The Humiliating Patient and Humiliated Psychotherapist

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Psychotherapists in private practice inevitably experience patients who aggressively and persistently “put them down.” Here is an example. Peggy was a new, middle-aged patient who, after ringing the doorbell, was greeted by a female psychotherapist saying “come in, come in” as Peggy entered a hallway. With annoyed face and irritated voice, Peggy responded, “Don’t say ‘come in, come in’ when I am already ‘in’.” Feeling slightly irritated, the psychotherapist said nothing as she ushered the patient into her consulting room.

After Peggy sat in the patient’s chair, she looked around and noted the room’s paintings and pictures. Focusing on shelves overflowing with books, she commented, “I don’t like the untidy look of bookshelves stuffed to overflowing.” The psychotherapist, now acutely aware of her growing anger in response to the patient’s criticisms, politely asked why the patient was seeking help. Peggy answered, “I have relationship difficulties.” As Peggy’s criticisms became a regular pattern of the psychotherapy, it became obvious that Peggy’s behavior with the therapist was part of a pattern of humiliating others, with consequential social isolation. This pattern eventually became the major focus of her psychotherapy.

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Patients who humiliate by verbally "putting down" their psychotherapists are not all like Peggy who criticized her psychotherapist in the initial therapeutic interactions and continued these into the middle phase of treatment. In comparison to Peggy, other patients may only criticize a psychotherapist in response to being misunderstood, a result of an "empathic failure" (Kohut, 1971), or a "disjunction" (Stolorow, 1987). As recognizing and repairing empathic failures and disjunctions is extensively covered in the self-psychology literature, occasional or intermittent humiliating behavior in response to disjunctions, and their repair, will not be the focus of this paper. Cases such as Peggy, however, where the criticisms commence from the first moment of meeting, clearly indicate that some patients need to humiliate their psychotherapist that goes far beyond the idea of a response to a disjunction, even though disjunctions may be triggered by and/or exacerbate the criticisms of such hypercritical patients.

Psychotherapists who sought professional consultations because of such patients have highlighted the importance of understanding the humiliating patient. These psychotherapists typically reported that their humiliating patients created for them the choice of either angrily confronting them, or surrendering passively to being manipulated and/or verbally battered. Their dilemma was as follows: if they confronted the patient, the patient might become violent, assaulting the psychotherapist or smashing up the consulting room, or by leaving treatment, but if they passively accepted their patient's humiliating behavior, the psychotherapy eventually stalemated with the psychotherapist in the victim role, having lost the patient's respect. As a result of this stalemate, psychotherapists experience increasing contempt from their humiliating patient, lost self-esteem, and less

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effectiveness with their other patients. Out of these consultations, and based on my own experiences with humiliating patients, a number of theoretical issues emerged that are useful for understanding and treating them.

These are discussed under the following headings: (A) An intersubjective treatment focus, (B) Negative affective experiences as a created reverse twinship, (C) Defensive, archaic merger, (D) Limit setting with merger-prone patients and, (E) Twinship as a reparative experience.

A. An intersubjective treatment focus

Treating humiliating patients has better results when the psychotherapy shifts from an intrapsychic to an intersubjective orientation. Under a Freudian or Kleinian theoretical perspective, a patient who is critical, negative, humiliating and verbally abusive, is understood to be motivated by an aggressive drive that has not been sufficiently "tamed." Consequently, limits are placed on the patient's behavior to contain that drive. In contrast, in an intersubjective orientation, a patient's humiliating behavior derives not from the patient's aggressive drives, but from the interactive patterns that developed from care-giving experiences during childhood. For example, an intersubjective view (Stolorow et al, 1987) of Peggy's critical complaint of the psychotherapist's invitation to "come in, come in" when Peggy was already half inside, suggests that Peggy had childhood experiences of being humiliated by a key carer, and was repeating this humiliating/humiliated relationship in the first interaction with the psychotherapist. Peggy was able to do this effortlessly because mother-child dyads involve the structuralization - imprinting if you wish - of

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reciprocal interactions (Hegel, 1807; Beebe and Lachmann, 1988, Lee, 1999). What could these interactions be?

