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UNDERSTANDING THE "DIFFICULT" PATIENT FROM A DUAL PERSON PERSPECTIVE

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ABSTRACT: This article examines the concept of the difficult patient from a two person perspective. Patient characteristics and behaviors may be problematic but the degree of difficulty is also related to therapist expectations, affective responses and needs, and capacity for tolerance. Suggestions for enhancing tolerance are offered. The shift from a one person to a two person perspective is illustrated by a case presentation.

KEY WORDS: two person or interactional perspective; therapist expectations; tolerance; difficult patients

INTRODUCTION

Contemporary psychoanalytic theory has moved from what has sometimes been described as a "one person" psychology to an acknowledgement that the treatment process involves an interaction between the two participants. More attention is now being directed to the dynamic interplay between the therapist and the patient. This theoretical shift offers an alternative conceptualization of the term "difficult patient," which was defined by Freud (1916–1917) as the person who could not form a positive transference with the analyst. In fact, a recent study (Noonan, 1995) which explored how twelve analytically oriented clinicians (Classical, Object Relational, and Self Psychological) made the determination that a patient was difficult suggested that therapists, regardless of orientation, continue to designate as "difficult" those patients who are unable to establish a transference and/or lack the capacity for self-reflection.

This article will present a reconceptualization of the difficult patient

from a "two person" or interactive perspective. Although patients may present with problematic behaviors, therapist characteristics specifically, therapist expectations and affective needs, impact on the treatment process. In that transference and insight, together with countertransference, resistance, and interpretation, are the mainstay of psychoanalytic treatment (Wallerstein, 1992), it is understandable that when patients seem unable to bond with therapists or lack the capacity for self-reflection, therapists may experience feelings of frustration and inadequacy and subsequently designate patients as difficult. As Schafer (1983) and others have suggested, patients who do not respond as therapists expect or anticipate will be considered problematic.

Additionally, patients who present with a seeming lack of transference engender intense reactions in the therapist that can be extremely hard to manage. Feelings of loneliness, isolation, and virtual non-existence are inherently painful and such reactions can be understood as originating from two distinct sources: 1) the thwarting of the therapist's legitimate need to feel effective and to feel significant to the patient, and 2) possibly from the patient's wish and desire to impart feelings originally experienced in relation to early caretakers into the person of the therapist.

A review of the literature and a discussion of the two person model will be followed by a case presentation which illustrates the shift from a one person model to a two person, interactive approach. This approach suggests that therapists' expectations and affective needs are integral elements of the therapeutic process and an awareness and acknowledgement of these factors can help therapists to manage their feelings better and enhance their tolerance.

LITERATURE REVIEW

"The history of psychoanalysis," according to Brandchaft and Stolorow (1984, p. 93) "began with difficult patients." Specifically, it began with the treatment of the hysteric, the quintessential "difficult" patient of the late-19th century (Jones, 1953). Hysteria was thought to be in women's imagination, and women presenting hysterical symptoms were held in contempt and treated with indignation by physicians. As a young neurologist just beginning his practice, Freud was referred and accepted cases that other physicians did not want or did not know what do with (Jones, 1953). Freud (1916–1917) maintained that the capacity for a positive transference (liking, loving, and respecting the analyst) was crucial to the treatment and thus to him the person who was unable to establish a stable transference was considered difficult if not untreatable. The conditions that Freud considered not analyzable included psy-

chosis, hypochondriasis, and narcissistic neurosis. He contended that people suffering from these conditions had not reached the developmental level of object love. Most recently, those diagnosed as borderline have been considered the most difficult to treat (Goldstein, 1990).

