Introduction

The relationship between psychoanalysis and psychiatry has been understandably complex and not without its difficulties. In this chapter I will endeavour to provide a conceptual framework for thinking about the differences between a psychiatric and a psychoanalytic approach. I will explore how the two disciplines might relate to each other in a more productive way and, through illustrations, show the relevance of analytic thinking to general psychiatric settings.

The term psychoanalysis covers a wide range which can be encompassed within the following broad categories: a body of knowledge of mind, a research method and a way of treating mental disorder. It will be important to keep this broad frame of reference in mind – for, in discussion of psychoanalysis in the context of psychiatry, it is easy to slip into thinking of it as solely a form of treatment for individual patients. This is a misunderstanding to be resisted, for reasons which will I hope become clear within the course of this chapter. For, it is as a direct consequence of its range that psychoanalysis has so much to contribute to the understanding and treatment of mental illness.

Psychoanalysis and psychiatry occupy conceptual domains that do not map onto each other and that are not symmetrical. Psychiatric theory and practice are informed by a large number of conceptually distinct paradigms. Some of these paradigms can live more or less happily alongside each other whilst others are in direct contradiction; some are entirely consistent with a psychoanalytic perspective, others are to varying degrees opposed to the whole approach that psychoanalysis represents. If one thinks, for example,

of the situation where a patient requires medication, much may depend upon the context within which it is given. Where this context emphasises an understanding of the psychological development of the illness, its meaning within current personal and social circumstances, there is no contradiction with psychoanalysis. But where the illness is 'understood' as a purely biological[1] phenomenon distinct from the person in which it manifests itself, that is where the person is viewed as a passive recipient of a pathological process, an object of this process and not subject, then the contradiction with a psychoanalytic perspective is clear.

The broad reach of psychoanalysis, involving literature, philosophy and culture is not unrelated to its manner of approaching mental disorder for, from this perspective, the dividing line between normality and abnormality is less clear and more complex.

Some Characteristics of Psychoanalytic Understanding

Normality and Abnormality

Psychoanalysis does not investigate the human condition from the perspective of 'normality', which was for Freud a convenient fiction. The relation of the abnormal to the normal in psychoanalysis is at once more complex and more problematic. Careful study of the abnormal reveals what the normal hides, shows what is immanent in it, for the neurotic speaks loudly about what the rest of us keep secret. It was Freud's appreciation of what was revealed in delusions of observation (an abnormal phenomenon) that led him

[1] The term 'biological is not quite correct here as a biologist is always interested in the interactions between the organism and the natural environment. The term biological psychiatry often, though not necessarily, implies a more restricted reference suggesting that the illness is completely derived from endogenous factors.

to appreciate the depth and archaicism of the normal primitive superego. Even within the most ordinary and most disregarded aspects of mental life (such as slips and symptoms), Freud found sublime aspects of the human struggle.

In '*Obsessive actions and religious practices'*, Freud (1907) showed the clear parallel between the strange private ceremonials and rituals of the obsessional neurotic and those that accompany religious practices. Both centre on the need to keep separate good and bad, the sacred and the profane, and both have intense feelings of guilt and ways of dealing with it as central to their content. The difference is that obsessional rituals are idiosyncratic to the individual, whereas religious ceremonials are collective and stereotyped.

This demonstration of the continuities between the apparently bizarre and abnormal and so-called normality, the insight that the achievements of human culture and the manifestations of human neurosis have more in common than our narcissism would regard as acceptable, is typical of Freud's thought. He goes on to say (referring to the difference between the neurotic symptoms and the achievements of culture),

> *'The divergence resolves itself ultimately into the fact that the neuroses are asocial structures; they endeavour to achieve by private means what is effected in society by collective effort' (Freud, 1907:73).*

Freud's attitude to religion is symmetrical to his attitude to neurosis. For both these human creations he showed considerable respect, in particular for their contradictory nature. Both are expressions of human problems *and* of our attempts to resolve them; they display what is highest and what is lowest.

Thus, in a certain sense psychoanalysis humanises our attitude to mental illness and serves as a useful break on those culturally endorsed projective systems that seek to view those suffering from mental illness as fundamentally 'other', not like us.

Ms T formed a precipitately idealised relationship with her psychotherapist who she claimed was so different from the psychiatrist who was not 'interested in her but only in his theories'. In one session her therapist made a mistake as to the age of her son. Suddenly the atmosphere changed. She turned on the therapist with scorn and contempt and said he was no different to anyone else; he obviously had never been listening to her at all. The atmosphere was now one of utter hopelessness. Later in her therapy she recounted that, as a child, to escape from a very disturbing situation at home, she 'holed up' in some caves nearby and painted over all the cracks in the cave with 'magic paint' in ordered to 'stop the monsters getting in'.

So one might say that she had, in the early phase of her therapy, used the magic paint of idealisation to create for herself a kind of personal sacred space, the cave of her childhood, where she could feel safe. The therapist's mistake, however, opened a crack where 'all the monsters' could now get in (as revealed in her attack on the therapist).

