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Difficult Patients

The secret of success for a psychotherapist is to treat patients who are not too seriously troubled. This is not a cynical remark for, in terms of human happiness, brief therapy with a basically healthy person with a definable problem is extremely worthwhile. However, attention needs to be given to more troubled patients for a number of reasons, including the fact that, in the ordinary professional work of psychiatrists, general practitioners, psychologists, and social workers, such patients are unavoidably present and often demanding, and in the experience of the trainee psychiatrist will tend to form a large proportion of his non-psychotic population. Moreover, psychotherapy with some sicker patients can be extremely effective and not necessarily lengthy; but it can also do harm.

The difficult patient is not necessarily the very sick one. Sometimes the difficulty may reflect an inappropriate selection for psychotherapy—something which careful assessment and an explicit discussion with the patient, of the aims and methods, can make less likely. At other times it can represent a difficulty in the therapist in the form of faulty technique or an awkward counter-transference. However, patients who threaten suicide, who overdose, or cut themselves, and patients who lose sight of the ''as if'' quality of the transference relationship are usually sicker than average. They also provoke, and may be responding to, more difficult counter-transference reactions. Because some covert and unacknowledged aspects of the therapist's response may be contributing to the difficulty, the therapist looking after such patients will always be helped by supervision. In most cases, if the therapist can calmly hold the line and make sense of the transference by relating it to the focal issues of the therapy, the situation will be contained, and this containment is a helpful experience and gives the patient more control over his own feelings. The reverse situation, in which the patient perceives or is given a collusive response, is experienced as alarming. Patients in whom such difficult transference–counter-transference reactions emerge are likely to be labelled as ''schizoid'', ''borderline'' or as having ''narcissistic personality disorders''. These labels are

used in the psychoanalytic literature, but unfortunately there is no agreement as to the precise diagnostic criteria. In the medical psychiatric diagnostic scheme, patients in this category may appear variously, and not always helpfully, labelled according to their predominant symptoms; for example, as ''personality disorder'', ''psychopathy'', or ''addiction''. The basis of the psychoanalytic classification is a developmental one, and the terms used draw attention to developmentally early failures. Such patients are different from less ill ones in that their problems in life and in their relationships are expressions of a poorly and incompletely developed self-structure. For the psychotherapist, it is crucial to recognize these cases because of the much greater risk of evoking damaging regression in them. The impaired ability of these patients to maintain a sense of self and a satisfactory relationship with others is manifest in many different ways, often in more than one way in a given patient. These ways include hysterical behaviours, such as uncontrollable bursts of disordered feeling, histrionics, clinging dependency on others, sexually perverse behaviours, frightening experiences of personal disintegration, feelings of unreality, paralysing obsessive states, massive use of the defence of projection with areas or episodes of paranoid thinking, and attacks on, or serious deprivation of, the self. While the ''ordinary neurotic'' may be gravely restricted by the various devices he relies upon to feel safe, such as denying feeling, bodily symptoms, symbolic or magical thinking and acting, and the placing of restrictions on his personality and forms of relationship, these sicker patients have lost control; they act out what the less sick patient contains or structures into some kind of a life.

In terms of the PSM they have a more precarious and contradictory self theory, a more arbitrary and inconsistent basis for self-judgement, greater confusion of contradictory intentional scripts, a more distorted, poorly integrated and simpler schematic representation of the world, and a confusion of self–self and self–other scripts, manifest in projection and projective identification. As is evident from this summary we are dealing with questions of degree rather than category, and hence the selection of patients for therapy remains problematic. While multiple symptomatology may draw attention to severe problems, recognition of the degree of disorder held in check by obsessional devices or by schizoid (i.e. cold, uninvolved, intellectualized) modes of relating to others may be more difficult. If there is evidence of areas of sustained competence in the history of a patient being considered for psychotherapy, or if there has been, or is, a good positive relationship with some human being, the therapist may derive some reassurance and be less alarmed by other areas of extreme disturbance. Most people would agree that frank schizophrenia or severe endogenous depression make a patient inaccessible to psychotherapy and indicate the need for pharmacological treatments, but there are many patients who have had psychotic episodes, or who experience some psychotic symptoms, who may be accessible to therapy. The judgement that this is the case would be based upon the ''mitigating circumstances'' named above, and also on the evolution of the patient–therapist relationship over the assessment sessions. If there is early evidence of contempt or destructive envy, or if there is idealization probably

covering over such feelings, the therapeutic path is likely to be a stormy one, whereas the expression of some realistic understanding of the therapeutic process, and the contacting of some depression or concern at this stage are positive signs.

