CHAPTER FOUR

Bearing and not bearing unbearable realities: the limits of understanding

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A famous dictum of Freud's was that bad men do what good men dream. The difficulty for staff working with forensic and psychotic patients is that they are working with patients who confront them with their own worst anxieties. They are being asked to manage the most extreme form of concrete thinking—murder and violence to the self, as in some psychotic patients, or murder and violence toward others, as in forensic work. Even in specialist services such as medium secure units, staff on inpatient wards are often not equipped to manage the extremely difficult task of understanding patients' concrete behaviours in symbolic terms. This is not a criticism of the staff, but an acknowledgement of the nature of the patients they work with. Constant exposure to the patients' very concrete modes of thinking inevitably erodes the staff's own capacity to reflect, often leading to "mindless", institutionalized responses that may recreate the patients' very early deprived relationships.

In this chapter, I describe my experience of applying a psychoanalytic perspective to such patients, seen in both institutional settings and in my private practice, and how such an approach might begin to translate patients' concrete enactment to often

painful and terrifying thinking. The unbearable thinking, which is deeply resisted, is often to do with the nature of early attachments, or, more specifically, the lack of secure attachments and, even worse, to do with the confusion and even reversal of the "who's caring for whom" relationship.

For myself, a very early experience of this was working on a ward that treated psychotic patients in which the staff had ceased to relate to the patients as individuals. The bizarre behaviour of the patients had led staff to behave in ways that were equally strange. The names of patients had been forgotten and there was no regular space for reflection, even the euphemistically named practice of staff groups for reflective thinking had been obviated. Not surprisingly, patients on this ward were acting in severely regressed and disturbing ways, confirming the staff's belief that they were unreachable. A consultative staff group was introduced which encouraged staff members to think about patients' communications. In addition, each patient on the ward was to be seen by a key worker at least twice a week at exactly the same time each week. This created a regular space within which to listen to the service user. This was subsequently written up and taken to a supervision group, where the meaning or apparent meaningless of the patients' communications were explored with myself and another colleague. This model of trying to listen and to think resulted in the team regaining an interest in patients' material, and this led to a more thoughtful atmosphere on the ward. One consequence of this was a gradual reduction in patient enactment.

The staff on this ward had become identified with projected aspects of the patient, particularly those that represent early infantile experience of breakdowns in attachment. The painful aspects of these communications are easier for staff members to identify with and replicate than think about.

In similar ways, a consultant is often brought in to deal with very complex problems, and is required to demonstrate a capacity for reflection, which might enable a shift to take place in the clinical staff's capacity for thinking symbolically and away from concrete identification with their patients' minds. This is a particularly difficult task for the consultant on wards containing very disturbed patients, as there will be a great deal of resistance in the organization as a whole, which often has as much resistance to

thinking as the patients in their care. Paradoxically, however, it has to be recognized that some of the most painful psychic experiences are unbearable and it is omnipotent to imagine that anyone can encompass them successfully through thought.

This is beautifully described by Hinshelwood (1993) writing about when he provided a consultation to a prison. The splitting required to work in such a setting defied thinking: staff, like the inmates they were working with, saw any therapeutic intervention as soft and, as such, a threat to the equilibrium required to manage the often cruel and violent setting. This resulted in the cult of the hard man dominating the environment, all therapeutic intervention was seen as part of a soft culture and, therefore, suspect.

The problem around thinking about psychotic and forensic patients has been exacerbated by the limited number of settings that offer a therapeutic milieu for the severely mentally ill or personality disordered. This means that psychotic and forensic patients are treated on wards that have little or no serious therapeutic function. Often, concrete thinking patients are met by staff who are not equipped with either time or space to consider the meaning of patients' communications.