In constantly experiencing her critical mother, Peggy learned to be critical too, typically covertly. A child's learning of the mother's humiliating role in conjunction with her own humiliated role, is similar to the technique of actors who, in learning their own lines, also learn the lines of co-actors in order to know when to speak. Such an intersubjective view of childhood's humiliating experiences suggests that Peggy was attempting to replicate in the therapeutic relationship the formative relationship of her childhood - with one extremely important exception: she reversed the earlier roles. Now, Peggy in the role of her mother overtly criticizes and humiliates the psychotherapist who, as if the child Peggy, is feeling humiliated and already becoming covertly critical. Peggy, as the mother, is taking the initiative in humiliating the psychotherapist, and the psychotherapist in the role of the child Peggy, passively accepts the humiliations and keeps her own critical response covert just as Peggy did as a child. So, in exploring the possibility of psychotherapy, Peggy seems to be seeking a psychotherapist who can assume Peggy's childhood role and then show Peggy how to transform it by doing so in the therapeutic relationship. How, then, does a humiliated psychotherapist respond so as to facilitate a shift in the patient away from the need to constantly criticize and/or humiliate others?

The answer seems to lye in the observation that humiliating patients persistently humiliate the psychotherapist until they feel their major relational experience growing up is experienced by the psychotherapist and understood. They are wary of words and interpretations, and are more influenced by the

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psychotherapist's example of skillfully managing them, that is, not counter-bullying them when they adopt a bullying role. This co-transference – for this is what it is - is neither transformed by angrily challenging the patient's humiliating behavior, which is experienced as attempting to humiliate the patient, nor does it help the patient if the psychotherapist is exceptionally tolerant on the assumption that a prolonged acceptance of this humiliating behavior will be enough to transform it. With these humiliating patients, a psychotherapist's genuine humbleness does not have a mutative effect because the humiliating patient has learned to both despise humbleness and despise the humble part of himself/herself. For when psychotherapists endure their humiliated role, the therapeutic relationship usually deteriorates or stalemates. This is because the psychotherapist's acceptance of humiliation was not experienced as anything new to these patients. They know only too well from their own upbringing what it is like to be humiliated – and despise it.

One way to resolve the dilemma of a permanent humiliating patient/ humiliated psychotherapist co-transference, is for the psychotherapist to explain the reason for the humiliating nature of the relationship, without shaming or humiliating the patient, or portraying the patient as a monster, so avoiding re-enforcing the experiences of an early child/parent relationship. The psychotherapist explains that the patient's criticisms are an unconscious attempt to communicate indirectly what the patient experienced as a child, by creating a situation where the psychotherapist temporarily becomes his/her experiential twin.

The explanation to the patient continues. Just as the patient felt humiliated as a child, so the patient unconsciously generates humiliated feelings in the

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psychotherapist, and so, in effect, shares his experience of humiliation. Such a potentially non-shaming interpretation by the psychotherapist may not get immediate acceptance, but it creates a new way of looking at humiliating behavior that gains the patient's attention. As this interpretation is unexpected and different, it sows the seeds of a new experience, which Kohut (1984) saw as the forward edge to the psychotherapy.

B. Negative affective experiences as a created reverse twinship

Theoretically under girding this understanding of the humiliating patient's behavior is Heinz Kohut's concept of a twinship selfobject experience. Why, for example, would Peggy want to create such a special twinship experience? Kohut (1984) makes it clear that twinship experiences, as with mirroring and idealizing experiences, make the patient more cohesive, harmonious and invigorated (p. 198). This means that if Peggy's need to be twinned is understood and accepted by the psychotherapist, she will temporarily – until contempt grows - become more cohesive and better functioning.

