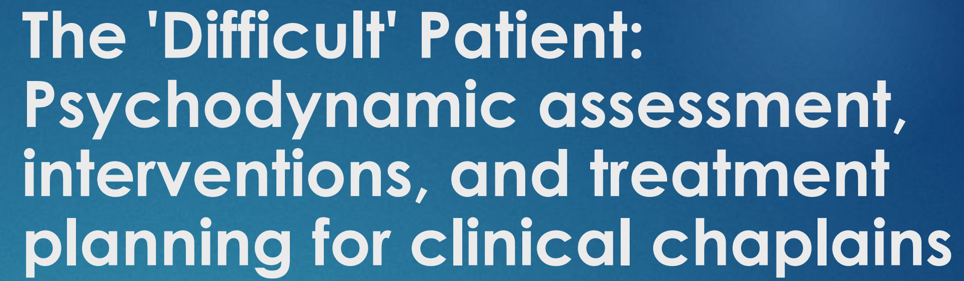

- **REV. DR. JESSICA A. SOMMAR, M.SC., D.MIN., BCC, LP**

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Objectives – by the end of this talk participants will be better able to:

- Identify, understand, and recognize our 'difficult' patients and their impact;
- Understand the importance of psychodynamic principles to spiritual care and chaplaincy;
- Assess and translate psychodynamically what our 'difficult' patients may need and want of us;
- Apply psychodynamically-informed language and tools in working with 'difficult' patients and the interdisciplinary team;
- Recognize internal dynamics for use of self in responding to 'difficult' patients;
- Develop treatment planning for follow up with 'difficult' patients.

What do we mean by the 'difficult' patient?

- Generally, the 'difficult' patient is one with whom we are finding it challenging to form an effective, therapeutic working relationship.
- But it can be any patient that arouses difficult feelings such as helplessness, confusion, inadequacy, alienation, and discomfort.
- Sometimes chaplaincy will be on notice of a 'difficult' patient by referral from distressed staff seeking our interventive care and relief.

A ‘difficult’ patient may show up as:

- Demanding
- Complaining
- Manipulative
- Dependent
- Frightening
- Suicidal/Homicidal
- Loud
- Defiant
- Irritating
- Non-compliant
- Passive
- Suspicious

So why is it important to apply a psychodynamic lens to work with ‘difficult’ patients?

- As chaplains, we want to feel we can reach our patients, to connect with them, and feel relatable to them;
- In hospitals and institutions, we learn to triage our patients quickly, form intimate connections as soon as possible, and under dramatic and challenging conditions of accident, illness and injury;
- We work fast because as chaplains we may or may not get to see the patient again during their inpatient treatment; we want to be as effective and therapeutic as possible.
- Doing this means we are processing, interpreting, relating, and assessing, sometimes inserting, our psyches into distressed people.
- When our best efforts are met with rejection, intractability, aggression or futility our own narcissism can be wounded causing grief, anger, and discouragement.

Outcome: Moral Distress

- Moral Distress is often defined as the clinician being unable to do what they were trained to do or being made to do something that the clinician was trained not to do.
- The accumulation of moral distress from working with ‘difficult’ patients, such as on a psychiatric unit or other institutional settings such as nursing homes, schools for special needs children and/or jails and forensic populations leads to burnout and burnup and is an important cause of **staff attrition**.

Are we blaming the patient?

- Sometimes we fear thinking of or speaking about a patient as ‘difficult.’
- We know from experience some patients regress to earlier, more primitive defenses as a response to trauma or expectation of trauma.
- If a patient is acting juvenile – restless, fussy, demanding, confused, disorganized, disoriented, distraught and aggressive – we may understand this as a temporary trauma-related regression response.
- We may be embarrassed or ashamed to admit to our negative responses to the patient’s regression. We avoid naming what is going on and fall into our own regressive response such as denial.
- Or we avoid. We believe it will pass and we will be able to assess and work with the patient soon. Or we ask someone else to work with them.

This is where a psychodynamically-informed lens may help:

Working **psychodynamically with a "difficult" patient** is less about applying special techniques and more about **changing how difficulty is understood and used**.