One of my first experiences of consulting to an organization brought this home to me. It was a hostel for the homeless. For my first three meetings with the staff, there was literally no room to meet: our first meeting was held in a garden shed. It was clear how the staff were unconsciously demonstrating their own difficulties in accommodating thinking about their clients by placing both me and themselves in a position of homelessness. I was able to explore the meaning of this communication through exploration of their thoughts about what it was I was being asked to experience when I turned up for planned meetings that had been forgotten about, or literally wiped off the timetable. Despite this exploration, it took several weeks before I was a properly acknowledged part of the schedule with a room set aside for our meetings. One way of dealing with this experience at the time could have been to insist on my right to a room. Another way was to accept that the experience of homelessness that these staff were being asked to manage by their clients had first to be projected into me; that is, I had to feel it. I then had to find ways of processing this experience and then to communicate it to the staff in a manner that they could accept.

The major exploration in these situations is an investigation of the mind of the consultant: do you have the equipment to manage to bear what we do? I remember feeling quite anxious about arriving for my appointments at this establishment, as I wondered each week whether I would be remembered, or have to experience psychological dismemberment with all its painful consequences. The link between homelessness and a sense of potential loss of identity could not have been brought home to me more forcibly.

Such concrete forms of communication are quite familiar to the psychoanalyst in the consulting room. For instance, a patient tells me how she has come to analysis because she and her boyfriend decided to have an abortion following her accidentally becoming pregnant by him. The boyfriend then disappeared and became incommunicado. She was left abandoned and alone to make a decision about whether she should have this baby or not. The patient was shocked to discover that she had unwittingly enacted her own early life experience. Her father impregnated her mother and then abandoned her; ironically, to go abroad to work with families requiring repatriation. She never saw him until she reached twelve years of age.

This concrete enactment of her own earliest experiences is, at one level, an unconscious attempt to gain mastery over the experience, with the unborn foetus being used as an unwilling container. The patient creates a new life redolent with all her own problems. In this scenario, she becomes the mother and the abandoning father is played by the boyfriend. It was a feature of this patient's early analytic work that she spent a great deal of time arguing that she should leave the therapy she had started with me so that she could go abroad to do work with disadvantaged children. This powerful need to re-enact eventually gave way to a series of dreams in which the question of whether or not a couple could start something and take care of it became something we could begin to think about. The analysis had survived early pressure to re-enact her formative experience.

The experience of consultancy to the homeless hostel and the analysis of the patient who aborts her foetus are similar. The main communication by both is at first evacuative, an attempt to gain mastery over unbearable experiences by placing them in the minds

and bodies of others. The patient, however, is able to assist the analyst by dreaming, bringing their own unconscious meaning to bear on the work. However, this function of proto-thought is not available to the consultant to an organization. For example, it would be difficult for Hinshelwood (1993) in the prison environment to ask staff about their dreams.

Freud (1911b) stated that action makes thinking possible and that some psychic elements of certain patients can only become recognizable through actions that later become thoughts. Acting out, therefore, can be seen as a dramatized dream acted during wakefulness, a dream that could not be dreamed that is often replayed over and over again in staff reactions to patients but is unlikely to be elucidated or understood.

I have been interested in the development of an approach to patient symptomatology provided by the recent innovation of Early Intervention into Psychosis Teams. My experience of this potentially useful model of early intervention is of often very young, enthusiastic staff becoming gradually burnt out and disillusioned through exposure to apparently relentless psychotic behaviour with all its attendant anxiety. Very little thought is given to the meaning of these communications, which are often extremely complex enactments at a very concrete level. Staff often fall back on models of "help" that involve befriending the patient or they become disillusioned, hopeless, and end up leaving the service for less arduous work. Having a model of the mind and how it functions helps staff to try to think about their patients' behaviour.

Every infant needs to project their anxieties into someone, a container, who can process them and return them to the infant in a more digestible form, so lessening anxiety. Failure in this, particularly around separation and death, means that the infant can be left with intolerable anxieties. The failure in containment is experienced as if the infant is intruded upon by his or her anxieties and, as a result, is likely to evacuate rather than reflect. This can often have a transgenerational quality, where successive traumas have been transmitted, often ending up with a patient who is adrift in a psychotic enactment, the meaning of which has been lost and can only be regained through analysis.

