CHAPTER 9

# Very troubled patients

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There is a tendency to think that psychotherapy services are for less disturbed patients, but psychotherapists who have worked in the NHS know just how foreign this is to their clinical experience. A large proportion of the patients referred for psychotherapy suffer from lifelong difficulties covering a wide variety of diagnoses, including "borderline", "schizoid", "bipolar", "severe depression", and "eating disorders", and, of course, these categories are not mutually exclusive. Many patients are or have been at serious risk of self-harm or suicide, and some have suffered from manifest psychosis.

These are people who have profound problems in managing human relationships, and so, naturally, they bring these problems to the relationship with professionals who are charged with their care. Sometimes they are referred for this very reason—that is, because they have stirred up unmanageable (often unacknowledged) feelings in health care professionals. They are often regarded as "difficult" as well as very troubled.

The above list spans the categories of "illness" and "personality disorder". This is not surprising, for from a psychoanalytic perspective the discontinuity in personhood implied by this contrast is more apparent than real. When examined in detail, the outbreak





of manifest illness tends to express, sometimes in bizarre and distorted form, conflicts and preoccupations that were part of the personality prior to the breakdown. Thus what *appears* as illness is understood, psychoanalytically, as a *personality development*, under the stress of certain internal and external conditions.

Individuals who become ill suffer from a kind of "fault line" in the structure of their personality. Under the pressure of a toxic interaction between a sensitized internal world and malign external circumstances, this reaches the point of breakdown. Where more benign circumstances prevail, the fault line continues as a source of continuous anxiety, but illness may not become manifest. So, too, in the case of psychiatric disorder involving multiple "comorbid" conditions, the different parts of a complex picture are likely to reflect different facets of the individual's character and personality.

This chapter focuses on patients with these more difficult and complex problems, and we shall be drawing on our clinical experience in the specialist service of the Fitzjohn's Unit of the Tavistock Clinic. In a manner reminiscent of Freud's description of neurotic people who reveal what the rest of us keep secret, these more disturbed patients can bring to our attention far-reaching psychodynamic issues that may otherwise remain hidden.

## *The assessment process*

The term "assessment" reinforces the idea that a patient is being subjected to an examination that he or she might pass or fail. This is likely to be especially unhelpful for very troubled patients, for whom the dice are already heavily loaded towards this disturbing binary view.

Mr C was referred to our service having had various treatments. Nothing had seemed to help. He arrived, entered the room, and waited a few minutes. He then said: "I want to have psychotherapy, and so it seems to me that I need to know what I must do in this meeting to ensure I get the treatment that, from what I understand, is likely to be most helpful."

Mr C makes this issue explicit, but it is likely that similar influences operate with less disturbed patients, albeit in a more

hidden, subtle way. There is much to be said for referring to the meeting not as an assessment but as a consultation, with the implication that a number of outcomes are possible.

Mr C reminds us of something else—namely, that patients arrive full of conscious and unconscious preconceptions and beliefs not only about the consultation, but also about the kind of treatment being offered. Such expectations will have been set in motion by a combination of the patient's own inner preoccupations *and* the reinforcement these have or have not received from the referral process itself.

*Case vignette: Ms D*

Ms D had suffered very serious deprivation in childhood. She had been known to the local psychiatric services for many years and had attracted a plethora of diagnoses and treatments. She had been admitted on a number of occasions, and always it was difficult to discharge her. The referring team felt exhausted. They conveyed to the patient how they were seeking specialist, intensive treatment for her. But Ms D's understanding of "specialist" and "intensive" was very different from what the team had intended to communicate. These words stirred up very primitive longings, so Ms D felt that at last she was going to be offered a longed-for situation where all needs would be gratified. "Intensive" treatment unconsciously meant to her that someone would be completely available, so she would no longer face the feelings of separation and abandonment that had dominated much of her life.

And so the scene was set for a disturbing encounter. For Ms D, the meeting was a kind of Kafkaesque rite of passage. She experienced the psychotherapist as an archaic father/guard on an entry door to an idealized maternal figure, and so it was inevitable that she would be disappointed.