In psychodynamic work, "difficulty" is not a patient trait—it is a **signal about something emerging in the patient care relationship.**

Psychodynamically, a "difficult patient" is usually someone for whom our ordinary modes of relatedness have failed or resisted;

The difficult patient is regressed and resistant in order to protect psychological survival and these defensive patterns strain relationships;

Affect, dependency, aggression, or autonomy may be hard or impossible to regulate interpersonally while the 'difficult' patient is so defended or reactive;

So, what we perceive as 'difficulty' may not be resistance to treatment or care—instead, it is the very material for the treatment to progress itself.

Psychodynamic?

- Let's take a closer look at what it means to think and work psychodynamically with our 'difficult' patients.

Sigmund Freud

A psychodynamically informed approach draws from the core principles and theoretical traditions of psychoanalysis, including:

Classical Psychoanalytic Theory (Freud)

- Unconscious processes
- Internal conflict (e.g., wishes vs. defenses)
- Defense mechanisms
- The importance of early childhood experience

Object relations: Klein, Winnicott and Fairbairn

Theory of Internalized relationships (“objects”) How early caregivers shape the inner world

Introducing concepts like:

Splitting

Projective identification

Holding environment

Play

These concepts have since been expanded by **Ego Psychology** (Anna Freud), **Self-Psychology** (Kohut) and current, modern theories of **Relational and Intersubjective approaches** (Lewis Aron and Peter Zimmermann).

Who can adopt/adapt psychoanalytic concepts in practice?

- Chaplains don’t have to be psychoanalysts to think psychodynamically.
- Nor do you have to ‘intervene, assess or respond’ in a classically analytic way.
- However, it does mean that your clinical approach can include the use of insight and core principles such as :
  - Unconscious processes both patient and chaplain
  - Internal conflicts wishes, drives and instincts
  - Attachment and relational patterns and more…And training will help!

Core concepts behind psychodynamic work with patients:

- Unconscious Influences: Much of what drives behavior lies outside conscious awareness.
- Past Relationships Shape the Present: Early experiences, especially with caregivers, form internal "templates" for relationships. These patterns often repeat in adulthood (e.g., trust issues, fear of abandonment).
- Focus on Emotions and Inner Conflict: Attention is given to feelings, especially conflicting ones (e.g., love vs. anger). Symptoms may reflect unresolved internal struggles.

Core Concepts continued…

Identify Patterns and Repetition: look for recurring themes in a person's life: Relationship styles, Self-perception, Coping strategies. These patterns are often re-enacted rather than consciously chosen.

The Therapeutic Relationship (Transference): Patients may relate to the chaplain/clinician in ways that reflect past relationships. Exploring this in real time helps reveal deeper emotional patterns.

Identify Defense Mechanisms: People unconsciously use defenses (e.g., denial, repression, projection) to manage distress.

Countertransference: the chaplain/clinician's emotional responses to the patient, shaped by: The patient's relational patterns; the chaplain's own history.

In modern psychodynamic thinking, countertransference is not something to eliminate, but rather something to seek, understand and use thoughtfully.

When we work psychodynamically we are:

- Attending to unconscious meaning and patterns
- Linking past relationships with present experience
- Observing defenses and emotional conflicts
- Listening to the patient's relationship (transference)
- Actively tracking our own internal reactions (countertransference)
- Engaging in a thoughtful use of self to deepen understanding and guide interventions.

Applying these concepts may well result in ***psychodynamic chaplaincy:***

Psychodynamic (or psychodynamically- informed) chaplaincy incorporates principles of psychoanalytic theory into the practice of spiritual care. It explores unconscious dynamics in human relationships and how past experiences shape present emotions and behaviors.*

**Psychodynamic Chaplaincy: Psychological and Spiritual Integration in Healthcare,* SCA White Paper, 2025

Isn't a chaplain a chaplain?

- For more than three decades, as a distinction within the field, the terms **clinical chaplain and clinical chaplaincy** have been explicitly used to refer to those whose practice is psychodynamically-informed or oriented.
- **Professional chaplain** is a broader term that includes anyone who has fulfilled specific requirements and made chaplaincy their profession.
- **Clinical chaplains**, in the customary use of the term, while not necessarily licensed psychoanalysts or psychodynamic psychotherapists, are specialists who approach and provide spiritual care accordingly.*

*Hall, Handzo, Massey (2016) *Time to Move Forward: Creating a New Model of Spiritual Care to Enhance the Delivery of Outcomes.*

How important is this distinction?