A patient, Dr L (all clinical material has been used with the consent of the patient and disguised to protect their identity), was

a young woman with a history of hospital admissions that began as a result of working on an obstetrics placement, where she had had to be involved in an abortion. She developed, apparently without precedent, a hallucination of her mother's voice telling her that she should kill herself for this mortal sin. (This patient's treatment has been written about elsewhere (Jackson & Williams, 1994.) She tried to kill herself on successive occasions, which involved cutting, lying down in front of an ambulance, and overdoses. Staff on the in-patient ward she was admitted to were sophisticated and able to understand the nature of this patient's proto-communications as a terror of loss, a reversal of difficult experience so that it was the ward staff who were constantly threatened with an experience of loss of someone that they were attached to. The fact that this patient was a health worker herself made this a powerful piece of projective identification for staff to process. This was the first time that this patient's communications had been thought about. It was the staff members who had to think and reflect on what the patient's communications might mean.

It emerged, after a great deal of work in the inpatient unit, then later in psychotherapy, that Dr L's own mother had been a survivor of six older children who had died in childbirth due to blood group complications. Dr L was her first surviving child. In individual therapy, it was eventually possible to discern this traumatized mother, who, like the staff, the therapist, and her daughter, the patient, felt unable to face the awful experience and the possibility of dead babies. She felt she was left alone in the world and accused of a crime of infanticide. Dr L's own feeling of culpability was a projection into her mother, who, probably due to her own pain and unprocessed guilt, was unable to deal with her child's aggressive impulses and returned them in a persecutory way. In enacting the abortion, she was presumably enacting her mother's feelings: "you are a bad murderous person who kills off other children and you deserve to die for your attacks on life".

The onset of dreaming during the analysis of psychotic patients can represent the beginnings of symbolic functioning and a move away from acting out of unconscious phantasy. Dr L's first dreams in her inpatient treatment tended to be about bombing and terrorism, where there was little evidence of survival. A turning point came with a dream in which

> The whole of London had been bombed, she had lost her cats, and her hands had been burnt. She was able to locate her husband's office in the city, which had been reduced to rubble. Despite the pain in her hands, she began to dig for him in the rubble because she knew he was still alive.

As we can see, the evacuative nature of the dreams, if contained in the minds of staff exposed to her thinking, begins to give way to something more elaborative and the beginnings of some painful work involving herself and the recovery of lost objects. When she was seen in outpatients in more formal analytic sessions, she had a dream that seemed at least to suggest that murderous feelings could be explored. In it there is

> An unknown doctor on a ward full of patients. All the patients are dying of a strange illness caused by someone shooting arrows up the patient's bottoms and some poison removing all the nourishment from inside of them.

While psychotic patients attack their own minds, the forensic patient enacts their unprocessed thoughts on the minds and bodies of others. For instance, a destructive attack on a young woman, in front of her small baby, by a man who clearly has murderous intentions towards her, once again fills our newspapers. In the absence of a more thinking response from society, it is often the next generation that is used as a receptacle. The man who attacks a young woman with a young child present could be seen to be reversing his own experiences of abuse and violence by unconsciously creating a situation where the child experiencing the abuse and violence towards their own mother by a murderous man is somebody else. The perpetrator, through a process of reversal, relieves himself of his own violent experience by evacuating it into the mind of the other.

Another example would be the apparently motiveless murder of Jamie Bulger by two young boys. A child who is abducted and killed a long way from anyone who could possibly intervene and save him is a chilling communication, albeit an unconscious one, forcing itself into the mind of society. A child dying where no help is available is surely also the story of the two killers, whose psychic death in cruel, negative environments led to this enactment. It is a

dreadful irony that the two boys who perpetrated this crime have probably received better help and education than they would have done had they been left in their respective homes and environments. "I write my story on the minds and bodies of my victims", as one young man I saw so eloquently put it.

These cases demonstrate how, after years of neglect, the acted-on child, adolescent, and adult eventually enacts their own abuse and neglect by abusing and neglecting another. This reversal and projective identification of their own experience is an attempt to evacuate into others unbearable experiences that they have felt evacuated into them.

The capacity to feel deeply with another human being and for this feeling to be reciprocated is one of the most profound experiences any of us can expect.