Kohut discovered the importance of the twinship selfobject experience through a patient who told him that she kept "a bottle on her bureau that she always kept stoppered, but that she imagined some person to be living in this bottle – 'my genie,' as she tried to joke – with whom she had endless talks during the period of her greatest loneliness" (p. 195). Kohut realized that the crucial part of this experience was the patient's need for a silent presence where she would talk to the twin, but

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where the twin did not have to respond. "Just being together with the twin in silent communion was often the most satisfactory state" (p. 196).

Although Kohut began with a "silent presence" as the central concept of his twinship selfobject experience, he extended this concept of "being with" to include a "doing with." This twinship consists of "The self sustenance that a little girl might get from silently working in the kitchen next to her mother, that a little boy might get from pretending to shave next to his shaving daddy or from working next to his daddy with daddy's tools in the basement" (p. 197). By including this "doing with" concept in the twinship experience, Kohut moved closer to the idea that twinship involves a process where the child takes on skills that makes him/her more like the person twinned. In this sense twinship becomes similar to Freud's concept of identification.

This view of a child wanting to be like the parent (and the patient similar to the psychotherapist) is different from the kind of twinship that Peggy enacted with her psychotherapist, because such humiliating patients want the psychotherapist to twin their lifelong experiences of being humiliated, not they twin their therapist! This form of "reverse twinship" (Lee, 1988) does not mean necessarily that humiliating patients seek the psychotherapist to permanently become like them, for it is generally sufficient that the psychotherapist shares their experience of humiliation until the patient no longer feels alone, misunderstood, empty and fragmented. Further, there is some evidence that Kohut (1971) thought a twinship could occur in either interactive direction in a dyad – the patient twinning the psychotherapist <u>or</u> the psychotherapist twinning the patient – when he theorized twinship as a separate line of development. For example, he talked about one of his patients needing the psychotherapist "to be a

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replica of himself" [the patient] (p. 194). In such a reverse twinship experience, patients would critically attribute to the psychotherapist feelings they have themselves. Kohut (1971) also gives his example of a patient attempting to humiliate him:

> The patient would …begin to see me as a person devoid of ambitions, as emotionally shallow, pathologically even-tempered, withdrawn, and inactive, and – although this image was at variance with some of my actual personality features and activities that were well-known to the patient – his sense of conviction about these fantasies was not disturbed by the co-existing contradictory information. A prolonged working-through process then ensued in which my personality was scrutinized and experienced as being torn by conflict. What was the analyst afraid of? Did he really have no ambitions? Was he really never envious? Or did he have to flee from his ambitions and from his envious feelings for fear that they might destroy him? After long periods of such doubts and worries the patient's perception of me would gradually change [pp. 194-195].

Kohut never developed the theoretical consequences of his insight into reverse twinship experiences. Nevertheless, it is clear that the patient's re-enactment of childhood experiences of humiliation, a reverse twinship with the psychotherapist helps in understanding, hence, treating the humiliating patient. But it is only one step.

C Defensive archaic merger

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Patients who need to humiliate their psychotherapist as a reverse re-enactment of childhood experiences are prone to seek an archaic merger, or what Michael Balint (1968) called, “a malignant regression.” Robert Knight (1953) once described a merger-prone patient who, as a result of her need for an archaic merger, placed growing, insatiable demands on the psychotherapist. This self-styled psychotherapist, a female Dean of Students at a College, was progressively cornered by the student’s demands because the psychotherapist was verbally abused and humiliated if she resisted her student’s request, whatever it was. In an effort to avoid being cajoled by the patient, she allowed the sessions to regularly go overtime, had sessions in her home in evenings and on weekends, had the student stay overnight in her home and, still later, slept in bed with her.

At times the student expressed an irrational hatred of the Dean whom she once pounded with her fists. When, at the student's request, the student sat on the Dean’s lap and fondled her breasts, the Dean raised no objections. But when the student tried to suckle an alarmed Dean refused, the student fragmented, then sought and was admitted to a psychiatric unit of a hospital. This case illustrates the precarious self-organization of merger-prone patients, and how refusing their demands after an expectation of compliance, can be experienced as a rejection of their defensive quest for archaic merger.