Of course, there are many ways in which such encounters can be played out. For example, a patient may sabotage the consultation in order to ensure he or she does not get help, thereby assuaging a masochistic need for punishment. Our point is that the consultation



process, especially with more troubled patients, can be overwhelmed by the effects of these primitive mental processes. In those cases where this occurs most powerfully, it is most difficult to see and to hold on to a balanced perspective.

Even experienced clinicians can succumb to this difficulty, and psychotherapists may go to great lengths to justify themselves to the patient. They may end up offering a treatment that they do not really think is likely to be helpful, either as an act of submission or in an attempt to fend off complaints. Yet in the face of great pressure, it is critical to maintain balance, and this is, perhaps, one of the most important determinants of whether the outcome of a consultation is or is not therapeutic.

It is not enough for a psychotherapist to focus attention on characteristics that belong to the ("suitable" or "unsuitable") patient, for there are many interacting factors to consider when thinking about the possibility of psychotherapy. As Murray Jackson was prone to ask: "What particular patient, with what kind of difficulties, living in what kind of social context with what kind of psychotherapist, with what kind of supervision, with what kind of back up (e.g. from local psychiatric services), and within what social context?" It may make sense for a patient with a particular kind of difficulty to embark on psychotherapy in one context, whereas it would not be appropriate in another.

*Case vignette: Mr E*

Mr E was a very severely disturbed man who had made a number of suicide attempts. In reviewing the course of his treatment, one could see that there was a pattern of negative therapeutic reactions—that is, the possibility of progress led to a worsening of symptoms. Just at the point where he seemed to be improving, Mr E would suddenly deteriorate and make another suicide attempt, perhaps prompted by feelings of guilt or hatred of feeling needy and dependent. Yet despite the profound despair and frustration he induced in those around him, the psychiatric team had not allowed themselves to become alienated from Mr E. They had a fairly realistic view of the dangers of embarking on psychotherapy, and they had made it clear that they would continue to see Mr E regularly, maintain contact with his key

worker, and share responsibility in all decision-making. They also understood that psychotherapy might not help, and, even if it did, there was bound to be an escalation of acting out.

A major factor that led to our offering Mr E psychotherapy was the support on which he and we could draw as he embarked on this inevitably disturbing venture.

By contrast, another patient, Ms F, revealed during the consultation that she spent all day sitting alone in her room and had practically no social contact. Although Ms F showed herself to be, at least to some extent, interested in understanding herself, it did not seem appropriate for her to embark on psychotherapy.

When patients with such a meagre social life commence psychotherapy, they can come to feel it is the only thing they have in their lives. They will spend much of their time ruminating over the contents of the last session, and awaiting the next. Here it is may be better to engage the help of a Community Mental Health Team (CMHT) in an attempt to mobilize the patient's investment in the world. If this is successful, psychotherapy may become a more realistic prospect.

On occasion, in such situations we have even made a kind of contract with a patient, suggesting that if the person can enrol in a course or take on a voluntary job, then we will seriously reconsider the possibility of psychotherapy. We would contrast this stance with another that may seem similar, but is different. We do *not* find it helpful to establish a treatment contract with patients of the kind, "If you don't cut more, then you can stay in treatment", because this may provoke perverse entanglement. When it comes to psychotherapy itself, we would merely anticipate that if things do rapidly deteriorate in the course of psychotherapy, then we could decide at the time whether to plan a meeting to end the treatment earlier than intended.

It has to be acknowledged that assessment is a blunt tool, and so we should not overvalue its predictive capacity. No matter how careful we are, we make mistakes. There are patients who were thought to be unsuitable but who, had they been given the chance, may well have proved their assessor wrong. At times, we accept patients who reveal themselves to be unable to use psychotherapy



or who make use of it in a malignantly destructive manner. Some individuals who in the consultation process seem to score highly on some imaginary scale of ego function, or of the capacity to use understanding, present a completely different picture once they embark on therapy. Britton has described the way an analyst may, in the context of a consultation, be able to talk to the patient *about* "it"—namely, some very disturbed part of the patient's character. But once analysis gets under way, the patient no longer talks about, but becomes, "it".