As we know, this capacity for deep involvement with significant others depends on our earliest experiences. How I experience you, and within that experience the emotional relationship we have, affects how I feel about myself. My knowledge of myself reflects how I feel known by the other.

One of the things we might get to know about ourselves if we are fortunate is that all of us have a capacity for destruction. No one is without this pleasure in destruction. It is only our capacity for getting help to bear this aspect of ourselves, and realistically valuing the achievement of loving intercourse, that can modify it. It is generally agreed that the excess of pleasure in human destructiveness may be in direct proportion to the weakness of love of human commitment.

But what about those for whom there has been little exposure to the power of a loving relationship—those who have been exposed to violence and corruption at the hands of their care-takers, violent couples and parental figures who appear to use their children, from the foetus onwards, as receptacles for their own psychosis? What hope is there for them, and those that work to help them to modify their behaviour in some way, when the basic requirement for parental containment has been reversed so that, in one generation after another, infants become receptacles for their parents?

Over the years, working at the Portman Clinic, I have come up against silent, deadly, self-destructive forces in some of the patients I see and hear about which are antithetical to any change or help.

These are patients in whom it seems the pleasure of physical or emotional annihilation takes over from fear of death. As we know, the sense of right and wrong, good and bad, develops very early on, laying the foundations for subsequent, more elaborate judgements of good and evil, rightness and guilt. Clinical experience has helped me to understand the dichotomy of good and evil, so that the problem of guilt as a consequence of innate destructiveness tends to assume a strongly expiatory significance, that is, healing comes to be seen as substantially coinciding with reparation for the damage done to the object.

The assumption here, however, is that the love object can be placed in a position of ideal goodness. This perspective appears to disregard the offences emanating from the object and tends to undervalue defensive, life-giving, vital hate. Hate is a way of keeping something alive. This has exercised me somewhat over the years. I believe that awareness by the patient of their destructiveness (and this is aided by our awareness of our own) is very important, but it is also crucial that there is recognition of the reality of our patients' experiences of profound trauma and, often, the transgenerational transmission of trauma. In all the patients I am talking about in this chapter, the idea that one can repair damage done to an internal object is sometimes rather far-fetched. The great disadvantage for our severely abused patients is that they have the right to hold a grievance with their objects for the rest of their lives.

This thought was disturbing for me, working at the Portman Clinic with perverse and violent patients, and at Chelsea and Westminster Hospital with borderline and psychotic patients. Was it just an omnipotence to engage with such disturbed patients and was I kidding myself that anything can be done? I still do not know the answer but "having a go" seems to be one possible way of counteracting some of the hopelessness that surrounds these cases. I have also been very surprised that the chance to think with someone, once weekly, has sometimes led to quite remarkable changes in some people.

I have been helped in this by my reading of Gianna Williams's excellent book *Internal Landscapes and Foreign Bodies* (1997). She provides a way of thinking about traumatized patients that is helpful. In a chapter entitled "Reversal of the container/contained relationship", she addresses the emphasis in psychoanalytic theory,

particularly Kleinian theory, on the adult as a container for the child. When describing children exposed to being used by their parents as a receptacle of massive projections, she reminds us that it is the adult who should have provided the function of containment had she or he been fit to do so, but instead projects into the child or the baby, or indeed, I would say, the foetus.

One of the great difficulties of working with psychotic, borderline, perverse, or criminal patients, who enact their psychosis on the minds and bodies of others, is that for a great deal of the time, one has to bear the experience of sharing one's mental space with someone whose communications can at first, and for some time, feel quite mad. Suffering and bearing this experience seems to lead towards some understanding that has helped them.

My first experiences of thinking about apparently mad things were at the Maudsley hospital. I sat with two patients. The first was a writer who was admitted to hospital for standing on top of a government building and shouting down to the people in the street that the second ice age was coming. She also later told me that she regularly listened to the shipping forecast on Radio 4 because at some point there would be a specific message indicating to her that the second ice age was coming. Her response to this message was to cut her wrists as it would be her blood that would save the world. She told me this in a voice that seemed reasonably normal. There was some element of hysteria in her manner, but she led a seemingly average life with a career and a family.

