing patients (as one of them said in describing himself) often hover over their lives, never really landing in their own bodies. As therapists, we need to be as fully present and grounded as possible with these patients, if we are ever to enable them to connect—as deeply as they are entitled to—with themselves, and with those they might love and be loved by.

NOTE

1. When my patient attributed my reserve to my need to hide the chinks in my armor, and so maintain his idealization of me, his interpretation may have been correct, but it was incomplete. For my reserve also reflected my thoroughly misguided adherence to what I now

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regard as a very problematic, if not downright destructive, view of the therapeutic relationship. In that traditional view, of course, it is rarely if ever to the patient's advantage to be informed about what is going on inside the therapist. I now believe, to the contrary, that this kind of knowledge can often serve the patient well—while the refusal to disclose it often does damage, as exemplified in my work with Andrew.

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CHAPTER 13

The Preoccupied Patient

Making Room for a Mind of One's Own

Patients with a predominantly preoccupied state of mind with respect to attachment are in many ways the polar opposite of dismissing patients. The latter often appear low on life, cut off from their feelings, and uncomfortable being close to others. The former often seem lively and vivid□ but also overwhelmed by their feelings and absorbed in avoiding distance from others. Superficially, at least, dismissing patients have little problem with their own self-esteem or autonomy, while those who are preoccupied are filled with self-doubt and fearful of being too independent. Dismissing patients almost always have trouble relying on others; preoccupied patients have trouble believing they can sometimes rely on themselves. And if the dismissing appear cut off from the resources of the social□emotional right brain, the preoccupied appear to have trouble harnessing the linguistically oriented left brain's ability to make orderly sense of disorderly experience. Paraphrasing Diana Fosha (2003), those who are dismissing can deal, but they can't feel, while in contrast, those who are preoccupied can feel (and reel), but they can't deal.

Preoccupied patients can be seen to fall on a diagnostic continuum with hysterics at one end and borderlines at the other. The former appear overwhelmed and helpless, but superficially cooperative and sometimes seductive. The latter appear angry, demanding, and chaotic. Both variations

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on the preoccupied theme involve patients whose lives are shaped most fundamentally by the fear of abandonment.

Such patients have been characterized as "merger hungry" (Goldbart & Wallin, 1996): "Because [their] greatest threats are separation, loss, and being alone, closeness is experienced as the greatest good: it is the solution, never the problem" (p. 90). As it happens, however, the way in which these patients pursue closeness usually winds up turning the solution into a problem. The hyperactivating strategy of preoccupied patients buys a modicum of security, but at an exorbitant cost.

Early experience with unpredictably responsive attachment figures has taught these patients that their best hope for securing the attention and support of others is to make their own distress too conspicuous to ignore. The problem with this solution is that it requires them continuously to scan for internal and external cues to amplify their distress. Thus, they tend to be all too aware of threat-related thoughts, feelings, and bodily sensations, and prone to exaggerate their significance; similarly, they are hypervigilant for actual or imagined signs that a relationship partner might be disapproving, withdrawn, or rejecting. The need to keep the attachment system chronically activated undermines the preoccupied patient's potential not only for emotional balance but also for self-esteem and trust in others.

In psychotherapy, therefore, if we are to help such patients to strengthen their capacities for emotional balance, self-esteem, and trust, we must offer them a relationship that presents an alternative to their hyperactivating strategy. Effectively, this means a relationship in which patients can come to count on the therapist's emotional availability and acceptance rather than feeling that they can obtain this quality of responsiveness only by defensively amplifying their affect, helplessness, and/or superficial cooperation. In other words, we need to provide preoccupied patients with a relationship that renders the hyperactivating strategy increasingly unnecessary.

This is far more difficult than it might seem. Conspicuous insecurity has become the most reliable means for gaining the attention of unreliable others. Thus it is hard to relinquish. In addition, these patients experience their overwhelming feelings, insecurity, and mistrust not as a "strategy" that they might be (at least consciously) willing to change, but rather as facets of their reality that anchor their sense of who they are. Unconsciously (and sometimes consciously), the preoccupied patient embraces these burdensome aspects of her approach to herself and others because they support both a strategy and an identity.

In dealing with the patient's felt need to embrace an approach that is self-defeating, it may be helpful to keep in mind that a therapeutic process is generally one that heals by allowing the patient to stay the same while changing (Bromberg, 1998b). Far from denying the importance of the strong feelings and the pursuit of closeness around which the preoccupied

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patient's sense of self is organized, we need to make room for more in the way of feelings and closeness. Specifically, we need to respond to the deeper feelings that underlie the patient's displays of distress. And we need to foster a more expansive version of closeness in which the patient can be more fully and authentically present rather than disappear into her preoccupation with the availability of others.