When the emergency team visited Mrs X, a different patient with a known history of psychotic illness, they found her in a terrified state. She had covered all the windows and doors with 'sellotape' to prevent the evil rays getting into her flat.

These two examples, one of a more neurotic situation and the other more clearly psychotic, serve to show how, despite the gross differences in mental state of the two patients, the content of their preoccupations is very similar. Both patients worked to create idealised retreats, a kind of personal religion, where they could be protected from destructive forces. In both situations the destructive forces, are felt to exist in the external world (in Ms As case the fantasied monsters, in Ms Xs case the evil rays). The content of their preoccupations is similar for both patients but the *form* it takes is entirely distinct.

Historical Continuity - a Developmental Perspective

A distinct but related feature of psychoanalytic explanation lies in its commitment to historical continuity. Freud's (1905) *Three Essays on Sexuality* not only provided a model of sexual development and of understanding the sexual perversions, but introduced a method of *understanding disorder in terms of development*. Disorder manifests aspects of mental life which at a different developmental phase might have been normal. Although we never lose completely earlier ways of functioning, when these more archaic forms come to dominate mental life they become the basis of psychopathology.

Psychoanalysis always seeks to make manifest historical continuities that underlie apparent discontinuities, whether this be at the level of general psychological development or at a more specific level. For example, those moments of change or transformation that manifest themselves in what we term a breakdown, often present themselves as impressive discontinuities. Where such discontinuities occur *apparently*, part of the task will be to show continuities in functioning but at a less apparent level. This type of understanding not only imparts meaning to symptoms, but goes further as the following illustrates.

Shortly after the death of his father Mr. D developed symptoms that were identical to those his father suffered. In the course of psychotherapy it was possible to understand that this expressed his identification with his father, unconsciously a way of keeping him alive. But it also expressed the guilt (making himself suffer) arising from the painful realization of feelings of triumph arising from death wishes towards the father.

This understanding at one and the same time addresses the meaning of the symptom, and displays its causal structure and causal history[2].

Tom Freeman (1981), a psychoanalyst who worked in a general psychiatric setting, gives the following excellent illustration of the impressive manifest break in continuity that characterises a breakdown.

[2] I am aware that I am touching on an important epistemological issue that cannot be dealt with here at any length. . For some, meanings and causes are entirely distinct whilst for others it is the intertwining of meaning and cause that characterises the human subject. It is this latter view which is consistent with psychoanalysis as discussed here.

A young man was admitted to hospital in an acute psychotic state. He said to the admitting psychiatrist, ‘‘If I look in your eyes you will be broken hearted.” “I am betraying you”

Freeman learnt from others close to the patient that this overtly psychotic phase had been preceded by an introspective depressive period in which the patient felt worthless and helpless following a betrayal in love. In this melancholic state, all recriminations against the girl who betrayed him were directed not towards their real target but towards himself. In other words the young man, in a typically melancholic manner, identified with his girlfriend (it is he, not she, who is worthless, or as Freud put it ‘the shadow of the object fell upon the ego’ (Freud, 1917, p. 249)) and in this way maintained his idealisation of her. In the psychotic phase, however, there has been a further transformation. The patient has ‘solved’ his problem through a psychotic identification - he has <u>become</u> *his girlfriend, it is* he *who is now the betrayer and someone else who is the betrayed, someone else who is ‘broken hearted’. The patient, because of the pain it brings, resists any restoration of continuity between the pre-psychotic and the psychotic phase.*

The very significant theoretical and technical developments in psychoanalysis since Freud have not altered its approach, in terms of the understanding of development, the link between development and pathology, and the relation of the ‘normal’ to the ‘abnormal’.

Personality and Illness: a problematic distinction

There is a further conceptual issue here that is of broad relevance but which is not immediately apparent. In psychiatric diagnosis it is important to distinguish between personality disorder and mental illness. This broad distinction has important relevance to the general appreciation of the patient and to rational plans for management. Such distinctions also have important value from an epidemiological perspective, particularly in terms of service planning. The kind of service necessary for mental illness, (which generally will be expected to be episodic, although episodes may be very long), will be different from that for personality disorder. In the latter there is a reasonable expectation that difficulties will be enduring, given they are functions of the whole personality structure.

When it comes to the individual, however, the separation between 'personality' and 'illness' may in itself be problematic[3]. What appears as illness may be understood, psychoanalytically, as a *personality development* under the stress of certain internal and internal conditions.[4] [5]

[3] There is some growing sense that that the simplistic distinction between mental disorder and personality disorder (which underlies the differentiation of axes in DSM-IV) is questionable , see for example (Westen 2006)

[4] By this I mean that some individuals may have a kind of psychological 'fault line', which under the pressure of a toxic interaction between the sensitized internal world and particular malign external circumstance is stressed to the point of breakdown. The fault line, which is often the source of pervasive anxiety, may in other circumstances be managed and so not become manifest.

