Who has the Ailment? A 21st century look at a classic paper

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The Ailment (1957)

Published by Tom Main (1911-1990) in the

Brit.J.Medical Psychology

He coined the term ‘therapeutic community’ in his 1946 paper written while working as military psychiatrist

1946-1976 Consultant at the Cassel Hospital

Trained as a psycho-analyst by Michael Balint; also vice president of new Royal College of Psychiatrists.

The Ailment is about what happens to staff in a residential TC

‘It is not difficult to notice the kind of staff ailment that I have described’

The Ailment refers to a kind of relationship that can grow up between some kinds of patients and their carers

A report of 12 patients in the Cassel: all female, all with long histories of mental ill health

8/12 came from medical families

Published *before* studies of institutional dynamics by Menzies Lyth or Gwynne & Miller

A highly selected sample of patients

- All had been in extensive treatment before which had failed
- Referrers emphasised how ‘special’ the patients were; and how previous treaters had not understood their special needs
- Referrers often went to great lengths to get them admitted; saying they could do no more for them ‘but she needs long intensive psychotherapy’
- Difficulties minimised or not mentioned e.g. ‘not really psychotic’, or no mention of self harm
- No particular diagnosis
- Nursing Staff who worked with these patients had high rates of sickness; leading to staff leaving

A special group in a special place

- Main's response to reports of nurses leaving
- He set up a group for nurses to reflect on their feelings about certain patients
- The first reflective practice groups?
- The importance of being able to express negative feelings towards the patients and each other: looking at conflicts between nurses
- And doctors! Who seemed reluctant to come to the group

This is early group research into psychodynamics of caring relationships

- Using material from the groups to piece together a picture of what was going on
- Using group members' memories and reflections in an early qualitative study

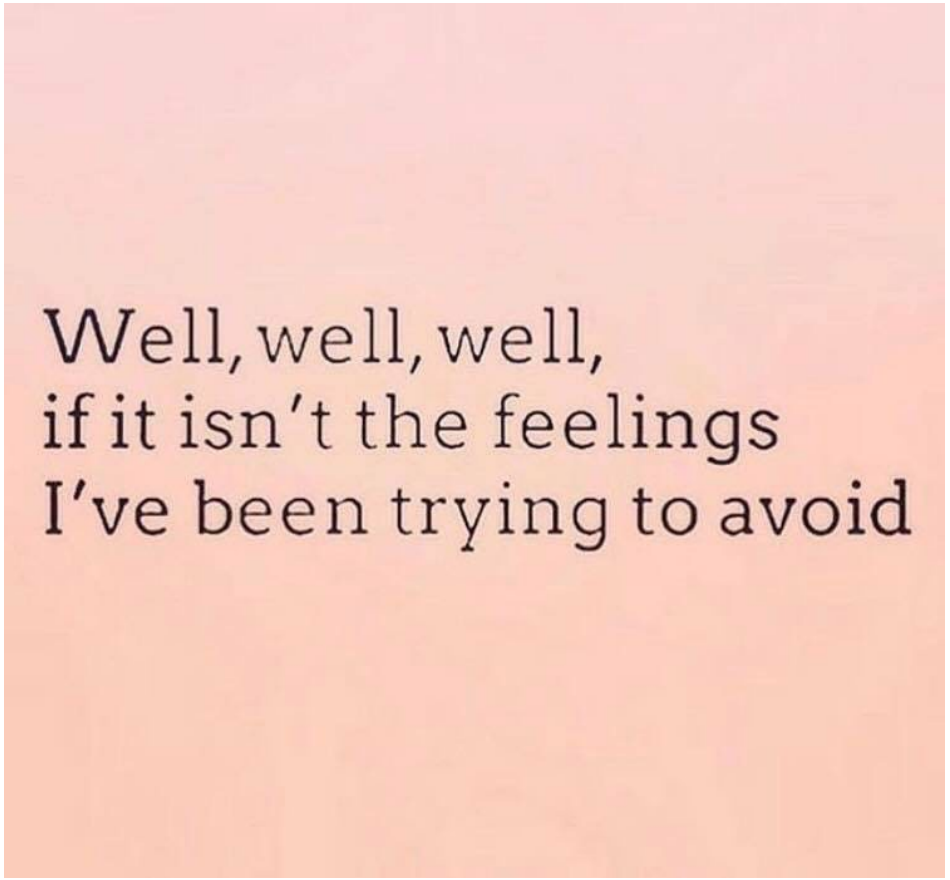
Themes that emerged from discussion: I

- Staff struggled with a group of patients with the following characteristics:
  - The patients did not get better or seemed to get worse
  - They initially seemed to get on well with staff
  - Then they were seen as more demanding or more vulnerable
  - They were described as having a ‘queenly air’ or present as exceptionally vulnerable and sensitive
  - Their treatment *must* be given at the right time in the right way and in the right amount
  - The nurse allocated would do everything they could to help: often going to extremes in term of staying when off-duty, advocating for special treatment for their patient, getting other nurses to come on board with them

Themes that emerged from discussion: II

- The ward team would then split into an 'In-Group' who '*really understood'* the special patient; and an 'Out group' who did not
- The In-Group were seen as heroic and kind; and the Out Group mean and unhelpful
- Despite this 'really good' treatment, the patients often presented as abusive, ungrateful, self harming, hostile
- As they deteriorated the treatment became more extreme e.g. massive doses of medications that could be dangerous
- Staff would go off sick and leave
- Eventually patient relabelled as ' psychotic' and discharged and/or transferred to another special treatment place