Many patients who are referred have been disturbed for a very long time, perhaps for most of their lives. So a question presents itself: "Why now?" In many cases it is a breakdown that brings patients to treatment—that is, their familiar defences have failed them, and they become overwhelmed with feelings of acute anxiety and despair. The structure that has provided them with a precarious stability up until this point constitutes their own unique combination of anxieties and defences; in other words, their character structure. To some extent, this has protected them from psychic pain, and now their most pressing concern is to be free of pain (which is, of course, entirely reasonable). So it is to be expected that they will endeavour to re-establish their previous defensive structure, and this may become apparent even in the consultation.

One familiar scenario is where a patient has been looked after by a CMHT, but the clinician who has been most responsible for his or her care is leaving. This generates considerable anxiety in relation to the consequences of the pending separation. Not infrequently, this goes unmentioned, and instead the referral may be framed in terms of the patient "coming to a point of wanting to consider psychotherapy". Then, at the end of the letter, the referrer writes: "As I have come to the end of my post here, please reply to Dr X who will be taking over from me next month." In other situations, a team may be failing to contain a patient; here, one option is to arrange a consultation to address *the team's* fault lines, as these have been revealed by the patient.

Another familiar kind of referral is that of patients who had been (say) cutting themselves very badly but had stopped for a period of time, perhaps when taking on a new job. Understandably, a clinical management team may have the idea that, now things

are stable, the patient might be considered for psychotherapy in order to get to grips with the underlying problem. Only sometimes is this idea well founded. Not infrequently, it is better to support and acknowledge what the local service has achieved and *not* go along with the idea that formal psychotherapy can do better. The potential disruption of stability is also apparent in those patients who do very well while on the waiting list, but become acutely disturbed when a vacancy arises and treatment starts. It is as if they are most comfortable in a world where treatment will be offered—but only in the future, never now.

Whatever the background to a referral, it is vital that, in the consultation, the clinician makes space for the more disturbed parts of the patient to come into the room. There are real dangers of conveying to a patient, however unwittingly, that more severe levels of disturbance will not be tolerated. When this happens, patient and therapist are drawn into a tacit agreement that the more disturbed elements will be kept out of view. This creates a kind of pseudo-alliance, which, when the degree of splitting can no longer be maintained, breaks down.

Nevertheless, one needs to do one's best to judge whether psychotherapy is likely to be helpful. When conducting consultations, we are not looking for the patient to prove him/herself. Our default position is to assume that the patient can be helped, unless we are led to think otherwise. In this regard, one of the most important issues to address is the patient's availability to understanding.

### *Case vignette: Mrs G*

Mrs G came into the consultation room, sat down, and patiently waited for me [one of the authors] to say something. It was clear she expected a battery of questions. I invited her to tell me something about herself. She spent some time listing her symptoms along with details of their duration, evolution, and intransigence. An atmosphere of deadening despair entered the room as she talked about herself in this alienated and objectified manner. After a while, I said to her: "It is as if you are describing an ill self which you wish to hand over for me to examine. Then I shall let you know what kind of treatment I wish to prescribe, without you participating at all."



This led to a palpable shift in the atmosphere. Mrs G began to weep, and she said: "I do not think I have really ever properly participated in anything in my life." Paradoxically, it was clear that at this moment she was more alive and participating, but in a manner that was, for her, very disturbing. As the meeting went on, not surprisingly Mrs G reached again for deadening defences to protect herself from this painful turmoil, yet one could see that the situation was fluid so that it made sense for her to embark on psychotherapy. In this case, a deepening of understanding was accompanied by a broadening of the contact with the patient, and the therapist had a sense of something mobile both in the patient–therapist interaction and within Mrs G's own mind.

Only sometimes does this kind of deeper contact bring evolution within the consultation. At other times it is fleeting, but even here it has great importance, as it points to the possibility of forming a therapeutic alliance. When deeply entrenched defences show little sign of movement, it can be vital to carry out further consultations to provide an adequate opportunity for this kind of development to occur.

