5. *The Ailment*

BY T. F. MAIN

When a patient gets better it is a most reassuring event for his doctor or nurse. The nature of this reassurance could be examined at different levels, beginning with that of personal potency and ending, perhaps, with that of the creative as against the primitive sadistic wishes of the therapist; but without any such survey it might be granted that cured patients do great service to their therapists and nurses.

The best kind of patient for this purpose is one who, from great suffering and from being in danger of losing his life or sanity, responds quickly to a treatment that interests his doctor, and thereafter remains completely well; but those who recover only slowly or incompletely are less satisfying. Only the most mature of therapists are able to encounter frustration of their hopes without some ambivalence towards the patient, and with patients who do not get better, or who even get worse in spite of long devoted care, major strain may arise. Those who attend the patient are then pleased neither with him nor with themselves and the quality of their concern for him alters accordingly, with consequences that can be severe for both patient and attendants.

We know that doctors and nurses undertake the work of alleviating suffering because of deep personal reasons, and that the practice of medicine, like every human activity, has abiding, unconscious determinants. We also know that if human needs are not satisfied they tend to become more passionate, to be reinforced by aggression and then to deteriorate in maturity, with sadism invading the situation, together with its concomitants of anxiety, guilt, depression, and compulsive reparative wishes, until ultimate despair can ensue. We need not be surprised if hopeless human
suffering tends to create in ardent therapists something of the same gamut of feeling.

It is true that he who is concerned only with research and is less interested in therapeutic success than in making findings will not be frustrated by therapeutic failure; indeed, he may be elated at the opportunity for research it provides; but such workers are not the rule among therapists. In much of medicine it is not difficult to detect something of the reactions I have described, together with defences of varying usefulness against them. An omnipotent scorn of illness and death, the treatment of patients as instances of disease, the denial of feeling about prognosis, are devices some doctors use to reach at something of the detachment of a research worker, which permit them to continue their work without too painful personal distress about the frustration of their therapeutic wishes. Refusal to accept therapeutic defeat can, however, lead to therapeutic mania, to subjecting the patient to what is significantly called 'heroic surgical attack', to a frenzy of treatments each carrying more danger for the patient than the last, often involving him in varying degrees of unconsciousness, near-death, pain, anxiety, mutilation, or poisoning. Perhaps many of the desperate treatments in medicine can be justified by expediency, but history has an awkward habit of judging some as fashions, more helpful to the amour propre of the therapist than to the patient. The sufferer who frustrates a keen therapist by failing to improve is always in danger of meeting primitive human behaviour disguised as treatment.

I can give one minor instance of this. For a time I studied the use of sedatives in hospital practice, and discussed with nurses the events that led up to each act of sedation. It ultimately became clear to me and to them that, no matter what the rationale was, a nurse would give a sedative only at the moment when she had reached the limit of her human resources and was no longer able to stand the patient's problems without anxiety, impatience, guilt, anger, or despair. A sedative would now alter the situation and produce for her a patient who, if not dead, was at least quiet and inclined to lie down, and who would cease to worry her for the time being. (It was always the patient and never the nurse who took the sedative.)

After studying these matters the nurses recognized that, in spite of professional ideals, ordinary human feelings are inevitable, and they allowed themselves freedom to acknowledge not only their positive but also their negative feelings, which had hitherto been hidden behind pharmacological traffic. They continued to have permission to give sedatives on their own initiative, but they became more sincere in tolerating their own feelings and in handling patients, and the use of sedatives slowly dropped almost to zero. The patients, better understood and nursed, became calmer and asked for them less frequently.

This story is, of course, too good to be true, and I have to report that since then occasional waves of increased consumption of aspirin and vitamins have occurred. Such a wave seems to have little to do with patients' needs, for it occurs whenever a new nurse joins the staff or when the nursing staff are overworked or disturbed in their morale.

The use of treatments in the service of the therapist's unconscious is — it goes without saying — often superbly creative; and the noblest achievements of man in the miracle of modern scientific medicine have all been derived therefrom. It is deeply satisfying to all mankind that many ailments, once dangerous, mysterious, and worrying, offer the therapist of today wonderful opportunities for the exercise of his skill; but with recalcitrant distress, one might almost say recalcitrant patients, treatments tend, as ever, to become desperate and to be used increasingly in the service of hatred as well as love; to deaden, placate, and silence, as well as to vivify. In medical psychology the need for the therapist steadily to examine his motives has long been recognized as a necessary, if painful, safeguard against undue obtrusions from unconscious forces in treatment; but personal reviews are liable to imperfections — it has been well said that the trouble with self-analysis lies in the counter-transference. The help of another in the review of one's unconscious processes is a much better safeguard, but there can never be certain guarantee that the therapist facing great and resistant distress will be immune from using interpretations in the way in which nurses use sedatives — to soothe themselves when desperate, and to escape from their own distressing ailment of ambivalence and hatred. The temptation to conceal from ourselves and our patients increasing hatred behind frantic goodness is the greater the more worried we become. Perhaps we need to remind ourselves regularly that the word 'worried' has two meanings, and that if the patient worries us too savagely, friendly objectivity is difficult or impossible to maintain.

Where the arousal of primitive feelings within can be detected
by the therapist, he may, of course, put it to good use, and seek to find what it is about the patient that disturbs him in this way. There is nothing new in categorizing human behaviour in terms of the impact upon oneself — men have always been able to describe each other with such terms as lovable, exhausting, competitive, seductive, domineering, submissive, etc., which derive from observation of subjective feelings; but the medical psychologist must go further. He must seek how and why and in what circumstances patients arouse specific responses in other human beings, including himself. If only to deepen our understanding of the nature of unconscious appeal and provocation in our patients, we need better subjective observations and more knowledge about the personal behaviour of therapists; and if such observations lead us also to the refinement of medical techniques, so much the better.