Since the time of Freud, much in the way of theory development has centered around understanding and treating these "unclassical" patients. The theoretical writings of Brandchaft & Stolorow (1984), Druck (1989), Fairbairn (1952), Kernberg (1975), Kohut (1971), Searles (1986), and Seinfeld (1991), attest to the analytic community's desire to explain and understand behaviors, characteristics, attitudes, and responses that were not explainable by already existing models. Many of these scholars and others including Stone (1954) and Loewald (1960) also introduced new treatment procedures or interventions as a way of either engaging the unclassical patient or of maintaining the patient through the many vagaries of the treatment process. Additionally, some anecdotal reports also suggest that certain patient characteristics render patients inherently difficult (Eigen, 1977; Liebermann & Gottesfeld, 1973). Finally, as recently as 1992, research carried out by Freedman and his colleagues concluded that difficult patients can be identified as those patients who are unable to establish a transference.

Explicit to each of these approaches is the assumption that it is something solely intrinsic to the patient that results in their being deemed difficult to work with. However, other scholars/clinicians contend that therapist reactions are solely responsible for patients being designated as difficult. For example, Brandchaft and Stolorow (1984) have suggested that throughout the history of psychoanalysis, patients have been designated as difficult due to their failure "to conform to or benefit from existing paradigms arrived at by existing methods of investigation" (p. 94).

Over the past three decades, the psychoanalytic community has directed more attention to the dynamic interplay between the therapist and the patient. Psychoanalytic theory has moved away from the theory of the detached therapist to the mutuality and dynamic interplay of the relationship and the awareness and understanding that the two parties involved do indeed affect one another (Druck, 1989; Loewald, 1960). Some empirical studies also suggest that it is the non-technical aspects of the treatment situation that are most closely related to psychotherapy outcome (Lambert, 1989). In a review of psychotherapy outcome, Lambert, Shapiro, and Bergin (1986) summarized the research on the variables that seem most likely to contribute to patient change during psychotherapy. They found that the process variables are closely linked to psychotherapy outcome and they suggested increased attention be directed toward understanding the complex interactions between the therapist and the patient.

DUAL PERSON INTERACTIONAL PERSPECTIVE

A dual person model suggests that the analytic venture be viewed as an interactive process with each participant contributing to that process. Therapist characteristics are as important to the therapeutic situation as patient characteristics and presentation. Rather then viewing the patient as inherently difficult because of his or her presentation and characteristics, the analytic situation "itself" is difficult based on the interactions between the two participtants. This shift in emphasis offers a new dimension to understanding, explaining, and working with the so-called difficult patient: thereby aiding and enhancing tolerance.

CASE PRESENTATION

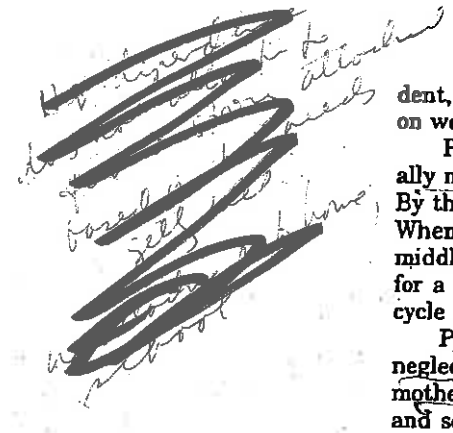
I began treating Peter, age 25, after he abruptly terminated with his therapist of one year. She would be relocating in four months and when she broached the subject Peter requested an immediate referral. He saw no point in continuing treatment or discussing the subject further since she would be leaving anyway.

Peter originally initiated treatment when he was 23 years of age. His wife of a few months had just given birth to their son. They had gotten married because of the pregnancy and Peter felt overwhelmed and trapped in the marriage. When his son was born, Peter began having fantasies of stabbing the infant. He was terrified he would act on these impulses and experienced intense guilt. He sought help at a local hospital where he was placed on medication and referred to a men's group. He refused to take the medication as prescribed and experimented with altering the dosage. He briefly attended group therapy but refused to participate and left the group because he could not relate to the other members and feared that listening to their problems could exacerbate his own. He was given an individual therapist but stayed for only 10 sessions. He felt she could not understand him and was only interested in the fee.