The key to recognizing an archaic merger is the patient’s extreme need for behavioral control over the psychotherapist. This seeking of total control by the merger-prone patient invites a comparison with Kohut’s concept of a selfobject experience. As noted in a previous paper (Lee, 2001), Kohut used the concept of

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merger in two ways: first the patient's use of the psychotherapist as an extension of his/her self-organization (a selfobject experience), and second, as an extreme, archaic type of merger. This distinction between selfobject experience and archaic merger is useful for two reasons. First, although the patient seeking a selfobject experience exercises limited control over the psychotherapist, whereas with an archaic merger, the control that is sought is unlimited. Second, while selfobject experiences lead to a patient's greater sense of cohesion, prolonged archaic merger experiences result in fragmentation, if not immediately, then eventually.

The inability of an archaic merger experience to produce anything more than a temporary degree of cohesion for the patient highlights its defensive character. The archaic merger represents a desperate attempt to prevent fragmentation, which eventually fails because a merging patient imposes impossible expectations on the therapist to permanently forgo self-agency and be absorbed into a monad. In such a monad, where the psychotherapist's needs are totally ignored or sacrificed, the relationship can never be stable. In order to remain cohesive, the psychotherapist's need for expressing self-initiative eventually emerges, breaks the patient's experience of merger, and creates disappointment, wounding and fragmentation of the patient. This fragmentation then increases the terror of a complete breakdown, which, in turn, leads to increased demands on the psychotherapist for merger, and the impossibility of this complete merger fosters further fragmentation, to be followed by more merger, etc., in an ever-deepening cycle of desperation and crisis.

The distinction between selfobject experiences, which Kohut viewed as narcissistic transferences, and archaic merger experiences, which he did not – it is an

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archaic, defensive function - is important in understanding a successful treatment approach with aggressively humiliating patients. With patients seeking narcissistic transferences, the psychotherapist accepts their needs for idealizing, mirroring or twinship experiences because these experiences help repair arrested developments of childhood. The defensive archaic merger is not considered a narcissistic transference because the acceptance of it does not facilitate new structuralization in the patient's nuclear self-organization.

Kohut refers to the archaic merger as "transference bondage" or "massive identification" with the therapist. About the defensive nature of this archaic merger, he says: "These…forestall the possibility of the full transference reactivation of the archaic narcissistic structures and thus of the attainment of psychological transformations in which the energies that were formerly bound to archaic goals are freed and become available to the mature personality" (1971, p. 31). He also thinks that those analysts who take on the role of "prophet, savior and redeemer" are more likely to actively encourage idealization that turns into massive identifications (1971, pp. 164-167; 1978, II, p. 752). This is because "inspirational therapy," places a patient under pressure to achieve some therapeutic goal or to expect the patient to be like the therapist, and induces gross identifications (p. 327).

Such a messianic approach rejects the patient's search for a twinship transference, and suggests that the emergence of an archaic merger comes from a failed twinship transference. Although this failure may stem from overt or covert messianic needs of the therapist, it also could come from a lack of needed self-structures to maintain a twinship with the therapist. Certainly, an important trigger of

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a defensive merger can be the failure of the therapist to accept the patient's initial hunger for a reverse twinship as expressed in a need to criticize the psychotherapist. Once a patient has developed an archaic merger in an effort to preserve self-cohesion, success or failure of the treatment depends increasingly on the firmness of the psychotherapist's self-organization. The cohesion and maturity of the psychotherapist's self-organization will help shape how firm and persistent the psychotherapist will be in managing his/her self-agency under the patient's pressure to merge.

Kohut thinks that most archaic mergers are temporary (1990, III, p. 346) and can be utilized to help maturate the patient, if the therapist is not locked into messianically saving the patient. He says, by "putting aside his often considerable discomfort at seeing his personality taken over by another, [the therapist] will quietly welcome them [gross identifications] as first steps in loosening lifelong defenses. And indeed, … these identifications are welcomed and interpreted correctly – as a forward move in the analysis." (p. 347). This paper claims a similar "opportunity" for forward movement can occur with patients whose gross identifications demand archaic, total control over a therapist's life.

