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**Malignant Rapprochement and Abandonment of the Container Function in Acute Psychiatric Settings**

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Parolles
 It lies in you, my lord, to bring me in some grace,
 for you did bring me out.
Lafew
 Out upon thee, knave! Dost thou put upon me at once
 both the office of God and the devil? One brings
 thee in grace, and the other brings thee out.
 - William Shakespeare, *All's Well That Ends Well*

**Introduction**

Individuals may, for reasons both conscious and unconscious, reenact the internalized templates drawn from past experience, reinforcing expected dynamics of reassurance or rejection. In either case, the role of a mental health provider becomes particularly germane, especially in fast-paced settings which attempt to address a vast personal narrative within a rather limited time frame, guided to a greater or lesser degree by symptom constellation checklists. Such settings, interpersonally fragile by their very nature, lend themselves to the potential for reenactments, as pressures placed on both provider and patient to communicate in “time-efficient” ways funnel what and how communication occurs. The force of the bidirectional projective pressures may result in the psychiatrist/therapist stepping into a role which serves to reinforce that the patient *must* live in a damaging and misattuned world in which there is no choice but to be further broken by the traumatizing template.

The quick turnaround time seen on inpatient units and the "stonewall" approach emergency room physicians may feel pressured to apply to patients seeking entry by any means necessary, lead to fertile ground for such reinforcement. The reliability of specific diagnoses occurring in acute care settings has been queried in the literature ([Lieberman and Baker, 1985](#_ENREF_22)), raising the question of how truly in touch we allow ourselves to be with the patient we are seeing, and how one’s subjective lens can alter how a patient’s presentation is conceptualized, even when using arguably objective (or at least somewhat standardized) diagnostic criteria. Taking a more holistic approach to patient care, including in the diagnostic assessment, is a tenet of the biopsychosocial-spiritual model, with the fourth component allowing for spirituality to be incorporated when developing a formulation ([McGee and Torosian, 2006](#_ENREF_26)). Including cultural context in the assessment of patients may lead to a change in diagnosis (in some cases a rather dramatic one) ([Adeponle et al., 2015](#_ENREF_1)), a troubling concept when one considers the rather distinct treatment approaches employed for different diagnoses.

In a more polarized frame of thinking, some patients with challenging personality traits may be equated, in the minds of providers, with malicious malingerers seeking to exploit the resources of the hospital, the scenario thus becoming a personal crusade for the provider to rid his/her milieu of the pernicious presence of such individuals. Indeed, it is a matter of much scrutiny how to be more finely attuned to psychopathology that is feigned versus that which is felt to be genuine ([Niesten et al., 2015](#_ENREF_28)), as though “diagnostic purity,” as dictated by criteria, somehow supplants the suffering that occurs beyond the surface presentation. The very etymology of the word “malinger” may derive from the French *malingrer* – “to suffer.” Despite this, to be seen as legitimately suffering is considered a luxury, which has to meet the clinician’s high bar, vetted through the Diagnostic and Statistical Manual of Mental Disorders (DSM). This is frequently seen when dealing with patients exhibiting Cluster B pathology (e.g., antisocial and borderline traits), as well as with patients with a history of substance abuse, who all-too-often are labeled as "drug-seeking," therefore lacking the potential for any veritable psychiatric pathology "worthy" of our time.

This flies in the face of well-known risk factors and comorbidity for major affective, anxiety, and psychotic disorders, all of which may have a comorbid personality disorder and/or substance abuse component to the presentation ([McDermid et al., 2015](#_ENREF_24), [Boog et al., 2018](#_ENREF_10), [Slotema et al., 2018](#_ENREF_35)). This, not to mention the well-known risk factors these latter conditions represent for attempted and completed suicide. It becomes a moving target whether or not the patient is presenting in the manner which the physician would like him/her to, which may be unduly influenced in a number of cases by likeability, as opposed to a more global approach incorporating known psychological and biological vulnerabilities which may be informing the presentation. Such vulnerabilities in patients, known to lead to significant effects on cognitive flexibility and ability to employ adaptive coping strategies, include childhood trauma, long-standing abuse of numerous substances, intellectual disability, and organic brain injury, among others.

There is a subjective/countertransferential value to appreciating defense mechanisms ([Danielian and Lister, 1988](#_ENREF_13)), but also a growing evidence base behind using them as part of a diagnostic assessment, potentially providing us with information about attachment schema and temperament/character traits ([Albucher et al., 1998](#_ENREF_2), [Porcerelli et al., 2016](#_ENREF_30)). The disavowal of primitive defenses as communicative strategies employed by patients experiencing great distress, attempting furiously to express the depth of their suffering in the time allotted, severs the use of countertransference and projective identification as diagnostic tools, individuality being lost in favor of diagnoses which eliminate the need for further consideration. Indeed, patients who frequent the emergency room with some regularity may find themselves caught in a cycle in which they cannot find the words and/or time to express their narrative, thus resorting to more extreme language in order to draw the attention of the listener (e.g., making suicidal or homicidal statements even if no such intent exists). If such statements do not find a semiological basis to support a “treatable” psychiatric diagnosis, the patient may be labeled as feigning or embellishing symptoms for secondary gain purposes and discharged.

