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Editorial

Malignant Alienation

Dangers for patients who are hard to like

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The assessment and management of suicide risk are among the most difficult clinical skills to acquire. Seager & Flood (1965) examined coroners' inquisitions on 325 suicides which occurred during 1957–61 and found that 4.6% had taken place during in-patient or day-psychiatric care, and 16% within six months of receiving such treatment. More recent work confirms the relatively common occurrence of suicide in spite of close psychiatric supervision. In Avon, 29% of all those committing suicide had been seen by a psychiatrist at some time during the previous year (Vassilas, 1993; personal communication). Clearly, much remains to be done in improving techniques of predicting suicide risk and in its management.

Sociodemographic, medical and psychiatric risk factors which may predict suicide have been well documented (Hawton, 1987). These are most useful with regard to long-term risk, but what the clinician needs primarily is guidance on how to identify those at immediate high risk. Relatively little attention has been paid to the systematic evaluation of day-to-day behaviour and relationship with others in the detection of such short-term risk.

Alienation in particular seems worthy of careful attention. Truant *et al* (1991) surveyed psychiatrists in London, Ontario, and found that 61% of respondents believed that those patients who were rejected, isolated or detached were more likely to commit suicide. Three of the top eight selected risk factors were in the category 'quality and continuity of interpersonal relationships'.

Morgan (1979) coined the term 'malignant alienation' to describe a process which appeared to have been common before suicide in a small series of psychiatric in-patients. It was characterised by a progressive deterioration in their relationship with others, including loss of sympathy and support from members of staff, who tended to construe these patients' behaviour as provocative, unreasonable, or overdependent. In some instances an element of deliberately assumed disability was invoked. Such alienation between patient and others appeared to have been malignant in that it gained momentum and was associated with a fatal outcome (Morgan & Priest, 1984). A further study of suicides among psychiatric patients in Bristol (Morgan & Priest, 1991) showed that the process of alienation was a theme in 55% of such deaths.

Components of malignant alienation

It is convenient to discuss the important components in malignant alienation in four parts: patient factors, staff factors, staff–patient interaction, and hospital environment.

Patient factors

As part of a research project with the National Institute of Mental Health, Fawcett *et al* (1969) studied 30 depressed suicidal patients at varying risk of suicide. Patients' interpersonal behaviour on the ward was documented, along with interpersonal behaviour before the illness (obtained from interviews with spouses/family and records of joint interviews). They identified four factors indicative of the quality of long-standing interpersonal relationships that discriminated a high-risk group from the remainder. These were: interpersonal incapacity (a lifelong inability to maintain warm, mutually interdependent relationship); marital isolation (interpersonal isolation and disengagement in spite of overt appearances of a conventional marriage, i.e. emotional divorce); distorted communication of dependency wishes (an inability to express directly dependency needs which might lead to support); and help negation (persistent withdrawal or denial of helpful relationships).

The authors felt this supported the hypothesis that the depressed patient at high risk of suicide had a long-standing inability to communicate wishes/needs effectively, predating the index illness. It is unlikely that these results are specific to a depressed suicidal group.

Henderson (1974) looked at the concept of care-eliciting behaviour from phylogenetic and ontogenetic perspectives. Normal care-eliciting serves important functions: survival of the infant initially (cf. attachment theory), and the maintenance of strong social bonds in adulthood. Pathological care-eliciting stands separately only insofar as it is disruptive for the individual, or would-be carer, or both. The signals

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used (e.g. parasuicide, conversion hysteria, factitious disorders, shoplifting) may cause distress to self or carer, but their consequence is developmentally ancient: they bring others closer.

However, there is the risk of exceeding the limits of tolerance of the carers. In addition, abnormal care-eliciting tends to evoke ambivalent responses in carers. According to Parsons (1951), adoption of the sick role is permissible only when the disability is considered genuine and the patient cooperates in efforts towards a return to health. Otherwise there is an infringement in the code relating to illness behaviour, a code held particularly strongly by health-care professionals.

The converse of our particular social code relating to illness was clearly pointed out by Samuel Butler (1872) in his novel *Erewhon* – where to be ill was to be punished but to be dishonest attracted care and sympathy.

Staff factors

Hospital staff may bring with them unrealistic expectations and aspirations for care giving. These vulnerabilities have been termed 'narcissistic snares' (Maltsberger & Buie, 1974), and may be universal among less experienced or poorly supervised staff. The three commonest snares are the aspirations to 'heal all, know all and love all'. These can be compounded by the magical hopes of the patient at the beginning of treatment, when carers may become infected with expectations of omnipotence. Clearly, the risk for carers is in finally feeling helpless, guilty and wishing themselves far from the patient.