Sitting listening to these kinds of communications, the first thing one feels is a pressure to make sense of their symbolic meaning, but the patient feels it is real and expects me to concur, not to start suggesting that it has symbolic meaning (for example, in the case just referred to, that the ice represents the patient's own destructiveness and that she is frightened it will destroy her world). To do this would seem to threaten her, suggesting that my reality is sane and hers insane. The transference, therefore, seems to be of one person with a very concrete sense of reality, while another person is in a state of confusion, trying to understand rather concrete thoughts which disorientate their own sense of reality. Thus, the first sensation one is forced to feel in these situations is anxiety and a sense that one should know how to communicate something meaningful. However, the latter is very difficult,

for whatever reason, not least the patient's certainty that they are right.

Another patient, a manic depressive man, had been admitted because he was feeling driven to jump out of the ten-storey window of the research centre where he worked. He could not bear doing his job any more. It soon became clear that this man felt that he had been made to do everything that he had ever done in his life. It was as if he had never made a decision of his own. He had become a doctor to please his father. He had married because his (prospective) wife had told him she would leave him if he did not. He had been wearing the same pair of shoes, despite their having holes in them, because he could not go to a shoe shop and choose a pair for himself. His father would sometimes take him out shopping, select clothes for him, and buy them. His plea to me was, "Please tell me what I can do to stop feeling so awful." It felt very cruel not to tell him what to do. In these situations, some awful catastrophe is being communicated, but the only response to begin with may be to feel pressure and anxiety to say something—but what?

With both patients, it seems to me to be important to resist grasping at apparent answers or understanding and to bear being with very concrete experiences that, to begin with, seem to lack meaning. What is being communicated to the therapist is something very powerful: an experience of trying to find understanding in a world that lacks symbolism.

Another patient is a south London gangster, a hard man who has probably organized murders. He is admitted into hospital because he is being driven mad by a persistent auditory hallucination from radiators in his home and in the pub. The music has the sound of a dulcimer and it is driving him mad. Clearly, something is being broadcast by the radiator. If these were dreams, we could probably have some understanding, but the problem is they are not. We might understand that the gangster has placed his gentleness, his goodness, the music of his soul, into the radiator, a thing of warmth, and it is now persecuting him. But what good does this do the patient who seems to be locked in a world where there is no symbolic meaning? It is real.

A transsexual man tells me he wants to cut off his "old man", referring to his penis. When I suggest this might have something to do with his castrating father, he feels attacked and threatened, call-

ing me a "mind fucker". I say it seems that I am not allowed to try to influence his mind but it is all right for him to mutilate his body. I am confronted by the spectacle of a man wanting to change into a woman, oblivious to what he is doing, and it is only I who has some feelings about his losing his "old man".

In these cases, there has been the introjection of an object performing the obverse of containment. In most of us, the introjection of an object that loves and protects the self, and is loved and protected by the self, is the basis of our security. Bion developed Klein's theory, stressing the function of this introjected object: to make things thinkable, understandable, and tolerable. He described the process of projective identification, whereby a child can have a parent into whom feelings can be projected, good and bad, for parental understanding. It is the parent who can name things and make sense of these sensations for the child, using their own experience of having been understood. Bion described these early protothoughts from the child as beta elements, and the mother's function of processing them as alpha function. The parent must have the capacity to bear the psychic pain the child cannot tolerate. Repeated experience of this process leads to an internalization by the infant of a thoughtful object, which gradually enables the child to deal with anxiety himself. I do not want to idealize this process—we can all be thoughtless at times.

As with the aforementioned Dr L, whose long history of hospital admissions began as a result of her being involved in abortions as part of her obstetrics and gynaecology training. In response to this, she developed a persistent hallucination of her mother telling her she should kill herself because she was evil. At some point in the psychotherapy, Dr. L became pregnant and was assailed by violent feelings towards herself and her baby. The feelings were strong, but another part of her resisted them. The experience of being with her in this conflict was almost unbearable for me. To feel responsible for an adult was one thing. To feel responsible for an unborn child was another. Dr L was communicating, in a profoundly confused way, something that was completely unconscious to her.