In working with the feelings— fear, anger, and desire— that underlie the drama, we bring the patient's once adaptive, now self-defeating strategy of hyperactivation into focus. In working with the patient's narrow sense of what is required for closeness, we illuminate aspects of her identity that the patient has previously had to deny— in particular, the strengths, ambitions, and needs for which her fears of abandonment have left so little room.

Exactly how we can work most effectively using this double focus on emotions and intimacy depends to some extent on our assessment of the patient— specifically in terms of their position on the continuum anchored by hysterics at one end and borderlines at the other. (Note that for didactic purposes I describe the "subtypes" here as if preoccupied patients could always be clearly differentiated along these lines; it's my clinical impression that often they can, but not invariably.) The different behaviors of ambivalent infants upon reunion with their parents in the Strange Situation may presage the different behaviors of the preoccupied patients we see as adults— the apparently helpless infant developing the more hysteric style, the infant who oscillates between clinging and angry rejection becoming someone who looks more borderline.

Regardless, there are preoccupied patients who clearly "lead" with helplessness while others all too quickly reveal their anger and their desperate demands. (The latter frequently have histories marked by trauma and loss and, thus, they may also be well described as unresolved.) Each of these two variations on the preoccupied theme requires a somewhat different therapeutic approach.

THE PATTERN OF HELPLESSNESS

Patients described with the term "hysteric" are so labeled because they appear hyperemotional and even melodramatic, just as most preoccupied patients do. What differentiates these hysteric-like patients from their more troubled cousins is that their dependency needs are less extreme, as are their reactions when these needs are frustrated. Because such patients are less apt to feel as if their lives are one long emergency, their approach to satisfying their relationship needs can be relatively more appealing and more successful.

Generally, they connect with others more through their helplessness

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than their anger. But while making no secret of their neediness, they do a poor job of satisfying their own needs or even really knowing them. Their center of gravity seems to lie outside themselves, as if they lived less inside their own mind than in the mind of others. Desperate to avoid being abandoned, they are too fearful to assert themselves and too willing to please.

When they enter therapy, they often present us with a contradiction. They may appear to have considerable psychological resources and may be quite accomplished. But in the treatment setting they conduct themselves as though they were powerless, both to manage their distress and to try to understand it. Early on, hoping for our help, they may strike us as eager patients, fully prepared to commit themselves, and very much in touch with emotions that evoke our desire to help. Quickly, we may develop with patients like these the expectation that they will be easy to work with. But first impressions can mislead. There's both more and less here than meets the eye.

Often these patients have more ability to manage and make sense of their feelings than they believe they do, know more about their experience than they are willing to grant, and have more assets as people than they are prepared to acknowledge. On the other hand, their apparent readiness to engage in a therapeutic relationship is less an indication of their ability to collaborate than a sign of their desire to comply and to please. To secure the comfort they hope that closeness to the therapist will bring, these patients know they must maintain the appearance of helplessness while also helping the therapist to feel good.

The challenge for us here is not to confuse the surface with the reality that lies beneath it, not to mistake the patient's defensive strategy for the difficulties it was designed to deal with. If we take the helplessness at face value, we may try to be helpful in ways that ratify the patient's sense that she is helpless. And if we are charmed or seduced into playing the great therapist, we may lose sight of her need to be the perfect patient. In so doing, we may deny our patient the opportunity to grapple with the fear and distrust that make her compliance and pleasing feel so necessary.

With such patients, we need to be alert to our overeagerness to rescue or to be idealized. But when, as so often happens, we find ourselves enacting such impulses, we have an opening both to do things differently and to illuminate key facets of the patient's experience. Once again, as the clinical material that follows makes vivid, the therapist can constrain as well as contribute to the patient's progress in treatment.

> An extremely competent academic whom I'll call Elaine sought my help after a series of panic attacks. Early in therapy, she told me that whenever there was a silence in our conversation, it made her acutely anxious. Apparently the last thing I wanted to do was to make this

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anxiety-ridden patient more anxious. Rather than take up the issue, I got into the habit of filling every silence. It took me several months to realize that in so doing I was doing her no favor. With some trepidation, I decided that when next a silence arose, I would let it be.

Unsurprisingly, in the quiet that came Elaine began to feel very anxious. But we were able to talk about it. It emerged that her anxiety bloomed in the silence because she felt helpless on her own to make sense of her experience— and feeling helpless, she said, scared her. I suggested that it was a bit of a puzzle that someone who made her living by making sense of experience should feel helpless to make sense of her own. In the conversation that ensued, she became aware of what she called a "surplus helplessness" that she had learned to cultivate as a child. Then and now, being overwhelmed was her best bet, she realized, when it came to connecting with her unpredictably available mother. Similarly, she connected with her father mainly around problems she was unable to solve by herself— homework when she was young, and later academic or work problems.

Farther into therapy, as Elaine became more comfortable with silence, she realized that, previously, she had felt threateningly alone when we were not in verbal contact, as if without words she would be unable to keep me with her. Now, in a way that was altogether new, she was capable of experiencing in the silence a more certain and ongoing connection between us. This was for her a cherished experience of being able to be alone with me, but alone together.