This may serve as confirmation of the impenetrability of the patient’s mind, which becomes something the provider does not wish to know. Within this framework, there would need to be a close alignment between symptom checklists and patient reporting in order to merit a containing and metabolizing alpha-function on the provider’s part ([Bion, 1959a](#_ENREF_5), [Bion, 1962b](#_ENREF_8)).However, if in an effort to conform to such expectations, the patient finds him/herself adopting a guise which betrays the true nature of where the distress lies, there is a pseudo-understanding occurring in the room, predicated on a mutual collusion in working with split-off, concrete symptoms, treated as “things” to be pieced together into a diagnostic puzzle, an entity which could be dissociated from the greater narrative of an individual’s life story. As aptly stated by John Arthos, in his analysis of a character in *Pericles*,

All happens in such a brief space the audience never gets in touch with [the character] (…) and so has little of the sense of tragedy but merely of misfortune and sadness. The narrative comes so fast the characters never have a chance to show their desire for life.  What we get are mostly fragments. ([Arthos, 1953](#_ENREF_3)) p.264)

The projection of a fully functioning mind which meets the provider’s threshold of symptom reporting, appropriate interpersonal dynamics, and cognitive sophistication to navigate information being demanded of and shared with the patient, lends itself to an almost inevitable misattunement and suboptimal appreciation of the dynamics at play, leaving both members of the dyad in a state of unanalyzed repetition. Such a misalignment of minds narrows the ability for an empathic understanding by the provider, who may write the patient off as "not wanting help," and shutting any doors which could deepen understanding of the origins of the patient's pain.

**Self-driven attacks on our container function**

Selective attention may take place to cues from external objects, eliciting skewed interaction dynamics on the part of the patient in order to draw out a particular response ([Fosshage, 2004](#_ENREF_16)).  As conditioning is informed by encoded memory, the amygdala (in interplay with the hippocampus) may predominate over the inhibitory input from the frontal lobe (access to which could lead to more flexible responses), with one’s experience of the interaction occurring in a more primitive, bottom-up neurobiological manner, gaining in intensity the more unprocessed and traumatic the experience may have been ([Shin et al., 2004](#_ENREF_34)). What may become lost in the assessment process is that the patient may be reacting to the world in accordance with his/her own experience, and to expect a mature and overly deferential manner of expressing symptoms may speak more to our own internalized templates and pressure *we* are under to eliminate complexity and hierarchical uncertainty. As Kernberg noted:

In borderline patients (...) the highest level depersonified superego structures and autonomous ego structures are missing, and early, conflict-laden object relationships are activated prematurely in the transference in connexion with ego states that are split off from each other. The chaotic transference manifestations that borderline patients typically present might be understood as the oscillatory activation of these ego states, representing 'non-metabolized' internalized object relations. ([Kernberg, 1966](#_ENREF_21)) p. 237

What Fosshage also emphasized as the primary instrument to effect a modification of old patterns of relating is a spirit of inquiry on the part of the provider ([Fosshage, 2004](#_ENREF_16)). Allowing a more free-flowing and playfully open curiosity only to patients lying on an analytic couch, as opposed to recognizing depth within the presentation of *all* individuals in *all* settings, betrays the sophisticated understanding we have of the human mind, reducing it to something easily deconstructed, exemplifying the use of omniscience as a defense against insight ([Sodre, 2012](#_ENREF_36)).

On the flipside, there is the danger of overidentification with the vulnerable parts of the patients, particularly if they speak in manners which are more closely aligned with our expectations and/or therapeutic powers. A patient who is admitted to a psychiatric unit and who identifies with such a rescuer/rescued dynamic, may split off the ability for self-advocacy and self-thought, creating the picture of an omnipotent provider who “knows” what the patient needs and thinks, and of a patient who can disown his/her own thinking apparatus. If this is allowed to persist during the course of the hospital stay, when the moment of discharge arrives, the reintroduction of the patient’s responsibility for his/her fate may feel like an aggressive projection on the part of the provider. Responding in kind, the patient may ricochet back the projection and lead the clinician to feel caught in an impossible scenario, paralleling that of the patient, stuck in a thought/no-thought zone. As Bell stated,

Many patients use admission to psychiatric wards to provide them with an immediate context for these projective procedures. Although, in the last instance, no-one can be absolutely prevented from committing suicide, it is easy for staff to become identified with an omnipotence which dictates that it is entirely their responsibility.(…) I have described a common central structure in suicidal patients, a primitive psychotic superego which demands omnipotence, not knowledge. It is easy for such disturbed modes of thinking to find a home, not only in the staff but in the institution itself, especially when this is backed up by an external world that demands the impossible. ([Bell, 2001](#_ENREF_4)) pp. 32, 36.

The emergency room and inpatient units can become perversions of the holding environment in which demands for an acceleration of the patient’s recovery process betrays the nuanced nature of healing. Such philosophies certainly have a basis in the reality of the pressures coming from insurance providers and hospital administration, but providers’ minds can become sequestered in the process, knowledge being abandoned in favor of full-scale identification with demands divorced from individualized needs, which extend well beyond diagnostic and billing considerations. The same can apply to the pharmacological properties of medications. The latter in many instances require some weeks to begin to take effect.