Peter's fantasies about hurting his son continued and he sought help at a local mental health clinic. He began and ended treatment with four different therapists before meeting Jane, the therapist with whom he worked for one year.

At our initial meeting, Peter informed me that he had only stayed in treatment with Jane because the clinic had refused to assign him yet another therapist. He believed he needed treatment but could not afford private therapy. The clinic had "forced" him to work with Jane and he had no options but to stay with her. The same day Jane told Peter she was leaving, he asked for a referral and told her he would not be returning. Peter called me the following day. When I met with him, he told me that Jane had given him the names of three therapists but since "one therapist is as good as another" he decided to continue with me.

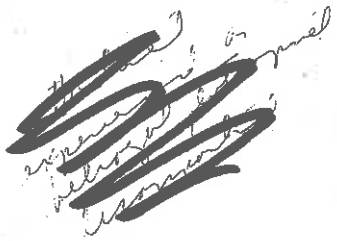
Peter was the third of five children born to a Peruvian mother and an Italian father. His father was virtually absent from Peter's life and he recalled only a few occasions when the father "would come around, beat up my mother and leave." Peter refused to talk about his father believing he had no impact whatsoever on his life. Peter was ambivalent toward his mother, alternating between feelings of sadness about how difficult her life was and feelings of anger and resentment for allowing what had happened to her. He described her as a depen-



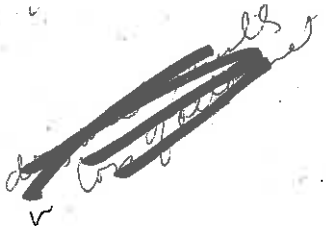
dent, fearful woman and he hated the dependency, particularly her dependence on welfare and subsequently her dependence on him.

Peter and his siblings always resided with their mother but were continually moving from one apartment to another throughout the New York City area. By the time Peter completed high school, he had attended ten different schools. When she could not pay the rent, mother would pack the children up in the middle of the night and flee to the homes of various relatives. They would stay for a short period of time and then move on to other welfare apartments. This cycle continued throughout Peter's life.

Peter's childhood memories were filled with examples of inconsistency and neglect. There was frequently little to eat, apartments were rodent infested, and mother would sometimes be neglectful and withdrawn, other times dependent and seductive. His mother was quite fearful of people and spoke little English. Peter and his two older brothers were her "protectors" and interpreters. For example, the living arrangements were frequently such that bathrooms were shared by many families and in these situations mother would take Peter or his brothers to shower with her. Peter also acted as interpreter with shopkeepers, school officials and welfare workers. He always felt demeaned and humiliated by these experiences.



Peter had few friends during his childhood and he spent most of his time with his siblings and watching TV. He was for a time close to his oldest brother who he admired and depended on like a father. At age 10, Peter encountered a bully at school and sought help from his brother. John refused to intervene, Peter felt betrayed, and never trusted his brother again. The themes of betrayal, disappointment, and entrapment were recurrent throughout his life and the life of his treatment.



One of Peter's most poignant memories and a memory that seemed to encapsulate his life experience and represented his core conflicts surrounded an experience with a third grade teacher. He had difficulty learning to read and when the class would begin reading lessons, he would become disruptive. The teacher took an interest in Peter and began working with him individually. His reading improved dramatically to the point where the individual sessions were discontinued. Peter was devastated by the loss of his teacher and in an effort to regain her attention he resumed being difficult and disruptive. This only resulted in his being transferred to another class. This experience became a metaphor for his life. To care about someone, to strive to succeed, to do better, to have wants and needs results in rejection and to Peter banishment. Throughout his treatment, Peter would often refer to this experience as a validation and justification for his mistrust and dislike of people.

Although TV served a soothing function and offered him some escape from the harsh realities of his life, it also became associated with danger. While watching TV alone one afternoon, he experienced himself as being drawn into the action of the program. It was a chaotic Key Stone cop adventure and Peter found himself in the midst of people confusedly running every which way. This experience terrified him and he refused to watch TV alone. As an adult, he only watched educational programs. He feared losing his fragile sense of self and his tenuous hold on reality.