My fear of triggering Elaine's anxiety resulted for a time in my colluding with her defenses instead of grappling with the underlying experience that made them necessary. In the process, I inadvertently confirmed her sense that she was helpless to deal with her feelings— most important, her anxiety about abandonment. On the other hand, once I realized what I was doing, and found a way to tolerate my own anxiety enough to change my behavior, her "surplus helplessness"— a version of the hyperactivating strategy— could begin to be understood. Later, when she was able to relax into being "alone together," I read her achievement as reflecting her gradual internalization of the experience of a secure base: She no longer needed to coerce me (through helplessness or distress) into being with her, because now, for the most part, she trusted that I was.

For patients like Elaine, a diminished reliance on the hyperactivating strategy goes hand in hand with a growing ability to experience the therapist as a secure base. Initially, of course, such patients bring their fears of abandonment to the therapeutic relationship. They cannot rely on the therapist's emotional availability or good intentions. Like ambivalent infants whose preoccupation with mother's availability leaves little room for exploration, their energies are absorbed in maintaining their connection to the therapist.

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Yet it is only to the extent that preoccupied patients feel less compelled to monitor or manage the therapist's responses that they can turn their attention more fully to their own experience. We make ourselves a secure base rather than a source of all-too-contingent support when we generate a relationship that offers more to the patient—and asks more of the patient—than the relationships that launched her.

Among the key features of developmentally facilitative relationships cited earlier (Lyons-Ruth, 1999), two are particularly salient here: inclusiveness and the necessity for a "developmental gradient." Specifically, we must aim for a relationship that encourages the patient to connect with as much of her experience as possible—especially that experience for which her original attachments made no room. And we must expect more of the patient than she may initially feel capable of. That is, we have to recognize and enlist resources in the patient that she may be unwilling or unable to recognize in herself.

Inclusiveness

The emotionality of the preoccupied patient often has an "other-directed" quality. When preoccupied patients express their feelings, the purpose is usually less to express themselves than to get the attention or help of others who, they believe, would otherwise be unavailable. This is, of course, the essence of the hyperactivating strategy.

Rather than collude with that strategy by being oversolicitous or overprotective (a seductive possibility), the trick is to be no more or less available when the patient expresses such "public" emotions than when she does not. Just as important, we need to deploy a kind of empathic Geiger counter that cues us with regard to the "private" emotions the patient can only express indirectly.

Here, once again, attention to the nonverbal language of the patient's body—as well as a focus on our own subjective experience—provides the best access to what the patient has learned to exclude. Obviously, the details here will vary depending on the particulars of the patient's history. However, in my own clinical experience, I've found that what frequently emerge, often in sequence, and are gradually integrated into the patient's sense of self are: mistrust and fears of abandonment; then anger and the allied ability to say "no"; and finally, sadness and authentic need, as well as the ability to say "yes"—and really mean it.

The Developmental Gradient

After getting off the phone with a patient who had just scheduled an initial hour with me, I realized that in the course of our conversation I had been

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inhibiting myself, verbally and intellectually, so as not to "hurt" her by exposing a contrast with her own apparent deficits in this area. Yet when we actually met, I became aware that she had the capacity (though she didn't typically exercise it) to be much more forceful and articulate than she had appeared to be over the phone. Clearly, she led with her vulnerability, and I initially responded by being conspicuously and unhelpfully overprotective.

With this patient (and others like her) it has proven essential to expect more, rather than less. Of course, we have to meet the patient where she is. Yet we usually fail the patient when we're too ready to assume that's as far as she can go. Far more helpful is the assumption that the patient is actually capable of feeling and thinking in greater depth than she appears to be. Across the board, in fact, there tends to be in preoccupied patients an underestimate of their strengths and resources—and it can be very problematic if we seem to take the patient's negative self-appraisal at face value.

On occasion, I have spontaneously confronted a patient's overmodest self-appraisal: "You say no one could possibly be interested in you. But I'm thinking: What's not to like?" In the moment, such an intervention can seem quite unproductive; over the long haul, however, it has sometimes provided a sort of touchstone—a vivid image of the patient's defensive denial of her own strengths. Though offered in a supportive spirit, this kind of confrontation is rarely welcomed because it is incongruent with the patient's sense of herself and presents a challenge to the patient's adaptive strategy. Probably more useful as a rule is simply to explore the patient's view of her own capabilities and how that view developed; in addition, it is vital to intervene in ways that implicitly communicate our conviction that the patient is capable of more than she believes.

For example, after one patient began a session angry and distraught about several recent interactions with her husband by whom she felt unheard, unseen, and gratuitously criticized, we deconstructed the episodes that troubled her and she recognized—almost in passing—that her husband had not actually ignored or attacked her at all: "It wasn't that he really didn't hear me or recognize me, it was just that I felt that way. The same for the criticism. I know he respects and loves me, he's not attacking me, he just has another opinion. But that's not how it feels."

