This paper is also published as a Chapter in a British publication: *Modern Mental Health*. Edited by Steven Walker; published in 2013, by Critical Publishing whose website is www.criticalpublishing.com (where the book can be purchased).

**Being disturbed: the impact of severe personality disorder on professional carers**

*Robert D. Hinshelwood*

<<Professional men, they have no cares. Whatever happens, they get theirs>>.

Ogden Nash, 1935.

**Abstract**

Ogden Nash’s quip implies a perfectly neutral attitude on the part of a professional to the affairs of the people he deals with. Perhaps it is a familiar view of professional people. We need our accountants, lawyers and so on to give us an objective view of our affairs. Maybe that should be what is needed from the caring professions. However, I have argued that within psychiatry carers are particularly disconcerted by the work they do (Hinshelwood, 1999; 2004). In the present paper, I wish to look in some closer detail at these interpersonal processes that occur between carers and those they care for, with particular emphasis on personality disordered people.

This Chapter will take a critical perspective, questioning and problematising the standard approach to care provision based on the consumer model as developed since about 1990 in the NHS. The critique will involve a perspective based on a relational model, in which 'users' will be recognised as in relation with their carers, rather than merely objects of care; and indeed 'carers' are, equally, in a relationship with their users. In other words the critical position is to focus on 'users' in context, and in the relational environment of care. Increasingly the discovery of the notion of compassionate care (DoH Commissioning Board, 2012), has begun to point to the human environment of relationship – the concern, feelings and generally of the psychic pain in providing and receiving care.

Diagnostic terms such as personality disorder, and role assignments such as 'user' even, will be used here only in their descriptive sense, and not in the labelling functions that allot persons to professional categories of abnormality or social role. The enquiry in this Chapter is a) whether such a contextualising of persons within relations may add to our understanding of care provision and its problems, and b) if it does so add, what does it lead to in terms of doing things differently.
The relational context of care
Consider,

_The patient was led into a quiet room for her relaxation therapy. She remained there with her nurse, who locked the door, and pressed a button on a tape machine which played for 20 minutes. The nurse sat down and appeared bored from over-familiarity with the tape. At the end the nurse switched off the machine, unlocked the door and led the patient out._

The occurrence is by all accounts not very uncommon and not at all exaggerated. It is not bad in that it follows a care pathway for the patient, observes ethical requirements, and manages health and safety risks. But, what, as the tutor might ask a class of trainee nurses, is wrong?

The answer depends on the point of view. In formal terms the nurse could not really be seriously faulted; the patient got her relaxation therapy. From another point of view, criticism might be strong; the context of the patient was assumed to be a machine playing a tape, whilst the relationship with the carer (the nurse in this incident) appeared to be relegated to non-existence. The role of care was interpreted as merely semi-custodial; keeping the door shut, switching the machine, and being a hand for possible crises. Any personal quality to this care functioning was preempted by a point of view that interpreted care in the strictly formal sense. What is demonstrated, hopefully, is that there are first of all different points of view about what care is.

Most people, if they were not a nurse on duty would find themselves rather averse to the formal, semi-custodial, and mechanical interpretation of the care depicted here. What makes a nurse, when she comes on duty, adopt that interpretation? She may have just dropped her child off at nursery, said goodbye to her husband with a kiss, rung mother about the visit at the coming weekend. I make this construction to emphasise that nurses providing care are actually emotionally sensitive, and normally related people. Only in the context of the relations at work, do they switch into another mode in which they interpret care in another way, a depersonalised and mechanical one.

Of course my construction may be wrong. The nurse may not have the ordinary relations of life. That may be common across the board of nurses. They may all be unfeeling battle-axes, at home and at work, alike. Is it the case that somehow this unit into which we glimpsed above has gathered into its recruitment net a highly selective set of such battleaxes why practice their profession in this way? No doubt
this is a research question which could be settled by the appropriate research design with data from the personality profiles of the nurses staffing the unit.

I am not going to report such a research project, though it would have been quite feasible to do. Instead, I want to explore another possibility. This is based on the hypothesis, that staff, such as the nurse depicted do in fact change their interpretive point of view in different contexts. This pressure of the human, relational, and group dynamic, context is in fact well-researched going back to the early social psychology experiments of Asch (1952), Sherif (1956), Milgram (1955) from the mid-20th century, and the Stanford Prison Experiment (Haney, Banks & Zimbardo, 1973).