Yet, the argued benefit of accelerated hospital stays, many times lasting less than a week, may border on a manic belief that medications will work faster if we simply wish it to be so. Even areas of the brain which undergo adult neurogenesis require around two weeks to consolidate medication or environmentally-induced change (Fischer, 2014). Within such a paradigm, positive or negative impact during this period of plasticity may heighten or mitigate dysphoria; as such, premature discharge to a destructive environment may do more harm than good. The very existence of a concrete structure surrounding the patient (similar to the “mother-environment” of Bollas) ([Bollas, 1979](#_ENREF_9)), as well as the notion of “doing something” through brief pharmacotherapy, may fuel the fantasy of manic repair in the clinician, who can split off the thinking part of his/her mind and disconnect from what needs to be heard in the patient. With shorter inpatient stays becoming the norm and the increasing reliance on medication management, the challenge is ever greater to come into contact with what the patient is truly trying to communicate. Worse yet, clinicians may learn to actively hate their own containing functions, which become treasonous affronts to superegoic/institutional demands. As such, the ability to relate is present but strongly disavowed, setting the stage for traumatizing enactments. As Bion stated in his development of the concept of -K:

The emergence [of] any tendency to search for the truth, to establish contact with reality and in short to be scientific in no matter how rudimentary a fashion is met by destructive attacks on the tendency and the reassertion of the ‘moral’ superiority (…) in the potency of *UN*-learning.” (Italics and caps in original.) ([Bion, 1962a](#_ENREF_7)), p. 98.

The concept of the fundamentally unkind superego may lead to a situation in which the clinician adopts a quasi-sadistic response as a reaction to the sense of helplessness in the encounter. Words become poor substitutes for actual empathy and, as a result, interventions are devitalized. Thus, even if the clinician says "the right thing," the misattunement which is deriving from a fundamental misunderstanding between the two parties may nullify the resonance of whatever is said.  As Ophelia stated, "rich gifts wax poor when givers prove unkind" (*Hamlet*, III.i.103) ([Shakespeare, 1603](#_ENREF_32)). This concept finds support in Money-Kyrle:

As to the negative attitudes to a patient which may also result from a temporary failure to understand him, these would seem especially to arise when the patient becomes a persecution because he is felt to be incurable. (...) It may be, however, that the analyst does not succeed in sorting all this out within himself before he reprojects the patient as something not understood, or foreign, in the external world.(…) If so, the patient is also likely to introject him in this condition and then feeling more desperate need of external help than ever. At such moments, the analyst may become disagreeably aware that the patient is still more urgently demanding that which he still less able to give consciously, a good interpretation[.] ([Money-Kyrle, 1956](#_ENREF_27)) pp. 364-5.

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 *Me: Good morning Mr. A, can we go into the other room to talk?*

*Patient: Why do we need to do that?*

*Me: There's another patient in here; it would be for privacy sake. (He was in a large room where other patients were located, and I wanted to speak with him in the smaller interview room.)*

*Patient: I don't want to move, man, I'm in withdrawal.*

We remained in the same room and continued talking. He gave vague descriptions of why he was there. He was irritable but answered questions. He alluded to the fact he did not wish to talk and did not want to discuss possible resources for treatment of his substance abuse and psychiatric symptoms. He called me by an abbreviated form of my first name at one point, in a rather dismissive manner - "Look [my first name], we'll just have to talk about this later, okay?" I had identified myself as "Dr. [my last name]," but imagine he saw my name on my badge. I admittedly felt affronted by this and made a point of not excusing myself. It felt that a hierarchy from which I could not remove myself was becoming crystallized and needed to be established. I tried to continue our conversation, at which point he angrily faced the wall.

*Patient: I'm in fucking withdrawal, I'm not talking about this now.*

*Me: It sounds like something shifted (referring to his turning to the wall and disengaging even more) . . . What just happened?*

*Patient: You already know all this shit, but you're pretending you don't, and you're not doing what you're supposed to do for it.*

*Me: Well, we're trying to understand better what you've been experiencing, so we'll know how to help.*

*Patient: You already fucking know it. I'm in withdrawal and I'm nauseated.*

*Me: We can certainly get you some Tylenol and Zofran for your symptoms...*

*Patient: All right, that's not perfect, but it's something.*

As I felt we had reached some truce, with his agreeing to take in something I had to offer, his nurse and I exited the locked area of the emergency room. There is two-way glass between the locked area and our staff work area, so patients and providers can see each other. After a short period of time, he called to us again. We entered to speak with him.

*Patient: Tylenol isn't going to do a fucking thing for me.*

*Me: Well, we'll start there, and we'll get you some resources to contact after we medicate you.*

*Patient: That's your job, so you can go and make a few phone calls, can't you?*

*Me: The programs like the patient to show some initiative in getting into treatment.*

I did not notice it at the time, but my very language was becoming distancing, moving from actually individualizing him as I had when I introduced myself, to referring to him now as “the patient.”

*Patient: I came to the ER, didn't I? That's showing enough initiative. And wanting me to take steps the way I'm feeling is fucking retarded.*

My brain slowly tightened and I sensed I could not reach this patient anymore. I sensed that my disengagement was not only inevitable, but was to be absolute.

*Me: We will give you the Zofran and Tylenol, wait a bit, print some resources and have you on your way.*

*(Mr. A turns to us.)*

*Patient: What do you fucking mean? You can't discharge me from here with no help.*

*Me: We'll give you resources for additional help. Just give us a moment.*

*(The nurse and I walk away from him to leave the locked side of the ER.)*

*Patient: HEY! GET BACK HERE!*

*(I scurry out.)*

The patient quickly got up and started pacing around the unit; he positioned himself to stare intensely at me through the glass; he showed no objective signs of withdrawal and could ambulate without issue. (As I look back, perhaps I took note of such signs as a way of rationalizing my lack of empathic attunement, disavowing the need to think any further about him.) After pacing for a while, he angrily laid back down where he was before. Shortly after, security was called and the patient was discharged in their company. He seemed quite chagrined.