When I asked how it did feel ("What's your sense of how it happens that you feel he's ignoring or attacking you, when with some other part of you, you think that he's not?"), she replied, "I honestly don't know"—as if that were clearly the end of her exploring. "But just because you don't know, does that mean you can't think about it?" Which she then, in fact, proceeded quite productively to do.

Because strong displays of emotion may have helped these patients make the best of a bad situation, they tend to let their feelings drown out their thoughts. We have to make room for their feelings, to be sure, but we

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must also encourage them to think about what they feel. A balancing act is required from us as therapists if we are to help activate the reflective self of the preoccupied patient. We have to do some thinking for the patient, but not too much. We need to model mentalizing—say, by articulating our thoughts about the feelings evoked in us as we relate to the patient. But rather than take sole responsibility for making sense of the patient's experience, we would do better to invite her to join us in the effort, or ask her to think aloud about her own experience.

As therapists, we must keep in mind that the patient is actually fearful of developing a sense of confidence and independence, because autonomy and self-initiative have been discouraged early on and so are inconsistent with the patient's beliefs about how best to secure the attention of others. Therefore, we will want to convey our awareness of how difficult it is for the patient to trust in her own resources.

Further, it may be particularly important—given the constraints on the patient's autonomy—to notice and make room for the surfacing of anger, criticism, or disappointment in relation to the therapist. When both partners can get through such protests relatively unscathed, it reinforces the patient's dawning awareness that autonomy and separateness can in fact coexist with closeness, contrary to the lessons of the patient's original attachment experience. But whether these early lessons are, or are not, updated will largely depend on what occurs between patient and therapist in the context of the new attachment relationship.

The Relationship: Patterns and Pitfalls

While it is true that the patient–therapist relationship, like all attachment relationships, is co-created, it is true in a particular way in the case of preoccupied patients, who tend to adapt, chameleon-like, to the expectations of others. Their desire to merge, driven by their fear of our unavailability, leaves them all too ready to submerge themselves—with the result that what we get is often what they think we want. The shape of the therapeutic relationship is, thus, very much a function of the preoccupied patient's attachment strategy in interaction with that of the therapist.

Of course, every such relationship is unique and unpredictable. Regardless of the clarity of our therapeutic intentions (attune to what lies beneath the affective surface, don't collude, don't reinforce helplessness) we are bound to be surprised. If we're not, we're probably treating a theoretical rather than a real patient, or conducting ourselves as though we were therapy machines, rather than spontaneous, emotional, and vulnerable human beings. Yet the surprises notwithstanding, there are characteristic patterns and countertransference pitfalls that mark the treatment of many preoccupied patients. Knowledge of these patterns won't stop us from fall-

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ing into them—nor should it. For recognizing the nature of our interaction with our patients may be the most significant part of how we get to know them and how they get to know us. At the same time, general knowledge of this kind can help us identify the character of our own unwitting participation in the relationship, which allows us, in turn, somewhat greater flexibility.

The patient's abiding fear of the therapist's unavailability results in (but is also sometimes hidden behind) the patient's zeal to connect. Her need for the reassurance and comfort of closeness may be expressed in a number of ways. Whatever else they may represent, the patient's apparent helplessness, displays of distress, compliance, seductiveness, and/or efforts to be a "good patient" are also implicit attempts to diminish distance and win the therapist's support. The earlier in treatment these overtures emerge—and the more intensely or inflexibly they are enacted—the deeper, I presume, is the patient's distrust and her anxiety about abandonment. As therapists, our responses to such overtures will be shaped, to some extent, by our own attachment style.

If we are more secure, rather than less, it will be easier to resonate with the deeper feelings that underlie the patient's indirect appeals for connection: the fear of not being taken care of and the anger at having to lose herself in order to secure the attention of others, as well as profound need and sadness. In a secure state of mind, we will be able not only to interact relatively freely, but also to help the patient make sense of her role in the interactions we co-create.

When our state of mind is more dismissing, we will probably need to be cautious about a number of possible pitfalls having to do with the fact that the patient's attachment strategy is the opposite of our own. Fearful to one degree or another of feeling and of closeness, we may find ourselves uncomfortable, or even put off, by the patient's intense affect and hunger for merging. To feel more comfortable, we may choose to help by trying to "corral" the patient's intense emotion with intellectual understanding. Rather than resonate with the patient's deeper feelings—or notice the lack of fit between what is being said and what seems to be felt—we may prematurely aim to provide the reassuring (for us) structure of words and interpretation. To which the patient may well respond by feeling alone and misunderstood, or by joining us compliantly in a "pretend" version of meaningful therapeutic exploration—or both.