A note on method
The method of investigation here is to develop a working hypothesis – that is, a hypothesis that does work in explaining the occurrences of events. There is not an attempt to test the hypothesis through its therapeutic outcomes. Rather it is tested in an alternative way. It is customary to make the assumption that a therapeutic approach is only testable by virtue of its yield of successful outcomes for users. This assumption is restrictive, and it requires the space of another paper to address this. It is sufficient, hopefully, to say that another method is appropriate for more subjective fields of study; this is a method which assesses the explanatory power of a hypothesis. In other words a theory that can explain more than a rival theory, has a claim to be a better theory (see for instance Edelson, 1984). This does not supplant the method of outcome study, but outcome evaluation needs to come after evaluation of explanatory scope.

In assessing theories, there are various characteristics; added to the two here – explanatory power, outcome success – there is also a criterion of plausibility; a theory that depended on the phases of the moon as determining of mood is less plausible before its explanatory scope, and outcome success are addressed. These issues relevant to the methodology of therapeutics cannot be further detailed in this Chapter, but lie behind the choice of method.

The search for explanation
Instead of re-doing such experiments, I want to develop a hypothesis about how such a thing can happen. In other words what the hypothesis has to cover is the fact that nurses who on the whole are highly caring people – in fact, the most caring that could be found probably – they end up bored, impersonal and unfeeling. Dubbing it ‘the Lucifer effect’, Zimbardo (2008) could speak as an authority on this process of corruption, having organised the experiment at Stanford. There, volunteers simulated guards and prisoners. The shock was that quite ordinary people became alienated brutalising guards, not simulating at all. This he said was a process connected to the Abu Graib atrocities. Inhumane behaviour occurred in Iraq.
when allied soldiers attacked and tortured civilians they were supposed to be protecting. Zimbardo tracked the cause to the anonymity of the guards, the de-individuating impact of uniforms, routines and so on. However such depersonalisation, and the bleaching of humanity from human relations had been well recognised throughout history. And in fact 50 years previously, Menzies (1959) described the depersonalisation that crept in and dominated the practice of nursing. She pointed to a very similar phenomenon but apparent in a very different institution. That kind of institutional pathology was then of great interest at the time, in the period following the Second World War and gave rise to the term 'institutionalisation' (Martin, 1952; Barton, 1959), with the classic account given by the anthropologist Irving Goffman in his book Asylums (Goffman, 1961) where he drew parallels between various 'total institutions', including prisons and mental hospitals.

Many processes in mental health services have negative results that go against the good intentions of the staff and hinder them in spite of themselves. Those with good intentions find themselves in organisational settings that they could not condone if they had a more objective view. In a way this is the saddest aspect, and yet at the same time it is the most human aspect of psychiatric care. Hardcastle et al (2007) in an original study addressed not just the users' reactions to the service and nits achievements, but those of the caring professionals as well. A number of individual cases were taken, at random, and personal stories of the experience of care in this case were gathered from the patient, doctor, nurses, relatives, social workers and so on. It presents a seriously disheartening account of the misperceptions and unread messages that appear to be endemic within a psychiatric unit.

Despite the prevalence of these descriptions of whole-institution phenomena, the problem has been to understand how this antithesis of care occurs even amongst those most committed to caring. Explanatory hypotheses have been difficult to generate, and until they exist, the what-to-do paragraph is difficult to write. I shall now develop such a hypothesis for consideration, but first we need to understand what it is that we need to explain. I shall draw attention to the following characteristics that appear resistant to explanation:

. The essentially self-defeating loss of compassion in humane work;

. the inability to bring the awfulness of one's own impersonal reactions to conscious awareness;
. the difficulty in reflecting on that loss;

. the observation that a depersonalisation and loss of identity is involved;

. and the observation that this is not merely an individual aberration but is collective within a specific institutional context.
This catalogue of features oversteps purely behavioural categories, and points to experiential ones, those of identity and a moral imperviousness in particular, also a severe restriction of awareness and self-awareness. Elementary features, the wearing of uniforms, seem shallow to explain the deep distortions of persons, work, and the care relationship.

The problem can be graphically illustrated in the following vignette. It points to certain relational issues that obtrude in the care setting. The example (Davies, 1996) is a team of carers involved in the rehabilitation of a serial offender. The professionals display their personal relatedness, which fails to deliver effective care, but instead becomes an involvement that risked potentially disastrous results. The following is my précis of the original account:

A disturbed man, Bill X, had a harsh mother as a child. She was violent and humiliated him. When released from prison where he had finished a sentence for brutal sexual crimes, he asked to be kept inside. The request was naturally refused. He subsequently engaged with the helping network in a specific way.