It is through an engagement that foregrounds the way the patient is *relating* that a psychotherapist is able to apprehend the person's psychopathology as a dynamic structure. This and only this can provide the basis for an adequate assessment of what the patient is both seeking and able to tolerate.

## *The dimension of perversity*

It might be thought that someone's availability to understanding co-varies with severity of psychopathology in a linear way. One might suppose that the more severely ill a patient, the less that person's capacity for being interested in him/herself. This turns out not to be the case. There are many patients referred for psychotherapy who would have low scores on any ordinary scale of disturbance but who, in the context of a psychoanalytic consultation, reveal themselves to be very heavily defended against

or even aversive to any possibility of self-knowledge. In such circumstances, the patient should be allowed a dignified retreat. On the other hand, it is not unusual to find very disturbed patients, including some who would be classed as psychotic, who respond well to attempts to understand them and then go on to make good use of psychotherapy.

One of the distinctions that we have found to be of great practical value is that between those states where a significant degree of perversity dominates the clinical picture and those where this is not the case. By the term "perversity", we refer to situations where the patient derives pleasure, often quite secret pleasure, from his or her deterioration and from frustrating the therapist's attempts to help. This pattern may have both masochistic and sadistic qualities. Masochistic pleasure may be derived from the patient's own self-destruction and sadistic pleasure from the tormented relationships formed with others.

This "dimension of perversity" is relatively independent of psychiatric diagnosis and is a serious problem that often goes unrecognized, especially when there is a focus on diagnosis rather than patients' ways of relating to themselves and the world around them. Whereas psychiatric consultation produces something like a still photograph, a psychoanalytic perspective unfolds more like a film that reveals psychopathology—sometimes including perversity—as a *living* phenomenon in the relationship between the patient and his or her world.

Consider two hypothetical patients, each of whom has strong suicidal feelings and impulses. In the less perverse patient, the wish to live is, as it were, "handed over" (projected into) the staff caring for him or her. But the motive here is to protect more hopeful and life-sustaining attitudes from powerful destructive forces within the patient. The patient does not yet have a self strong enough to withstand a primitive part of the personality (superego), which takes an inwardly punitive stance, and he or she is relieved that others take on some responsibility for his or her survival. Then, with the capacity to form a working alliance with a therapist, the patient can gain in strength and gradually take back the wish to live.

In the more perverse situation, the aim is different. The more the patient rids him/herself of the wish to live, the more he or she



idealizes death. Often this is accompanied by feelings of triumph. A patient such as this can become contemptuous of those who are trying to help and can even sneer at efforts to keep him or her alive. Having said this, when perverse modes of functioning are predominantly defensive, they may be available for analysis and even relinquished in the course of psychotherapy.

## *The question of abuse*

Sometimes patients are referred for their having suffered sexual abuse, as if this alone constitutes justification for the referral. Once again, the patients' ways of relating to themselves and others are what really matter. And, of course, such ways of relating can have a powerful influence on other people's behaviour and experience.

Mr H, a man in his twenties, had been sexually abused and severely neglected as a child. The referral from his GP included a newspaper cutting describing a recent court case with details of the horrible abuse this man had suffered as a child. One had the impression that the publicity surrounding the case was linked to the reason for referral. It seemed that the GP did not want to be seen to be negligent. But enclosing the cutting was perhaps also a way of concretely handing on undigested awareness of this terrible situation.

In the event, the patient did not attend any of the appointments offered. This was despite the fact that he kept in touch and ensured that he was sent further appointments. He became angry when, in a letter, it was suggested that his non-attendance may indicate ambivalence about pursuing psychotherapy and that he might want to discuss this with his GP. It seemed to us that the patient needed to maintain contact with the possibility of getting help but dreaded it ever happening. Such patients often believe they will, in the consultation, "have to talk about the abuse", which would be likely to stir up unmanageable feelings.