[5] A related issue here is that whereas psychiatrically one may speak of a patient as having more than one illness, from a psychoanalytic perspective the patient has only one illness which expresses itself in different way., and which is inseparable form his character.

A breakdown manifests itself as a most impressive discontinuity, *apparently*, but when examined in more detail may show in bizarre and distorted form conflicts and preoccupations that were part of the personality prior to the breakdown. In fact the ability to help the patient integrate his pre- and post-breakdown state is an important part of working analytically with such conditions, as is the less welcome discovery that recovery is not recovery from the difficulties that brought about the illness. These continue, though at a less manifest level, within the character structure of the individual patient. This commitment, to the restoration of continuity to that which appeared to be discontinuous, again manifests the developmental perspective, central to psychoanalytic explanation.

Mr A, an academic, suffered from a severe manic depressive disorder. When manic he felt himself to be possessed of a kind of knowledge that was absolute, that was his sole possession- and thus believed that he was the object of considerable envy. When depressed he felt himself to have been ejected from his epistemological paradise and now, as an inferior creature, the object of contempt by all. However during his so-called 'normal phases', Mr A revealed himself to be still overwhelmingly preoccupied with his position relative to others; more precisely with his position in the mind of his primary object, originally his mother, relative to others. This obsession, which governed all else in his life was, in his more normal phases kept hidden (though quickly made manifest in his analysis).

Symptoms versus structures

From a psychoanalytic perspective symptoms are the outward expression of deeper structures. Treatment therefore aims at understanding the underlying psychic structures as a route to removal of symptoms.

Mr B, a man in his early thirties, presented in an agitated depression. It emerged that he was in an acutely bereft state having been abandoned by his girlfriend who had chosen instead his closest friend. This persecuted state seemed to be a manifestation of an oedipal depression; he felt forced to watch the couple, his fiend and his ex- girlfriend, both thought of as in a state of continuous pleasure and triumphing over him. However, within a few weeks of psychotherapy with a young woman therapist, he was 'cured'. He was back at work, functioning well, feeling happy in the world and very far from his depression. Indeed, he had a new girlfriend who had herself chosen him over her husband. His sessions were full of long accounts of the virtues of his new girlfriend, which were related in such a way as to make his therapist feel, as she put it, like 'irrelevant observer'.

From a symptomatic perspective the man is cured, but looking at things more deeply one might say that the psychic structure remains unaltered. The psychic furniture has not changed; there are still three 'chairs', two occupied by a couple and the other occupied by a depressed, excluded party. In his present life the last chair is now occupied by the husband of his girlfriend, and in his therapy by the therapist, the 'irrelevant observer'. The excluded person is the target of a projective system which serves to rid the self of

unbearable feelings of rejection/exclusion, now located in a third party. Such a situation is of course inherently unstable.

This vignette serves to make a broader point; most patients tend to seek help at a point in their lives when there has been a breach in their ordinary defensive structure which protects them from psychic disturbance[6]. Their most urgent aim is thus to restore their psychic equilibrium in order to be free of unbearable psychic pain. Thus, in the initial phases the therapeutic situation is often used to restore the original structure, the status quo ante, and this is probably inevitable[7]. Some patients will leave treatment at this point having accurately perceived that continuing treatment, because it will undermine this defensive structure, threatens them with a return of symptoms. It is only managing the return of symptoms within the therapeutic setting, however, that can provide some real and durable protection against further breakdown.

The role of agency

From a psychoanalytic perspective an individual is never only a passive recipient of their illness, they are always involved in the manifestations of their disorder.

Mrs P, a woman in her thirties, was referred for an assessment for psychotherapy. She had suffered from chronic depression for many years and had already undergone various

[6] The popular term for this state is of course 'a breakdown' and in many ways it is quite accurate, as the cause of the disturbance is a breakdown in the capacity to maintain the defensive structure. The consequent state is usually of mixed anxiety and depression and this was the usual diagnosis up to the 1980's, when many of these cases came to be diagnosed as suffering from depressive disorder. The phenomenology, however, remains the same although the label is different.

[7] For an excellent discussion of the subtle but profound effects of this need for psychic equilibrium see Joseph, 1992

treatments. When invited to tell me of her difficulties at the beginning of the consultation she gave me a detailed and in many ways very competent account of the illness, much of which consisted in going through a list of symptoms. The atmosphere was one of utter lifelessness; she talked only of her symptoms and not of her self. It felt as if she was handing her 'ill self' over to me for consideration in a manner that was quite self-objectifying. When I pointed this out to her, saying that she appeared to be wanting to give me a list of all the things that assailed her, to hand them over to me for diagnosis and recommendation for treatment without having to participate in this process at all, she started sobbing and said 'I don't think I have ever participated in anything in my life'. One could see here that an important move had taken place, where she showed a capacity for insight. Paradoxically, in her discussion of not participating, the patient was *now participating in the interview in a way that was very real, but also quite disturbing.*

The point that I am making here is that it is sometimes only through an engagement which foregrounds the way the patient is relating, the way this reveals their psychopathology as a dynamic structure expressed in the relationship with the mental health professional, that one can form an adequate assessment of what the patient is seeking.