He was dangerous and a specific plan had been set out at the hostel he was to go to, to ensure that only male staff dealt with him. However the arrangements quickly broke done for extraneous reasons. He was taken into intensive counselling by a female worker; and a female prison visitor who had visited him in prison continued to see him, including taking him to her home where he assaulted her. Another female worker offered counselling, sometimes in evening sessions, and afterwards said she had forgotten he was a rapist! The female staff had been drawn into taking up powerful professional roles with him, to be inviting, and then to withdraw from him, giving him that intolerable feeling of powerlessness again.

So, the care network responded disastrously to his continuing disturbance. The staff did not seem to realise that the arrangements had broken down. What went wrong could be traced very specifically to a repetition of the experience of care the man had as a child. His mother was very powerful and controlling and continually made him feel powerless; he had effectively no father with whom to identify. His sense of male power was unpractised and uncontrolled. In the hostel the male staff disappeared – changed job, or went on courses, like the ineffective father, and the female staff did their best to take over, as mother had.

The staff seemed unable any longer to think about the client realistically, or even to remember his case fully. The fairly simple professional insight that his violent and humiliating criminal activity is connected with violence and humiliation he received from his mother seems never to have been usable.
Davies’ presentation arouses concern that the man’s evident wish to receive some sort of help for his internal state, was not ‘read’ by the helpers, and he progressed to further violent crimes, one of which was the assault on the female helper. There is commonly a problem ‘reading’ the plea for help from such troubled people. Instead, the carers, in this case, became caught up in the intra-psychic ‘drama’ of the person they care for. There is a very specific concurrence between the man’s own sought-after parent, and the actual carers he came across. His action of requesting to stay in prison, for instance, was outside the remit of the prison authorities, and no doubt felt bizarre even to the man himself. He was helplessly rejected. The attack on the ‘caring’ visitor lacked any conscious significance, but unconsciously spoke to his humiliation by women and the revenge he sought.

The deeply personal past, in which the Bill X was trapped, came to be represented in actual terms by the present selection of people. The women in the team became embodiments of the mother who caused such humiliation. This was predicted, consciously and a plan made, but, because of the obscure social forces, professional prediction changed to unconscious enactment without the staff realising how they had forgotten the prediction, or their professional task and work. The man’s demand was treated with a ‘care’ response, but not a reflective one. It was a sentimentalised sympathy, which passed as maternal caring, but in the event became his experience of maternal humiliation. Neither the man, nor the carers were able to articulate what was happening. No proper symbolisation, conscious representation, or thought survived. They unconsciously played out the man’s powerful issues, in the care context, and this interfered with the minds and work of trained professionals. They carried out their conscious tasks, apparently unaware of how this man’s conflicts were determining the care network. Such dramatisation, by staff, of the inner worlds of those in the institution, is a very common (but unrecognised) phenomenon (Hinshelwood, 1987). Thus the work of the team and of a whole service can be said to be affected by this process.

This vignette illustrates the main characteristics listed above. The staff succumbs to very odd identity issues, as if they play out roles for the index client, abandon the capacity for important professional thinking, and lose awareness of what is happening to them. The context is relational. The team, and, shall it be noted, the client himself, operated in relation to each other.

In the next section, I shall therefore pose a hypothesis on the basis of this account, which can be investigated for its ability to explain the phenomenon. It will take a critical position vis a vis the labelling function of the phenomena and the behaviour of individual personality traits that appear to be corrupted. It is not character traits that ‘behave’, but persons. And, in the present account, persons behave in the context of relations with other persons. The hypothesis adopts the view that much happens outside the awareness of people, in the gaps as it were within the relations between them, and creates what can be called an implicit culture, composed of shared and hidden (or unconscious) attitudes towards the work, and towards the subjects of care.
Subjective experience and the social defence system

The deeply internal impact of the work on the team collective is striking and demands that we turn to a psychology that is not driven by objectivity, but has its focus on the inner world of experience. There is only one direction in which we can turn. As Glen Gabbard said of psychoanalysis:

<<In an era of quick-fix managed care approaches and rampant biological reductionism, we can derive a great deal of gratification from the fact that we still see value in the unique subjectivity of the person who comes to us for help. We seem to be entering a new version of the Dark Ages, an era when treating others with understanding, compassion, and patience is viewed as cost-ineffective and too time-consuming. We can all take a measure of gratification from the fact that in this darkest of times, we are the bearers of the flame>> (Gabbard, 2000).