To use an analogy: it is one sort of observation that some gynaecologists seem to have a need to perform hysterectomies on the merest excuse; it is another that some women seek hysterectomy on the merest excuse. It is not easy to say about a needless hysterectomy which of these is the victim of the other’s wishes, which has the more significant ailment, and which derives more comfort from the treatment. In a human relationship the study of one person, no matter which one, is likely to throw light on the behaviour of the other.

In the light of these considerations I propose to discuss some events in the hospital treatment of a dozen patients. All were severely ill and before admission had received treatment at the hands of experts; some had already been in several hospitals and had received many treatments. Further treatment likewise did little to help them; for none was really well upon discharge from hospital and most were worse. The diagnoses vary from severe hysteria and compulsive obsessional state to depressive and schizoid character disorder. The patients were admitted at different times over a period of two and a half years, but I came to group them as a class of distinct feature because of what happened. The last of these patients was discharged over five years ago [before 1952], but I am still ashamed to say that I was pushed into recognizing common features by nursing staff who compelled me to take notice of events that had been for long under my nose.

It began this way. The nurses were concerned about a number of their members who had been under obvious strain at their work, and sought to know if this could be avoided. It was a question relating not to unstable women whose distress could have been regarded merely as personal breakdowns unconnected with work, but rather to valuable colleagues of some sophistication and maturity. The senior nurses met with me to discuss this matter, and I found that they were aware of several episodes of severe individual strain, almost of breakdown, that had occurred over the past three years. I had known of two breakdowns of clinical severity, but I was not aware of the others, which had been concealed by the individuals in question. These were now discussed in the open and every case was found to have been associated with the nursing of some particularly difficult patient who had not improved with treatment, and who had been discharged not improved or worse. These patients had been the subject of much discussion during and after their treatment, but even with the passage of time the nurse concerned had been unable to reach a workaday acceptance of the bad prognosis and the failure of treatment. We now found that in spite of having made intensive and praiseworthy efforts with these patients, far in excess of ordinary duty, at least one nurse — sometimes more — felt that she had failed as a person, and that if only she had tried harder, or known more, or been more sensitive, the failure would not have occurred. This feeling ran side by side with another — a resentful desire to blame somebody else, doctor, colleague, or relative, for the failure. Each nurse who felt thus was regarded with sympathy and concern by her colleagues as having been associated with patients who were dangerous to the mental peace of their attendants.

It was decided to meet twice a week as a group and to make a retrospective study of all cases that the group listed as major nursing failures. The list contained the dozen names of the patients I mentioned earlier. At that time none of us knew that we were setting out on a trail that was to take us months of painful endeavour to follow.

THE RESEARCH METHOD

At first it was difficult to discuss these patients except by resort to the rather lifeless terms of illness, symptoms, and psychopathology, medical and nursing procedures and intentions, and we made little headway. We had yet to discover the potency of group
discussion as an instrument of research into relationships with patients. Slowly, following clues in the discussion, the group turned its attention to matters of private feeling as well as professional behaviour with these patients, but this was not easy, especially at first, and many times the group ran into difficulties revealed by silences, depressed inactivity, frightened off-target discussions, and distaste for the investigation by one or more of its members. Sometimes I was able to interpret the difficulty, but the other members did so as often. The group was tolerant of the difficulties of its constituent members, and was ready to slow up and wait for anyone who had found the development too fast or the going too heavy, but it stuck to its task and grew the courage step by step to reveal a surprising pattern of old unsettled interpersonal scores hitherto unrecognized by all of us, which had revolved around the nursing of these patients. Private ambitions, omnipotent therapeutic wishes, guilts, angers, envies, resentments, unspoken blamings, alliances and revenges, moves towards and against other nurses, doctors, and patients' relatives, were shown now both to have animated some of the nursing procedures offered these patients, and to have been concealed behind them. We had known that these patients had distressed the nurses, and had called forth special effort by them, but we were astonished to find out how much this was so, and how much feeling and complex social interaction had lain behind the events of patient management.

All the patients had been in hospital for several months and we turned next to study the records of their daily behaviour. From discussion of these the group was able to reconstruct and relive in detail, with more or less pain, the covert configuration of emotions within which these patients had been nursed. We were all aware that the therapeutic passions and intrigues which the group now proceeded to examine with frankness, and more or less pain, were matters of the past, but there was solid agreement—in which I share—that they could not have been examined in vivo and that the truth about them could be admitted to common awareness only after time had allowed feelings to cool and wounds had been licked. We were also agreed that only a group could achieve the capacity to recall past events with the merciless honesty for detail and corrections of evasions and distortions that this one required from and tolerated in its members. With each patient discussed, the nurses gave courage to each other and growing insights were used more freely, so that with later cases it was easier for the nurses to recognize and describe the quality of the patients' distress and their own emotional and behavioural responses to it. Finer observations were sometimes made about the later cases, and, when this was so, the earlier cases were re scrutinized for the presence or absence of corresponding phenomena.

All findings about any event had to be unanimously agreed by those involved before they were recorded. This led to difficulties when the behaviour of doctors came under discussion, for the group contained none. We now determined to invite the doctor concerned with the case when it was under discussion, but this was not a success. The group was now a year old and had grown an unusual capacity for requiring the truth without reserve, and a frankness about emotional involvement with patients, together with a number of sophisticated concepts which presented difficulties for anyone who had not shared in the development of the group's work. Moreover, the group was anxious to get on and was no longer as tactful about personal reticence as it had been when it began. One doctor refused the group's invitation. Two came once, but one declared afterwards that his job was with the patient's psychopathology and not with staff behaviour. (He borrowed the group's findings on one of his patients a year later and lost them.) A fourth came twice and was manfully helpful about his own involvement but was much upset by painful revelations. It must be remembered that these patients were not only nursing, but also medical failures, and, as I hope to show, had a remarkable capacity to distress those who looked after them.