The decision about what form of treatment to offer and how extensively to aim to change the patient is a difficult one, about which little agreement exists. Orthodox psychoanalytic treatment is probably unsuitable, even for those few for whom it is available, for these patients can easily become locked in battling and erosive treatment relationships. Variations in analytical technique are a current topic of hot but unresolved debate. Winnicott (1965) has argued that the need of these patients is for the provision of a symbolic "holding" and "unclever ego-support" which "like the task of the mother in infant care, acknowledges tacitly the tendency of the patient to disintegrate, to cease to exist, to fall forever". Treatment of intensity and long duration may be the only way to provide a good enough basis for re-integration. This type of work is outside the scope of this book, but some of the literature referring to it will be mentioned in the discussion section of this chapter. The approach may involve accepting a degree of regression in the patient which is only justified if circumstances can permit a long-term contract. Other approaches, however, seem to be satisfactory for many patients. Group therapy, which carries fewer risks of severe dependency and regression, can often be very helpful to these patients and less sick group members may be helped by their presence in the group (Pines 1981). Working in the group does require, however, some capacity to share, and that is not always available.

Two other approaches will be discussed in this chapter. The first is the deliberate provision of a very limited amount of therapy time, designed to minimize the chance of regression and to maximize the patient's awareness of ambivalence while, at the same time, energetically and supportively offering explanatory concepts and using direct methods that can enlarge the patient's control. This approach is based upon the belief that in these, as in less sick patients, the addition of active methods enlarges the patient's sense of his own capacity, while the limited care offered implicitly conveys the expectation that the patient can find new resources, and in this way serves to alter his assumptions and predictions about his value and performance. The experience of an intensely ambivalent transference is less frightening when it is not linked with the heightened sense of helplessness that can accompany the regressed transference in treatment carried out in purely interpretive ways. The second approach involves the brief provision of carefully planned institutional care.

STRICTLY LIMITED THERAPY: TWO CASE HISTORIES

Kate

Kate was under psychiatric care between the ages of 16 and 20, during which time she spent a year as an inpatient with a diagnosis of schizophrenia. She was treated at that time with electroconvulsive therapy and with prolonged drug treatment. She

was referred for a psychiatric opinion once more at the age of 30, at which time she was complaining of depression and of phases of extreme lack of confidence. At her first interview she talked about hearing voices instructing her or debating her behaviour, but she said she always felt able to act independently of them. Her main complaint was that "I don't know who I am". Kate had left school (illegally) at the age of 12, and, although she had obtained some further education and training later, she had been unable to find work for the past 2 years. Despite this unpromising history, Kate, once given the chance to talk about herself and her life, used therapy very constructively. She was seen for 25 half-hour sessions over a 15-month period. During this time her previous pattern of relating, which was marked by idealizing attachments to (lesbian) partners which had always been followed by disappointment and rejection, was given up. She became much more accepting of herself and more able to be at ease with other people, and she reported no further hallucinatory experiences. At the end of treatment she found suitable and interesting work. Quite early on in her therapy she brought the following poem, which had been written some 2 years previously; the last line of the poem seems to indicate unextinguished hope which, in some sense, was realized metaphorically in her brief therapy.

MOTHER MOTHER

Mother I fear you reard me wrong cause I pick up my head, can't tell where I belong, Mother something's hurting me bad, Something's hurting me real bad, Life has beginning for something that I never had, Sometimes I feel my life has come and gone, I have in this world, But I'm only looking on, I can't understand, Its too far over my head, I'm living in the life, But I'm really dying instead, Yes mother, I'm really dying–dying–dying, but you'll never understand (you-fucking-stupid-bitch), You reard me wrong cause I lift up my head and I can't tell where on this earth I belong, Mother something's terribly wrong
Mother here I am.

This case is an example of the value of "unclever ego-support". From disturbances of her childhood and adolescence, and from an experience of hospitalization, recalled as incomprehensible and unhelpful, Kate had derived a view of the world as hard to predict and of herself as unacceptable. Her attempts to find total acceptance had led to further rejections, and her unemployment was a further contribution to depression. Therapy was an opportunity for her to tell, and make better sense of, the story of her life, and to understand her needs, while giving up the hope of ideal solutions to them.