Disregarding the bitterness of the sentiment, Gabbard's import is that the bearer of the flame that enlightens the subjectivity of persons is the psychoanalyst's approach. Moreover, the critique implied is that cost-effectiveness is not so easily glossed over. Indeed the risks in Davies' case suggest that an insight into the subjectivity of the team, as it evolves together, is highly important, and is worthy of question, investigation, of the time involved, and of the costs should risks become actual.

What can the theory of anxiety and defence explain?

The single message is that there are hidden processes in individuals which emerge in relations with others (and therefore within groups) which players may often be unaware of. Psychoanalysis does not supplant the psychology of conscious experience, and of personal behaviour. But when mysterious things cannot be explained, it may be as well to check if the hidden world of the psychoanalyst has any explanatory leverage to complement the conscious psychology.

The psychoanalyst's focus is on psychic pain, and the way the human mind renders it subterranean. This is surely, on the face of it, worth looking into when considering such high stress occupations as mental health care, general nursing, custodial prison work, and the endangering career of a soldier in the army.

Against such assaults on the personality, the person takes cover. So, the hypothesis, I am proposing to test is the following:

*the stress of the task leads to processes largely outside of awareness that tend to distance carers from the stress, but in the process distort the task, the forms of practice, and the nature of care.*
This is not pathology, this is humanity. Moreover, the individual member of staff, the carer, is an individual in a context. And the context of the carer has multiple dimensions; it includes the impact of the user, plus the presence of other carers also working under similar impacts. Individually, and also collectively carers take action to protect themselves, from too much stress.

The hypothesis being developed is that the emotional impact on the individuals who provide care for people, spreads into effects on the organisation as a whole, on its sets of cultural attitudes, often implicit, and on the work practices which are determined by these attitudes. These are insidious processes that occur outside of awareness, and push attitudes and practices into forms that will alleviate some of the stress of the working activity.

Studies of the kind of impact on the organisation, arising from emotional stress that affects the members, have appeared regularly since Elliott Jaques psychoanalytic understanding of the unconscious process in a factory, and Isabel Menzies (1959) classical study of a nursing service. Organisational attitudes, working practices, and even the overall task of the organisation become adapted to this secondary goal of implicitly relieving stress. Menzies showed that the stress of nurses on long shifts with patients who are frightened, dying, mutilated, and in physical pain can be relieved by the implicit attitude and practical requirement that the nurse keeps an emotional and relational distance from her patients.

A long series of similar studies have been reported showing similar ways in which cultural attitudes and practices, defend the individually stressed carers from the impact of the stress: see also Miller and Gwynne (1972), and the numerous papers in Obholzer and Roberts (1994). These unconscious collective processes that Menzies found in general hospitals (Menzies, 1959; Skogstad, 2000), have been found in psychiatric hospitals (Donati, 1983; Rees, 2000; Chiesa, 2000), and in community care (Morris, 2000). The upshot of these empirical findings is the sad recognition that those of whom most tenderness in care might be expected, may become the most corrupted into depersonalising those they care for.

The objective approach
Psychiatric services deal with difficult people, those who society in general cannot. Forensic services deal with the most difficult of those difficult people (Gordon & Kirtchuk 2008). Then public opinion and government are surprised that it is such difficult work. My argument here is that such people are difficult because they make a difficult emotional impact on their carers. Then carers have to deal with themselves as well as their patients/clients. How we deal with ourselves in these services may not always be to the benefit of the patients, and I shall try to show how this hypothesis explains the sometimes detrimental deterioration of our services.

A while ago (Hinshelwood, 1999), I wrote about the effect of the scientific turn in psychiatry – with the question whether its specific culture is influenced by the emotional impact of the work. The culture within psychiatry has been increasingly
objective (in Britain, at least) over the last 30-40 years, and this derives from a number of obvious factors that come together.

One of the factors is the harvest of humane care that comes from accurate diagnosis and scientific treatment.

However, that is only one of the factors. There are others, which do not of course discount the importance of scientific work in clinical practice, but enhance it for other purposes. Such factors include:

1. there is a large overlay of professional pride, and competitiveness with other medical specialities that comes from being especially scientific;

2. marketing techniques are powerful, even when selling to professionally trained people, and drug companies have considerable financial resources to buy effective branding and marketing, which understandably they use for their best advantage when possible;

3. and there are issues not at all as open and available to view as the two above, but which arise from the problems of stress, demoralisation, and quite relentlessly constant challenge to the guilt and repair impulses of caring professionals. These espouse a scientific attitude because of the objectivity and emotional distancing inherent in science.