Some patients and referrers have the idea that describing the abuse, perhaps in detail over and over again, is helpful; however, it needs to be recognized that some patients have to wall-off feelings in order to get on with their lives. This may not be pathological,

and defences may need respecting. If the walls are demolished—for example, when sexually abused patients testify against their abusers in court—this can lead to breakdown and an enduring deterioration in functioning. We have had patients who have felt under pressure from their local service to come into psychotherapy in order to talk about the abuse they suffered as a child, but who in a consultation are relieved by being freed of this pressure and having their need to protect themselves acknowledged and accepted.

*On not offering psychotherapy*
*Case vignette: Ms I*

Ms I, a 40-year-old childless Brazilian woman with a history of depression and a suicide attempt, was referred by a consultant psychiatrist. She had disclosed to the psychiatrist that in her childhood there had been extensive sexual and physical abuse perpetrated by her mother and stepfather. She felt responsible and deserving of this abuse. As a means of managing intense feelings, memories, and flashbacks, she had been self-cutting since early adolescence. Previously Ms I had received different forms of psychotherapy. She remained under the care of the CMHT, and she occasionally made use of their crisis and out-of-hours service.

In the questionnaire that we send all patients, Ms I wrote that she has so many "issues" that she loses orientation and does not know what to address. In describing her childhood, she made no reference to either of her parents. She wrote about feeling completely alone with her worries. There was an aunt to whom she would turn when upset as a child. She had done well at school and university and was now working as a science teacher. She had felt very bad after having had an operation on the scars caused by her self-harm, and she wrote that maybe that had triggered the suicide attempt.

Waiting by the lift prior to the first consultation, the clinician noticed an angelic-looking woman emerging from an unexpected direction. She seemed to be looking for something and walked right past her. When the therapist caught up with her and led her into the consulting room, she left the door wide open and



looked completely lost. She said she did not know what the meeting was for, and that she had been sent here. She didn't know what kind of place this was.

The psychotherapist addressed Ms I's sense of disorientation, and Ms I said it would feel easier if she was asked questions. The therapist pointed out that that would create a situation where she was responding to what someone else wanted. This seemed to be what she felt in relation to being here—that she was sent, and that someone else thought this might be a good idea. Ms I agreed and said that it was not something that she would have thought of. Later in the meeting, she described how it was her partner who had persuaded her to have surgery to remove her scars.

Ms I conveyed she felt hopeless that anything could change. She said she had learnt not to expect anything, because she could not bear to be disappointed. She had anticipated that maybe having a job would make things different, but things had not worked out that way. She spoke of feeling bad about almost everything she did.

The therapist asked: "Almost everything?" Ms I replied: "One thing I think I can do is teach science, but I'm not saying that I am good with young people. None of my colleagues would say that I am bad with them, but no one knows how difficult it is for me." She continued: "When I had psychotherapy there was somewhere to put these things, and also to leave these things. But my partner thought things were worse when I was having psychotherapy." She said nothing about her childhood, and the therapist felt it was not a topic that could be addressed in the consultation.

The therapist had a chilling association in response to meeting Ms I. This was to a scene in the film *The Downfall*, about the last days of Hitler and his entourage in the bunker in Berlin, where Goebbels' wife is poisoning her children. This led the therapist to see the patient as both victim and perpetrator in a deadly scene of this kind. In her inner world, the patient seemed subject to a relationship with a figure who could not tolerate any imperfection or blemish, and to be wedded to the idea that such

blemishes have to be eradicated. Overall, it felt to the therapist that Ms I was like a dazed child who would follow one blindly, as if enthralled by a deeply flawed parental figure.

The CMHT provided support and management, and they reported no problem with Ms I's work as a teacher. We were struck by how dismissive Ms I was towards her own capacities, and we became concerned that the well-functioning network that was containing and supporting Ms I had also lost its sense of doing a good job. The degree of perversity evident from the history and the manner in which Ms I presented to the assessor led us to believe that it was too dangerous to offer her psychotherapy— we considered that to do so would be to collude with the omnipotent idea that all damage and scars can be removed. We thought psychotherapy would be more likely to exacerbate Ms I's destructiveness and might well lead to suicidal feelings. In our judgment, Ms I was receiving optimal help already, although (as in some other cases of early developmental trauma linked to sexual abuse) we did give serious thought to referring her on for inpatient psychotherapy.