**The place of projective identification and the bidirectional malignant rapprochement dynamic**

After discussing the difficulties clinicians may encounter in attempting to connect meaningfully with patients while attending to intrapsychic pressures which cannot objectively be disavowed, I will discuss an additional level of interpersonal dynamics which may hinder relatedness in the clinical encounter. There may be forces driving the patient to draw the clinician into an unsatisfying, retraumatizing interaction, reinforcing the impossibility of being helped. In an attempt to underline the primitive nature of such dynamics, I will draw from Margaret Mahler’s description of the separation-individuation process - in particular, the interface between dependence and autonomy, which characterizes the rapprochement sub-stage. I will provide a brief theoretical overview, and a clinical vignette for further illustration.

In her description of the separation-individuation sub-stages, Mahler underlines how cognitive and motor processes develop in tandem, with the child experiencing a progressive sense of separateness as he/she is able to physically move away from the mother. This ability coincides with the feeling of wonder and excitement that the discovery of such motor skills brings with it. This occurs during the practicing sub-stage (which Mahler times at around seven to 15 months of age) ([Mahler, 1972](#_ENREF_23)). The mother still serves as a home base to concretely “refuel” the child and needs to be checked in with from time to time.

As the child encounters the rather awesome nature of reality, there is a realization of one’s smallness and helplessness, which the newly discovered motor skills can only do so much to allay. As it is, there is something of an attempt to return to the security of the dyad, perhaps a re-immersion into the symbiotic sub-stage. This is the nature of the rapprochement sub-stage. Tragically, the cognitive development of the child that has taken place will not allow for such a return to this blissful fusion, aware as he/she has become of separateness, and tremendous frustration may follow. It is thus up to the caregiver to negotiate this delicate period, with sensitive containment by the mother being required to avoid a breakdown in the child’s coping skills, with the potential (per Mahler) for borderline pathology to occur if this situation is mishandled. She emphasizes the need for the caregiver to be “quietly available” in attending to the child’s need for a containing presence, ultimately allowing for verbal communication and a tolerable sense of separateness and autonomy to supplant the need for symbiotic fusion ([Mahler, 1972](#_ENREF_23)).

As highlighted before, the clinician may feel a tremendous pressure to conform to quick assessments, draining the possibility of the patient showing any spontaneity or liveliness beyond the firm frame of the timed encounter. In an emergency or crisis situation, a deadening may take place as a means of avoiding loss of control within the encounter. The provider who refuses entry of what the patient is stating may be seen as akin to the mother who is unable to take in the child’s projections, leading to a further destabilization of a psychic structure already in a vulnerable state. According to McDougall,

We often discover that the mother was seen as being too emotionally fragile to play a coherent maternal role.  She is frequently recalled as forbidding any display of emotion on the child's part, as though it were too much for her to bear. ([McDougall, 1989](#_ENREF_25)) pp. 97-98).

What becomes reenacted between patient and provider is a form of *malignant* rapprochement, as though both individuals’ lives have evolved beyond the point of a benign and containing attunement being possible. As the child is forced to struggle with his/her cognitive and motor development while separated from the caregiver in the practicing substage, being shunned from the possibility of a symbiotic re-immersion, so too the patient cannot find his/her way into the mind of the provider and be held. Both parties have moved on.

The second layer of consideration I wish to illustrate is that some patients may have the unconscious need for a reenactment of an “Edenic rejection” to take place, as it will provide him/her with the reinforcing impetus to set the destructive internal object world into a state of vibration.  When the inner cord needs a rejecting force to set it off, this is where the stage becomes apt for a re-traumatizing enactment. It would seem intuitive that if a patient did not reach the consciously desired outcome (e.g., inpatient hospitalization), there would be an operant conditioning response not to return, yet there are cases in which it is exactly the negative outcome which serves the operant function, but in the opposite direction (i.e., as reward and not punishment).

The rapprochement with a punitive (though paradoxically rewarding) outcome, occurring inside an environment which is supposed to be helpful may be reminiscent of early experience, in which the caregiver was someone who, despite the neglect or abuse, became the bedrock which the individual is hard-wired to seek in times of need, internalizing the template which may become the basis for interpersonal dynamics, to be relived throughout one’s life ([Critchfield and Benjamin, 2008](#_ENREF_12), [Sandler et al., 1973](#_ENREF_31)).  This is in line with Bowlby's statement that we have rather limited power when choosing reinforcing environments, and there are developmental forces which may impel us to set up destructive scenarios, despite a possible willingness to behave differently.

In order to limit epigenetic sensitivity and so ensure consistent development despite fluctuations of environment, physiological and behavioural processes are evolved that buffer the developing individual against the impact of the environment. Acting in concert, these processes tend to maintain an individual on whatever developmental pathway he is already on, irrespective of most of the fluctuations that might occur in the environment in which further development will be taking place. ([Bowlby, 1973](#_ENREF_11)) p. 367.