D Setting the limits on humiliating, merger-prone patients

Psychotherapists of a previous generation were taught to give careful attention to the therapeutic arrangements (Stone, 1961) that formed the context in which the psychotherapy took place. Arrangements took into account the sessions – their frequency, times, and length; financial matters – the fee and how it is paid; social

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interactions – the absence of social contact; the rules for handling lateness, missed, and cancelled sessions; and the issue of confidentiality. The arrangements, once agreed upon, were expected to be followed - unless there was a compelling reason to change them - because they were viewed as an invariant context in which the therapeutic action took place, and as a baseline to make a patient's acting out easier to detect and interpret. A patient's deviation from the arrangements was considered resistance to the psychotherapy and explored for unconscious meanings. It was claimed that "limit setting" enabled psychotherapy to take place within the "space" formed by therapeutic "boundaries," and was seen as a necessary pre-condition for undertaking the psychotherapy.

This view of a limit-setting pre-condition for psychotherapy derives from a Freudian theory of analytic neutrality. Such a theory recognized the powerfulness of the psychotherapeutic context because it sought to standardize (neutralize) the arrangements so these would not influence the psychotherapy, and so that unconscious drive-derivatives would become more clearly recognized as projections. Such reasons for limit setting arise out of a view that emphasizes the importance of the intrapsychic in psychotherapy. But psychotherapeutic experience with merger-prone patients shows that if the "limits" are applied strictly based on the need to recognize drive-derivatives, it is extremely difficult if not impossible to make psychotherapeutic gains.

Psychotherapy using an intersubjective view of limit-setting with humiliating, merger-prone patients is not motivated by the idea that limit-setting is a precondition that enables psychotherapy to take place: with such patients the process of limit-

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setting is considered a central experience of the psychotherapy itself. Merger-prone patients attempt to alter the usual therapeutic arrangements when their need for an archaic, defensive merger expresses itself in excessive demands on the psychotherapist for special time and attention. How the patient's attempts to bend or break the traditional therapeutic arrangements, is handled, largely determines if there can be a reasonable therapeutic prognosis.

Traditional limit setting with humiliating, merger-prone patients poses special problems. If the psychotherapist strictly adheres to the traditional arrangements and refuses extra psychotherapeutic contact, especially telephone calls, merger-prone patients may resort to dangerously destructive or self-destructive behavior. For they experience a psychotherapist's strictness in adhering to arrangements as yet another humiliating rejection similar to those experienced during and since childhood, reinforcing the very self-organizing experience that psychotherapy is meant to change. On the other hand, if a psychotherapist tolerates the patient's demands for merger and constantly alters the therapeutic arrangements to suit the merger needs of the patient, the patient's prolonged experience of the psychotherapist as a humiliated twin stirs up feelings of contempt for the psychotherapist and, via twinship, self-contempt, self-disgust and self-disrespect. The patient's rejection of the humiliated psychotherapist under these circumstances is to prevent twinship feelings with the psychotherapist reinforcing their experience of being humiliated as a child.

From an intersubjective point of view, the setting of limits with the humiliating patient is a process that involves negotiation and invites the co-operation of the patient. One married patient, for example, who had been in twice-weekly

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sessions for six months, began making demands for special treatment from the psychotherapist as the summer vacation period approached and the patient discovered that the psychotherapist would not be available for the month of January. The patient, who had been critical of just about everything the therapist did, unleashed a increased torrid of criticism during sessions before Christmas, made numerous phone calls between sessions, and kept demanding that the psychotherapist postpone her vacation schedule. When the psychotherapist did not acquiesce to the patient's demands, the patient became more distressed, fragmented and dysfunctional.