Psychiatric health-care professionals are particularly prone to expectations of healing all, for two reasons. Firstly, the personality of the carer is often the therapeutic tool, unlike surgery or medicine where the means of treatment are simpler to separate from the self. Thus the psychiatric carer confuses professional capacity to heal with a sense of self-worth. Secondly, change in psychiatric patients often occurs slowly, frustrating the drive of those ardent to see improvement.

The expectation for omniscience is as much a snare. The experienced psychiatrist does not follow intuition beyond a certain point, and hunches are constantly examined against the clinical evidence. Following one's empathic sense alone as to whether a patient is suicidal or not can be fatal.

The third snare is that the carer should love all. Unfortunately, objectivity can be compromised in an attempt to be seen as a caring person – particularly with patients whose transference will involve denouncement of the carer as cold or uncaring. The carer is left open to attack on a disposition to lovingness. Once breached, this brittle defence may crumble, leaving the carer feeling initially helpless, then retaliatory.

Staff–patient interaction

In many staff, strong negative feelings may be provoked by patients. Knowing which patients provoke these feelings and how staff deal with the feelings is crucial to understanding the alienation process.

Colson *et al* (1985) examined which patients are perceived by staff as 'difficult to treat'. This concept is important, as the staff's view of a patient as difficult to treat may exert a powerful influence on the patient, the carers and the treatment process, with implications for progress and prognosis. Four symptom clusters were found that related to staff perception of treatment difficulty, and also to perceived poorer progress and prognosis. In descending order of influence the factors were: withdrawn psychoticism, severe character pathology, suicidal depressed behaviour, and violence/agitation.

It is suggested that patients with these characteristics interact in a particular way with staff. Perhaps psychotically withdrawn patients ('regressed, withdrawn, isolated, bizarre') are experienced as most difficult to treat because they are difficult to engage and inaccessible to interpersonal intervention. The patient with severe character pathology ('demanding, plays one person against another, manipulative, moody') may repel staff by the intense and troublesome contact made. The behaviour of the suicidal depressed patient ('self-abusive, depressed, regression after progress') is seen as difficult to treat because of the patient's tendency to react to the prospect of progress with depressive feelings of defeat.

This points to the crucial containing role of the therapeutic alliance with difficult patients, and how problems could arise if the alliance fails, or cannot be formed. The therapeutic alliance may have a protective role, protecting patients from the strong negative feelings engendered in staff when patients are perceived as difficult to treat.

Perhaps the most difficult provoked feeling to contain is hate. Some patients are unable to contain their own hate for a needed person (e.g. parent, nurse or doctor). Instead, the hate is projected and the patient feels better as responsibility for the hatred is shared ('I hate him and he hates me') and anxiety reduced ('You hate me so my hate for you is justified'). Direct and indirect means are then used to provoke carers' hate, to substantiate the projection. Abusive, disparaging language, sullen silence, repeated

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somatic complaints or forgotten appointments may all kindle the ire of carers (Maltsberger & Buie, 1974).

Countertransference is inevitable in all patient contact. In its broadest sense it means the carer's emotional response to the patient, stemming from both the specific carer–patient relationship and the disposition of the carer. Conscious countertransference can usually be controlled, and may shed light onto details of the patient previously hidden. Unconscious countertransference may give rise to well rationalised but destructive acting out by carers.

Countertransference hate may be found at the heart of the malignant alienation process, and deserves attention. Countertransference hate has two components: malice and aversion (Maltsberger & Buie, 1974). While carers find the malicious component harder to tolerate, it is the aversion which is most dangerous to the patient. The carer's malicious feelings imply a preservation of the relationship with the patient, whereas the aversive impulse tempts the carer to abandon the patient. It is this abandonment (alienation on the ward, premature discharge, transfer) which has lethal potential. Paradoxically, the temptation is to abandon the patient in order not to bear the countertransference malice.

The internal economy of countertransference hate in carers consists of a subtle balance between defensive postures and conscious awareness. Of course, carers are compassionate and non-judgemental, and do not vent punitive, rejecting, murderous or disgusted feelings on patients. However, carers are human, and have the potential for these feelings, although it is individually difficult to admit to them. Intolerance of the hateful countertransference may also explain its absence from standard psychiatric textbooks.

The defences used to prevent conscious awareness of countertransference hate include repression, reaction formation, projection, and distortion/denial. Repressing the feelings is relatively safe for the patient, but the carer may convey aversion/hostility by non-verbal messages such as clockwatching, inattentiveness or yawning.

The other defences can have lethal consequences for the patient. With reaction formation (turning the countertransference hate into the opposite), the carer is oversolicitous, experiences an anxious drive to help, and meddles. Like an overindulgent parent, the carer may overprescribe and overhospitalise. Projecting the countertransference hate ('I do not wish to kill you, you wish to kill yourself') is experienced by the carer as a dread that the patient will commit suicide, no matter what. This can lead either to imposition of unnecessary controls (as if to 'provoke' the suicide), or to rejection of a 'hopeless case' (if the aversive element dominates). The mute, suicidal patient is particularly likely to become the target of projected countertransference hate. To sit for hours with such rejecting patients can evoke hateful fantasies.