- Working in hospitals and clinics with those suffering from accident, illness, injury and facing end-of-life, ***a clinical chaplain*** may provide more variety in interventions using the depth of their experience with and understanding of our unconscious and conscious processes. Such as working with dreams, associations, imagination and fantasy.
- This training is especially useful when working with behavioral health inpatients on Med Surg as well as on psychiatric units. Often denoted as ‘difficult’ patients.

Clinical chaplains and psychodynamic principles:

- Demonstrate by continuing to deeply engage in supervision, reflection and peer support providing recognition, understanding and familiarity with unconscious processes in themselves and others;
- Demonstrate understanding of the conscious and unconscious dynamics of group behavior and a variety of group relations;
- Demonstrate an ability to communicate effectively and engage in spiritual care delivery with persons across cultural and social boundaries;
- Demonstrate an ability to work effectively as a member of an interdisciplinary clinical team;
- Demonstrate an ability and ongoing commitment to effectively use the behavioral and social sciences, particularly those that support a psychodynamic approach to chaplaincy.

**Psychodynamic Chaplaincy: Psychological and Spiritual Integration in Healthcare,* SCA White Paper, 2025

How will psychodynamically-informed care help with our ‘difficult’ patients?

- By attending in our care visits to:
  - Manifest content [what is said] and
  - Latent content [what lies hidden, unconscious]
  - Transference [patient to chaplain] and
  - Countertransference [chaplain to patient]

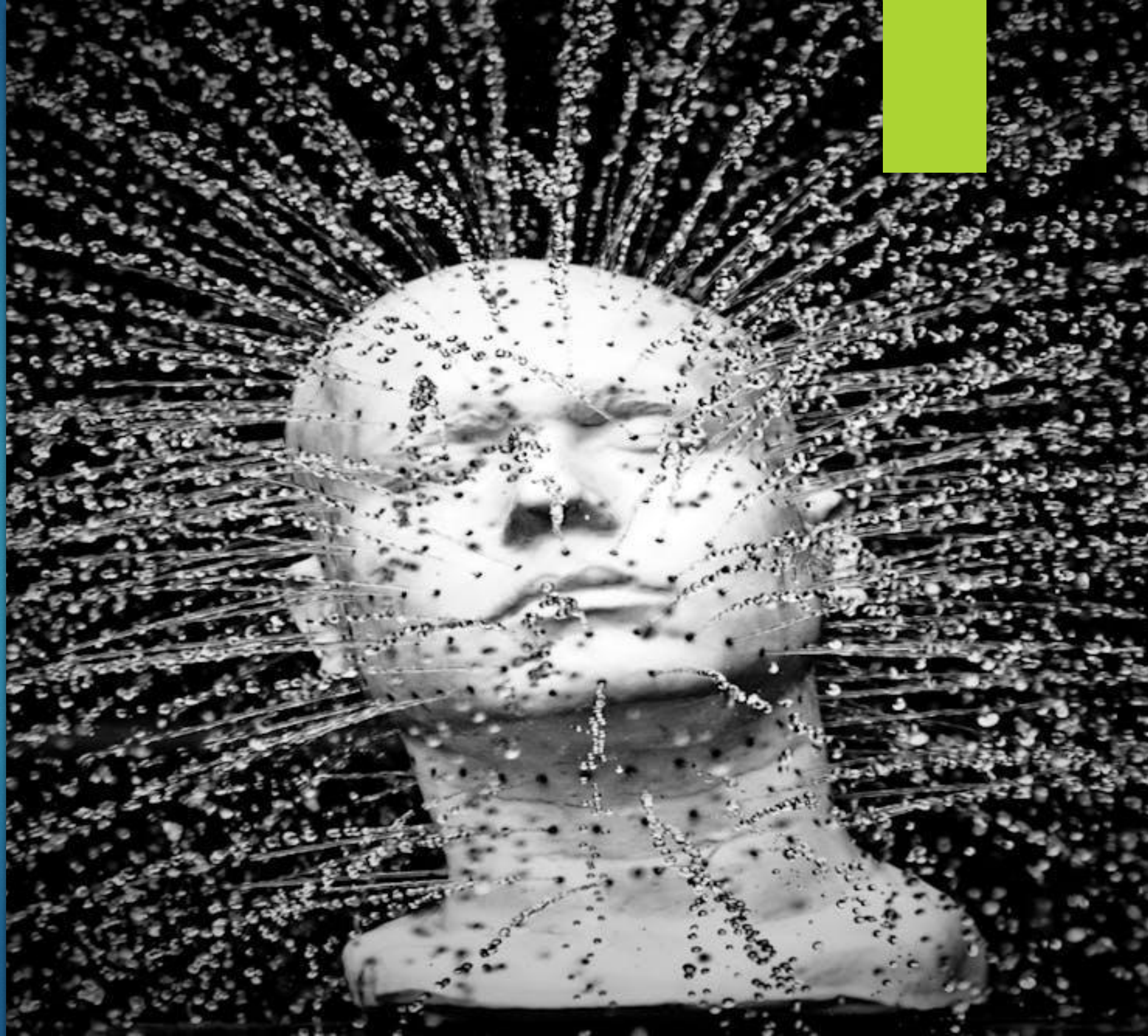
- Chaplains may have more tools to provide assessment, treatment interventions and treatment planning.