I gradually realized that it was possible, despite there not being any knowledge of her family history, even though there were volumes of psychiatric notes and files, to understand her apparently mad communications. They contained the profound impact of

a traumatized mother on her infant. Dr L's mother had felt unable to face the awful experience of dead babies, feeling unconsciously that it represented something of her own murderousness. This was mirrored in my own countertransference feelings, in that my inability to feel able to help Dr L was a reflection of a mother's inability to give life to her children. Due to her own history, she was then ill-equipped to deal with her daughter's normal aggression, which then erupted in Dr L when she was required to participate in an abortion. She felt she was left alone in the world and accused of a crime, and probably persecuted by her mother's own unbearable guilt.

Dr L's feelings of culpability were an example of her attacks on a mother who, due to her own pain and guilt, was experienced as unable to detoxify her first child's aggressive impulses. Instead, she returned them to her child in a persecutory way. In enacting the abortion, Dr L was, in fantasy, becoming what her mother may have felt herself to be: a bad, murderous person who kills off other children and who deserves to die for these attacks on life. It was only very gradually, through a process of discovering whether I corresponded to this projection, that is, that I would hate her for what she had done, that the beginning of some other form of object relation began to develop.

Bion described this process, where the object is impervious to the child's projections. Not being acceptable to the object, they are returned unprocessed into the child and appear as a 'nameless dread'. Williams describes this process where the child is used as a receptacle for the parents' return of the projections into the child. As in the example of Dr L, these are still projections looking for containment but they are unlikely to be understood by the child, anymore than the mother's mother in this case could comprehend them.

As Williams (1997) says, this involves the introjection of an object which is not only impervious, overflowing with its own projections, but also is looking for a place to be understood, and comes to reside in the mind of the infant. I think this a profoundly important addition to our work with severely abused and traumatized children and adults. As she goes on to say, just as the introjection of the alpha function is helpful in establishing links in organizing a psychic structure, the introjection of the opposite disrupts and fragments the

development of personality. Williams links this helpfully with current attachment theory and disorganized, disorientated, insecure, ambivalent, and avoidant attachment. The attachment theorists suggest that the attachment figures of children who have been traumatized have themselves experienced severe trauma.

I have in mind an adolescent patient, a victim of serious violence and sexual abuse as a child, suicidal, and having exhausted a number of other services.

Ms D was a concern to her parents because she was failing at school. Having initially been somewhat successful, she had become increasingly withdrawn. In our first meeting, she sat opposite me, and I asked her to tell me about herself. In the beginning, she was able to tell me that her parents had sent her to treatment, but then lapsed into silence, with a beseeching look that felt extremely uncomfortable. This continued until the end of the session. I felt rather trapped with this silently pleading patient, and I was confused and rather irritated when I brought the session to a close. I saw her for three months, trying to establish some contact, and each session was marked by this behaviour. She would sit opposite me and move as if she was going to speak, then fall back in her chair, apparently defeated, looking at me with this imploring expression. I found myself egging her on to say something, to let it out, or I would scramble around in my own countertransference, trying to find something coherent to say.

Of course, I now realize it was the incoherence I was being expected to bear. I was able to say something about her fear of the effect the words she wanted to say might have on me. But each session was the same, over and over, until I began to dread seeing her. I would hope that she would not come, but she did, relentlessly on time to every session, repeating the same behaviour. I would collect her from the waiting room, where she sat with a hopeful expression while I was feeling apprehensive about the next fifty minutes. Obviously, I knew that either something was being communicated or that I was being incompetent. As each session came and went, it added to the sense of cumulative dread and disappointment. I thought of bringing the treatment to a close or suggesting I bring in paper or pencils, which might relieve her need to put things into words, but she shook her head and seemed to indicate that she required me to bear this endless enactment.