Distortion/denial is another route to impaired judgement on the part of the carer, who selectively attends to the facts of the clinical situation in order to repudiate and devalue the patient. The patient is seen as a hopeless case, or a dangerous person. There is a lack of basic respect for the patient as the carer experiences indifference and finally rejects the patient.

Hospital environment

In a benchmark paper, Winnicott (1949) likened caring for the psychotic or difficult patient to a mother caring for a demanding baby:

> "However much he loves his patients he cannot avoid hating them and fearing them, and the better he knows this the less will hate and fear be the motives determining what he does to his patients."

Winnicott saw this hate as normal, but pointed out that particular aspects of the hospital environment are not conducive to openness about hate: such openness may be seen as professionally unacceptable, and unsafe (for both staff and patients) to express openly, and patients may be regarded as too ill for staff to let them know how much they are hated. However, without some recognition in hospital, the hateful feelings will be sublimated or projected elsewhere. In addition, the staff may not be 'good enough parents', able to be hurt while hating so much, without payback (acting out of countertransference hate), and able to wait for rewards. If rewards do not come (the patient does not improve and go home), then there is the risk of payback. As Winnicott suggests, "Down will come baby, cradle and all". Essentially, there may not be the culture in psychiatric hospital wards necessary to discuss openly these powerful negative feelings.

Malignant alienation – a synthesis

We suggest the above factors all play a part in a particular process, the terminal phase of which is called malignant alienation. Real benefits in the clinical care of psychiatric patients could accrue from understanding the process in the following way.

Patients involved in this process may have longstanding problems in communicating their needs effectively, attempting instead to have their care needs met in less appropriate ways. These patients

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may have infringed the 'sick-role' code, claiming illness without cooperating in attempts to return to health, perhaps in the absence of understandable disability. This provokes an ambivalent response in carers.

The patients perceived as difficult to treat can be described as withdrawn psychotic, having severe character pathology, suicidally depressed, or the violent/agitated. In common there is a poor, unformed or failed treatment alliance which is unable to contain these perceived treatment difficulties.

In addition, carers are often unaware of their own vulnerabilities (narcissistic snares), and may work in a culture not generally receptive to open discussion of the powerful negative feelings generated.

At the end, with only a shaky therapeutic alliance, countertransference hate remains unconscious, and is acted out by carers towards the patient. The difficult patient is alienated and finally placed at high risk of suicide.

Strategies for preventing and managing malignant alienation

Certain clinical strategies may be useful in preventing and managing the alienation process. These may be itemised as follows:

(a) equating challenging behaviour with an inability to seek help in other ways, and acknowledgement of the patient's possible inner distress

(b) promoting a ward environment in which any negative feelings among staff members can be acknowledged openly at staff meetings and ideally at support groups (this aspect of clinical work should be an essential ingredient of effective supervision: staff members should be helped to acknowledge, bear, and put into perspective their countertransference hate)

(c) providing insight into staff members' own vulnerabilities and expectations in providing care provision (such self-awareness is vital in those who have a need to develop special close relationships with certain patients and who encourage close dependency)

(d) early identification of those patients whom staff perceive as failing to improve, particularly when there are demands from staff for their discharge from care (setting limits of patient behaviour is an important strategy in clinical care but requires scrupulous assessment of the reasons why they should be implemented)

(e) early identification of a lack of therapeutic alliance

(f) providing post-recovery conjoint sessions with a spouse or other significant person for those patients who have particular difficulty in communicating their needs effectively (exclusion of significant others in the management of suicide risk may itself be hazardous).

It may also be possible to extend these ideas out of the psychiatric hospital ward and into other caring environments where malignant alienation could occur. The prevention and management of the malignant alienation process in potentially suicidal patients may have close analogy with the psychosocial intervention which has been shown to be effective at preventing relapse in schizophrenic patients whose close relatives exhibit high expressed emotion (Leff *et al*, 1985).

The present scene

A thorough understanding of malignant alienation is particularly important at the present time as new styles of psychiatric services place increasing emphasis on care in the community (Morgan, 1992). While such developments are commendable, the process of change must depend upon an appropriate balance between in-patient and community facilities. Regrettably, in-patient units are often greatly reduced in size before community resources have been developed adequately. The resulting need for rapid discharge will make it even more difficult to assess adequately the needs of patients at risk of suicide. The process of malignant alienation then becomes an even greater hazard unless facilities in the community really can assume functions lost from in-patient provision. Establishment of community care should not be at the expense of providing help for the difficult, the awkward, and the demanding, who at times may need protection from the negative, aggressive aspects of ourselves (Hill, 1978).

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