What is unconscious process?

Since Freud and expanded over time, unconscious process refers to mental activity that occurs outside of conscious awareness.

These processes influence thoughts, feelings, behaviors, and perceptions without the individual being aware of them.

In psychoanalytic theory, unconscious process often involves repressed desires, unresolved conflicts and primitive drives that shape behavior indirectly – out of our understanding and our control.



Examples of Unconscious Process:

- Defense mechanisms such as repression, denial, intellectualization, minimization as well as earlier defenses such as regression, splitting and dissociation
- Unconscious transference reactions and projections
- Dream content
- Implicit biases and/or attitudes
- Parapraxis or slips of the tongue or action [enactments].

Projective Identification

- **Projective identification** is a core psychoanalytic concept (developed by Melanie Klein and elaborated by later object relations theorists) that describes a **complex interpersonal and intrapsychic process**—not just a defense, but a way of relating.
- **Projective identification** involves three linked steps:

1. **Projection**
   The patient disowns or cannot tolerate a feeling, impulse, or part of themselves (e.g., anger, neediness, vulnerability) and **projects it into another person**.
2. **Interpersonal Pressure / Induction**
   Unlike simple projection, the patient **interacts in ways that subtly pressure or evoke** those feelings in the other person.
3. **Identification (in the Other)**
   The other person (e.g., chaplain) may begin to **feel, think, or behave in ways consistent with what was projected**.

Example of projective identification processing:

- A patient, because of shame or another strong emotion or conflict, disowns feelings of **helplessness**.
- They speak in a way that is vague, disconnected, or confusing
- The chaplain begins to feel **ineffective, lost, or incompetent; their mind feels muddy, foggy or empty**
- That feeling is not random—it may be something the patient **cannot bear in themselves**
- The chaplain can then think:
  - "Am I being made to feel something the patient cannot experience or articulate?"
  - If so, might I be able to use this information/communication to understand, assess and offer an appropriate intervention?

Difficult patents: Paranoia

MANIFEST: How the patient presents

LATENT: What may lie underneath consciousness

Paranoid Presenting Patients

Manifest: may appear depressive or manic, hyperactive, with hysteria

- Depressives will appear sad and hopeless; will disagree with most everything that is offered or outright reject help.
- Manic, Hyperactive and hysterical patient will demand many things, unrelentingly, and immediately and will reveal that they are insatiable and cannot be satisfied with any compensations or reasonable responses.

Latent transference may reveal paranoia, self-hatred and rage

- Depressives may unconsciously deeply resent and fear your health, your job, your position, your race or status. Feeling unworthy, useless, unwanted and deeply flawed as a human being.
- Manias may unconsciously fear self annihilation, disintegration and disappearance if others are not listening, doing and caring in every moment to their demands.

Paranoid [without psychosis]

Countertransference

- Depressives may provoke feelings of hopelessness, uselessness, frustration, incompetence and fear for patient.
- Manias may provoke anxiety, distractedness, confusion, distress and the sense of wanting to run away with urgency. May feel fear of being overrun, overwhelmed or sucked dry.

Interventions

- Depressives: wait them out but not with too much silence. Careful listening, eye contact and lack of agenda are confusing to them, and they will become curious in you. That will be the beginning of a transference you may be able to work with.
- Manias: look out the window, don't pay too close attention, don't be alarmed or afraid, don't mock, but still don't leave. Stay, be neutral and calm, the mania will not know where to go. They may shift to aggression such as insults or worse. Stay with them, when ready ask: what is it like to be you?

Histrionic patients

BOUNDARIES!