The situation discussed here trenches upon the problematic distinction between 'illness' and 'personality' discussed above. But there is a further issue that is of some importance and it is this. Certain patients, because of the nature of their psychopathology, will pressure others to treat them as passive recipients of an illness, as is they have been

infected by a kind of ‘depresso-coccus’. The doctor should prescribe antidepressants as if they were psychic antibiotics, and so treat the ‘illness’ as if it could be alienated from the rest of their personality. Some kinds of psychiatric approach can, unwittingly, collude with this objectification.

I hope above I have shown some of salient features that characterise a psychoanalytic attitude to mental illness. Below, I will aim to show in more details the applications of this perspective to different situations. These will focus around the theme of the relation of the intra-psychic to the interpersonal, and the application of this knowledge base more generally in terms of psychoanalytic informed management and the understanding of the relation between the patient and staff.

From the Intra-psychic to the Interpersonal

In some of the case illustrations above I have already touched on the area of psychosis, but will here expand on this area. However, an important caveat can perhaps be stated at the outset. It is *not* being suggested here that the enormity of the problem of psychosis might be better dealt with by individual patients having available to them skilled psychotherapy. This is clearly unrealistic and in any case there are many patients who would not benefit from this approach. What *is* being suggested here is that a deeper understanding of the relation of the intra-psychic to the interpersonal can inform our understanding of psychosis, which can in turn contribute in an important way to the management of cases particularly in terms of the therapeutic milieu which forms a vital

part of the treatment situation. This is something I will return to in the concluding part of this chapter.

Freud's classic account of psychosis, the Schreber Case (Freud, 1911) remains relevant today. Schreber, a highly intelligent judge, wrote a very detailed account of his psychotic illness which came to Freud's attention. In form Schreber's illness progressed from a severe anxiety state to the development of a delusional system, a frequent occurrence familiar to many psychiatrists. Many patients, suffering from a psychotic breakdown, present at first in an acutely anxious state. The patient is aware of something catastrophic happening to him, but he cannot describe it. He may be confused, say that he is falling to pieces, that the world has been altered in some indescribable way. Out of this chaos a delusional system 'crystallises', and this has the benefit with providing an explanation for what has been happening. Characteristically, such delusions take the form of messianic ideas (as in Schreber) or paranoid delusions[8]. One patient for example developed the delusion that the CIA had implanted a silica chip in his brain and were trying to control him for some malign purpose. It may seem that living in the grip of such thoughts would be unbearable, but psychiatrists and psychoanalysts have found that, once the full delusional system has developed, the patient often becomes much calmer. He is no longer confused as he now (delusionally) 'knows' what is happening to him. For Schreber, the

[8] Freud observed that megalomania and paranoia are closely related and also that one can transform into the other. In the case of Schreber, what started off as a paranoid delusion (his belief that he was to be used homosexually by his doctor) transformed into the megolamanic delusion - God's planned intercourse with him as the realisation of the messianic idea.

changes inside him were all part of what he called 'the order of things'; that is, it conformed to a grand metaphysical scheme[9].

Freud makes the point, and this remains relevant, that the delusion is *not* the illness per se but is *the attempt to recover*. 'The delusional formation, which we take to be the pathological product, is in reality an attempt at recovery, a process of reconstruction', writes Freud (Freud, 1911: 71). The central catastrophe is the loss and fragmentation of meaningful contact with the world and the delusional system is an attempt to rebuild a world of meaning. The delusion gives expression both to the inner catastrophe and to the attempt, with whatever limited resources, to recover from it.[10] From this perspective, the

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[9] Schreber's delusional system bears some resemblance to the crazy thinking so well captured by Stanley Kubrick's film 'Dr Strangelove'. One of the characters in the film, the mad general, is aiming to bring about a world apocalyptic scenario in order to rid the world of a terrible communist plot which he has endowed with omnipotent power, and which seeks to drain away his 'precious bodily juices'. Unfortunately such thinking is not confined only to science fiction films as there are those, who occupy high positions of power in world politics, who believe in an Armageddon that will bring peace everlasting, presumably conceived as returning to a state of primary bliss.

[10] Freud (op cit) finds a poetic description of this process of catastrophe (the destruction of the inner world) and reconstruction in Goethe's *Faust* :

[Woe! Woe!]
Thou hast it destroyed. The beautiful world,
With powerful fist,
In ruins t' is hurled
By the blow of a demigod shattered ...

Mightier
For the children of men,
More splendid
Build it again
In thine own bosom build it anew.
(Part 1, Scene 4) (quoted in Freud 1911 p.70)

patient cannot be ‘cured of their delusions’ without any understanding of the condition that necessitates their construction[11].