The doctors were very willing to discuss their patients in terms of psychopathology and of treatment needed and given, but were uneasy when it came to matters of personal feeling. They could not discuss the details of their own difficult personal relationships with these patients, even in obvious instances of which the group was now well aware, except defensively, in terms of self-justification or self-blame. The group members were prepared for the doctors to have the same difficulties in discussing old staff mistrusts and covert manoeuvres over patients as they had experienced themselves, and were sympathetic when these proved too great to allow quick collaboration. The nurses already knew much about the doctors' behaviour with all of these patients, and, while critical, they were also charitable about it because it had been so...
similar to their own. It was clear to all how hard the doctors had tried with their patients, how they had worried, as had the nurses, had stifled their disappointments, and made further efforts, and how they, too, had worn themselves to their limit. It was soon clear that it was unfair to expect them to contribute freely about these matters, for they had had no opportunity of developing in the group, of sharing in its members' growth from reticence to frankness, in their pain of overcoming resistances, and in their pleasure at finding new ways of viewing their own behaviour. As one nurse said: 'You have to go through it yourself before you can feel easy about what we have found.'

The doctors' views outside the seminar were that these difficult patients needed better diagnosis, better interpretation of ever more primitive feelings, more precise understanding. They, too, were inclined to feel very responsible for the failure of treatment, to search for defects in themselves, and to hint at blame of others in the environment - nurses, doctors, or relatives.

Now these attitudes were exactly those with which the nurses had begun. The research group had to decide whether to put the brake on its own adventures and wait for the doctors to catch up in sophistication, or to continue without them, with all the deficiencies of information this would mean. The doctors, forewarned of difficulties and of criticism, and lacking the same group need as the nurses to investigate occupational hazards, had also carried more responsibility and were certain to experience problems in the group. These matters would plainly make for heavy going and, I felt, would complicate an already difficult section. We therefore surveyed the responses evoked by them and this account is the poorer thereby. The doctors' troubles with these patients are, however, known in general outline, and at least some features of their behaviour were made plainer.

We proceeded with our survey of hospital events in detail and then we came to the question of how far the patients' behaviour had been characteristic not of them but rather of the hospital setting. We therefore surveyed the responses evoked by them in others prior to admission and we made an interesting finding. In hospital, because they had received all sorts of unusual attentions, we had come to refer to them in the group as 'the special patients'. Now we found that they had been 'special' in the eyes of other people before they had come into hospital.

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Prior to admission these patients had evoked in their attendants something more than the exercise of practised skills. The referring doctors were level-headed people, some of ripe judgement and deserved reputation, but each felt his patient to be no ordinary person and each asked that she be given special status and urgent special care. They made special appeals, and in their concern and distress were not content that their patients should be scrutinized and admitted by the ordinary procedures of the hospital. They made almost passionate demands for the waiving of routines because of the patients' distress, and they stressed the special helplessness and vulnerability of the patients in the face of stupid judgements.

The fact that some of these patients had been in mental hospitals and that several had a history of self-destructive acts in the past was mentioned - if at all - not as of warning significance but as an example of former wholly unsuitable handling. In two cases there was a clear statement that if the patient was not admitted soon, she would have to go to a mental hospital, the implication being that this disastrous step would be all our fault. Great stress was laid on the innate potential of the patient and the pathetic and interesting nature of her illness. Poor prognostic features were concealed or distorted and the group learned to recognize the phrases 'Well worth while' and 'Not really psychotic' as having been ominous special pleadings. Personal relationships and past obligations between referrer and hospital doctor were traded upon where present, and four of these cases were first mentioned at friendly social gatherings after the hospital doctor had been offered drinks and a meal by the referrer. In every case the referrer also spoke to
the hospital several times by telephone and sent one or more letters.

The referrers had all decided that their patient needed intensive psychotherapy and wished to leave little choice of decision to the hospital. Some seemed to fear that nobody but the patient's distress, and wanted to rid themselves of their responsibility, with professions of goodwill. Concern for the patient was emphasized; impatience or hatred never. They asked for help for the patient of the kind they had devised, and wished to leave so little choice to us that it seemed as if we had to be their omnipotent executive organ. It was clear that whatever admission to hospital might do for the patient, it would also do much for them.

In some cases the patient belonged to more than one doctor at once, having gone from one to another without being, or wishing to be, fully relinquished by the first; but there was little consultation between these doctors, and entry into hospital was then less an agreed policy between all doctors and relatives than a determined act by the referrer wishing to rescue the patient from a situation and from people he secretly mistrusted.

All these patients were female. This gives no surprise in a hospital where two-thirds of the patients have always been female, but it may have other significance. Eight were either doctors, or doctors' wives, daughters, or nieces, or were nurses; a ninth had given blood for transfusion and then because of sepsis had had her arm amputated, with great uneasiness among the surgeons concerned. These medical connections are not typical of the usual hospital admissions, and raise the interesting possibility that these were patients who sought intense relationships with therapists because of their personal past (all of us have heard the story of the doctor's son who said that when he grew up he was going to be a patient). At all events, the referring doctor's freedom of decision was made more complicated by such a medical background, and his prestige in his local medical world was sometimes at stake.

IN HOSPITAL

I shall not describe the patients' personal histories, complaints, symptoms, moods, personal habits, or the classical diagnostic features of their various states. These were of a kind commonly found in mixed psychiatric practice with severely ill patients, and none explains the nature of the object relations, nor why they, more than other patients with similar diagnoses, became 'special' and invoked in their attendants so much omnipotence and distress, so great a desire to help, and so much guilt at the gloomy prognosis.
Rather, I shall describe something of their behaviour and of the behaviour of the staff.