Setting the limits became the major focus of the remaining sessions before the vacation. The strategy of the psychotherapist was to respond to the patient's fear of being abandoned, yet limit how far this responsiveness went. First, she explained that the patient was distressed in anticipation of her [the psychotherapist's] pending absence during January, and that the patient feared this absence would bring back experiences of being abandoned as a child. The patient seemed to understand and agree with the psychotherapist's explanation, but this agreement did not lessen the patient's terror at the thought of being abandoned.

In order to reduce the between-session-phone-calls, the psychotherapist offered an extra (third) weekly session for the remaining three weeks prior to the vacation, pointing out that this extra session offered more reliability than the hit or miss of the patient telephoning when she was with other patients or was unavailable because of personal matters. The patient left the session undecided about the extra session, but later telephoned to make arrangements for it. When the complaining

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telephone calls from this patient did not reduce, despite the extra weekly session, the psychotherapist reduced the number of phone calls to which she responded.

At the next session, the patient was very distressed about the psychotherapist's reduced responsiveness to her phone calls and accused the psychotherapist of not caring for her. The psychotherapist then indicated that although she cared about her as a patient - why else would she offer the extra sessions - she also had to balance this care for her, with care of herself. She shared that after months of practice without a break, she had reached a point of being so tired that she needed periods of rest and unavailability so as to avoid fragmentation and possible illness. She reminded her patient that if she developed a serious illness she would not be able to see her at all. This explanation enraged the patient.

She now felt that the psychotherapist would blame her for any illness the psychotherapist contracted. In reply, the psychotherapist said that if she [the psychotherapist] became sick, only she as psychotherapist would be responsible, because the illness would not be from the demands of the patient, but because she had not said "no" to the patient when she, the psychotherapist, had reached her personal limits.

In the next session the patient's anger and criticisms had decreased, even though the focus remained on the impending vacation. The psychotherapist then handed the patient a piece of paper on which there were the names of two psychotherapists who would be willing to see her for an emergency session while she was on her vacation, should one be needed. The patient took the piece of paper, but

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began criticizing the psychotherapist for wanting to get rid of her. The psychotherapist replied that the only way of knowing if this was so would occur when the time came to resume sessions in February. The patient then switched to requesting the psychotherapist's mobile phone number. The psychotherapist gently refused, explaining that she would not be taking her mobile telephone with her on her vacation, and that where she was going would be out of range anyway. And so on.

This clinical vignette illustrates how setting limits with humiliating patients is not clearly and cleanly determined in one session. It is not as simple as that. For it involves a strung-out negotiating struggle that sometimes takes place over many sessions. The issue of the limits to the psychotherapy with merger-prone patients may emerge into the foreground of the psychotherapeutic interaction at any time. Therapeutic gains occur as a result of these sessions where patients struggle to merge with the psychotherapist, and where the psychotherapist's goal is to negotiate arrangements in such a way as to not humiliate the patient nor be humiliated by the patient.

From the above example, it can be seen that the primary struggle in a relationship with a merger-prone patient is over the psychotherapist's needs. The customary practice of seeing psychotherapy patients according to a set schedule, and no contact between sessions except for emergencies, is explained as enabling the psychotherapist to have periods of self-replenishment. When merger-prone patients want to be in total control of the psychotherapist at all times, they interfere with this need for self-replenishment. If the psychotherapist allows the patient to take complete

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control, the psychotherapist becomes increasingly at risk for becoming fragmented and for the therapeutic relationship to deteriorate into a chaotic, dangerous mess.

So, in explaining limit setting to merger-prone patients, the explanation needs to avoid focusing on the patient's good, and relies on the psychotherapist's need as the motivating force behind the restrictions on the relationship. In effect the therapist is declining the messianic role that is expected by an archaic, merger-prone patient. Therapeutic benefit from this explanation is gained through the patient's twinning the non-grandiose psychotherapist. As a result of the psychotherapist setting limits, the patient imitates by similarly setting limits on his/her other relationships. In fact, one of the signs that the struggle to set limits has been successful is the way the merger-prone patients are able to more firmly say "no" to the demands of other relationships, where they formerly allowed themselves to be manipulated and then resented this manipulation.