It would behoove the clinician to develop a space for containment even in acute care settings, as this could provide a model for a new form of object relating, one that can withstand the intensity of the patient’s projections while maintaining a thinking mind. Even in short instances of relatedness, the message might be conveyed and internalized that the patient’s communicative style can be understood as something other than purely evacuative and inexorably damaging. In his discussion of the repetition compulsion, Freud stated, “the patient does not *remember* anything of what he has forgotten and repressed, but *acts* it out. He reproduces it not as a memory but as an action; he *repeats* it, without, of course, knowing that he is repeating it” ([Freud, 1914](#_ENREF_17)) (p. 150). Such pressures to repeat may be decreased by facilitating more freely mobile ego-functioning ([Freud, 1936](#_ENREF_18)), which may be promoted through a processing of the powerful unconscious forces into something that can be understood.

**Finding a relational middle ground**

Given the landscape described, a socially stunted scenario may unfold, in which it is concretely demonstrated that words can lead to no good.  It no longer becomes about restructuring damaged object relations, but about reinforcing the inescapability of existing templates.  This dynamic is fueled by the clinician's counter-projective identification, the lens of which dictates that the patient be forthcoming, open, vulnerable, and sheepishly susceptible to the magical repair fantasies the provider may foster. As understanding is compressed into a minimal interaction time, there may be a reversal of roles in which the clinician's unmetabolized beta elements are projected into the patient, with the potential for the provider to act out his or her more aggressive urges, particularly given their relative hierarchical power.  Such scenarios may play out rather concretely by, for instance, placing the patient in a seclusion room, giving medication against his or her will, or simply discharging the patient from the emergency room or inpatient setting, showing that there is indeed something overwhelming about elaborating a creative and collaborative union between patient and provider. The use of psychopharmacology in itself can serve to further this defensive structure on the part of the clinician, as sedation becomes a concrete way of eliminating the unknown in the patient (and the known, for that matter), frequently being turned to in emergency settings. This is not to say that these interventions are not many times warranted to ensure patient and/or staff safety, but my argument refers to instances in which there is more of a gray area regarding the necessity of such strategies.

Indeed, what would be hoped for on a therapeutic level would be for such encounters to engender a containing experience for the patient’s projections, while the clinician holds his/her own in abeyance. We know that, even in the best-case scenarios in which the clinician is open to working closely with the communications being conveyed, there is still a forcefulness which may take place, as the patient attempts to push the provider to become psychically destabilized and conform to a pre-defined role. Recalcitrance to blindly doing so on the clinician’s part may be met with an escalation of projective efforts ([Bion, 1962a](#_ENREF_7)), as the threat of non-conformity may lead to the possibility of a new object relationship, a proposition both enticing and terrifying. It is the therapist’s endurance and ability to work through the difficulties at hand that can help the patient to internalize a containing object. As such, the encounter, however brief, will be a gift to be built upon after the dyad parts ways. However, if such a process is not even entertained, the clinician’s potential for therapeutic containment being split off and disavowed, there is no space for playfulness or discovery.

The patient encounters a deadened object which will not even participate in a full-scale destructive reenactment, but rather turn the meeting of minds into a revolving-door shunning, overly organized by a funneling of a wealth of subjectivity into something drily descriptive. Such a self-induced paralysis of mental capabilities is evocative of Joseph’s concept of the “addiction to near-death,” but imbues the clinicians with the potential for keeping their own related and lively parts at bay, in a strangled state of deadness which cannot allow for actual contact with the patient in front of them to take place, lest something interpersonally generative and creative take place. To quote Joseph:

[In]patients really dedicated to self-destructiveness, this internal situation has a very strong hold over their thinking and their quiet moments[.]” ([Joseph, 1982](#_ENREF_20)) p. 451.

Within this flipped scenario, it becomes something of a farcical reversal of Freud’s comment on patient resistance to showing improvement:

 No stronger impression arises from the resistances during the work of analysis than of there being a force which is defending itself by every possible means against recovery and which is absolutely resolved to hold on to illness and suffering[.]” ([Freud, 1937](#_ENREF_19)) p. 242.

In this scenario, given the stranglehold placed on the potential created within the encounter, the script has already been written, in a way, and novelty cannot be tolerated. Echoing Feldman, what can become attacked in the dyad is the therapist’s “world of thought, creativity, meaning and change,” and replaced “with one dominated by paralysis and terror. (…) These [destructive operations] invade, not in order to annihilate or even to kill, but to attack meaning, clarity, movement, exploration, and any form of creative interchange, as an expression of hatred towards life and liveliness” ([Feldman, 2000](#_ENREF_15)) (p. 56).

The following case vignette draws from my own experience while doing brief, weekend rounds on an inpatient unit, seeing several patients I did not know over a short span of time. It is a setting which invites a different mindset altogether, as rounding physicians are both present and absent from the treatment of these patients, given that the primary team is present during the week, and rotating psychiatrists fill in over the weekends, summoning the spectral presence of empathic care, without much time or ability to leave a lasting mark. I was covering around 20 patients a day over a three-day weekend and had very limited time to spend with each. I am transcribing the brief interactions I had on each of the three days with one particular 80-year-old woman on the geriatric unit. She tried hard to convey to me her existential despair, suffering from chronic major depressive disorder and not having encountered a treatment which had truly helped her. I could hear the hollowness of my responses, hurriedly taking in the agony she was conveying, yet strangling my own powers of metabolizing what I was hearing in order to provide something therapeutic.