Alternatively, we might be unconsciously relieved to be able to find our disavowed affect and dependency in the patient rather than in ourselves. In this case, we may be inclined to collude with the patient's defensive strategy. For example, we may take her emotional neediness too much at face value, while feeling implicitly reassured that we have no such needs of our own. Similarly, to buttress our self-esteem, we may take on too readily the

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role of the brilliant therapist idealized by the overtly helpless (but covertly controlling) patient. In this enactment, we may remain unconsciously, but purposefully, ignorant of the patient's mistrust and anger, while for her part, the patient is self-protectively manipulating our narcissistic needs.

When we are in a more preoccupied state of mind with respect to attachment, the issues we confront in the relationship with the preoccupied patient will be different. On the one hand, we will likely be more capable of empathy with the patient's experience because of its overlap with ours; on the other hand, our own fears of abandonment can make it difficult for us to do much more than empathize. Should we wish to address the partly defensive nature of the patient's helplessness, for instance, we would need to convey a perspective that differs from hers. But doing so requires a degree of separateness that we may easily confuse with aggression or experience as threatening to our ongoing relationship with the patient. Thus, our own preoccupation with attachment may incline us to "join" the patient in her distress, but without intervening in the ways that might ultimately help her cope with it better. By the same token, we may yield to the impulse to "rescue" the patient rather than help her to recognize her own resources. In addition, our own bias toward feeling rather than thinking can interfere with our ability to mobilize (both in ourselves and in the patient) the "left brain interpreter" that makes sense of emotional experience so that it can be used as a signal, rather than experienced as a burden, a symptom, or merely a fact.

The Erotic Transference

Beyond the foregoing interactions that commonly occur in the treatment of preoccupied patients, we frequently encounter what I would describe as "intimate transferences" along with their countertransference complements. Ordinarily discussed under the heading of erotic transference, these interactions have a dimension of sexuality, romance, and/or unappeasable longing that is often significant in its own right, but may also obscure underlying attachment issues.

As a number of writers have pointed out, the nature of the erotic transference–countertransference situation that develops depends largely on the gender of the patient and therapist involved (Person, 1988; Wrye & Welles, 1994; Kernberg, 1995). I would add that a second influential factor here is attachment style.

Very briefly, intimate and (especially) sexualized transferences are overall most likely to arise when the patient is a woman and the therapist a man—at least to the extent women in general tend to fear separateness, while men, again in general, are more likely to fear closeness. Hence, for women, particularly those who are preoccupied, the pursuit of a romantic or sexual connection to the therapist often represents not only a defense

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against distance, but also a defense against more fundamental attachment issues. For men, by contrast, the avoidance of romantic or sexual feelings for the therapist often represents a defense against deeper involvement as well as the characteristic masculine solution of segregating sexuality and attachment. When men, especially dismissing men, do develop sexual feelings for the therapist, those feelings are still apt to reflect avoidance of closeness and dependency, because sexualizing the therapist can be, for a man, a way of devaluing him or her as an attachment figure on whom the patient might be tempted to depend.

The emotional impact upon us as therapists of the patient's erotic transference may differ according to our state of mind with respect to attachment. If our style is more dismissing, we may welcome the patient's romantic or sexual longing because it bolsters our self-regard. Alternatively, we may be put off because we experience such longing as a challenge to our customary distance from others. But if our style tends to be preoccupied, we may welcome the patient's desire as a signal of closeness. On the other hand, the same desire may be experienced as deeply discomfiting because it represents an overture we must reject — and we assume the patient will feel that it is she herself, not just her desire, that we are rejecting.

Ideally, we can allow ourselves to be the object of the patient's longing, without either encouraging it unduly or feeling compelled to shut it down. To the extent that we can make a place for this longing, we have an opportunity to explore its role in the therapeutic relationship — and, by extension, its role in the patient's other close relationships. Is sexuality used as a surrogate for attachment, an indirect route to it, or an avoidance of it? Central in the treatment context is the fact that the patient's longing for the therapist is one that can never be fully gratified. As such, it may represent the living out of the pattern of frustrated desire that characterized the patient's original attachment(s) as well, perhaps, as her contemporary ones. Sometimes the erotic transference is an important waystation for the preoccupied patient en route to the development of a deeper capacity to trust and to love. But if the therapist is either too pleased or too discomfited by the patient's desire that welcome development may be thwarted.

As I mentioned at the outset, preoccupied patients can be understood to fall on a diagnostic continuum. Thus far, I have focused on that end of the continuum occupied by those patients whose hysteric-like features include helplessness, the amplification of affect, and seductive compliance. It is the opposite end of the continuum to which I turn next.

THE PATTERN OF ANGER AND CHAOS

Research suggests that many, if not most, borderline patients have a preoccupied state of mind with respect to attachment. These patients are found

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with great frequency to fall into a particular subclassification: fearful preoccupation with traumatic events (Patrick, Hobson, Castle, Howard, & Maughan, 1994; Fonagy et al., 1996). It appears that patients at the more troubled end of the preoccupied continuum have often experienced histories marked by recurrent trauma or losses that remain incompletely resolved. In AAI terms, such patients are both preoccupied and unresolved. Therefore, much of what I'm about to say may well apply not only to patients at the more troubled end of the preoccupied continuum, but also to patients who are unresolved.