Peter managed to receive a General Equivalency Diploma but always minimized this achievement believing he was graduated merely to get him out of the school and to inflate the Board of Education statistics. Seeking some direction, wanting to get away from his family and hoping to further his education, Peter enlisted in the Army. He could not tolerate the discipline of military life and on

two occasions went AWOL. He received a general discharge, returned to live with his mother, and secured an entry level job with a city agency. Although he resented it, he turned his paychecks over to his mother. She convinced him she would be homeless without his money and he "owed" it to her because she had kept the family together. The siblings had all left home and refused to contribute to her financial support.

Peter began dating a young neighborhood woman and she soon became pregnant. Diane also came from a troubled background and Peter believed she purposely became pregnant to "trap" him into marriage. He had no intention of marrying her until his mother said he was just like his father, i.e., getting a woman pregnant and then abandoning her. Again, he felt trapped and manipulated: He could stay home and keep taking care of his mother or marry Diane and be trapped with her and his child. He married Diane just before the birth of their only child.

Peter grew more and more resentful of his situation, was verbally abusive to his wife, and held a succession of jobs. He hated working for other people and would invariably get into some altercation with employers or colleagues. He would either quit or be fired and then move on to other clerical positions. The only friends he had were through his wife. He had little contact with his own family but was involved with Diane's family. Like his mother, they were also receiving welfare and he hated their dependency on the "system."

SHIFT FROM A ONE PERSON TO A DUAL PERSON PERSPECTIVE

From the outset of treatment, Peter could be described as a "difficult" patient. Although he never missed a session, he used them either to stare silently out the window or to complain bitterly about his life, his inability to fit into this world, his family, jobs, etc. He presented himself as though he were being forced to come: "if I don't come here, I'll probably stab my son and end up in jail. This is better than jail."

Peter was tortured by the thoughts of hurting his son but there was no indication that he would actually act on such fantasies. He refused to explore his feelings about his son, elaborate on any issues, or consider alternate ways of handling his problems. Any attempt at empathy regarding his present situation or his past experiences was dismissed and he often voiced frustration about his inability to afford a "real" therapist (due to his limited income he was being seen at a reduced fee). Frequently, Peter would abruptly walk out of sessions or not respond to questions. He generally treated me either with disdain and revulsion, or complete indifference.

Peter was unrelentingly self critical and could only soothe himself by watching educational TV. Exploration was viewed as either intrusive, critical, or was used as evidence that I didn't understand. He would become angry at my inability to read his thoughts adding, a "real" therapist would be able to. Again, empathizing with his disappointment in me or reaching for the anger led nowhere. Whatever intervention was attempted was met with silence or the response that I didn't understand him and never could. He seemed to lack any capacity for self-reflection or insight and always felt he had no control over what happened to him or impact on his situation. For example, in one session he described an incident which occurred with a co-worker. They had gotten into a disagreement, Peter became verbally abusive and the co-worker reported him to their super-

visor. Peter was enraged that she had done this. I attempted to empathize with his feelings and to explore the situation. He was non-responsive and silent. Out of frustration I asked "how do you imagine your co-worker felt about your yelling at her in public?" This was undoubtedly an inappropriate intervention to use with a man whose needs and feelings had been ignored and who always had to consider the needs of others rather than his own. I was clearly acting toward him as others had and Peter became enraged at my question accusing me of being just like everyone in his life. To him my intervention was evidence that I cared more about this anonymous co-worker than I cared about him. Peter held onto this incident and repeatedly referred to it as "evidence" of my true feelings toward him.