The last of these patients was discharged over five years ago and all the staff concerned have learned a lot since then, but it would be a mistake to suppose that these patients were in the hands of beginners, either in psychotherapy or in nursing. Of the seven doctors involved, at least three would be regarded as experts, two as well trained, and the others as serious apprentices. The nurses were all qualified but fairly young, and, like the doctors, keen to do good work. None of the staff — this may be a severe criticism — was of a kind that would easily admit defeat.

Each of these patients became 'special' after entering the hospital, some almost at once, others after a month or two. This was not only because of the referring doctors' wishes, their histories of ill-treatment by others, their difficult lives, or their medical relatives, but because of something in themselves. Not all severely ill patients are appealing; indeed, some are irritating; but all of these aroused, in the staff, wishes to help of an unusual order, so that the medical decision to treat the patient in spite of manifestly poor prognosis was rapidly made. The usual open assessment at staff conference tended to be quietly evaded, made indecisive, or regarded as unnecessary; or it was avoided by classifying the treatment as a special experiment. Each patient was felt to be a worthwhile person, who had been neglected, who could not be refused, and who, with special sensitive effort by all, should be given whatever chance there was without any red-tape nonsense. To every occasion one or other of the nursing staff also rose above her best, wishing to make a special effort to help, to rise above 'mere' routines, and to be associated with a compelling case in spite of the extra work it would seem to involve.

It is interesting that under special arrangements all of these patients fairly quickly acquired special nurses, usually one, occasionally two. Thereafter, this nurse engaged upon a relationship with the patient that became closer than usual, and both, because of the sharing of crises, became closely in touch with the therapist outside of the usual treatment sessions or case conferences. These nurses were regarded by the doctors and the patients and themselves as having a special feel for the patients' difficulties and a quality of goodness and sensitivity that was all-important.

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The group came to call these features the 'sentimental appeal' (from the patient) and the 'arousal of omnipotence' (in the nurse). The nurse thereafter soon came to feel that she possessed a quality that the others lacked, and began to protect the patient from unwelcome hospital routines and unwanted visitors or staff. She would instruct other staff how they should behave towards the patient and directly or by scheming would ensure that the patient's need for special privileges or freedom was granted without much demur. She would modify or evade hospital procedures if these were distasteful or upsetting for the patient and be much more permissive and tolerant of special demands than was her usual custom.

The patient's need for special attention was, however, never satisfied except for the shortest periods, so that the nurse was led to demand ever more of herself. She came to feel that distress in the patient was a reproach to the insufficiency of her own efforts, so that the handling of her patient became dictated less by her decisions and more by the patient's behaviour. Most of these nurses believed, and were supported by the patient's doctor in their belief, that their efforts for the patient were of great significance, and that, by being permissive, even at heavy cost to themselves, they were fulfilling unusual but vital needs in the patient. The nurse usually felt that where others had failed the patient in the past by insensitive criticism, she, by her devotion and attention to the childlike wishes of her patient, could sufficiently still turbulent distress, so that the doctor could better do his work of interpretation.

As week after week went by the patients became more disturbed, but this was seen only as evidence of how ill they always had been basically, and of how much more devotion they needed than had at first been imagined. The nurse would remain with her patient during panic, anger, depression, or insomnia, soothe her with sedatives, in increasing amounts, protect her from unwelcome situations or unwanted stimuli, ensure that she had special food and accommodation, and special bedtimes, and was given attention immediately she needed it. More time, more sessions, more drugs, more attention, more tact, more devotion, more capacity to stand subtle demand, abuse, ingratitude, insults, and spoken or silent reproach were required of the nurse by the patient and by the 'in-group' around her, doctors and colleagues. The
patient's wishes, covert rather than overt, were felt to be imperious in that they should stand no delay. Crises occurred of anxiety, depression, aggression, self-destructiveness. The nurse might have on her hands a patient sleepless, importuning, and commanding attention, distressed if the nurse wanted to go to the toilet or for a meal, liable to wander cold in her nightdress, perhaps ready to burn herself with cigarettes, bang her head against the wall, cut herself with glass, or dash outside. The nurse's time and attention became ever more focused on the patient so that she would voluntarily spend part of her off-duty, if necessary, with the patient.

The favourite nurse came to believe, from subtle remarks by the patient, that the other nurses, good and effortful though they were, did not have the same deep understanding, so that she would become the patient's unspoken agent, ready to scheme against and control colleagues whose behaviour she felt, through no fault of their own, to be unsuitable for her patient. Increasingly the nurse concerned found herself irresistibly needed by the patient, and sometimes by the therapist, to take over more and more responsibility for some of the patient's ego activities, to think for and decide for the patient, to see that she remembered her appointments with her doctor, to fetch and carry, to protect from stimuli, to supervise ordinary bodily functions, such as eating and bathing and lavatory activities. The nurse felt it was woe betide her if she did this badly or forgetfully. To a greater or lesser degree each of these patients ceased to be responsible for some aspect of herself, and with the most severe cases the nurse was expected to diagnose and anticipate the patient's wishes without the patient being put to the trouble of expressing them, to have no other interest than the patient, and to be sorry if she failed in this.

There was a queenly quality about some of these patients in the sense that it became for one nurse or other an honour to be allowed to attend them in these exacting ways, and by subtle means the patients were able to imply that unless the nurse did well, favour would be withdrawn, and she would be classed among those others in the world, relatives, previous attendants, etc., who had proved to be untrustworthy and fickle in the past. So skilled were these implications that some nurses became rivals to look after these patients, and felt it as a sign of their own superior sensitivity when the patient finally preferred them to another.

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The disappointed, unfavoured nurse might feel shame, envy, resentment, and sulky turn elsewhere for other comfort.

