## How Can Practitioners Deal Constructively with a Patient's Distrust, Skepticism, Disappointment, Criticism, and Anger Directed at Them?

***Answer by Dr. Hammer***

I find myself returning repeatedly to the issue of authenticity. I will give you an example.

**Example**

An African-American man was referred to me by a psychiatrist. The patient was a huge man. At the end of the first session, as he was leaving he placed his hands on either side of the door to my office, announcing that he was going to destroy it, because he had been denigrated—the referring psychiatrist who was treating his wife lived in a more upscale part of town (Fifth Avenue) and he was sent to see a psychiatrist living in a less upscale part of town (Central Park West).

I stared at him for a moment and then spontaneously acknowledged that if this was his intention that I had every reason to believe from his size and anger that he could do it, easily. I made no move to oppose him or call for help. We stared at each other for a few moments and suddenly he relaxed, turned around and left. I realistically acknowledged his power and this enhanced his self-esteem sufficiently that he did not to have to act to prove it. I continued to see this man for many years and continued a correspondence for years after his life and mine took separate geographical paths.

Within the context of the therapy, the patient's negative feelings can cause hurt and fear and this must be acknowledged so that they know that they have power. At the same time they must also see that though they can hurt, their negative feeling (as differentiated from action) cannot destroy. The practitioner must acknowledge the hurt that they do not like, while pointing out that they are still there functioning. The practitioner can feel the patient's power while becoming less afraid of it.

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## How Should Practitioners Handle the Cessation of Treatment and/or Relationship?

See the final section in Chapter 4 on "Separation and Termination."

## How Should Practitioners Cope with "Difficult" Patients?

For example, this could include a patient who is always trying to control or dominate the practitioner and the process regardless of the stated or agreed objective of treatment.

***Answer by Dr. Hammer***

The following, taken from Chapter 6 of my book, *Dragon Rises—Red Bird Flies*,[3] seems relevant here:

> *Except in instances of "possession" (control by external forces), human beings strive to contact others within a context of positive emotion.*
>
> *Human experience may not always allow the positive emotions to flourish; in many circumstances, negative or hostile contact may be all that is possible and, paradoxically, may be life-sustaining. If life requires this as an enduring condition, negativity becomes a way of life.*
>
> *Negativity is maladaptive and it ultimately fails. Negativity is annoying, and our understandable response is to destroy or contain it. This is a natural reaction but is rarely therapeutic, except under very special circumstances (in a context of proven love). The therapeutic community, since the dawn of our era, has experienced this negativity as "resistance" and has reacted to it with professionally rationalized and distilled hostility, known in the literature as "analyzing the resistance," "shock treatment," or "chemical restraints."*