A further feature is worthy of note here. The patient’s awareness that his inner world is in danger of total collapse is projected outwards. He does not say ‘my inner world is falling to pieces’ but instead that ‘the world is coming to an end.

The work of Melanie Klein has considerably extended our understanding of such very disturbed states. She described primitive states dominated by the processes of splitting and projection. This account, through its more detailed understanding of the complex interrelationship between internal and external, provides a richer understanding of the psychotic world as exemplified by Schreber. Such patients conceive of themselves as having a special relation to good and evil forces. This can take place on a grand metaphysical scale (as with Schreber), or their concerns can be more local as in the following example.

A psychotic young woman in hospital felt she had to protect all the patients from the evil doctors and nurses who she believed were determined on sexually abusing them. On talking to her, it seemed that she had split off good aspects of herself and projected them into the patients who had to be protected from her own violent sexual impulses, now located (again through projection) in the doctors.

[11] This compares well with Marx’s discussion of religion where he criticises those who seek to urge people to abandon religion (a symptom). He writes, “To call on them to give up their illusions about their condition is *to call on them to give up a condition that requires illusions* ” p245 italics in original

We find the more normal variant of this situation in fairy tales and also in religious doctrines, where the idealised fairy godmother is *all* good, and is kept widely apart from the wicked step-mother who is only bad.

The interminable struggles between good and evil forces, so basic to all religious doctrine, from this point of view derive from our projection of the division in our own minds onto the heavens. Such narratives give representation to powerful internal struggles, the need to protect idealised internal objects from persecutors, and the use of omnipotence (magic etc.) to perform this task.

Klein (1935, 1940) described a major developmental move, the depressive position, which brings momentous changes to the psychological landscape. The self and the world become more integrated and this brings a capacity to tolerate guilt and other forms of mental pain[12]. The pain felt at the inception of the depressive position is acute and often unbearable and so can be a source of dangerous acting out. This understanding adds a very important dimension to what underpins the familiar psychiatric observation that just at the point where a patient seems to be recovering from depression, the greatest vigilance is necessary because of the higher risk of self- harm.[13] Progress brings the possibility of integration which in turn brings unbearable psychic pain. Where this can be borne (and this will include both internal and external factors) then further progress can

[12] There is an important distinction to be made between 'depressive illness', a schizoid state of mind, and the 'depressive position'. Although the latter may manifest painful states of mind including feelings of despair, loss and guilt, it is not a schizoid state. The painful aspects derive not from splitting and projection but from integration.

[13] Classically this was understood as related to the removal of the limitation on action imposed by the presence of psychomotor retardation. This is not inconsistent with the psychoanalytic perspective.

be made. But where this pain cannot be managed it can be the source of suicidal enactment.

Klein considerably enriched and broadened our understanding of the processes underlying splitting and projection. She described how in phantasy the mind can split off aspects of itself and project them into external figures, these figures becoming identified with what has been projected (a process she termed 'projective identification'). This mechanism has very broad relevance to the understanding of the puzzling and disturbing relationships that psychiatric patients form with the mental health professionals looking after them[14]. The deepening of this understanding has been one of the major growth points in psychoanalysis in the last 50 years. It needs to be emphasised that the processes described by Klein are *internal* processes occurring *within* the individual. However, what we have come to understand is that all of us act upon the world to bring about the realisation of these phantasies so that they become real events in the world. In other words phantasies, to use Sandler's (Sandler 1976) very apposite term, become *actualised.*

Miss B, a patient in analysis, was internally dominated by a cruel primitive superego which she felt watched her every move. She experienced any attempt at self-control as in the service of this superego and so could not distinguish between it and ordinary ego functions that sought to protect her from danger, in other words the superego masqueraded as the ego. This resulted in a wholesale projection of her sane awareness of the danger she was in into her analyst. Left free of any concern for herself, Miss B took

[14] For a fuller discussion of the origins and development of the concept of projective identification, see Bell (2001)

increasingly dangerous risks, such as driving whilst under the influence of sedatives with, apparently, complete equanimity, whilst her analyst became increasingly horrified as the momentum of her self-destructiveness gathered pace. She said that she experienced the ending of sessions 'like a guillotine' . This was a very apt description as, having projected important ego functions into her analyst , she left the session in a 'headless' state. The situation deteriorated to such an extent that it became necessary to admit her to hospital.

On the ward she behaved in a very provocative way to the nurses. She would go off the ward without telling them where she was going, leaving them with an overwhelming anxiety that she was about to carry out a very self-destructive attack. She might say for example, in an apparently calm way, that she was 'going to the shops' as if this was a quite ordinary and banal event, whilst at the same time conveying that she would be near the pharmacy where, by implication, she might buy some paracetamol. At other times she would telephone the ward from outside but not speak when a nurse answered and then hang up. The nurses found this unbearably tantalising. This resulted in an escalation of the need for the staff to control her and she was restricted from leaving the ward. The situation then further deteriorated and the nurses became worried that she might carry out a serious attack upon herself at any moment. The final result was that she was restricted to a small room where she was continuously observed. She then became acutely anxious and declared in a terrified voice,' I can't stand this place. I'm being imprisoned'.