I was quite aware of what was happening, as I witnessed myself speaking with her while disavowing the part of my mind capable of thought. It was as though I was in a waking coma, frozenly seeing myself interacting with the world in a way I could not recognize as my own, yet unable to change it as it was taking place. However, over the course of the weekend, that split-off portion of my mind gradually came back to me, in the humbled manner it could. My responses to her slowly acknowledged the essential limitations of the setting, as well as the limitations to the kind of psychiatrist I could be for her under those circumstances. To her repeated statements about her worsening depression and existential despair, and her more direct questions -“What is the meaning to all of this?” and “What if I never can find a reason for being and remain in this rut forever?” - my answers were of evasion and concreteness, yet I was quite contemplative over the period of time in question, and the unease I felt at my own stance began to break down the omnipotent ropes of my dismissive stronghold. Brief excerpts (though not far from the full extent of our interactions) follow:

**Day 1**

*Patient: I’m not doing so hot… I know I just got here, but I’m worried about whether there’s anything at all for me…*

*Me: You’ve only been on the medication for a short period of time, you really need to give it a chance to work.*

*Patient: I’m afraid it will never work. I’ve been on medications before. I’m 80-years-old, and I don’t see a meaning to all of this.*

*Me: I’ve seen these antidepressants work wonders for people. This way of thinking can be part of your depressive state. We do need to stop for today though.*

*Patient: You don’t seem to care.*

 **Day 2**

*Patient: Same thing… Still not feeling great… I spent the day feeling depressed.*

*Me: Again, it is too early to tell if the medication is helping; it won’t be during these three days I’m seeing you that we will notice anything appreciable.*

*Patient: I’m just losing hope… People here tell me to think positive and journal “good things,” and I try to… But nothing really happens here.*

*Me: It’s the weekend; once Tuesday comes, your team will be back and there will be many more activities on the unit.*

*Patient: What, like drawing with crayons in a group? That doesn’t help anything.*

*Me: Again, you’ll have a chance to discuss things in further depth in a couple of days.*

*Patient: You don’t sound too hopeful.*

*Me: I’ll check in with you again tomorrow.*

*(I walk away.)*

Later, as I’m leaving the unit, she calls out to me to speak again. Our exchange does indeed illustrate, in a scorchingly brief but powerful way, the blinders that I had put on and the minimal degree of depth I was allowing to be accessed within myself.

*Patient: Doctor, I have a question for you.*

*Me: Yes, ma’am.*

*Patient: You know, sometimes it seems like you don’t care or that you’re dismissing my concerns.*

*Me: And what was your question?*

 **Day 3**

*Patient: I’m still depressed.*

*Me: Your team will be in tomorrow, and additional forms of treatment can be explored.*

*Patient: This is something that has been consuming me for a long time; it’s beyond depression. I don’t know if anything can help it.*

For the first time in three days, I actually tried to stop and consider the whirlwind I had been sucked into. I noticed and was feeling quite ashamed and guilty about my responses of the previous two days. It was as though I could actively observe myself disavowing my knowledge base and skillset, mindlessly giving in to unseen forces which hated my individual thinking prowess. I attempted to individuate as best I could and disentangle myself from the malignancy of the rapprochement taking place.

*Me: There is probably nothing I can say which is going to be helpful to you right now. You’re telling me about something very deep-seated and which has been the culmination of a lifetime of experiences; it would be foolish for me to imagine I can understand the fullness of what you’re asking. It may very well be the case that nobody can answer your question, that no medication will help, and that there is no understanding to be had. You are probably noticing that this setting is far from optimal to do justice to what you seek help for; the focus is indeed on medications, and it may very well be a false promise of a magical solution that may never come true… It is the unfortunate nature of our field.*

I gave in to my limitations. Oddly, this was the one day in which she smiled and seemed relieved by my statements. It would seem that it is the realness of dealing with another actual human which served as a greater consolation.

In a similar vein, I am reminded of two examples from the analytic literature. The first is by Winnicott, who noted the poignant statement his patient made to him, which perhaps serves as an apt analogy: “The only time I felt hope was when you told me that you could see no hope, and you continued with the analysis” ([Winnicott, 1960](#_ENREF_38)) (p. 152). The second was pointed out by Feldman, as he noted that Melanie Klein’s attempt to be a good and reassuring object for her patient (Richard) led to a paradoxical response of suspicious splitting. Her attempt at becoming the idealized object was not containing but rather led to Richard highlighting (through projection) the presence of evil in the world. In discussing this paper, he argued:

 If, instead, she had interpreted his anxiety about the damage or loss (…) and all it represented, and her part in this process, she would have conveyed that, while she might well be feeling anxious and distressed, she could still continue to function analytically. She would not have been demonstrating such concern to be a good object forRichard,but her capacity to tolerate him experiencing her as more mixed, and more real. ([Feldman, 1993](#_ENREF_14)) p. 279.

**Conclusion**

If it is indeed true that it takes two to think an individual's most disturbing thoughts ([Ogden, 2008](#_ENREF_29)), and that, irrespective of the setting and the nature of the interaction, the provider is somehow being drawn into playing a part in the patient's script ([Bion, 1959b](#_ENREF_6)), it can be useful to take a step back from our more immediate calls to action, allowing for the process of inquiry and containment to unfold naturally. This will require the abandonment of the well-known instruments of omniscience, omnipotence, disavowal, and magical thinking (particularly with regards to ascribing miraculous properties to still incompletely understood biological treatment modalities). Given the predominantly biological direction the psychiatric field is heading in, and the slowly extinguishing focus on insight-oriented psychotherapies, optimism is not a concept which is easy to hold on to.