E Twinship as Repair

The clinical example above illustrates how, in effective psychotherapy with humiliating patients, the treatment moves from a reverse twinship where the patient creates negative affective experiences in the psychotherapist, to a twinship of the psychotherapist that repairs faulty structuralization. Through the psychotherapist's persistent refusal to surrender his/her irreducible core self-organization, the patient firms up his/her own self-esteem and self-organization through an identifying form of twinship. What makes this form of twinship so powerful is the merger state of the patient. Why is this?

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Understandably, the humiliating patient's criticisms and demanding, bullying behavior can be difficult and exhausting for a psychotherapist to manage. Such patients have been described as "patients from hell" and, because of the difficulty managing their psychotherapy, psychotherapists have focused on the distress of these patients and the distress they generate in the psychotherapist, and miss the healing opportunities that exist during the patient's fragmented, merger-prone state. For in such a desperate merger state, the patient's fragmentation activates early developmental processes that are involved in the generation of self-organization and self-cohesion. True, such an early developmental state also generates enormous fears of being humiliated and abandoned, but when the psychotherapist gently but firmly insists on retaining his personal self-agency, the twinship process leading to structure building takes place despite the deep-seated fears of retraumatization.

It is important to understand that twinship with these patients is not a choice, whether to twin or not. They don't have the necessary internalized structures in this sector of their self to make a choice. The merger state triggers an identifying twinship process. This means that any fear or uncertainty that the co-transference generates in the psychotherapist will be twinned and reinforce the patient's already over-activated fear-terror affective system (amygdalo-hypothalamic-periaqueductal gray neural circuits) and make the patient worse. On the other hand, an experienced psychotherapist who insists on protecting his/her own self-agency offers a model that generates enormous growth in the patient as the experience of negotiating limits takes place over many sessions.

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In one case the patient kept insisting on wanting to see the psychotherapist socially on weekends, and the psychotherapist kept gently refusing, but exploring the feelings of being rejected each time he refused. After about three months the patient dropped the subject and seemed more settled. However, the subject was back again after another three sessions. Again the request was met with patience and kindliness, but also with firmness. The subject was then dropped after several sessions, to return again after some months. In fact the issue was to reappear intermittently for the next two years, but the periods between the re-emergence became longer, and the amount of time taken on discussing the issue was shorter. Such is the way change tends to take with such patients.

A patient’s eventual acceptance of the psychotherapist’s limit setting may not be the completion of the psychotherapy, even though the patient is more capable of saying “no” and has an increase in self-agency. What also emerges once the therapeutic relationship settles down is an increased capacity for trust. In fact an increased sense of trust is necessary for the patient to surrender the need to communicate his/her negative affective experiences by humiliating the therapist and others in a social context.

Another sign of progress with the humiliating patient is the patient’s reaction to empathic failure. These failures no longer lead to merger defenses and if responded to as the psychotherapist’s temporary lack of empathy, the relationship can be repaired without repeating the struggle to set limits.

Concluding Remarks

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Treating humiliating patients can be very difficult, and even disastrous for patient and/or psychotherapist if the treatment fails. Treatment of such patients should be undertaken only by experienced psychotherapists or by psychotherapists under the supervision of a psychotherapist experienced in the treatment of these patients. In the hands of relatively inexperienced or untrained psychotherapists, patients with a need to humiliate are liable to become more scathing and hostile as they recognize that they are not being understood and that the treatment has no chance of being effective. They may even be so incensed by the failure of yet another relationship, that they seek revenge by falsely accusing the psychotherapist of sexual abuse. Is it little wonder that many of these difficult patients give up on psychotherapy and end up on the medication/hospitalization merry-go-round? Even so, as difficult as their psychotherapeutic treatment may be, humiliating, merger-prone patients can be enabled, through hard work and prolonged exposure to experienced psychotherapists, to have rich and rewarding lives. Unfortunately, those humiliating, merger-prone patients who don't have a successful psychotherapeutic experience are condemned to lives of misery and committed to making the lives of others miserable too.

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