The increasing emphasis on an objective scientific approach is very striking in recent decades, and the success of pharmacology in creating highly psychoactive substances has alleviated a great deal of suffering in many of our patients; however that success has also gone along with side-effects that arise from scientific objectivity.

The hypothesis of this paper is that the emotional distance between staff and patients of the objective scientific approach can serve to protect mental health workers from the noxious and difficult emotional impact on themselves. For instance, people with schizophrenia are difficult because of their strange and meaningless behaviour and utterances. Psychiatric services can use scientific explanations to provide meanings which are lacking in their patients. However, the meanings that are substituted for their patient’s personal experiences are those of the material process of brain physiology and neuronal biochemistry. The person of the patient is left on one side. As we say he becomes depersonalised. The tendency is to exonerate the schizophrenic from responsibility for his behaviour and symptoms. Instead it is the illness that is responsible, and psychiatric carers relate in the first instance to his illness and not to his experience (see Barratt, 1996, for careful observation and description of these processes).

This is somewhat unfortunate since the patient’s actual experience is significantly confirmed by this approach. A central feature of schizophrenia is an existential one in which the person loses a sense of his own identity and self. Winnicott called it an
interruption in the sense <<of the continuity being>> (Winnicott, 1960). So I am indicating a kind of fit between the sets of attitudes in scientific psychiatry, and a specific feature of the schizophrenic experience. From both directions the patient feels less of a person, because of a) the disorder, and also b) the culture of professional carers. This unfortunate fit contributes to an enduring cycle of interaction which is a factor, promoting the well-known tendency for schizophrenia to become chronic.

In summary, cultural attitudes in psychiatry can be employed to help staff deal with the impact of their patients, whilst at the same time those attitudes make the task of caring harder and so have a self-defeating influence. Somewhat similar interactions occur in working with severe personality disorder people – with a similar combination of self-protection and self-defeat. Such a perverse result is another challenge for the hypothesis to explain.

**Why are SPD patients difficult?**
SPD patients confront staff with another challenge. Not one of meaninglessness. Severe personality disordered patients offer the opposite, a relationship too intensely suffused with human feelings – usually very unpleasant ones. These patients operate predominantly within a world of feelings. Characteristically, ‘personality disordered’, or ‘severe personality disordered’ patients', directly and deliberately (though unconsciously) interfere with our feelings. We feel intruded upon and manipulated. And indeed, we are. As Malcolm Pines wrote, we feel impelled to conform to a pattern imposed by the patient, so that we begin to feel provoked, hostile, persecuted and [have] to behave exactly as the patients need us to, becoming rejecting and hostile (Pines, 1978).

We are impelled in ways we are hardly aware of, yet follow. Our roles as professionals can become seriously distorted. One example is Richard Davies (1996) vignette I started with. His example is not necessarily usual in that the team tried very hard to accommodate this man, despite their emotional blindfolds. More frequently, the experience is disagreeable, and the obvious manipulative intrusions feel like a kind of abuse of us, of our time and our help.

As I wrote in a joint paper with Kingsley Norton. The trademark of SPD patients is an impairment of their interpersonal and social functioning. This makes it difficult to engage many of them in treatment since the clinical encounter with them is frequently marked by negative feelings, both in them but also in the staff involved in treatment. Intense and controlling feelings in the latter serve to perpetuate or aggravate an aggressive, or passive-aggressive, response from patients (Norton & Hinshelwood, 1996).

Given the mounting negativity – on both sides – it is not surprising that the mental health professional may indeed suffer his or her own painful mental disturbance. As a result, abrupt resignations, illness, anxiety, sudden and unexpected anger, inability to continue working with a patient, massive guilt feelings, despair, envy of patients'
acting out, helplessness and exhaustion faced with patients' devaluation have all been described (Greben, 1983; Drum & Lavigne, 1987; Miller, 1989). In this way, the care role fails, and the mental health professional, despite his training, is in danger of being overwhelmed.

The professional reacts very differently with people with this kind of impaired relating, compared with his/her reactions to patients with schizophrenia (or with the interpersonal dynamics of other patients). With severe personality disorder, the patient is not depersonalised into an object, but instead strongly retains moral qualities, expressed in a series of condemnatory labels – ‘bad’ rather than ‘mad’. Diagnostic categories such as psychopath or hysteric mean more usually, ‘The patient is not ill at all and is wasting our time’. The use of diagnostic categories betrays again the attempt to climb into a scientific attitude immune from the emotional turmoil. But here it is a thin disguise for a psychiatrist who has lost his role, and finds himself an ‘abuser’.