The patients were not merely insatiable for attentions such as conversations, interpretations, sedation, hand-holding, time, and other things that could be given purely as a matter of duty. They required that these attentions be given with the right attitude and even that the person giving them should do so willingly and with enjoyment. For instance, the nurse would be told, 'You are looking tired', in a tone that was less of concern than of reproach. Or she would be accused after making some considerable effort that she had not enjoyed doing it. Most of these patients were extremely sensitive to negative feelings in their human environment and the group called this 'paranoid sensitivity'. The nurse would, at a look of misery from the patient, feel guilty about any reluctance she might have had in providing something for her patient and feel afraid that the patient would detect this. For derelictions of duty or of feeling the nurse might feel punished by the patient's becoming turbulent or exposing herself to injury or threatening such a possibility. Nevertheless, there was something about the patients that made nursing them worth while.

Behaviour of the same order seems to have occurred with the therapists. Under the stress of treatment they gave unusual services, different from those given to other patients, more devotion, greater effort, with desperate attempts to be good and tolerant and to interpret the deeper meaning of each of the patient's needs, and to avoid being irritated or suppressive. They, too, felt their extreme worth for the patient. As the patients became more insatiable for attention, more deteriorated in behaviour, restless, sleepless, perhaps aggressive and self-destructive, and intolerant of frustration, the doctors' concern mounted and they were drawn increasingly - except in one case - into advising the nurses on management. The group came to recognize confusion of roles as typical of the situations that grew around and were created by the particular quality of distress in these patients. Therapists accustomed to non-directive roles would give advice on or become active in details of management. Nurses or doctors whose roles were of management only would become minor psychotherapists during crises, blurring their several roles and professional obligations. Once staff anxiety grew beyond a certain point, therapy became mixed with management, to the detriment of both. The
therapist might advise nurses or encourage them to make further efforts, tell them to allow more sedatives if the patient could not sleep, to avoid frustrating the patient in various ways, to carry on sensitively and devotedly and to remain tolerant and friendly. Nurses whom the patient did not like came to be ignored by the therapist and he might try to get the more responsive kind. The nurse thus honoured would be resented by the others who felt hurt by the implications that they were too insensitive.

All of these patients had extra treatment sessions over and above the agreed programme, and for some there grew up an arrangement that, if the patient were badly distressed in the evening, she or the nurse could telephone the doctor and he would come to the hospital and settle the crisis by giving a session in the patient's bedroom. Increasingly, the therapist accepted his importance for the patient and, showing mistrust of the nurse's abilities to manage the patient well, began to take more decisions himself. Having been indulgent with sedatives, some nurses, alarmed at the dosage now required, would attempt to get the patients to accept less, but by distressing the doctor, sometimes by telephone, these patients would usually succeed in getting the nurses' decision reversed, until massive doses might be required daily.

The doctors' unusual attentions were, of course, regarded by them as being unorthodox, and they were uneasy that, no matter what they did, their interpretative work did not make the situation better. They pursued their interpretative work ever more intensely and more desperately and continued to do what they could to meet the patient's need for a permissive environment that could tolerate the patient without frustrating her needs. Neurotic diagnoses tended to be altered to psychotic terms and all the illnesses came to be regarded as even more severe than had at first been thought.

Thus, during their stay in hospital, these patients became 'special', and particular individuals became worn out in the process of attending to their needs. The patients, appealing at first, and suffering obviously, slowly became insatiable, and every effort to help them failed. Nothing given to them was quite enough or good enough, and the staff felt pressed and uneasy that they could not help more. Now this was like the situation that existed prior to admission with the patient and the referring doctor. But for the hospital it was more difficult to pass the case on.

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I must now mention some of the effects on the other staff, those not involved, whom I will call the 'out-group'. These were not principally concerned in the treatment of these patients, but from time to time cared for them in minor ways on occasions when some member of the 'in-group' was unable to do so. They could be regarded as those whom the patient had not honoured. At first, in open, polite ways they would disagree that the patient should be handled with special devotion, and sometimes they doubted whether the patient should be handled at all except in a mental hospital. The in-group regarded this view as unworthy (although they did not say so openly), and the out-group thereafter concealed their opinion and felt unworthy or resentful or even envious of the verve and courage of the in-group. Later, as the patient became worse, the out-group would become bolder and would discuss among themselves their beliefs that the treatment of this patient was unhealthy, unrealistic, and a waste of time, and later still they would endeavour to keep out of what they felt scornfully, but secretly, to be a dangerous and unprofitable situation. They would resent the disturbance the 'special' patient created for them and their own patients, and then became increasingly critical among themselves of the in-group, blaming it for the patient's distress and criticizing its handling of the situation as being morbidly indulgent. Stanton and Schwartz (1949 a, b, c; 1954) have well described the subsequent fate of the in-group. Under the felt, but undisclosed, criticisms it is driven to justify its performance; it withdraws increasingly from contact with the out-group and concentrates on attending the patient, who, however, only becomes more distressed. Two languages now grow up, one describing the patient as 'getting away with it', 'playing up the staff', 'hysterically demanding'; the other using terms like 'overwhelmed with psychotic anxieties', 'showing the true illness she has hidden all her life', 'seriously ill'. The out-group now regards the in-group as collusive, unrealistic, over-indulgent, whereas the in-group describes the out-group as suppressive, insensitive to the strains on an immature ego, lacking in proper feelings. Our research group confirms that this was the case with these patients. The later development of the group situation was agreed to be as follows.

Eventually, the main nurse of the in-group, having lost the support of the out-group and the personal goodwill of colleagues once important to her, and needing but failing to get justification
from her patient's improvement, would become too disturbed to carry on. She would become anxious, or ill, or would suddenly and unexpectedly become angry or in despair with the patient and now feel that it was fruitless to work with such an unrewarding patient or to do good work amid such colleagues. She might say that the patient was far too ill to be nursed outside a mental hospital or might develop the opinion that the patient should be given continuous narcosis or ECT, or be considered for a leucotomy. With the growth of unspoken disagreement between the in-group and the out-group these patients—who could sense unspoken tensions unacknowledged by the staff—would get worse and increasingly seek evidence of the reliability and toleration of the in-group and of its capacity to control the out-group. Then later, when the distress in the in-group mounted, the patients would become panicky, aggressive, and self-damaging, demanding and despairing or confused.