The patient here has ‘actualised’ (Sandler, op cit) her inner situation. What started out as an inner conflict between aspects of herself, an intra-psychic situation, has now been transported into a conflict between herself and the nursing staff, namely an interpersonal situation. The superego watching her all the time is of course inescapable, but temporary relief is achieved through projecting it elsewhere in this way. Now, it is not her own superego but instead it is the nurses on the ward who are felt to be imprisoning her. An inner situation has been transformed into a spatial one.

It is also important to note that the patient’s provocative manner did engender a good deal of hostility towards her which was never really owned by the staff. Although the maintenance of the patient under continuous observation served, manifestly, a wish to protect the patient from suicide, at a deeper level, it also, I think, satisfied a hatred which had been recruited in the staff and which was associated with some excitement.

These situations are not uncommon. Many patients use admission to psychiatric wards to provide themselves with an immediate context for these projective procedures. Although in the last instance, no-one can be prevented absolutely from committing suicide, it is easy for staff to become identified with an omnipotence which dictates that whether the patient lives or dies is entirely their responsibility. They come to believe themselves to be the only ones capable of really understanding the patient. The determination to save the patient acquires a religiosity, as the staff come to believe themselves to be specially selected for this mission. Hostility that is denied and split off to this extent can quite suddenly return, and with a vengeance. Nurses and doctors who have felt impelled to see

the patient *only* as a suffering victim, to repress any understandable hostility to the patient, may snap and suddenly find themselves thinking that the patient should no longer be tolerated, must be immediately discharged. Such situations, if they become the source of enactment, may even bring an apparent improvement, not based on any real development but through the gratification of the patient's need for punishment; relieving him, temporarily of the persecuting omnipotent guilt.

It was Tom Main (Main, 1957) who originally studied these processes in detail showing how the splits in the patients mind are relived, in the ward, as divisions among the staff. The 'saintly' group, described above, who endlessly suffer on behalf of the patient and who believe the patent to be only a victim of his damaging early relationships, have their counterpart in another group of staff who see the patient only as manipulative and 'attention seeking', which must be 'confronted'.

Where these staff disturbances remain unacknowledged the situation can quickly escalate, with catastrophic results. The container, the ward, breaks down in its capacity to contain the patient and suffers a kind of institutional breakdown. It is important not to underestimate the effects of this kind of catastrophe on the staff, particularly in terms of persecuting guilt and feelings of worthlessness.

Through its capacity to make manifest the manner in which illness relates to the underlying personality, the way in which it is expressed in relationships, psychoanalysis has provided us with a tool that enriches the phenomenological understanding of mental

states; rendering them not only as static descriptions but as dynamic entities. This richer understanding can make a vital contribution towards the formulation of management plans, and also form a basis for understanding the patient's way of relating to the team or institutional context that is providing his care.

One of the central distinctions that I have found to be of real practical use in the day to day management of clinical problems is that between those states where a significant degree of perversity dominates the clinical picture and those where that is not the case. By the term perversity here I am referring, amongst other things, to those situations where the patient derives pleasure from his deterioration. This may have both masochistic and sadistic qualities; masochistic pleasure from his own self destruction, and sadistic pleasure from the tormented relationships he forms with the staff. This dimension is relatively independent of the psychiatric diagnosis. It is a frequent though insufficiently recognised problem in severe depressive states. Two patients manifesting the typical symptomatology of severe depression may in their different ways of relating reveal distinctions in degree of perversity, which in turn have important implications for rational management.

It needs to be emphasised that in referring to perversity here I am referring not to a moral category but to a description. Further, there is no straightforward link between degree of perversity and aetiology. Some patients dominated by perverse modes of functioning have themselves, in childhood, been victim of prolonged perverse treatment, for others this does not seem to be the case.

Mr. F was a 38 year old eastern European man who came from a very severely disturbed background, though disowned knowledge of this himself. He was admitted to a ward where I was working, after a series of episodes of self harm including self cutting, overdosing and a serious attempt at drowning which required resuscitation. The diagnosis was of 'treatment resistant depression'.

He was clearly a very difficult patient to manage and I was asked to discuss the situation with the team. I learnt that Mr F was relentlessly negative, saying that he had nothing to live for, that his life was entirely meaningless. Mr L, his special nurse, saw it as his job to persuade him otherwise, but without any success

Special care was provided for the patient on a daily basis. In discussion it emerged that there was a 'politically correct', so to speak, way of talking about him - that is as someone who was very ill, suffering, who needed special care; but there was another, much more negative view which it was difficult to own.