During these first two years of treatment, my reactions to Peter also fluctuated. I began with a real concern and empathy for him and, though this continued, I also began dreading the time of his appointments, felt angry and abused, and I entertained fantasies of retaliation. At times, I felt as though I literally did not exist or like I was a mere piece of furniture. I questioned my competency, felt inadequate and, like Peter, I wondered if a more experienced therapist might serve his needs better. At one juncture, I suggested a possible consultation. He adamantly rejected this idea because 1) he couldn't afford anyone else and 2) he wasn't starting "this useless process with anyone else". Although the suggestion was coming from genuine concern, I also realized that I was hoping to bring this treatment to an end.

During the second year I realized that I not only dreaded Peter's appointments, but during his sessions, I was daydreaming and purposely focusing on anything but him. My own reactions were becoming intolerable and in order to protect him and myself, I was becoming as indifferent to him as he was to me. As he was in his own world, I was drifting into mine. I just wanted to get through the sessions.

I had been working with Peter from a perspective that suggested the patient's characteristics alone determined the degree of difficulty. Based on a one person model, Peter's inability to establish a transference, his lack of capacity for self reflection, and his detached, concrete and superficial presentation would fit the criteria of the difficult patient. Though I had been monitoring my reactions, I also accepted them as understandable and appropriate to his presentation. However, we seemed to have reached an impasse and I needed to think more about what was going on between he and I. In that a two person or interactive perspective emphasizes the mutuality of the treatment process rather than focusing exclusively on the patient's characteristics, it was necessary for me to look beyond Peter's presentation and examine the therapeutic dyad. Because of Peter's characteristics, I had been too willing to accept that he was inherently "difficult".

I recognized my own expectations as being inappropriate. Peter was an unclassical patient and as such he could not be expected to engage in the therapeutic process as I understood it. He was unable to establish relationships and thus my attempts at bonding felt engulfing and intrusive to him and frustrating and depriving for me. Peter also seemed to lack any capacity for self-reflection. He always felt trapped, manipulated by others, and helpless to influence his own life. I, on the other hand, believed he was an active participant in what was happening to him and I thought if he could only begin to recognize this he would be able to alter his circumstances, reactions, and feelings. Instead, this approach left him feeling misunderstood and criticized and left me feeling ineffective and incompetent. My expectations and need to "fit" Peter into my preconceived ideas

about the nature of the treatment process were partially responsible for the reactions I was experiencing. I needed to modify my expectations to fit his needs and capacities.

To feel valued, significant, and connected to another are legitimate human needs and, though seldom written or talked about, therapists also possess such needs. As Klauber has suggested it is from the ". . . mutual participation in analytic understanding that the patient derives the substantial part of his cure and the analyst his deepest confidence and satisfaction" (Klauber, 1981, p. 46). When I was with Peter, I felt unimportant and insignificant and this was extremely painful. Initially, I felt guilty about my own needs but, as I came to acknowledge and accept these needs, I also became more comfortable with them and more able to manage my feelings of deprivation, loneliness, and isolation in relation to being with Peter. I also realized that if I could find something in Peter to care about and connect with, he would be easier to tolerate. Peter was a tortured and painfully unhappy man and the circumstances of my own background helped me to connect with him on this level. I could identify with his pain and I felt a real appreciation for his suffering.

It was also easier to work with Peter and manage my feelings once I had a means for explaining his behavior. Psychoanalytic theories have been generated partly to explain phenomena that appeared inexplicable and having theories to draw on can facilitate the clinician's understanding and acceptance of another's behavior. I found the work of Searles (1986) and Seinfeld (1991) particularly helpful in revising and expanding my thinking about the transference and my reactions to Peter. As Searles (1986) has suggested, Peter seemed to be in an "out of contact phase" meaning I was closed out of his world and this was where he needed to keep me. My reactions could be understood as representing a replication of aspects of his early object relations and this in itself could be considered a form of transference. He seemed to be trying to impart to me, in the only way he could, the feelings associated with his early childhood experiences. Sometimes, I seemed to be experiencing the same feelings of isolation, loneliness, manipulation, and degradation that Peter had felt as a child. At other times, Peter seemed to be attempting to cast me in the role of these original objects. His mother had been indifferent to his needs, his father had abandoned him, his brother had not protected him, and his teacher had rejected him. Peter was attempting and almost succeeded in inducing me to act toward him as they had. He had no control over his life or his early relationships and in the transference, he seemed to be turning passive into active by either shutting me out or by trying to get me to act out against him.