The therapist, the centre of the in-group, might now, in an effort to preserve his benevolence, advocate the least savage of the physical treatments mentioned, but he might consider others; he might say that he himself was prepared to carry on but felt that the other staff were incapable of giving more, or that because of the risk of suicide the patient should be sent to a closed hospital.

During their stay seven patients were, in fact, given continuous narcosis and one had a few ECTs. Four were discharged to closed hospitals, two dying there a year or two after admission from somatic illnesses to which they offered little resistance, one having had a leucotomy. One patient was discharged to an observation ward. One committed suicide in the hospital, and another did so after discharge to relatives who refused advice to send her to a mental hospital. Of five patients discharged home, one later had a leucotomy, three remained in analysis and are now leading more stable lives, and the other needed no further treatment.

Even when drawn from three hundred patients, such severe failures are dismal. It is true that the previous therapies of these patients—one had been in fifteen hospitals—had failed and that they were all referred as major problems, except one who was thought of as a straightforward neurotic; but failure, after so much effort, is bound to disappoint. These failures did more than disappoint—they left all concerned with mixed feelings of uneasiness, personal blame, and defensive blaming of others. They got under the skin and hurt.

Our findings agree with those of Stanton and Schwartz that certain patients, by having unusual but not generally accepted needs, cause splits in attitudes of the staff, and that these splits, if covert and unresolved, cause the greatest distress to the patients, who could be described as 'torn apart' by them. These two writers warn against easy assumptions that the patient is trying to drive a wedge between staff members, and they point out that the patient's distress can be dramatically resolved if the disagreeing staff can meet, disclose and discuss their hidden disagreements, and reach genuine consensus about how the patient could be handled in any particular matter. We found, however, that the staff splits, while precipitated by disagreements over present events, occurred along lines of feeling and allegiances that had existed prior to the patient coming into hospital. These have too lengthy a history to be described here, but they were complex and hidden from us, until our painful study, under the mask of co-operative feeling by which every community defends itself from disruption. In other words, something about these patients widened and deepened incipient staff splits that would otherwise have been tolerable and more or less unnoticed. Some of the phenomena I have described, particularly the terminal social phenomena, are good examples of the social processes to which Stanton and Schwartz have drawn attention. Their research was not, however, able to include the part played by patients in situations of covert staff disagreement, or the nature of the patients' wishes. Because of the particular research instrument I came to use—group discussion—I am in a slightly better position to demonstrate the patients' part in increasing incipient disunity. I quote two examples.

One nurse told the research group that there was something about one patient that she alone knew. The patient had told it to her in confidence so that she had felt honoured and trusted more than any other nurse. She had respected the confidence and had spoken to no one about it. It was that the patient had once had a criminal abortion. The group listened to the nurse in silence, and then first one and then another nurse revealed that she, too, knew of this, had been told of it in confidence, had felt honoured, and had also felt that the others were too condemnatory to be told
about it. We subsequently found that other patients had used similar confidences – which we came to call 'the precious little jewels of information' – to form special relationships with several nurses, making each feel more knowing than the others, and inhibiting them from communicating honestly with one another. It was as if the patient wanted each nurse for herself and that each nurse came to want the patient for herself. Thus, split and silenced, each was prepared to be sure that none of the others had the same inner awareness about what was good for the patient, and to feel that the others in their ignorance could only cause distress.

Here I am reminded of the way in which, prior to admission, various people had rescued these patients from others whom they mistrusted, and of how often the hospital’s sensitivity in turn was mistrusted by the referrers.

My second example concerns a patient whom I visited because of a raised temperature, but whose psychotherapist was another doctor. She was emotionally distressed so I spent longer with her than I had intended and I emerged from my visit with the knowledge that I had a better feel for her emotional difficulties than her own therapist had. I realized in all fairness that this was not his fault; for I could not blame him for being less sensitive than I. I then spoke to the patient’s nurse and saw from certain hesitations in her account that she believed that she had a better feeling for the patient than I had. Each of us believed the other to be lacking in feeling of the special sort needed. I spoke to her of my conjecture and found it to be correct, and we were able thereafter to find out that this patient had made more than ourselves believe that, while everybody was doing his or her best, all were really lacking in finer emotions, and only one person in the place was really deeply understanding - oneself.

DISCUSSION

I have had to condense and omit findings, such as the large number of minor somatic illnesses that these patients developed, the alarming capacity of at least one to venture, without discoverable physical cause, perilously near the edge of life, and the way in which, before and after admission, people tended to evade telling these patients the full truth if it were painful, but I have given the main outlines of some complex events which merit scrutiny.
whom they share responsibility, and how the patient goes from one to the other and from one crisis to another. When this happens it is rarely oneself who is wrong-headed, involved, or blame-worthy, for one is simply doing what one knows to be in the patient's best interests. If, in the words of that convenient phrase, therapy has to be abandoned for external reasons beyond the therapist's control, we cannot help it. We simply did our best in the face of difficulties. With recalcitrant illnesses this end to a therapeutic relationship is far from unknown.

The question to which I now invite your attention is: What is it about such patients that makes for these difficulties? Perhaps there is no general answer, but I offer, with hesitation, some formulations from existing theory which may be relevant to the features I have described.