### *On risking psychotherapy*
### *Case vignette: Ms J*

Here we describe what happened when someone who, despite presenting with high risk and some perverse tendencies, was accepted for psychotherapy. We follow this case beyond the initial consultation to illustrate how the outcome may be finely balanced between benefit and potential harm.

Ms J was a middle-aged woman referred by a consultant psychiatrist after she (the patient) had become frustrated with non-psychoanalytic psychotherapy. She was a perfectionist, but she cut herself secretly.

The initial part of the consultation interview was very difficult. The therapist became increasingly aware of Ms J's need for control, as well as a great deal of self-contempt. Ms J used the phrase: " if I am to gain admission". She felt she was going to



be admitted into something that would provide for her and relieve her from the burden of the constant persecution that she had suffered all her life. The therapist also noted how Ms J used the word "audition" to describe the process they were engaged in. It turned out that Ms J saw many things she did in life as performing, rather than being herself.

There was battle for control at the commencement of the interview, but in due course this began to ease. However, the therapist was very concerned about the patient's cutting and put it to Ms J that they were dealing with quite serious and destructive feelings, which might be stirred up by embarking on treatment.

Ms J seemed to understand this. At the same time, she was capable of twisting the therapist's meaning, as if he had insisted that she had to cure herself in order to receive treatment. Yet in the end, in part because of the supports available for treatment, Ms J was offered psychotherapy.

Within weeks of the start of Ms J's twice-weekly psychotherapy, the self-harm began to escalate. Following a session in which there was some real emotional contact with her psychotherapist, Ms J cut alarmingly close to a major artery. She conveyed a perverse dimension to her behaviour, describing scenes of locking herself in the bathroom for long periods of time as her mother knocked anxiously on the door, and taking pleasure in her mother's escalating fear and frustration. This captured the situation experienced by the therapist, who was made aware of the possibility of something terrifyingly destructive going on but was shut out, with no access to any concern in the patient. Ms J could not bear to feel small, helpless, or distressed, such feelings being diminished by her active self-harming.

Despite all these difficulties, over the first year Ms J appeared to derive some benefit from psychotherapy and at times showed a real capacity for concern, and the serious self-harm diminished. She became involved in a very disturbed affair in which both partners seemed to be torturing each other. She would feel alternately very needy in relation to her partner (associated

with feeling suicidal) or rejecting and abusive (associated with cutting herself).

After the first Christmas break, which was difficult for her to manage, Ms J returned to say she had had a successful holiday, had ended the affair, and had begun to think of starting a family with a man she had long known. She could easily not have survived the last year, she felt. She spoke of what she had, in particular her job and her resumed old relationship, each of which she could so easily have lost. She said that her first priority should be to maintain both, and she went on to say that she had decided to end the therapy.

We thought Ms J had regained some equilibrium during the break and was terrified that this would be disturbed by returning to the sessions. It became clear that she felt there was an area inside her that was full of terrifying feelings. Yet she also felt she had some control, in the sense of being able to lock them away. To receive help was to cause trouble internally, and Ms J knew it could easily lead to dangerous enactments. It was clearly important that the therapist was not critical of Ms J's decision to end the therapy, that this was not viewed as a failure, and that future re-referral was possible. Ms J left in a thoughtful way.

## *Conclusion*

In offering consultations to very troubled patients, it is very important to be flexible, as patients are individuals who cannot be fitted into a formula nor slotted into an agenda. Given that many have such harsh figures in their internal worlds, we need to be careful neither to submit to nor avoid these, but at the same time not become confused with the figures and so add to the patient's torments.

Our aims are modest. We do not expect patients to emerge from therapy in a radically altered state. Indeed, it is often a major achievement for therapist as well as patient to throw off the tyrannical idea that the person *should* recover. Even individuals



who are unable to change very much can find the experience of being understood both profound and immensely valuable. When patients feel their differences and limitations are accepted in a non-judgemental way, then they, too, may find that they can begin to accept themselves more.