As it became possible to talk more freely, however, staff spoke of the hatred that was stirred up in them. The nurse who was 'specialling' him described how all meetings were arranged by the team and never by the patient. The patient would reluctantly agree to come, but always added '.. if you *think there is any point'. The staff felt extremely burdened with the day to day responsibility for keeping him alive and found it very difficult when the patient said he enjoyed being there (on the ward;) it was 'like being in*

a country spa'. It also emerged that a number of the nursing staff worried more about this patient than anyone else and further, that this worry invaded their personal lives to the degree that even when they were not on duty they thought about him and phoned up to make sure he was still alive. Each of them felt very alone with this worry, as if it was their own very personal responsibility.

The crucial moment in discussion came when the senior consultant, Dr J, felt able to describe her distaste at a scene she was constantly exposed to when the patient's wife visited the ward. They would exhibitionistically caress each other sexually in full view of the staff and patients. This was done just sufficiently to make it clear what they were doing, but not so much that it could be censured.

We understood this in the following way. The very public excited 'intercourse' that was taking place on the ward made manifest the malignant type of continual 'intercourse' that was taking place between the patient and the staff. That is that projecting his wish to live to the degree that the staff continually felt responsible for keeping him alive, had become a source of addictive excitement for Mr. F. This excitement seemed to derive from at least two sources: being rid of the burden of his wish to stay alive, but also from a perverse triumphant mockery of that wish, which the staff had to suffer for that wish was now located in them

From a psychoanalytic point of view Mr F belongs to that group of patients who project the wish to live into other people. Although some of these patients, having projected their

wish to live, feel relieved and in fact can allow others to help them, this is not the case here where there is a more malignant relationship. The more the staff own the patient's wish to live, the more the patient, so to speak, is free of it[15]*. It is typical of these patients that they tend to overwhelm staff's capacity to cope and anxiety about them tends to invade the personal life of the staff. In some situations staff feel that they cannot even have holidays.*

In order to be able to provide appropriate care for Mr F it would be necessary that those looking after him do not feel that they have to take full responsibility for whether he lives or dies (this is of course how they end up feeling, but it is important that this position is not supported externally).

It is also very important in these situations that no individual member of staff be psychologically isolated with the patient and the team make sure that they regularly discuss their involvement with him. This is in order to avoid a splitting process (that is where, for example, one staff member can be idealised and another denigrated, or one staff member become drawn into unrealistic hopes for the future of the patient).

Ms D appeared at first to be similar to Mr F. She too filled the staff with unbearable anxiety as to her suicidal capacity. Although at first perverse psychopathology seemed to predominate, over time this gave way to a more melancholic picture. She had made innumerable mutilating attacks on her skin by slashing it. Her skin seemed to represent

[15] Hanna Segal (1993) provides an excellent account of the triumph over the wish to live drawing on literature and clinical work.

her sexual body which she regarded as disgusting. She felt full of 'bad, disgusting thoughts', particularly of abusing children. She felt that she could only rid herself of this identification with her abusing parent through quite literally cutting it out of her body. She had managed, however, to spare her face and hands and this appeared to represent a limited capacity to hold on to something good in herself.

Once on the ward, however, she tended to project into the staff all awareness of these good aspects of herself, she herself sinking further and further into her melancholic state. The fact that in this case the staff felt able to maintain a belief in her, despite being constantly provoked, turned out to be of great therapeutic importance. Here the primary motive for this projection outside herself of her wish to live seemed to be more for 'safekeeping, perverse mockery being much less evident. After some improvement she too, like Mr F, showed a marked negative therapeutic reaction and became more acutely ill. Although there were some perverse elements the predominant difficulties arose from the unbearable psychic pain consequent on the awareness of damage done to her good objects[16]*, which to some extent really was irreparable.*

Concluding Comments

In this chapter I have focused on the patients internal world and his immediate context but, before closing I would like to give due recognition to the importance of the wider

[16] The term 'object' here may require some explanation. This is a term used by psychoanalysts to refer to internal figures, laden with emotional significance, which , although largely unconscious, have important determining effects upon our mental life. For example, for some people their whole mental life is dominated by feelings of guilt /self blame. This is the conscious derivative of being unconsciously persecuted by 'damaged internal object's'.

contexts within which this care takes place; these might be pictured as a series of containers rather like those Russian dolls[17]. So, at the first level there is the individual patient's mind and the disturbing thoughts and feelings it has to manage, then there is the relationship between the patient and his immediate carer (usually the primary nurse), then the context of that relationship, perhaps the psychiatric team and the ward[18], then there is hospital/institutional structure, and so on up to very broad societal levels which would include Government policy. All these levels have important effects and at any moment one level may have a more determining effect than others. Further, different levels may act to support each other in a positive way, as occurs when intermediate management structures serve as buffers absorbing pressures from above and below, containing them and thus insulating other levels.