The suffering of these patients is noteworthy. Those who had not spent their lives for others as doctors or nurses were worth while for other reasons, and the majority could be roughly described as decompensated, creative masochists, who had suffered severely in the past. In her description of a patient whose torturing distress was similar to our patients', Brenman (1952) points out the use made by the masochist of the projection of his own sadistic demands on to others who are then cared for by self-sacrifice. Others have in somewhat different terms described similar phenomena (A. Freud, 1937; Klein, 1946). These patients, as the referring doctors said, were or had been or could be worthwhile, that is to say, they had shown some capacity for serving others at cost to themselves. But in none of these women had the defence of projection with masochism succeeded fully, and even before admission their suffering contained marked sadistic elements which were felt and recognized and resented more often by relatives than by doctors. Though they spoke of the world as being impossibly insensitive and demanding, these patients were themselves unremittingly demanding of love, and tortured others to give it by stimulating guilt in them, by self-depreciation and by the extortion of suffering. Self-neglect and helplessness cruelly reproached the world for being no good, and some of them seemed to wish to die in escape from an unproviding world. Tormented by childlike needs and rages, they tormented others also.

The angry response of the out-group and the readiness for suffering of the in-group may be seen as sadistic and masochistic responses to the sado-masochism of these patients and their raging demands for nurturance, but this is not a complete view.

I am sure you will have noticed their need for material tokens of love and goodwill as well as the eventual instability, passion, and ruthlessness with which these were pursued. The hostility that reinforced these needs seems to have given rise to features that can be viewed in terms of Klein's work: fear of the tortured object as a retaliating object, appeasement of her by flattery and seduction, demands for more attention as reassurance against the possibility of retaliation. You will note also how these patients isolated and controlled the behaviour of their objects and counterattacked by savage suffering and appeal when the revengeful potential of their damaged objects seemed great; and how they sought regular reassurance that the object and its goodwill were still alive, reliable, and unexhausted. These fruits of aggressive feelings are most easily discernible in the patient's relationship to the nurse, but there is no reason to think that the therapist enjoyed any immunity from them – indeed, the evidence is all to the contrary. The more the in-group insisted by its actions that it was not bad but good, the more the patient was beset with the problem of trusting it, and of needing proofs that it was not useless, unreliable, and impure in its motives. This in turn further stimulated the staff to deny hatred and to show further good, whereat the patient was beset with the return of her problems in larger size. Thus insatiability grew, and it is interesting to notice that every attention, being ultimately unsatisfying, had to be given in greater amount, poisoned as it was, not only by the patient's motives on the one hand, but by the in-group's hidden ambivalence on the other.

In spite of the fact that the patient frequently feared and attacked the in-group, she turned to its strength whenever she felt threatened by other agents. The attempts of the in-group to be all-powerful on her behalf may now be seen as a response to the patient's need to idealize it, and its belief in the badness of the out-group as its attempt to evade and deflect the patient's projection of sadism. Nevertheless, the in-group itself contained its own problems of mistrust, of finding good and bad among its own members. Mistrust of others made for such confusion in the roles of therapy and management that the nurse could be said to be inhabited not only by her own wishes, but by the wishes of
therapists, which sometimes contrasted and warred within her. It is only a slight exaggeration to say that at times not only the patient but the nurse was confused about who was who.

Many of the severe panics, depressions, confusions, and aggressive outbursts of these patients may thus be viewed as deriving from the sadism that lay behind their suffering. But, while this explains the later aggressive secondary features, it does not explain the more naïve wishes that were noticeable, especially during the early stages of their therapeutic relations. These wishes were at that stage not aggressive or passionate, but seemed rather to concern an expectation in the patient that was difficult to meet. This simple basic expectation was that someone other than herself should be responsible for her; behind the aggressive use of suffering, it was not difficult to see a basic discontent with life and its realities. This is found, of course, in all sick and suffering people. In the early stages following admission the nurses were not much tortured by the patient. In addition to all else they were moved by helpless, unspoken, and childlike qualities of appeals which became complex only later. The patient's aggressive use of distress can be viewed as sophisticated versions of the signals an infant uses to dominate his mother and bring her to help him. Like infants these patients had a simple, self-centred view of the world—it had to manage them because they could not manage it. Infants need an agent who, in the face of distress, ought to want to diagnose the need and the quality of the satisfaction sought, and the behaviour of our patients with their nurses seemed to contain such needs. The nurse had to undertake responsibility for many of the patients' ego activities which the patients seemed to wish to discard. Some would require her to behave as if she had no identity or biological independence of her own, but was rather a feeling extension of their own body.

The queenly honouring of the nurse with a task that she might regard as difficult is similar to the charming and friendly way in which a baby will deal with his mother. Anna Freud (1953) has pointed out that, like any parasite, the baby does not excuse his host for its failure but attacks her, reproaches her, and demands that she make up for her fault and thereafter be perfect. (I would add here that his queenly love comes first and his displeasure is secondary to imperfections in his host.) The mother is a part of the pair, taken for granted, without right to leave, and Anna

Freud has described the baby's sense of the personal loss of part of himself if his mother walks away. If the mother can give only one response (e.g., feeding) for all forms of distress, an addiction to this imperfect response is created for the assuagement of all needs, and this addiction can never be quite satisfying and therefore has to be given for ever. The situation can arise out of the mother's limitations, or anxiety, or stupidity, or from her pursuit of theories of child care. Perhaps any theory relentlessly applied creates an addiction.

These patients also fit the description of the early stages of infancy to which Winnicott has given the term pre-ruth. They needed more love than could easily be given and could give little in return except the honour of being cared for. They could be quieted but not satiated by desperate acts of goodwill, but they were afraid of the inconstancy of their object, so they would cling to what they had and seek more. The fact that they were aggressive towards and contemptuous of their objects need not blind us therefore to the fact that needing is an early form of love. But catering for the object's wishes is impossible in the early stages of development prior to what Klein calls the depressive position.

Balint (1952) points out that the infant requires his mother not only to be constant and to manage the world and his own body for him in automatic anticipation of his wishes, but also to enjoy it and to find her greatest joy in doing so, to experience pain when he is unhappy, to be at one with him in feeling, and to have no other wishes. He goes on to indicate that the impossibility of these requirements, except for the shortest periods, leads not only to a disconsolate, forlorn longing for this state, but to a fear of the impotent, helpless dependence on the object. Defences therefore arise against the state and its pain in the shape of denial of dependence, by omnipotence and by treating the object as a mere thing. The pain of not being efficiently loved by a needed object is thus defended against by independence; and under the inevitable frustration of omnipotence hatred of the object for not loving arises.