Histrionically organized

May present and appear:

- Infantile organization. Will likely plead for your attention and become immediately attached; often somewhat sexually flirtatious yet inconsolable, unreachable, impulsive, unpredictable, demanding multiple things at once, somatizing many ailments and fears, anxious and maybe even delusional at moments; denying medications and testing distrustful as their reality testing may fail and their memory as well. Everything is split between good and bad, idealized and devalued.

Latent and unconscious transference

- There is often a sexualization of care from boundary violations in early childhood and an unconscious wish to control others through flirtatious and sexualized actions and demands. These patients will reveal themselves, breasts, penis etc. unconsciously and may blame you as 'asking for it.' The only way they may experience closeness is through sexuality, shocking you and a repetition compulsion of their original violation. The more powerful you are the more they will unconsciously attempt to control and attach.

Histrionically organized patients

Countertransference

- Overwhelm! Shocked! Wanting to run away but feeling locked in place and cannot leave. The more plausible the demands and complaints the easier it is to get sucked into the hysterical drama. Surprised and insulted by flirtation and fear from exposure to genitals or sexualized language. Paranoia as chaplain may fear being accused of causing the patient's sexual behavior. Infantile behaviors feel manipulative and provoke anger.

Interventions

- Find your calm; establish boundaries firmly but with sensitivity. Explore patient's helplessness and sense of being out of control. The patient will respond to authority well but will expect something for being 'good.' If possible, have a chaplain of the same sexual orientation attend to patient to defuse sexual interest. The flirtation will continue but it will be less provocative. Spirituality may also be sexualized and there may be religious ideation. Assess and explore.

Narcissistically organized patients

Narcissistic personality organization

May present

- Superiority. Demanding, but help resistant—meaning patient will provide roadblocks to all suggestions and insights you have; silently compliant, judgmental, and rigidly distrustful, both victimizing and victim, devaluing and idealizing. Also generally non-compliant until a mirror identification is made with a clinician of high rank i.e., someone patient feels is on the same level, can idealize and therefore trust; grandiose, verbose, insulting, and rude, most often will explain your work to you. Patients may feel a re-enactment of their narcissistic wound by being helpless, deflated and empty through accident, injury or illness and respond with barely simmering rage unexpectedly. Scorn.

Latent unconscious material

- Fears deeply their wounded sense of self and lack of wholeness, emptiness; dependent upon others for self-esteem and worthiness; suffers terribly from shame and the fear of being shamed and humiliated. Believes anything they do that protects them from these terrible fears and shaming experiences is allowed and entitled. Suffers from an inability to access their true self, recognize true value and true self esteem.

Narcissistic patients

Countertransference

- Anger, disgust, alienated, incapable and unworthy, devalued, afraid and insecure as well as bored by repetition of story, statements, self-importance and patient's inability to acknowledge anyone other than themselves – even if their significant others and children and there.

Interventions

- Mirror back feeling tone rather than manifest content. Allow narcissistic exhibitionist needs. If patient is strident and not compliant ask what it is like to feel there is no one capable to care appropriately for their needs. Silent listening, practicing presence will often provoke patient's disgust, distrust and an attempt to humiliate. Twinning can help, same sex to same sex, sit, talk and assume their mannerisms, and body postures subtlety, they will feel a sense of comfort and relax. When this happens, you can assess and begin to work with them.

Obsessive compulsive personality organization

OCD personality organization

May appear as:

- Bright affect. Fussy, anxious, restlessness and constant movement, shifting of body and eyes, words and stories, inconsolable, work, drug or alcohol dependent, obsessive thoughts, ruminations, demands testing and medications to be repeated, anxious fears that morph and shift, distrustful of you but mostly of themselves, anorectic and reality testing may be impaired at times. Attention deficit, lack of focus and concentration. Accident prone and drama prone. Inability to relax, Cannot explain or locate physical pain or suffering except mental distress. Impulsivity/disinhibited.

Latent unconscious material

- Annihilation anxiety, fear of falling into nothingness, lack of connection to self and dissociation from their body. Fear they don't exist, are not safe, have never experienced safety or only partial safety gained through compliance and effort to be what others demand. False self organization that needs repetitive actions or thoughts to hold the atoms of their self-state together. Sense of being insane or falling insane. Suffering is not experienced in the body but in the mind. Body is not a trustworthy source; early violation. Often focused on anality, transactional nature, scrupulosity in religious or other belief systems. Trying to get it right so they can relax, but it never arrives.