Preoccupied borderline patients often experience life as an ongoing crisis. Their emotions are not merely painful but overwhelming in their intensity. Rather than sensing a stable sense of self, these patients feel chaotic inside, and empty. Their relationships are frequently stormy, ending often in what feels like betrayal. Torn between their terror of dependency and their bottomless need, they may appear desperate for help, but tyrannized by their conviction that their needs will drive help away. In desperation, they may approach, but in fear and anger they withdraw. As a therapist with such patients, I have often felt like someone trying to save a drowning man who fights off aid as if it were an attack. The challenge with such patients is not to let ourselves be pushed away.

Margaret Mahler uses the term "hatching" in writing of the psychological birth of the human infant (Mahler et al., 1975). As the therapist of a borderline preoccupied patient, it's very much as if we're called upon to sit on a chick or an egg that seems to be doing its best, or worst, to knock us off our maternal perch. To provide (and preserve) the new attachment relationship the patient needs, we must be able to offer a combination of empathy and limit setting. Neither is sufficient on its own to "contain" overwhelmed and overwhelming patients like these or the fear, anger, and hopelessness they are all too capable of evoking in us. When the therapeutic relationship can become sufficiently containing, the patient has the opportunity to develop the kind of internal and interpersonal stability for which her first attachments provided no models.

Empathy

Unless we can understand and, to some extent, resonate with the patient's internal experience, we will be unable to help. Without the therapist's empathic attunement, the patient is likely to feel unrecognized and alone, or worse, threatened and betrayed. Yet such attunement is usually hard won. It depends on at least three things: our ability to draw on relevant theory and research, our openness to the full spectrum of our own experience, and our capacity to interact with the patient in ways that neutralize, at least temporarily, the mutually generated obstacles to empathy and connection.

Fearfully preoccupied with trauma, these patients are often quite ex-

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plicit about experiences with their parents□ or experiences of being abandoned by their parents□ that left them overwhelmed and sometimes terrified. Their parents, like parents of preoccupied patients generally, were unpredictable, to be sure, but they could also be angry or unavailable in ways that were scary.

A patient told me that his father, an alcoholic police officer, could be unpredictably brutal. The patient's job had been to somehow keep this explosive man entertained or distracted when he appeared on the verge of violence. Sometimes the patient was successful. When he wasn't, he could become the target of his father's rage. Once, his father drew his pistol and pointed it at the patient's head.

Part of the tragedy for patients like this one is that such scenes of childhood victimization continue to be enacted in the patient's subsequent relationships, including, most importantly, the patient's relationship with himself. Fonagy (2000) theorizes that In place of the □constitutional□ or true self, these patients have internalized the representation of an □alien□ self that embodies the responses of the abusive attachment figure. But because this alien self is both persecutory and at odds with the true self, it must be expelled. The resulting projection of this dangerous internal presence ensures that others will be experienced as persecutory. When others are not available, the patient may feel compelled to persecute himself, through vicious self-attack, including, sometimes, self-mutilation. Fonagy's theory can help us make sense of disturbing behavior that might otherwise function as an obstacle to empathy. Such understanding may be especially vital when our interaction with the patient threatens to mimic the interactions of his past□ as was the case with the son of the policeman whose traumatic history I touched on a moment ago.

Following an unusually collaborative session, this patient arrived twenty minutes after the hour was to have begun, making no comment about his lateness. He was to have paid me, but told me he didn't have his checkbook. He said that he was sick of therapy, and that all this talk was just getting in his way; without it, he'd probably feel much better.

Around the lateness and the missing check, I found myself feeing irritated, but when he began to attack our work together, I started to feel quite angry. Then it occurred to me that I was being invited to play his angry persecutor, because if I were instead a collaborator, then he would be left alone with the persecutor inside him. Moreover, he might experience me as inviting him to take the foolish (perhaps unconsciously life-threatening) risk of trusting me.

I wondered aloud if perhaps he were trying to pick a fight rather than feel close. I added that my guess was that a session like the last one in which we had been able to work so closely together might very well have made him anxious. I should not have been surprised when he

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> angrily took issue with my suggestion. My interpretation, however, served both of us well. It enabled me to stay with him, rather than feel pushed away. It was also an interpretation he could eventually make increasing use of as we re-experienced, many times, scenarios very much like this one.

Obviously, there's a lot more theory and research to draw on in our efforts to grasp the experience of our more troubled preoccupied patients. Splitting, embeddedness in experience, failures of mentalizing, and the overarching metaphor of the self overwhelmed by a powerful, malevolent other are all useful constructs to which we will shortly return. But beyond theory, personal experience is a resource that can enhance our compassion for patients whose blatantly self-destructive and frequently offputting behavior can be hard to tolerate, much less feel empathy for.