In these patients the need to be at one with the object could be seen in small ways, not, to be sure, in the angry, revengeful, or domineering behaviour, but in the occasional, early, moving helplessness, in the requests for small satisfactions, in the need for harmony in the relationship and for identity of purpose. The later
guilt-driven obedience in their objects was very disturbing to the patients, but I am impressed with the nurses’ enjoyment of the earlier simple tasks when both parties could be pleased, the one to give and the other to receive. The nurse truly enjoyed then the honour done her of being accepted by the patient. Smaller enjoy­ments of this sort also occurred when the patient’s simple pleasure might consist of doing some small thing for the nurse. Perhaps it was the rapidly succeeding suspicion of the danger of being helpless and dependent in the future that led the patient to become independent, omnipotent, and demanding, and thus begin the cycle of guilt induction, omnipotent care from the nurse, insati­ability, and suffering.

In drawing attention to these theories of infant behaviour I am in no way suggesting a common psychopathology for the various illnesses from which these patients suffered, which merit full study in their own right. Rather, the possibility arises that certain features of these patients, particularly those that give rise to common behaviour problems, may have primitive origins of a basic order. Nor do I suggest that proper nursing could cure these illnesses; only that the nursing response to these patients and the events of management are crucial moves in a primitive type of object relation that is strainful for all and, if not well managed, may become unbearable for all.

The splitting of the staff (including the splitting of the in-group) can be thought of as a wedge of the kind a child will drive between his parents, but, while this explanation will fit the aggressive splitting activities of the patient, it does not fit the fact that shortly after admission of a patient the nurses would compete with each other to respond to her silent appealingness. The patient was involved in the split from the first and was later active in maintaining it, but did not seem to cause it in the first place. I am reminded more of the rivalries formed among a group of middle-aged women when a baby whose mother is absent begins to cry, and of the subsequent contest among the women for the honour of being allowed to be of service to him, that is, to be actively distressed by the baby’s distress and made actively joyful by his joy. In such an innocent way the baby may evoke rivalries that already existed within the group in a latent form. He may then become distressed by these rivalries and even make them worse in his search for security; but in the first place he may have wished neither to seek them nor to exploit them. It is true that our patients later became distressed, aggressive, and insatiable and then further divided their world in an attempt to control its imperfections, but they were also particularly sensitive and vulnerable to disharmony in those around them; and, as Stanton and Schwartz have shown, the resolution of felt but undeclared disharmony among their attendants can have a dramatic effect on patients’ distress. I would suggest, therefore, that the earliest, but not the later, staff splits were caused by competitive responses in the staff to primitive but impossible appeals from the patient, and that the succeeding hidden competition among the staff led the patient to insecurity and then to the panics, mistrust, demand, hatred, and the later active sophisticated splitting activities I have described.

The patient’s distress at the splits in the staff may be viewed in terms of the unhappiness experienced by a child whose parents are not on speaking terms and who is made happier by the restoration of a harmonious atmosphere in the home. But it might also be viewed in terms of an infant’s distress when in the care of an ambivalent mother, or of a mother who misunderstands his needs and pursues, for her own reassurance, authoritative theories on child care. I am inclined to the latter possibility because the splits that distressed these patients contained no sexual preferences and because they were equally distressed when receiving ambivalent or determined but inappropriate care by one person, although I realize that this is not a conclusive argument.

The hopelessness, the omnipotent control of the object and the disregard for its purposes, may be seen as defences against the dependence of primitive love. Certainly the touchiness and the ruthlessness, as well as the growing insatiability and the mounting sadism that split the patient’s mind and give rise to confusion, panics, depressions, and severe suffering, are inherent dangers with these patients. Lastly, I draw attention to the repetitive pattern of the traumatic rejections that beset these patients’ lives, both before and after admission, and to the possibility that this contains compulsive elements.

**SUMMARY AND CONCLUSION**

I have described a behaviour syndrome in terms of object relations. Although gross forms are outlined, it is held that minor forms of it
can be noted in most medical practice. The patients concerned bore various classic diagnoses, but constitute a type that cuts across the usual medical classifications and can be recognized essentially by the object relations formed. This syndrome is difficult to treat successfully, and tends to create massive problems of management. Further study is needed of its psychopathology, sociology, management, and treatment.

The patients suffer severely and have special needs which worry all around them. They tend to exact strained, insincere goodness from their doctors and nurses, which leads to further difficulties, to insatiability, to a repetitive pattern of eventually not being wanted, and to the trauma of betrayal; it also leads to splits in the social environment which are disastrous for the patient and the continuance of treatment.

Sincerity by all about what can and what cannot be given with goodwill offers a basis for management, although it leaves untouched the basic psychological problems, which need careful understanding, but it is the only way in which these patients can be provided with a reliable modicum of the kind of love they need, without which their lives are worthless. More cannot be given or forced from others without disaster for all. It is true that these patients can never have enough, but this is a problem for treatment and not for management.

It is important for such patients that those who are involved in their treatment and management are sincere with each other, in disagreement as well as agreement, that each confines himself to his own role, and that each respects and tolerates the others’ limitations without resort to omnipotence or blame. It is especially important for each to avoid the temptation to induce others to become the executive instruments of his own feelings and wishes.

Believing that sincerity in management is a sine qua non for the treatment of the patients I have described, I offer one piece of advice. If at any time you are impelled to give advice to others (to be less hostile and more loving than they can truly be) – don’t.

I cannot conclude without paying tribute to the nurses and doctors who allowed me to share the study of their difficult work, and without acknowledging the pleasure I have had in formulating with them these ideas.

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