His barely concealed angry rejection often confirms the life experience of such patients whose carers have in fact proved rejecting or worse. A very large number of these patients have a personal history of childhood abuse from the people who are supposed to care. It may not be physical abuse, but psychologically and emotionally inappropriate handling that displays a lack of empathic response. The outcome for such children is an adulthood in which they persist in equating care with abuse. Confronted in this emotional way, by a new carer, the SPD patient may frequently proceed with considerable suspicion and unresponsiveness. This has disastrous effects.

The carer expects and assumes his patient will acknowledge the care, and will show due appreciation. When his care is treated with suspicion and as if it were abuse, he can feel affronted, offended, and condemned. In short he feels his care is abused by his patient. As a result he is in difficulties with this patient, feeling angry at someone for whom he is supposed to remain caring. At this point it appears the carer may go in two possible directions. One is that his professional super-ego and guilt leads him to bend over backwards to accommodate, as in Richard Davies vignette, trying ever more desperately to get his care acknowledged for what it is. By pursuing confirmation of his caring capacities, he risks losing his professional judgement. The other reaction is to become actually rejecting as if the patient has indeed become a harsh and judgemental super-ego. Then he may discharge the patient from the service or perhaps refer him on to another service. In either case, he ceases to see the patient as in fact a patient he has become an abuser of the carer.

Here is another instance in which the reaction of carers to the difficulties they suffer from the impact of looking after the most difficult people, has side effects. With SPD patients it is a little more complicated, and a lot more emotionally disturbing, than with schizophrenic patients. Caring for SPD people leads to being invaded and taken over, whilst his charge regards him as an abuser of someone already traumatised. In these various ways, the staff of services caring for SPD may become similarly caught up in psychodynamics that act out the impact or avoid the
pain of the impact of working with difficult patients who, having been abused, tend to pass on the experience to their carers. In many ways, staff deals with the guilt and pressure by going along with ways of relating that are determined by their patients. Partly to appease the apparent need, and partly to reduce the stress that presses in on the workers, they take the easy way out. What is difficult is to protect the capacity to think about these experiences as illustrated in the Davies example. And specifically to think about the pressures that mould the experiences. That capacity to reflect and even know themselves as professionals can be inhibited and lost, as we saw.

Results
It is possible to claim that the hypothesis we developed does have an explanatory value vis a vis these apparently self-defeating processes that can be found in high stress caring institutions. Most staffs are extremely dedicated, well-intentioned and do a great deal of good for their patients. What we need to explain are certain unacceptable and hitherto unexplained negative developments that go on in the culture of these high-stress institutions, and in the individual persons working there as carers. And it is now possible to understand and explain these more negative developments as unfortunate, collective, and seemingly hidden modes of trying to cope.

What to do
The hypothesis that the particular tensions described in this paper result in damaging consequences for the team, may be tested in various ways. First as I have shown the hypothesis has a wider explanatory scope, but a further test is its practical application. The test is whether it leads to ways of working with better results – better outcomes. The kinds of outcomes that count as 'better' is itself a research question, and cannot be dealt with here (but see Hinshelwood 2002). Instead here I shall give an illustration which has features in common with the earlier vignette of the ex-prisoner who put out of action the professionals' ability to think about the case, Bill X in the Davies example. The problem of managing these processes is that they are not apparent to the objective eye. They creep up surreptitiously from behind. As in all instances of the effects of the unconscious life of individuals it is difficult to manage them consciously. Thus those minds that are impacted upon, need the opportunity to think through their experiences in a setting that is not exposed to the impact. They need to find a state of mind that can take the entrusted experiences from those patients and recast them in some therapeutic way – avoiding as far as possible those defensive means of dealing with the projected experiences. Because the unconscious effects are so strong, SPD patients were for a long time regarded as untreatable. Interestingly however, they have recently been deemed amenable to treatment. They are no longer <<a diagnosis of exclusion>> (NIMHE, 2003). Can, therefore, the loss of objective thinking be
compensated for by a some designed and managed input? – that is, to institute a reflective space.