Once I was able to acknowledge my conributions to this difficult treatment situation, I modified my approach and interventions. Instead of trying to enter his world, which he experienced as my being intrusive, I accepted his need to shut me out and keep me at a safe distance. I refrained from interpretations which Peter experienced as criticism and I limited most of my responses to what was happening inside the treatment relationship. Although I had tentatively attempted this early on in the treatment, I had been put off by his responses. His anger and indifference had made me question my own abilities and competency and he had intimidated me. I now felt more confident and able to withstand his abuse and/or indifference. When he was indifferent to me, I left him alone but my thoughts were focused on him and when he needed to put me down, criticize my competency, or be generally disparaging of me I accepted this as what he needed to do.

Additionally, I shared with Peter what I thought was going on, not how I

was feeling, but rather, how controlled and manipulated he felt by being in treatment and how frustrating it was for him that I couldn't read his mind. At those times, when Peter was verbally abusive, I commented that it seemed he was trying to get me to act as others had toward him. Finally, when it seemed he wanted to be left alone, I would ask if this was the case and if he didn't respond I would say that: "I was still here even if he chose to ignore me. I was not going to get rid of him no matter how hard he tried to get me to."

Peter had always felt trapped and manipulated by others. My expectations of him and anger at him for my feeling alone and isolated was replicating these experiences. Peter needed to be with someone who expected nothing from him and who could provide him with the space to be who he was. In modifying my interventions I was better able to provide him with what he needed.

For about seven months Peter continued to vacillate between indifference and denigration of me but the treatment situation, at least for me, felt decidedly different. I no longer dreaded his appointments nor did I drift off into my own world. Then within about a six week period, two situations occurred that had a profound effect on his functioning and on the treatment. His reality testing became quite impaired, paranoid ideation was evident, and he feared for his sanity. During these times, he became very dependent on me and called me numerous times throughout each day. Peter seemed to be soothed by knowing that I was available to him and that he could connect with me whenever he needed to. Although external circumstances precipitated his regression, he seemed to trust in the safety of the treatment relationship and he was able to allow me into his chaotic, disturbed inner world.

However, after these incidents subsided he berated himself for his so-called weakness and dependence and, although he resumed being detached, there was a decided change in his presentation. He seemed to be struggling to find a way to communicate his feelings to me and when I commented on this he said he wanted me to know him but that there were no words that could communicate how he truly felt. Again I shared with him what I imagined his feelings to be and the impact of his early experiences. He very tentatively shared how frightened and alone he felt as a child, how much he needed his mother, and how "crazy" he thought he was. He recalled that as a child he had once happened by a butcher shop and when he saw the meat hanging in the window, he imagined it was the mutilated body of his mother. He told no one of this fantasy but from that time forward he worked hard to control his thoughts and kept a distance from others. He thought his aggression would kill them.

This memory brought us back to the original reason for his coming to treatment: the fear of killing his infant son. Although Peter was never able to reflect on the origins of his hostility, he shared more and more of his fears and inner chaos. He had now let me into his inner world. Peter remained in treatment for three more years. Although his relationships remained superficial and somewhat disappointing, he began to pay more attention to his own needs and desires. Eventually he and his wife agreed to an amicable separation, he was less involved with his mother, and he established an apartment, living on his own for the first time in his life. He maintained financial responsibility for his son and spent time with him each weekend. He worked for temporary agencies which afforded him more autonomy and independence and there was less risk for the interpersonal conflicts which had plagued him during attempts at steady employment. Most importantly to Peter, he no longer feared for his sanity.

DISCUSSION

A dual person interactional perspective suggests that therapist expectations and needs are important factors in determining if a patient will be deemed difficult to work with. The therapist's tolerance can be enhanced by acknowledging and accepting these reactions and needs, locating something within the patient to connect with, and having a theory to explain behavior.