OCD personality organization

Countertransference

- Anxiety. Overwhelmed by movement, speech and demands. Repetition of the same theme and stories can provoke sleepiness, boredom and inattention. Feeling of numbness and fogginess, disconnection and wanting to leave the room. Devalues and splits often meaning things of the self is all good or all bad. Fear of impulsive acting out including self-harm by patient. Reality testing may be faulty at times.

Interventions

- Be mindful of the distance – closeness continuum. If you draw too near too fast the patient will usually withdraw with scorn; if you are too far away patient will become more and more dramatic to hold your attention. Most are intelligent and hold important positions though the infantile presentation may not reveal this at first. Join with them through the mind and its suffering. Save working with connecting them to their bodies until you have time to work with them.

Anti-social personality organized

Anti-social personality organization

May present as:

- Stubborn, intractable, help-resistant, angry to rageful, rebellious, impulsive, unpredictable, distrustful, rude sometimes obscene, bellicose, demanding; emotional detachment, showing little to no regard for the feelings or well-being of others. This detachment can manifest as a lack of empathy, remorse, or guilt for their actions, making it challenging for them to form meaningful connections. In relationships, this emotional void can lead to manipulation, deceit, and exploitation of others. Impulsive. Aggressive.

Latent content:

- Early deprivations and actions may be an attempt to restore connection despite distancing and often abusive behavior towards others. Weak or absent moral structure, others are not separate or meaningful others, they are objects to use; repetition compulsion to repeat early failures in life. Feeling deeply unsafe and insecure; often seek containment via enactments that bring them to institutions, hospitals, psych units. But once there, rebel at rules and regulations.

Anti-social personality disordered

Countertransference

- Fear. Disgust. Rage. Aggression. Helplessness and futility. Incompetence and inability to feel love or hope. Feeling manipulated and dehumanized. Pity.

interventions

- Lack of respect, lack of sense of others as human beings or like themselves. Unable to symbolize or reflect leads to impulsive actions and words. Show no fear, no weakness. Strength may be admired or a curiosity and may hold attention for a time. Talk of feelings will irritate and alienate. Talk about power, control, intelligence/coolness, danger and escape or outsider status to form connection.

Limitations of this presentation

The psychodynamically informed materials are provided for an understanding of some personality disorders that appear in ‘difficult’ patients. Not all disorders are covered here. The purpose is to provide some psychodynamic understanding and tools for the chaplain to find their feet for first assessment and intervention, a means of accessing and connecting to the ‘difficult’ patient to begin the unique and priceless work of spiritual care.

This presentation understands that the audience are already masters of their spiritual care processes at their respective hospitals and institutions and won’t operate out of their scope of practice.

- We have opted for a life of open sensitivity. Pain is unavoidable, true for patients and ourselves. *M. Eigen*

References and Trainings

- Eigen, M. *(1977). On Working with 'Unwanted' Patients, Int. J. Psychoanal., (58):109-121.*
- Hall, Handzo, Massey (2016). *Time to Move Forward: Creating a New Model of Spiritual Care to Enhance the Delivery of Outcomes.*
- Lingiardi and McWilliams, (2017) *Psychodynamic Diagnostic Manual*, 2nd Ed., Guilford Publishers.
- *Psychodynamic Chaplaincy: Psychological and Spiritual Integration in Healthcare*, SCA White Paper, 2025.

- **Trainings**:
- **Psychoanalysis: Blanton-Peale Institute and Counseling Center**, 7 West 30th St., 9th Floor, New York, NY 10001. Office phone: 212-725-7850. Also offering training **in PSYCHODYNAMIC TRANSFORMATIONAL THERAPY FOR RELIGIOUS TRAUMA CLINICAL CERTIFICATION**, this September. For more information send email to patp@Blantonpeale.org.
- The **Spiritual Care Association** is offering a **Clinical Fellowship in Psychodynamic Chaplaincy**, beginning this September. This 9-month program is designed for chaplains who want to deepen their clinical practice—developing greater capacity for presence, listening, and meaning-centered care in complex situations. Participants who complete the program will be awarded the Clinical Fellow in Psychodynamic Chaplaincy Certificate. Details are in the information sheet **linked here**.
- **National Psychological Association for Psychoanalysis**, 40 West 13th Street **I** New York, NY 10011 **I** 212.924.7440 **I** contact@npap.org.

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