The misalignment of patients’ needs with the reductionistic psychological constructs we at times impart to them leads to a series of inefficient and concrete measures by both parties, demonstrating that communication need be escalated to the level of the egregious. This is something of a cautionary note given the incidence of mass violence in our society; the splitting-off of such acts as being perpetrated by people who were beyond help only fuels our basic misunderstanding of the core disturbances within one's psyche. By ignoring their complexity and ultimate humanness, the voice of desperation begging to be heard may only find an outlet through irremediably damaging and diffuse means, a splintered projection of poisonous beta elements which had never found a containing ear through more subtle channels. To illustrate this, I quote a line from a suicide note shared with me by a patient's acquaintance, which in many respects speaks rather succinctly to the point of the paper: "It is those who are easiest to hate that need love the most."

Productive clinical work requires the therapist to be able to survive the patient’s destructive attacks ([Winnicott, 1969](#_ENREF_39)), as this aids in distinguishing fantasy-based expectations from the actual object, a working-through suggested by Freud as well in his discussion of the patient turning the object into an effigy of an archaic introject ([Freud, 1937](#_ENREF_19)). As Winnicott stated,

The destructiveness plus the object's survival of the destruction places the object outside the area in which projective mental mechanisms operate, so that a world of shared reality is created which the subject can use and which can feed back into the subject. ([Winnicott, 1969](#_ENREF_39)) p. 715.

The consequences of this not happening is where we run into trouble, as posited by the argument of this paper. It is heartening that the place of trauma within an individual’s life is becoming much more integrated into assessment and intervention strategies, as institutions adopt principles deriving from the “recovery model” in mental health ([Young et al., 2014](#_ENREF_40), [Thornton and Lucas, 2011](#_ENREF_37)). While the pressures from both parties in the dyad may push towards reenactment without the opportunity to subsequently process what took place, it must be held in mind that, irrespective of the situation, we are in a position to provide a healing experience to someone who has known a world we cannot ever fully grasp. Acknowledging this, as well as the limits of what we can provide while still opening space to be curious with our patients, may perhaps keep both them and us in contact with what remains very much alive and wishing to be discovered.

**References**

ADEPONLE, ADEMOLA, GROLEAU, DANIELLE & KIRMAYER, LAURENCE. 2015. Clinician reasoning in the use of cultural formulation to resolve uncertainty in the diagnosis of psychosis. *Cult Med Psychiatry,* 39**,** 16-42.

ALBUCHER, RONALD, ABELSON, JAMES & NESSE, RANDOLPH. 1998. Defense mechanism changes in successfully treated patients with obsessive-compulsive disorder. *Am J Psychiatry,* 155**,** 558-9.

ARTHOS, JOHN. 1953. Pericles, Prince of Tyre: A study in the dramatic use of romantic narrative. *Shakespeare Quarterly* 4**,** 257-270.

BELL, DAVID. 2001. Who is Killing What or Whom? Some Notes on the Internal Phenomenology of Suicide. *Psychoanalytic Psychotherapy,* 15**,** 21-37.

BION, WILFRED. 1959a. Attacks on Linking. *International Journal of Psychoanalysis,* 40**,** 308-315.

BION, WILFRED. 1959b. *Experiences in groups and other papers,* New York.

BION, WILFRED. 1962a. *Learning from Experience,* London, Karnac.

BION, WILFRED. 1962b. The Psycho-Analytic Study of Thinking. *International Journal of Psychoanalysis,* 43**,** 306-310.

BOLLAS, CHRISTOPHER. 1979. The transformational object. *Int J Psychoanal,* 60**,** 97-107.

BOOG, MICHIEL, VAN HEST, KLAARTJE, DRESCHER, TAMAR, VERSCHUUR, MARGOT & FRANKEN, INGMAR. 2018. Schema Modes and Personality Disorder Symptoms in Alcohol-Dependent and Cocaine-Dependent Patients. *Eur Addict Res,* 24**,** 226-233.

BOWLBY, JOHN. 1973. *Attachment and Loss: Volume II: Separation, Anxiety and Anger.* London: The Hogarth Press and the Institute of Psycho-Analysis.

CRITCHFIELD, KENNETH & BENJAMIN, LORNA. 2008. Internalized representations of early interpersonal experience and adult relationships: a test of copy process theory in clinical and non-clinical settings. *Psychiatry,* 71**,** 71-92.

DANIELIAN, JACK & LISTER, ERIC. 1988. The negative therapeutic reaction: the uses of negation. *J Am Acad Psychoanal,* 16**,** 431-50.

FELDMAN, MICHAEL. 1993. The dynamics of reassurance. *Int J Psychoanal,* 74 ( Pt 2)**,** 275-85.

FELDMAN, MICHAEL. 2000. Some views on the manifestation of the death instinct in clinical work. *Int J Psychoanal,* 81 ( Pt 1)**,** 53-65.

FOSSHAGE, JAMES. 2004. The explicit and implicit dance in psychoanalytic change. *J Anal Psychol,* 49**,** 49-65.