There is in fact a long history of treating personality disorders, known since 1946 (Main 1946) as the therapeutic community method. This is of considerable relevance to what I have been saying about the potential for major enactments in the relations made by SPD people. Although in residential care of any kind, SPD patients do create enactments amongst their colleague patients, in the therapeutic community these incidents are kept especially under review, reflected upon, and subjected to therapeutic commentary. In other words, the staff has a new field of observation available for them. Though reflective thought is severely inhibited, the therapeutic community can offer a crucially different opportunity in this respect. Staff can gain a reflective distance from enactments in the community as a whole, and they are not confronted with them on a face-to-face individual basis. Staff need to think together about how the community (including themselves) may be caught up in the unconscious dramatisations. There are a number of ways in which this is important which I would like to list, but first I shall give an example from a therapeutic community.

The community was organised for this kind of thoughtful reflection. In this instance the unwittingly playing out roles was brought into professional thinking. In this example two key workers were able to discuss their particular dramatisation for a patient Joe. Here is how it happened:

Joe, an adolescent was transferred from a private service where he had been an in-patient for over a year. He had been admitted because of depression, self-harm and suicidal risk. The therapeutic relationship had broken down. The admitting Consultant Psychiatrist then made a referral to the adolescent department of the Cassel Hospital, a tertiary SPD service run as a therapeutic community, to which he was subsequently admitted. Once there similar patterns of non-communication were soon replicated at different levels of the community i.e. he would remain silent during his individual therapy sessions and would isolate himself in his room for long periods. The relationships with his primary workers (the key nurse, and the therapist) developed a deep split.

He experienced his therapist (a man) as insensitive, threatening and unable to offer any understanding or help. In the countertransference, the therapist felt frustrated, useless and jealous of the closer and more constructive relationship Joe had with his female nurse. These two divided as a working couple. They were only able to discuss Joe's situation in a joking manner seemingly as an avoidance of the feelings that a more meaningful discussion might evoke. Joe's efforts to split the 'couple' of nurse-therapist reached a climax when he wrote to the Consultant of the unit asking for his therapist to be changed. The tension around Joe's care was manifested as a difficulty that his primary workers had in having a professional discussion.
This was explored in a joint session with senior members of the team during the nurse-therapist supervision. Significantly, it was noted that in a recent family meeting, the lack of communication in Joe's family, particularly between his parents, had been highlighted. The family was dominated by the ineffectual parental relationship, which somehow had been recreated in the roles of the staff in the hospital.

In the course of this discussion, the therapist and nurse could start a more open exchange of feeling and this continued in other more informal settings. Joe’s despair and failure – felt in this instance by the therapist – met, in a new way, a much more helpful and encouraging side (carried by his nurse).

A plan was made with the nurse to encourage and support Joe's attendance at his therapy sessions. In the thinking space provided by the nurse-therapist supervision the omnipotent and destructive fantasies behind Joe's request for a change in therapist, something he had managed to enact in other care settings, were understood and challenged. The therapist became more aware of the origin of his counter-transference feelings. The internal conflict in Joe between despair and hope were recognised as dominating both family and community. With the greater integration within the staff team, Joe could begin to reconcile the divisions he had made within his relationships and in himself. He successfully attended his therapy sessions during the rest of his time at the Cassel Hospital and was able to express and work through his feelings towards the therapist in a new way and to move on to think about his discharge plans. Nurse and therapist, too, were able to communicate more efficiently in this important phase around Joe's follow-up plans (Santos & Hinshelwood, 1998).

Admittedly this is not as grave a form of acting out as is frequently encountered, but it enables us in slow motion as it were to observe the important feature of the reflection. There are several features which contribute to this being a successful piece of reflection:

1. the individual carers were able to feel they can work something out and to increase the scope of their awareness, and thus to feel less helpless;

2. with this sense of awareness they were enabled to resist playing a part in the way that the carers in Davies' example did succumb;

3. to reflect on the occurrences, is not to reject, as so often occurs. Instead a recognition developed in the key workers, so they could be with, or remain with, the disturbance without being overwhelmed by it;

4. perhaps most significant of all, the two members of staff were able to speak together in a constructive and fruitful way, in fact in a manner that did not replicate the implicit divorce that existed between Joe's parents;

Funzione Gamma, rivista telematica scientifica dell'Università "Sapienza" di Roma, registrata presso il Tribunale Civile di Roma (n. 426 del 28/10/2004) www.funzionegamma.it
5. and finally in consequence, Joe was, shall we say, better held, in the hospital’s parental embrace, able to resume a therapy process.

In connection with the last of these factors, the fruitful interaction of the staff together, in a way that contrasted with Joe’s experience of carers, I have in mind a short quote from Elliott Jaques:

<<Individuals may put their internal conflicts into persons in the external world, unconsciously follow the course of the conflict by means of projective identification, and re-internalise the course and outcome of the externally perceived conflict by means of introjective identification>> (Jaques, 1955).