In this connection, I have found it valuable to be able to locate within myself echoes of the patient's experience. For example, when feeling exasperated with a patient whose tenacious resentment over past injustices seemed to hurt only herself, I helpfully recalled how extraordinarily difficult forgiveness has been, on occasion, for me. We understand others most deeply, I'm quite certain, on the basis of shared experience. Sometimes, of course, the commonalities can be difficult to recognize, or too uncomfortable to acknowledge, even to ourselves.

Making empathy possible□ our empathy for the patient and our patient's empathy for herself□ often necessitates interventions that have the potential to dissolve barriers to it. The primary barrier to empathy is the therapist's negative countertransference. When we feel frightened, angry, diminished, or dominated by the patient, it can be difficult to put ourselves in the patient's place enough to grasp the emotional logic of her experience. And without the therapist's doing so, the patient has no basis upon which to extend empathy to herself.

Feeling the negative countertranference is probably inevitable. Perhaps it is even desirable, as a way of getting to know the patient and the reactions she may evoke. On the other hand, drowning in the negative countertransference is not inevitable, nor is it desirable. Sometimes, finding a way to put our troubling experience into words, either silently or with the patient, is sufficient to modulate our feelings. But sometimes it is not. This is where limit setting comes in.

Limit Setting

When we communicate a limit, we are not attempting to control the patient. It's unwise to attempt the impossible. Our capacity for self-control, however, allows us the option of telling the patient what we will or will not do, given a particular set of circumstances. The formula here is: If you do

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X, I will do Y. If you throw something at me, the session is over. If you allow me to speak to your physician and your psychiatrist, then I will continue to meet with you. If you call me to talk about your suicidal feelings, the only thing I will talk to you about is whether or not I need to call the police to get you to the hospital. Obviously, different limits are called for with different patients with different therapists in different situations. But with the kinds of patients I've been describing, some limits are almost invariably necessary in order to protect both parties and the treatment. They guard all concerned against too intense a negative countertransference, which can make empathy impossible and in the process eliminate the potential for the patient to experience the therapeutic relationship as a secure base.

Acting on a limit we have set is often initially disruptive, as when I called the police to the home of a patient after he was unable to tell me that he would not commit suicide, and he became enraged. But such disruptions are also occasions for repair. The patient was eventually able to recognize my action as springing from a desire to protect him rather than a wish to cause him harm or exert my control. With a patient like this one, the therapist's willingness to engage and struggle is absolutely essential; in its absence, the patient may feel we have given up on him—and the feeling may be justified. Of course, the engagement and struggle that are so necessary also take a toll. Yet when our efforts result in a deeper, closer, more productive relationship—and particularly when the patient gets better—such a patient can come to be among those who matter to us most.

The Relationship: Patterns and Pitfalls

In some ways these more tormented patients who lead with anger can be seen to present the same psychology as the preoccupied patients who lead with helplessness—but everything about that shared psychology is amplified. The affects are more extreme as is the sense of embeddedness in experience, the limitations on mentalizing, and the associated impulsivity. And although both kinds of preoccupied patients live in a mental space that has been colonized, so to speak, by their original attachment figures, the nature of those figures is different.

In the helpless patient, the subjective experience is of the internalized other looming so large as to take up most of the mental space, leaving little room for self-definition. In the internal conversation here, the voices are largely those of others responding loudly and clearly to the self, whose voice is indistinct. In relationships, the patient is correspondingly preoccupied with the other and vague about her own needs, views, and ambitions.

For the angry patient, it's as if the internalized other not only looms large but also is malevolent and seems regularly to threaten the self. In rela-

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tionships, this malevolent other is frequently projected onto (or into) those upon whom the patient might be inclined to depend, including the therapist. The result is that the patient is mainly absorbed in fending off perceived danger rather than recognizing and trying to satisfy her own desires.

In framing a stance with such patients, it is helpful to recall Fonagy's account of the responses of secure parents to their children. These responses convey the parents' empathy for the child's distress; their appreciation of the wishes, feelings, and beliefs that are the context for the child's behavior; and, finally, their ability to cope with experience the child finds overwhelming. As therapists, we need to aim for a similar kind of responsiveness with patients whose internal and interpersonal experience is so threatening, specifically because they have so little capacity for compassionate understanding of themselves, so little awareness of their own intentionality, and so little confidence that their experience can be managed.

Largely lacking a reflective or mentalizing self, these patients live in a subjective world whose character is defined by physical rather than psychological realities, actions rather than words or thoughts, bodies rather than minds. Consequently, we need to demonstrate that we are on the patient's side, that we understand, and that we can cope. With such patients, in a variety of ways, it is initially more what we do than what we say, more what we show them than what we tell them, that has impact.