For six months we continued with this perpetual, silent behaviour. My rather formulaic interpretation also continued, despite the fact that I was fed up with using it and had little belief that it would have any effect. Then, one day, she responded. I had said yet again that she was showing me what it felt like to be with someone who creates a feeling that something is about to happen, only to be disappointed; that this might actually have been her experience, or her fear of what might happen here, if she was able to speak. She whispered, "Yes." I felt anxious that the moment might be lost so I just responded with another yes, said in as unthreatening a way as possible. Then, in a very quiet voice, she told me about how her father had been visiting her room over the years, but not since she had started coming here, and that he would masturbate her and himself.

Suddenly, because she could put her experience into words, the behaviour I had been living through over six months seemed clearer. I said that this had felt very difficult to say to me, and up until now she had been showing me what had happened to her through her actions in the sessions. In some ways, she had to see if I could bear it before she could talk about this experience. She again whispered "Yes."

I had the usual anxieties that what was being communicated was a fantasy or, indeed, a communication more about what was happening between us: who was exciting whom? Who was abusing whom? But her profound need to begin to think about her real experience impressed itself upon me far more powerfully.

Of course, the enactment continued because I was now in the same position that she was in, with the knowledge of her abuse in my head. I had to know what to do about it. Should I remain silent as she had done? Should I assume that the abuse had stopped, which it may not have done? Or should I use the information she had given me, in confidence, to bring awareness of what had happened to the notice of the social services? Her dilemma, of when to speak or not, now became mine. I explored this with her, how it seemed I was at present really able to understand her dilemma, while she was watching me very carefully to see what care I had to give her at this moment. Her father had left her with the confusing problem of what to do with an adult who does not know the difference between hurting his daughter and taking care of her. She had

now shared that difficulty with me, and I think she was wondering if I, as an adult, had any other way of dealing with it than keeping it quiet, as she had done.

She agreed. She said she did not want to hurt her father by getting him into trouble but she did not want what he was doing to continue. She was frightened because she felt it had only stopped because he was afraid that she would tell me. We were able to think about this together. Just as she wanted to share this problem with an adult, she was also aware that adults were not to be trusted and she was afraid I would do something with the information she had given me or, conversely, not do anything.

The question seemed to be about how we could help an adult who dealt with his own confusion about his sexuality by using her, and making her muddled about her own feelings. What seemed very important at this time was that I did not add to her distress and we could decide on a course of action together. It seemed that she was very frightened of my reaction to her revelation; I had first to relive the experience with her so as to gain her trust. When someone has been enacted on mindlessly, it seems it is necessary for the therapist to bear this experience long enough in the countertransference before any symbolic meaning of the experience can be communicated.

If a child has been the repository of cruel acts, however mitigated by the circumstances of the abuser's own formative experiences, is there any hope of reparation or any possibility of repair?

The sexual perversions I have witnessed in the patients I have seen seem to be a distorted development of the entire personality and mental structure. Sexualization and violence become a mental state that is used to withdraw from reality and the need to relate to the world. Unlike Freud's view of a development of infantile polymorphous perversity, a withdrawal into sexualized mental states means that any humanizing influences that may occur in that person's life have to be attacked. These sexualized states of mind obliterate the need for human relationships.

The clinical problem is how to help the patient benefit from treatment, as it appears in the beginning to be the analyst who must breach impenetrable barriers. Sometimes, the patients we see *have* to resist the powerful forces of humanization, love, concern, and the importance of ethical right and truth. These things, which we might

consider to be life forces, are the very thing that is likely to make them aware of the paucity of their existence. Thus, what we think is life-giving to our patients is, in fact, perceived as a horrendous threat. A less disturbed analytic patient once told me that if she believed what I gave her in the sessions was what she needed, she feared she would become a ferociously greedy child, unable to control her needs, which would either destroy me or leave her to gorge herself on food until she killed herself with obesity. It is useful for her and me to imagine a part of her holding a ham roll to her head saying, "If you get any closer I'll kill myself with this." At one level, she is terrified of her need of me and the object. On the other hand, she is also aware that after a lengthy period of neglect at the hands of a very disturbed mother (she had been excommunicated from her mother at the age of twenty), she is justified in questioning if she did anything so awful to this parent.