FREUD, SIGMUND. 1914. Remembering, Repeating and Working-Through *In:* STRACHEY, J. (ed.) *The Standard Edition of the Complete Psychological Works of Sigmund Freud.* London: Hogarth Press.

FREUD, SIGMUND. 1936. Inhibitions, Symptoms and Anxiety. *The Psychoanalytic Quarterly,* 5**,** 415-443.

FREUD, SIGMUND. 1937. Analysis Terminable and Interminable. *In:* STRACHEY, J. (ed.) *The Standard Edition of the Complete Psychological Works of Sigmund Freud.* London: Hogarth Press.

JOSEPH, BETTY. 1982. Addiction to near-death. *Int J Psychoanal,* 63**,** 449-56.

KERNBERG, OTTO. 1966. Structural derivatives of object relationships. *Int J Psychoanal,* 47**,** 236-53.

LIEBERMAN, PAUL & BAKER, F. M. 1985. The reliability of psychiatric diagnosis in the emergency room. *Hosp Community Psychiatry,* 36**,** 291-3.

MAHLER, MARGARET. 1972. Rapprochement subphase of the separation-individuation process. *Psychoanal Q,* 41**,** 487-506.

MCDERMID, JOANNA, SAREEN, JITENDER, EL-GABALAWY, RENEE, PAGURA, JINA, SPIWAK, RAE & ENNS, MURRAY. 2015. Co-morbidity of bipolar disorder and borderline personality disorder: findings from the National Epidemiologic Survey on Alcohol and Related Conditions. *Compr Psychiatry,* 58**,** 18-28.

MCDOUGALL, JOYCE. 1989. *Theaters of the Body: A Psychoanalytic Approach to Psychosomatic Illness.* W. W. Norton & Company.

MCGEE, MICHAEL. & TOROSIAN, JENNIFER. 2006. Integrating spiritual assessment into a psychiatric inpatient unit. *Psychiatry (Edgmont),* 3**,** 60-4.

MONEY-KYRLE, ROGER. 1956. Normal counter-transference and some of its deviations. *Int J Psychoanal,* 37**,** 360-6.

NIESTEN, ISABELLA, NENTJES, LIEKE, MERCKELBACH, HARALD & BERNSTEIN, DAVID. 2015. Antisocial features and "faking bad": A critical note. *Int J Law Psychiatry,* 41**,** 34-42.

OGDEN, THOMAS. 2008. Bion's Four Principles of Mental Functioning. *Fort Da,* 14**,** 11-35.

PORCERELLI, JOHN, HUTH-BOCKS, ALISSA, HUPRICH, STEVEN & RICHARDSON, LAURA. 2016. Defense Mechanisms of Pregnant Mothers Predict Attachment Security, Social-Emotional Competence, and Behavior Problems in Their Toddlers. *Am J Psychiatry,* 173**,** 138-46.

SANDLER, JOSEPH, HOLDER, ALEX & DARE, CHRISTOPHER. 1973. Frames of reference in psychoanalytic psychology. V. The topographical frame of reference: the organization of the mental apparatus. *Br J Med Psychol,* 46**,** 29-36.

SHAKESPEARE, WILLIAM. 1603 (2016). Hamlet. *In:* BRAUNMULLER, A. (ed.) *The Pelican Shakespeare.* New York, New York: Penguin Books.

SHAKESPEARE, WILLIAM. 1605 (2001). All's Well That Ends Well. *In:* MCEACHERN, C. (ed.) *The Pelican Shakespeare.* New York, New York: Penguin Books.

SHIN, LISA, ORR, SCOTT, CARSON, MARGARET, RAUCH, SCOTT, MACKLIN, MICHAEL, LASKO, NATASHA, PETERS, PATRICIA, METZGER, LINDA, DOUGHERTY, DARIN, CANNISTRARO, PAUL, ALPERT, NATHANIEL, FISCHMAN, ALAN & PITMAN, ROGER. 2004. Regional cerebral blood flow in the amygdala and medial prefrontal cortex during traumatic imagery in male and female Vietnam veterans with PTSD. *Arch Gen Psychiatry,* 61**,** 168-76.

SLOTEMA, C. W., BLOM, JAN, NIEMANTSVERDRIET, MARIEKE, DEEN, MATHIJS & SOMMER, IRIS. 2018. Comorbid Diagnosis of Psychotic Disorders in Borderline Personality Disorder: Prevalence and Influence on Outcome. *Front Psychiatry,* 9**,** 84.

SODRE, IGNES. 2012. Who's Who? Pathological Identifications. *In:* ROUTLEDGE (ed.) *Projective Identification: The Fate of a Concept.* East Sussex.

THORNTON, TIM & LUCAS, PETER. 2011. On the very idea of a recovery model for mental health. *J Med Ethics,* 37**,** 24-8.

WINNICOTT, DONALD. 1960. Ego distortion in terms of true and false self. *The maturational processes and the facilitating environment.* London: Hogarth Press.

WINNICOTT, DONALD.1969. The Use of an Object. *International Journal of Psychoanalysis,* 50**,** 711-716.

YOUNG, SHARON, SCHACTMAN, LISA & SNYDER, MATT. 2014. Early report on the effectiveness of a recovery model oriented therapeutic community for individuals with complex and persistent recovery challenges. *Psychiatr Q,* 85**,** 329-43.

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