Ronald

Ronald, a young man of 23, consulted after having been hospitalized briefly for a "heart attack" which, in fact, had been the worst of a series of panic attacks accompanied by palpitation. This last attack had occurred when travelling by train back from a visit to his girlfriend, Mary. The symptom seemed associated with anxiety and the need for the reassurance of the presence and admiration of others.

He described quite unrealistic ambitions professionally and revealed a "superman" view of himself which divided the world into superpeople like his girlfriend and himself, and the second-class majority. He was initially given a general interpretation of his other-dependence, accompanied by some behavioural advice (rehearsal in imagination and graded exposure) which gave him control over the symptoms. Over the next two sessions, which were at monthly intervals, a picture was gained of his background. His mother was both adoring and critically demanding of the patient. She denigrated his father, who was seen as amiable but effaced and ineffective—a view epitomized by mother's account of Ronald's birth: it was a home confinement, the sun, of course, was shining, but it was also very cold, and father had become so distracted by reading the paper with which he was supposed to light the fire, that the room was too cold for Ronald's arrival. Another memory of importance was at the age of 11, at which time he remembered being very depressed, which he related to his final exclusion at that age from the parental bed.

Ronald traced the evolution of his superman self to the sense of feeling unwanted at the age of 11; he saw himself then as bravely facing the pain of that situation and as adopting a nihilistic view of human activity, in both respects seeing himself as superior to his fellows. At the same time, he saw his persistent need for approval as leading to conflict with his more self-accepting peers, which set him apart as different – more serious and misunderstood – but once more as superior. A third strain was linked with his identification with Nietschze, who was seen as both superman and as going off the rails; to reassure himself that he need not go off the rails, he had to dismiss as inferior anybody who seemed hostile to, or who disagreed with, him; while the approval of those who were sympathetic, and preferably older, was crucial if his doubt and fear were to be contained. These threats had combined to present him with two dilemmas: "*either* superior *or* mad", and "*if* not admired by admirable people, *then* contemptible".

After the third session, his girlfriend gave him up and shortly after that he became much more anxious and depressed. From this time on, he began to dismantle his self-idealization and became able to tell his friends something of his troubles and to mix with the common herd to the extent, for example, of watching football matches which previously he had always avoided doing. A date was fixed for the end of therapy, and the sessions were increased to become fortnightly rather than monthly. Therapy aimed at supporting him during the process of losing his idealized girlfriend and losing his self-idealization, while simultaneously dealing with the involvement and anticipated loss of his therapist. He developed some homosexual anxiety in the company of friends during this time, which was relieved following the interpretation of some unacknowledged passive homosexual feelings in his transference relationship.

In Ronald's case, his narcissistic problems represented a continuation of mother's critical idealization. While her care included affection, it had been at the cost of denying any strength to the father, and had left him with either idealization or denigration as being the only modes of relating to himself or to others. In losing his

idealized girlfriend, and in having to accept that he was not my only, or most favoured, patient, he went through a lot of emotional pain, being partly sustained in this process by some residual idealization of himself as a good patient, which I probably colluded with to some extent. It was also true that he showed courage and worked hard at this task. At a follow-up interview about 8 months after termination, we looked back on the therapy; the following are excerpts from a tape-recording of this interview:

> To some degree, since I started the therapy and broke up with my girlfriend, I have had no close friends. The way I treated my close friends, I didn't want to do that any more, so basically I decided to go it alone. The need is still there to have people tell you how great you are; I just avoid it to some degree . . . As I see it, one by one I've withdrawn from those special people. I started off having my mother, in childhood, with me; then I had Mary, so I had two; then possibly with you I had three. But I think you were, from the beginning, saying "I'm going to go", which was very constructive, it sort of hooks you exactly where you want to be hooked and makes you very powerful. It also means you've got to manage without . . . It didn't impinge on me rationally, but looking back on it, the deprivation was a far more important aspect of it than I had recognized . . . If I had seen you once a week or more than that I'd have been in real trouble. I was always in danger of having my own personality submerged by yours or in giving out everything to you . . . I would have loved to have been you twice a week and if I had there are all sorts of problems that I wouldn't have faced. Between those fortnightly meetings there was always a drawing up of charts and thinking about it and that was all part of doing it on your own. Since I last saw you, it has been the same thing. It has been to some extent recognizing that I have seen things, and if I had seen you during that week it might have gone further and faster. But the fact that I have done them on my own, that I haven't got you, was useful . . . When the final deprivation comes, you have been through it ten, fifteen times before and it is just a bigger one of those and you can just start to mesh reality in with your picture of it . . . From quite an early stage, I was starting to say, you know, 3 or 4 months, how many more weeks have we got, and at the end it came like a sort of fear of death; the end became very significant, but towards the end it seemed to me in a sense I was wanting just to get free of you . . . I was expecting it to be a relief, I was expecting to get part of myself which I had given away back but I didn't feel like that, I was very depressed and confused but I think but it was a sort of confusing out of which something comes . . . The most important change is to be in touch with feelings. I mean, you said, "You're not very much in touch with your feelings" sometimes, and that basically is what it comes down to – to be in touch with your feelings. What I learnt from therapy was that your expectation immediately is that you're going to be put in touch with nice feelings, you know, things will become rosy and marvellous, and that was the first disappointment and disillusion . . . But if you have completely lost relationship with your feelings, nothing good has any satisfaction for you. If something good happened to me I couldn't value it because it was never good enough. It doesn't make you the superman you want to be, it just means, it makes you feel, well, I'm 6 feet tall, I'm not 100 feet, you know it's no good, everything good is more or less lost to you and when things that are bad hapen to you you can't face them head on, or come to terms with them, or even cry about them. I mean, grief is a sort of therapeutic process, but instead of feeling sad it's all converted into hostility towards yourself, mocking yourself, anger towards yourself. . . . Initially what happened to me was that being in touch with my feelings meant being in touch with a certain amount of grief and guilt and anxiety; now, if someone says, "Are you anxious?", I say, "Yes" because I recognize I am, although far less anxious than I was.

> The thing is that being slightly anxious and recognizing you're anxious, or even being very anxious and recognizing it, is much easier to bear than being terribly anxious and not recognizing it at all. Also, it's only very recently that I've grasped that by not being a superman I'm not being a failure. Before, if someone said, "Look, you're not a superman" I would think I'm a failure. It's only very recently that I started to recognize I'm not a superman, that I am human, therefore I'm not a failure.

In a follow-up letter two years later, Ronald reported that his realistic career plans were proceeding well. He was still busy thinking about himself, he felt he could do that quite successfully, concluding with the words:

> My relationship with my new girlfriend is fraught with problems but seems to work somehow; I make all the same mistakes I made with Mary but I try to resolve them differently in the light of experience . . .
>
> It can scarcely be said — and here I am close to tears — that I have made a swift recovery . . . while mourning the loss of Mary, I have taken time to do a thorough job and mourn my childhood too . . .

The letter ended with a discussion about whether to seek psychoanalysis.

Nearly 4 years after the end of treatment, 18 months later, he reported progress in his profession, a continuing and closer relationship with his girlfriend, and better terms with his parents. He wrote:

> How do I feel? Melancholy, despairing, anxious, still cursed by a pervasive optimism, nervous, ill-at-ease, frightened, ashamed, depressed, and lacking a secure sense of self-esteem. I still feel very often that meeting people is a performance in which I must attempt to impress them. What is different is the degree. All of these feelings are weakened. My self-knowledge has grown. And in recent months — for the first time — these unpleasant feelings have become tolerable . . . most gratifying is a noticeable increase in the clarity of my thoughts, which has always been dogged by confusions, forbidden areas, paradoxes, rationalizations . . . I am happier and sometimes plain "happy" . . .

The symptoms which brought Ronald into treatment were the physical effects (and secondary anxiety about these) of a mismatch between self as perceived and the idealized self he required himself to be and required idealized others to see him as. Therapy had first had to control and translate the symptoms, and thereafter had initiated a slow process of self-acceptance on more ordinary terms.