Another patient I saw at the Portman was a young man who had come into treatment because he was unable to sustain a relationship. He was heavily into sado-masochistic practice. He did not want help with this aspect of his life: he just wanted help to meet someone who would participate in the sado-masochism with him. He told me that it was his sado-masochism that had saved his life. He and two friends had been arrested after political unrest in his country of origin, had been imprisoned and tortured. Both his friends had died in captivity, but he had survived and flourished in jail, and had even gained the admiration of his captors for his capacity to bear the pain inflicted upon him. It was his interest in sado-masochism preceding his capture, he said, that had sustained him. The other two had missed their families, but he had learnt to love his cruel persecutors. One could see why finding a partner might be difficult, but one had to sympathize with his view. Do these perversions, therefore, have a survival remit?

André Green, in many of his writings, considers the destructive drive to be aimed at destroying the meaning of everything and that good has to be rendered meaningless. Real destructiveness, or what he terms evil, is not the opposite of love, but coldness and absence of love are. Destructiveness is, therefore, an attack on the emotions and any relationship between human objects. No understanding is possible, as this is attacked because it involves taking account of another person and their needs and interests. These assaults are

occasioned by a particular form of pleasure that makes annhilation preferable to any good. In its most primitive form, as seen, I believe, in sado-masochistic patients at the Portman, it is the fascination of absolute destruction and domination of the helpless victim which gives rise to pleasure.

This is at the more extreme end of what might be called identification with the aggressor, but it involves an attempt to rid oneself of all awareness of goodness. At times, I have felt sickened, rejecting, sometimes hatred, as a result of what such patients are putting me through, that is, hopelessness. I have often had to live with the guilt that if they did not attend again, I would be relieved. At other times, I have felt hope, but this is hard to sustain. I have had to overcome profound pessimism about my own capacities as a human being and as a therapist. The need for patients to have a bad object in these cases is paramount.

I hope that, in this chapter, I have demonstrated that with patients suffering the severity of difficulties that I have been referring to, psychotic, perverse, and forensic patients, what is required by the practitioner working with them, be that in a community, outpatient, or inpatient setting, is the capacity to try to bear emotional states of mind that can often feel unbearable, and sometimes are unbearable. It also requires the capacity to try to consider enactment as not only an evacuative process expelling these unbearable emotional states, but also as having a symbolic meaning. In as much as this is possible, and it is not possible without collegiate and institutional support, the beginning of understanding, rather than enactment, may eventually begin to emerge.

References

Freud, S. (1911b). Formulations on the two principles of mental functioning. *S.E., 12*: 213–226. London: Hogarth.

Hinshelwood, R. (1993). Locked in role: a psychotherapist within the social defence system of a prison. Journal of Forensic Psychiatry & Psychology, 4(3): 427–440.

Jackson, M. & Williams, P. (1994). *Unimaginable Storms:A Search for Meaning in Psychosis*. London: Karnac.

Williams, G. (1997). *Internal Landscapes and Foreign Bodies: Eating Disorders and Other Pathologies*. London: Karnac.

CHAPTER FIVE

Thinking about antisocial behaviour and mental health in Youth Offending Services

William Crouch

Introduction

Now a decade old, Youth Offending Services are the result of reforms of the youth justice system and, specifically, the 1998 Crime and Disorder Act (Home Office). At the centre of the new approach to youth crime was a duty placed on local authorities to provide interagency services to address offending by young people through the establishment of Youth Offending Teams (YOTs). More recently, many teams have expanded the services they provide and have become Youth Offending Services (YOS). Teams are multi-disciplinary, with social workers, probation officers, police officers, education workers, and health workers collaborating to meet the needs of the young people referred to them by courts, the police, and other agencies. The development of YOTs has resulted in mental health practitioners, mostly psychologists, being seconded to these teams from their health trusts.

The young people worked with by youth offending services are without doubt a group that need the help of specialist mental health workers. Research has highlighted that rates of mental health problems in adolescent populations are high: one in five children and adolescents experience mental health problems (Audit Commission,