Therapist Expectations

Transference and insight have always been considered essential components of the treatment process (Wallerstein, 1992). Although there are varying definitions of transference, most would agree it represents some form of bonding with the therapist. The bonding may be either positive or negative but at the very least there is some connection. For patients who present with a seeming lack of transference, the emphasis has been placed on the goal of establishing a bonding either by joining the patient's world or by attempting to get the patient to join the therapist's world. However one conceives of accomplishing this task, which varies according to perspective, the goal remains consistent and the work is carried on within the transference.

Insight or the capacity for self-reflection is also considered necessary for psychological change. Self-reflection suggests the patient's capacity, at least in part and temporarily, to step outside of him or herself and observe and examine actions, feelings, attitudes, and thoughts in relation to the self and others. The patient is also encouraged to explore whether these are appropriate to present circumstances and relationships or actually represent reactions to earlier situations and objects which are being reenacted or transferred into the present.

Many patients are unable to utilize standard analytic procedures. An integrative perspective as suggested by Goldstein (1990) emphasizes that the treatment must meet the needs and capacities of the patient rather than expecting or anticipating that the patient will fulfill the dictates of any one model or any one orientation. The study findings (Noonan, 1995) on which this article is based suggested that regardless of orientation, therapists continue to find patients difficult if they are unable to engage in the analytic process as we the clinicians have come to understand it. This is understandable when one considers both the length of training which therapists undergo and the commitment to their work that therapists evidence. As professionals, we believe in the process and when our efforts are thwarted our sense of competency can be and often is compromised. However, in being aware of and acknowl-

edging our own expectations, we can adjust these expectations to the patient's capacities and level of functioning thereby being better able to help the patient and enhancing our own tolerance.

Therapist's Affective Needs

Therapists are first and foremost human beings and as such have needs, self-object needs in Kohutian terms, which include the need to feel significant and valued. As professionals, we are reluctant to acknowledge or speak about these needs but in a dual person model, the needs of the therapist are recognized as important factors in the treatment process. When as therapists we encounter patients, such as Peter, who are detached and treat us as "thinglike" objects, we are likely to experience strong responses because our legitimate affective needs are being frustrated. In such instances, as was the case in my work with Peter, there is the risk of becoming either apathetic or detached from the patient or of consciously or unconsciously provoking termination. It is essential that we 1) be aware of and acknowledge our needs and our reactions when these needs are frustrated and 2) examine and understand how these reactions impact on our tolerance, acceptance, and ability to work with such patients.

Establishing a Means of Connection Between Patient and Therapist

The clinician's tolerance also can be facilitated by locating something within the patient to connect with. This will vary from therapist to therapist because, for a variety of reasons, certain patient characteristics appeal to certain therapists. Humor, intelligence, sensitivity, ethics, or the experience of suffering are but a few of the patient characteristics which may resonate with the therapist thereby providing the therapist with a means of connecting with the patient.

Theoretical Knowledge

Finally, the worker's tolerance can be enhanced by drawing on one's theoretical knowledge. A thorough, in-depth knowledge of psychoanalytic theory can aid the therapist in being more tolerant of patients because it offers a means of explaining behaviors that the therapist may either personalize or blame the patient for. The theory itself may not be as important as the fact that the therapist has "a" theory which along with other factors can help sustain the therapist through the treatment process.

CONCLUSION

A dual person, interactional perspective suggests that while patients may present with difficult behaviors, it is the therapeutic dyad that needs to be examined. Although we are professionals, we also bring certain needs and expectations to the treatment situation. Being able honestly to acknowledge and examine these factors can help us better to understand and accept our patients. Additionally, it is important that we try to locate something in the patient that we can connect with and that we utilize our understanding of theory to help us understand our patients better. Each of these factors taken together can help us to remain consistent and reliable thereby offering our patients a uniquely different relationship.

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