SYMBOLIC REGRESSION DURING BRIEF INPATIENT CARE

Despite the general emphasis in this book on preventing regression, there are occasions when permitting a limited, controlled regression is profoundly healing. Our culture frowns on helplessness and offers few opportunities for it, yet, for some people, being allowed to go back into permitted helplessness enables them to revise the terms of their relationships and their independence towards a much healthier state. I have seen two patients in whom severe injuries from road traffic accidents necessitated prolonged hospitalization. In one, the accident was the result of a suicidal attempt, made after 5 years of drug therapy for schizophrenia. The surgeon stopped all medication and she used her "licenced" dependency in the surgical ward to begin a process of recovery that 5 years later was still progressing. The other patient was an unhappy, withdrawn young woman, whom I had treated psychotherapeutically without much success. In this case, she was not responsible for her accident. She too was deeply moved by the care she received and, despite chronic pain, was relieved of much of her inner bleakness by the extensive care she received following the accident. These stories serve to reinforce my belief that therapists should not turn their faces inexorably against the possibility that regression can be a benign experience.

I believe there are some adult patients similar to the unintegrated children in residential care described by Dockar-Drysdale (1968) who, before they can grow, need the experience of a permitted, controlled, time-limited period of symbolic regression, as inpatients or, sometimes, as daypatients.

My experience in this form of management is based upon work in the University Health Service at Sussex, which has a small inpatient unit. (In describing this work I would like to acknowledge the collective contribution of my colleagues there, and especially the work, in developing the approach, of three senior nursing sisters, Nancy MacKenzie — who, partly as a result of this work, is now a psychotherapist, Cecily Manser, and Ginette Dight.) Because of the high level of staff communication involved, and the inevitability of staff tensions evoked by these patients, the approach I am going to describe would not be manageable in a large unit caring for patients with a wide range of problems. However, the provision of a small "intensive care unit" within the context of a general admission ward would not be impossible, and would, I believe, make the containment of such patients less disruptive and more therapeutic.

Selection of patients for this kind of care is a difficult matter, demanding that one distinguishes in advance benign from malignant regression, and my own experience has included wrong choices in which the experience was not helpful and was, in some cases, probably harmful. These patients, in some sense "negotiate" the right to regress, and the nature of this negotiation is predictive of the likely outcome. In the cases which went badly it was marked early on by threats, blackmail, and destructiveness and by the failure of myself and the staff to satisfactorily block acting-out and establish adequately strict limits. This led to recurrent bitter struggles and the generation of extreme staff dissension. With more experience in handling the therapy, the management, and the staff reactions, however, such faulty decisions became avoidable.

Where this intervention was successful, the therapist and patient had already established a good working relationship, in the course of which the patient had become centrally preoccupied with certain historically early issues. The patient evoked in the staff the kind of concern similar to the maternal preoccupation described by Winnicott. They saw themselves as revisiting aspects of the past, or as going through some kind of necessary journey. One such patient, for example, drew the curtains of her cubicle on admission, saying that for the time being she only

wanted to concern herself with the weather inside and, during the 6 weeks of her admission, she slowly parted these curtains as she prepared herself to return to the world.

Many of these patients were preoccupied with the stories of, or enacted deeply ambivalent fantasies about, their births, which they saw as having been dangerous for both themselves and their mothers. One, for example, whose admission was prompted by a hypomanic episode, summed this up by saying, "When I was born, my mother nearly died and I was slow to breathe". During their admissions, most of the patients listened to music a great deal, painted, and wrote, often using these products as communications with the therapist. In all cases, they asked for the return of this material at a later stage in therapy, as if they now felt strong enough to take charge again of their chaos or did not want to leave it in the control of somebody else. The drawings and paintings were usually initially unformed, violent in mood, most often in black, red, or brown. Later, they often included images of birth or of body parts, breasts, penises and body cavities predominating, even in patients quite innocent of any knowledge of Freud or of Melanie Klein.