When their behavior regularly pushes us away, seems incomprehensible, and leaves us feeling that we'll be lucky to muddle through, it can be helpful to keep in mind that patients like these are struggling internally with titanic emotional forces. Externalizing or interpersonalizing this excruciating struggle□ handing it off to us or □sharing□ it□ can be a way for the patient both to manage overwhelming feelings and to communicate them.

> In one memorable session, the patient whose father had threatened him with a gun told me that he was comforted by the knowledge that he could always blow his brains out with his own pistol, recently purchased, that he kept in a drawer near his bed. Just taking it out and holding it, his finger round the trigger, helped him feel more at ease. He had no intention of killing himself now, he assured me, but he felt suicide was his ultimate destiny.
>
> Hearing about this gun for the first time, I felt myself becoming extremely anxious, not to mention angry, at being placed in the position of dealing with a threat over which I had such limited control. (I also had a sickening recollection of a man whom I had seen in therapy just once as part of a couple: Before we could meet for a second session, I learned in a message from his wife that he had shot himself.)
>
> I asked the patient how it felt to have told me about the gun. He

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> said he was relieved, both to have the gun and to know that I knew about it—this way there was no secret. Great, I thought, I'm glad you're being so honest with me: Now I'm going to have to punish you for trusting me by taking away your security blanket. I felt as if he were pointing his gun at my head. I told him that guns scared me, that suicidal patients with guns really scared me, and that I couldn't be any help to him if I were to continue to feel this scared. If he wanted me to keep on working with him, I said, he was going to have to bring me the gun.

There is a great deal that could be said about this episode. For now, let it illustrate several points about patients like this one. First, the patient's subjective world is a world of physical actions and the therapeutic dialogue here is, above all, an action dialogue. Second, the patient communicated the nature of his world to me through behavior that evoked it in my own experience: In some sense, I felt his fear, powerlessness, and anger, along with my own. Third, the knowledge that his behavior was communicative and that my behavior also needed to be, helped me to intervene firmly but without being punitive or threatening—in other words, it helped me to cope. Fourth, we were able over the course of subsequent sessions to situate the patient's superficially calm, but deeply desperate behavior in the context of his unbearable feelings and his conflict about hoping for my help. These were experiences that allowed the patient (paraphrasing Fonagy, 2000) to find himself in the mind of a benevolent other as a thinking and feeling being. And, yes, he did bring me the gun.

Of course, we are "tested" repeatedly by such patients. It is to be hoped that we succeed more often than we fail. But even when we fail—say, by becoming punitive or withholding—there is the opportunity for repair. Moreover, we can show the patient in this context and others that there is room for failure, that some failure is inevitable, and that it can be tolerated to the extent that we don't confuse the part with the whole. In other words, we can show the patient a relational and affective world that is not all or nothing, black or white, now or never. Beyond the world of splitting that the patient generally inhabits, there is also one that is more integrated.

Again, however, it must be stressed that in dealing with patients who split and who, rather than articulate their feelings, act them out with dangerous and sometimes life-threatening consequences, our ability to maintain a thoughtful and integrated perspective can sometimes simply evaporate. In the face of the stress and the demands of the work, we will inevitably, at times, feel overwhelmed, frightened, helpless, and/or enraged—very much as these patients must have felt with parents whose own difficulties placed impossible burdens on their children. As the therapist of such patients, our saving grace may be the support we are able to find, after the

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fact, in others, in ourselves, and, to some extent, in our theories. There is, moreover, the reality that many, if not all, of these patients can effectively make use of their relationship with us to get better, to heal.

The Place of Mindfulness and Meditation

The "hyper-hyperactivating" strategy of the patients I've been discussing appears to be associated with a highly reactive autonomic nervous system. Literally, as well as figuratively, these patients have an exaggerated startle reflex and are slow to regain equilibrium. They are vulnerable to intense and rapid reactions to perceived threats, as though the responses of the amygdala were unmodulated by the hippocampus. When the sympathetic branch of the autonomic nervous system is activated, they can become extremely agitated as if in the mode of fight or flight. When the parasympathetic branch is triggered, they can become drowsy, can appear dissociated, or may "freeze."

Because meditation seems to have the potential to calm the body (as well as to strengthen mentalizing) it can play an especially useful role in the treatment of this subgroup of preoccupied patients, some of whom I have consequently taught to meditate. With some of these patients, I begin each session with a brief period of meditation. Such patients have not infrequently entered my office in a state of apparent agitation. Typically, we have exchanged a few words in acknowledgment of their feelings before beginning to meditate. Emerging from a five- or ten-minute meditation, these patients usually appear calmer and seem more capable of considering their experience without feeling emotionally and physiologically overwhelmed by it.

The background for their autonomic overreactivity may well be early attachment experiences that were either acutely or chronically traumatic (Schore, 2002). As I've suggested, the more troubled patients with a preoccupied state of mind with respect to attachment often bring with them to therapy a history of unresolved trauma or loss.

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