Alternatively, as I have described elsewhere (Bell, 1996), anxieties instead of being contained are amplified as they are cascaded downwards through the system. The 'marketisation' of health care creating competition between Trusts and fears of takeover, that is constant survival anxiety, can do considerable damage to the staff's capacity to carry out their primary task, their primary source of satisfaction, and so do considerable damage to morale.

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[17] Although I have not in this chapter made explicit reference to Bion's concept of 'container-contained' (Bion 1962) this concept is central to much of the material discussed but particularly so in the following paragraphs

[18] A good illustrative example of the effects of the larger context is provided by Arthur Crisp (personal communication). He made a simple study logging daily the number of events of acutely disturbed behaviour occurring on a ward. Viewed from the narrow perspective of the immediate context each event seemed to have a more local cause, but what was revealed was a predictable rise in such incidents in relation to the proximity of the ward round.

Managers on closely monitored performance reviews may become, understandably, unable to contain the enormous threat they are under. What starts off as high level Trust budgetary concern may, in such situations, be transmitted rapidly downwards through the system with the end result that a nurse finds himself inappropriately flooded with anxiety about a Trust's future and so feels impelled to shape admission and discharge policy with this as his determining consideration.

Where there are supportive structures that can provide a framework for understanding the patient, the manner in which his difficulties are manifest in the relationship with his carer, where mental health workers can trust their immediate colleagues and superiors to be able to share with them how they 'really' think and feel about the patient, the 'unofficial, or less 'politically correct' story, and where they can come to see that even the most bizarre and disturbed communications from the patients are not just 'noise' to be ignored but communications full of ordinary human meaning, then the scene is set for enthusiastic involvement in the work rather than the alienation and disillusionment that can so often come to dominate the ward and out patient settings.

All psychiatric symptomatology is expressed within the context of human relationships. It is because of its capacity to grasp phenomenology as a living phenomenon in the relationship between the patient and his world, that psychoanalysis can make such a valuable contribution to the understanding and management of the individual patient and his wider context/milieu.This supports staff morale, one of the most important therapeutic

elements in the care of the mentally ill and perhaps the one of the least studied. It receives insufficient attention in strategic plans for mental health.

In 1953 a WHO report comparing the treatment in different psychiatric hospitals concluded that the most important single factor in the efficacy of the treatment given in a mental hospital is “an intangible element which can only be described as its atmosphere”. I hope in this chapter I have given some indication of the kind of activities that can make a substantial contribution to building and preserving this atmosphere.

Bell, D. (2001) Projective Identification. In C. Bronstein (ed.), *A contemporary introduction to the work of Melanie Klein*. London: Whurr

Bell, D. (1996) Primitive Mind of State. Psychoanalytic Psychotherapy, 10: 45-58

Bion, W. (1962) *Learning from Experience.*, London: Heinemann

Freud, S. (1905) Three essays on the theory of sexuality. In J. Strachey (ed.), *The Standard Edition of the works of Sigmund Freud, VII.* London: Hogarth

Freud, S. (1907) Obsessive actions and religious practices. In J. Strachey (ed.), *The Standard Edition of the works of Sigmund Freud, IX*. London: Hogarth

Freud, S. (1911) Psychoanalytic notes on an autobiographical account of a case of paranoia (Dementia Paranoides). In J. Strachey (ed.), *The Standard Edition of the works of Sigmund Freud, XII.* London: Hogarth

Freud, S. (1917) Mourning and melancholia. In J. Strachey (ed.), *The Standard Edition of the works of Sigmund Freud, XIV.* London: Hogarth

Freeman, T. (1981) On the Psychopathology of Persecutory Delusions. *British Journal of Psychiatry, 139: 529-532*

Joseph, B. (1992) Psychic change: some perspectives. *International Journal of Psycho-Analysis, 73: 237-243*

Klein, M. (1935) A Contribution to the Psychogenesis of Manic-Depressive States. International Journal of Psycho-Analysis, 16:145-174

Klein, M. (1940) Mourning and its relation to manic depressive states*. International Journal of Psycho-Analysis, 21: 125-153*

Main, T .F. (1957) 'The Ailment'. *British Journal of Medical Psychology, 30: 129-145.* Reprinted in T. Main (1989) *The Ailment and Other Psychoanalytic Essays.* London: Free Association Books

Marx, K. (1843) A Contribution to the Critique of Hegel's Philosophy of Right. Introduction republished in *Early Writings Marx*. Harmondsworth:Penguin Books

Sandler, J. (1976) Countertransference and role responsiveness. *International Review of Psycho-Analysis, 3: 43-47*

Segal, H. (1993) On the clinical usefulness of the concept of the death instinct. *International Journal of Psycho-Analysis*, 74:55-61

Westen, D., Gabbard, G.O. and Blagov (2006) Back to the Future: Personality Structure as a Context for Psychopathology. In R. Krueger and J. Tackett (eds.), *Personality and Psychopathology*. New York: Guilford Press

World Health Organization, (1953) *Expert Committee on Mental Health: 3rd Report*. Geneva: WHO