The process was usually clearly related to some kind of metaphoric rebirth in which the transference was initially positive or idealizing, as representing the missed or forgotten experience of good mothering, followed by the emergence of destructive anger and sadness as separation was faced; but the power of these destructive feelings was now made tolerable by the fact that they had experienced the ability of the therapist and of the nurses to be strong as well as caring. During these admissions, which were usually about 3 weeks in duration, therapy sessions were continued and briefer contact might be offered three or four times a week, with the therapist and nurses in constant communication, in order that the transference meanings of all that went on could be shared. Patients, during their admission, were required to dress, make their beds, and take meals in the common room with other patients, but in other respects could choose between staying in their rooms, listening to music, or painting in the common room. Many expressed a need for solitude, and restricted or refused visits from friends. The timing of their discharge had to be determined by the therapist, always over some resistance. As in therapy in general, emphasizing the time-limited nature of the admission serves as an ever-present reminder of the fact that it represents a metaphoric revisiting, not an attempt to make good past hurts and deprivation. After discharge, many of these patients sustained some connection with the staff, usually by visiting as daypatients, and in time our experience of this led us to design a special room furnished with cushions, a record-player, and paints, called "the time-out room", representing essentially a privileged space where the right to be unhappy, or silent, or anxious was granted. Once that room was established many patients in therapy made some use of it, and it served as an even more safely restricted but, for some, adequate experience of care, and reduced the need for admission.

Close and detailed communication between all staff members involved with the patient is essential. Without it, the patient will continue to use his usual self-

defeating strategies to extract from staff those responses which have been so pain producing and persistent in the world outside, seeking care by means of incapacity, provoking rejection by provocation, and maintaining his fragmentation by locating different and often warring aspects of himself in relationships with different people. Staff tensions in units caring for such disturbed patients can sometimes be the source of a patient's deterioration: sometimes they are the indirect reverberations to a patient's state. Either way, staff must share their experiences of the patient to prevent harmful effects on both themselves and the patients.

In terms of the PSM, the effect of controlled regression is upon the self-identity criteria. Inability to care for the self, punitive attitudes towards the self, unclear definitions of the boundaries of the self, and the confusions of relationships with others due to projective identification have characterized such patients. What is offered is a combination of a safe, holding environment, with interpretation and explanation. The safety is both in the care and in the understanding, and in the explicit definition of boundaries that is achieved through careful defining of staff and patient roles. In this respect the geographical line between patient accommodation and the kitchen or staff quarters served frequently as important physical representation of separateness and differentiation.

The intense enactment of these issues seems to achieve a critical shift in the intrapsychic "balance of power", so that destructiveness, previously acted out upon the self or projected on to others, or guarded against by massive self-restrictions, becomes less frightening, and trust and hope become stronger. To complete this chapter, I will give a patient's retrospective account of her admission.

Beth

Beth sought therapy at the age of 28, for depression. She had felt unhappy at the age of 19 and had received some therapy at that time. Her present, more severe, depression dated from the birth of her child 3 years before, and from the breaking up of her marriage soon after that time. She had failed to engage herself satisfactorily in a career and she was currently in an emotionally confused tangle with two men. Beth was the only adopted child of relatively elderly parents. Her adoptive father, whom she remembered as warm but ineffective had died some years before, and she and her adoptive mother had a difficult, rather distant, relationship. Beth's admission to sickbay was precipitated by the end of her relationship with one of the two men. The following is Beth's recollection of her "breakdown" and admission to sickbay, which occurred some months after starting therapy; the account was written 2 years later.

> This is truly like remembering labour pains. Almost now I remember my descriptions of the time, as they were told to others, as much as I remember the experience . . . I sank into the mental cushion of the sickbay; that in itself was felt as a great death, out of socially-mediated life and living to dependency: letting-go, asking for help, recognizing pain. To begin with, for a couple of days, just ache and conscious withdrawal, getting through the day with polite interactions with others, hugging the ache. Then a more

profound withdrawal from the social world, a real journey inwards with its accompanying passage through time, back. This was being in "my" room, noise an agony, people exhausting to interact with because they had to be engaged with completely as the defences went down. But at the same time as they were related to completely in the present, they were also slotted into the internal world, they became actors in past events and feelings simultaneously. This must make such an experience truly becoming a child. The world exists as an extension of "I" and only in that way does it make sense. It felt like living consciously and unconsciously simultaneously; the latter a world where time didn't pass out of sight but was somehow incorporated in the present sensation. I seemed to go back and back, or rather wider and wider in my emotional map, so that all things had great significance. It was like unrolling the map of meaning and perception from how one recognizes that a knitting pattern is a message to your moral code. Things jumbled out, all elements of synthesized presentations to the world; for example, finding the fairy-tale ancestors of the poems I had written . . . I was trying to reconstruct, attached to my therapist, held by my therapist, who as guardian of the ego allowed me to redraw its shape. I remember waves of mental pain as this process went on, coming and going. My therapist seemed in absolute communication with me. I remember a moment of panic when I felt shut in and struggling to get out, as if I had reached my birth again. With that sensation came a knowledge inside me that I believed I had destroyed my parents by existing. I struggled through the mental birth canal using my therapist's presence and hope and will-power. It began to be *my* life, *my* entrance in the world. I had made a claim on existence. It seemed if I looked and kept looking at the feelings, if I swam through them, then I would get out the other side. I wouldn't sleep because the man who had recently left me could enter my mind's window. I wouldn't leave my room because people, like emotional giants, would absorb my energies, and even in my room, noises hurt my skinless mind. I stayed physically still and felt something run the tape of my history through me. But once I believed I existed I began to head out towards some undefined state of the future. I committed myself to a future, and to being different, and headed for that."