In Joe’s case he was able to insert his problematic ‘parents’ into the persons around him in the external world, and there to witness them at variance with each other. However in this instance, the parental roles adopted by the carers created a situation in which Joe could witness the course of this parental conflict and as a result offered him a model for greater integration in himself.

The outcome of the use of this hypothesis/theory was indeed the possibility of a continuing therapeutic relationship, and a treatment success, at least in terms of the patient’s return to a normal life. This is one success only but it indicates that the hypothesis does not just have explanatory power, but promises at least some outcome success.

Conclusions
The speculative hypothesis developed has been investigated in various ways. It postulates unconscious collaboration in developing cultural attitudes which distort the work, the practice, and the effectiveness of treatment in psychiatry especially with difficult patients. First the hypothesis appears to be explanatory of occurrences which can only be weakly addressed by other hypotheses drawn from social psychology, and from the criticisms about the limitations of training. And secondly at least one case shows that the explanatory power follows through as a treatment success, in this category of notoriously difficult and frequently rejected kinds of people.

We started by applying a critical leverage to the current over-emphasis on objectivity and the social construction, by care organisations, of an isolated individualism in contrast to the context of the client plus his carers. The outcome of an objective approach fails to touch the subjective aspect of the care culture. Instead, using the example especially of severe personality disorder, a simple relational hypothesis was based on 'inner' subjective aspects of reacting to each other. The simplicity is however belied by non-awareness of the threatening impact that this dimension of care work has on workers (and even perhaps on the readers of research papers on care work!). The testing of the hypothesis offered has led to explanations of largely unexplained occurrences which dishearten and demoralise carers and lead to less good
provision for users. The results of the success of this hypothesis, is not to advocate a technical role, a mechanical or scientific technology. Carers find they need to seek each other out for support, personal involvement, and to participate in reflection. In the end it is not just what carers do, nor even what they think and express, it is how they are and how they relate which counts.

It is because they are living, acting, relating beings that they can care, and provide the specific attention. And moreover, an approach restricted to simple objective evaluation is just that, it is over-simple and simplistic (Hinshelwood, 1999; 2010). The importance of being in a relational context is not something that can be taught; it is merely being human. Instead, what may be teachable is the capacity to reflect on relational contexts. For instance a series of Workshops have been conducted over a number of years set up with the aim of learning from action within relationships (as opposed to words), and reported by Hinshelwood et al. (2010).

Even limited successes in this direction are of great importance; the capacity to participate in a living situation is enormously heartening, to users and carers alike. It is the wish to engage with those who suffer that takes us into the business in the first place, and the ability to retain a real engagement with that suffering is the core of the job satisfaction we seek. The widely offered means and attitudes for escaping to a distance from the impact of the suffering, and towards scientific objectification, is one of the saddest things about our work, since it takes us away from the satisfactions we most seek. Finally, it has to be left to a later communication to discuss the choice of method. Here, a hypothesis is tested by estimating its explanatory value, not in the first instance its outcome achievements. This method, known in the language of logic as 'inference to best explanation' (see for instance, Hacking, 2001), may be as indicative as empirical outcome studies, but is neglected.

The importance of understanding that we have more than one kind of method for testing our hypotheses is great, as we need to address the phenomena a hypothesis explains – such as, in the present instance, the demoralisation of those working in psychiatry with SPD patients. It is not in fact very useful to test by outcome, theories for which there is no explanatory scope, or even those for which there is unknown scope. Once we have hypotheses with explanatory scope, then we can then point to new 'action paragraphs' to be tested by outcome. The evidence of this paper is that our hypothesis can find specific ways of thinking and working that are informed by proper explanation.

References


Funzione Gamma, rivista telematica scientifica dell'Università "Sapienza" di Roma, registrata presso il Tribunale Civile di Roma (n. 426 del 28/10/2004) www.funzionegamma.it
R. D. Hinshelwood, is a Fellow of the British Psychoanalytical Society and a Fellow of the Royal College of Psychiatrists. He was Clinical Director of the Cassel Hospital 1993-1997, and since 1997, Professor of the Centre for Psychoanalytic Studies- University of Essex, UK. He is author of Dictionary of Kleinian Thought (1989), and Clinical Klein (1994); and more recently author of Suffering Insanity (2004), and Research on the Couch (2013).

e-mail: rhinsh@essex.ac.uk