DISCUSSION

The first two cases discussed in this chapter are examples of patients with quite major problems, treated satisfactorily with brief therapy. Psychotherapy limited in intensity and duration may not be adequate for all such patients, but provided no unrealistic hopes are raised, which means that the point of the "principle of deprivation" in such treatment is fully explained to the patient, it is not likely to do harm, and may be surprisingly helpful for some. For any patient well enough to pursue some kind of life in the world, it seems logical to try such an approach before exposing the patient to the risks either of intensive therapy or of hospital admission. Therapists in training, working in this way under supervision, will learn much from the experience of the treatment of these difficult but very educational patients.

Sicker patients may be so cut off that any kind of therapeutic contact is hard to make; or so disturbed that it is hard to sustain. This group of borderline patients is very difficult to define, and the extensive literature reviewed by Perry and Klerman (1978) revealed a degree of vagueness and diversity in the diagnostic criteria startling even for psychiatry. Holzman (1978) argues that the central feature of the

heterogeneous group gathered under the title of "borderline" is that of unstable psychological organization, manifest in what Menninger had called *dys*function. In the psychoanalytic view, these poorly integrated states are rooted in early developmental failure. Pine (1979), discussing psychopathology in relation to the developmental studies of infants (Mahler *et al.*, 1975), suggests that a key factor determining this kind of pathology may be how far issues in the relationship with the mother were unresolved prior to the development of a sense of separateness, or are rooted in problems around the separating experience. Steiner (1979), writing most eloquently from a Kleinian view point, suggests that "a full account of the borderline patient . . . requires a description both of the depressive anxieties he is not able to tolerate and of the schizoid mechanisms which he is obliged to make use of". This view is part of a three-way understanding of the term borderline. He sees these patients to be diagnostically between neurosis and psychosis; he sees their experience as being represented metaphorically by their feeling always on the edge of, or between, conflicting identities and social realities, and he sees their theoretical position in Kleinian terms as being between the paranoid–schizoid and depressive positions. In Steiner's view, the difficulties of therapy are based upon the pervasiveness of the primitive defences of splitting and projection, and upon the angry and dispiritingly negative transference, which must be endured if depression and reparation are to be contacted. However, he suggests that therapy should not be put off and notes that very significant change can be achieved "even if once-a-week treatment is all that can be offered".

Other analytical accounts are to be found in the writings of Winnicott (1958; 1965) and Guntrip (1968) and in the remarkable account of a very prolonged therapy by Milner (1969). Blake (1968) provides a straightforward account of the very taxing therapy of borderline patients, whom she defined as:

> . . . people who have not developed a capacity for concern or for whom concern is such a limited or painful experience that, in their efforts to cope with their environment, they still feel so persecuted and anxious that they need to operate as if concern is either a luxury . . . or a handicap . . . .

She describes how such patients often have "special" needs to modify, usually in minor, possible ways, aspects of the conventional therapeutic arrangements, and suggests that premature interpretation of these may be experienced as punitive and may deprive the patient of the experience of being symbolically held, in Winnicott's sense. Other analytical accounts are to be found in Kernberg (1967, 1974) and in the voluminous writings of Kohut and his followers, summarized in Kohut and Wolf (1978). These professional accounts may be supplemented by the autobiographical novel by Green (1964) which remains one of the most moving accounts of severe mental illness in the literature. Finally, anyone attempting to combine psychotherapy with inpatient care will need to read Main (1957) with his clarification of how patients can exploit or engender staff conflict in tune with, and to the exacerbation of, their psychopathology; and also the more systematic study by Stanton and Schwartz (1954).