An account of defences used by professionals



- Staff reported having strong feelings of guilt, anxiety, fear of blame, anger and repulsion towards the patients
- So they used individual defences to manage them: especially manic defences of heroic rescue or denial of the reality of what was going on
- Denial of hatred and fear
- Institutional defences: support for staff who gave 110%, denial of boundary violations in terms of time, collusion with confusion of roles

Fascinating (and familiar) dynamics

- Molly tells Nurse A. a secret: 'I'm telling you because you are the only one I can trust'. Nurse A recounts this only to find that Molly has had exactly the same conversation (*in the same language*) with everyone else
- Dr M goes to see Cathy at her therapist's request. At the end of the session, he comes away feeling that he has a **much** better idea about Cathy than her own therapist, about whom he feels mildly critical. He mentions this to the staff; only to find that they all feel the same.
- The patient has a narrative of suffering and mistreatment that invites sympathy, and **(crucially) criticism of previous carers**
- The patient invites the health care professionals to join them in condemning others; and proving themselves to be better professionals by treating the patient successfully
- But when this doesn't happen, the professionals feel alarmed, ashamed and redouble their efforts (envy and competition)

Memorable quotes

- Of staff who prescribe high doses of sedatives for disruptive patients 'In no case did the staff take the sedatives'
- 'It is not difficult to notice the kind of staff ailment I have described; the same contempt for the limitations of theory, ability and realism; and the same disclaimer of responsibility'
- 'The torment of child-like pain and rage leads to the torment of others'
- 'It is only a slight exaggeration to say that at times it was not clear who was the nurse and who was the patient'
- Of the patients: 'Someone other than herself should be responsible'
- 'They got under the skin and hurt'

Main's solutions

- Reflective groups for staff to examine troubling relationships
- 'The psychotherapist must seek how and why and in what circumstances, patients arouse [these] responses in other human beings, including himself' (sic)'
- 'In a human relationship, the study of a person, no matter which one, is likely to throw light on the behaviour of the other'

'*My own choice of viewpoint is partly authorial, a detached recorder of events, and partly to move into the minds of the different characters; seeing with their eyes, expressing their emotions, hearing their words*' p123

Are Main's ideas familiar?

- Most people who work in close institutions of any kind experience similar cases
- Especially true of organisations which manage high risk psychopathology AND offer long term residential care
- Ailment dynamics are common in services for people whose conditions make professionals anxious e.g eating disorders, suicidality, forensic
- Noteworthy features:
  - Unpredictable psychopathology (alternating grandiosity and vulnerability)
  - Competitiveness and envy between professionals
  - Oscillations between hostile and helpless states of mind
  - Uncontained and unmetabolised hostility
  - Issues with agency and passivity

Since the Ailment was published

- Many studies of how organisations defend against staff distress
- Menzies Lyth (1959, 1963): nurses in an acute medical service
- Miller & Gwynne (1972) : dynamics in long stay residential care for the 'incurable'
- Hinshelwood and Skogstad: defences in mental health services
- Tavistock studies into the primary task of organisations and the Leicester Conferences about authority
- Multiple changes in NHS services and delivery of care (especially psychological therapies) with oscillating idealisation and denigration of skills
- Many NHS mental health services encourage reflective practice by staff but also encourage fragmentation of care

Locating disturbance in systems

"I know you're scared, honey. But he's already in your room. Why not give him a chance?"

- Main was locating disturbance in the staff
- But was also wondering if the disturbance was a mirror of something in the patient
- Or was the disturbance in the space between them? A dynamic disturbance of the relational bond?
- Is it problematic to think about 'location' of psychological problems in one person or group?

Attachment theory and the relational mind

- A theory of how children develop (a) a capacity for making enduring close relationships over time and (b) how they use those relationships at times of stress, pain, anxiety, vulnerability
- Ethologically driven: group animals with extended infancy/growth periods need attachments as protection during times of vulnerability
- Homo sapiens does more: we create verbal/narrative representations of our attachments to use when we are stressed or anxious or vulnerable
- Attachment narratives: revealed in *how* we talk, not just the content of what we say

Relationships with others are crucial to how we manage emotions

- Especially the afflictive emotions
- Pain, anger, fear, panic, hatred, shame, grief, wish to hurt
- People with secure attachments manage these emotions better
- They neither avoid them nor get enmeshed with them
- They create a narrative that is reality based, authentic in tone, open to emotional experience, aware that feelings are not always what they seem and can change, tolerance of uncertainty

A ‘secure’ reflection on a complex experience

I feel I’m stuck in my previous age… the age I was when I did my offence.. Time’s passing here and there are things I’m not doing.. I want to capture time with magazines and pictures to know what I was doing when I was here… What will it be like in 10 years time? Where will we be? What will I think on my deathbed about this time?’

Disruption of attachments can disorganise our minds

- Loss or threat of loss can drive people ‘mad’
- 2009 US study loss of a relationship in the past year was a predictor of later violence
- 2014 US study: increased rate of manic depression in the year after bereavement
- 2016 Scandinavian study: early loss of parent by bereavement was a predictor of homicide by people with psychotic illnesses

Attachment loss & narrative incoherence

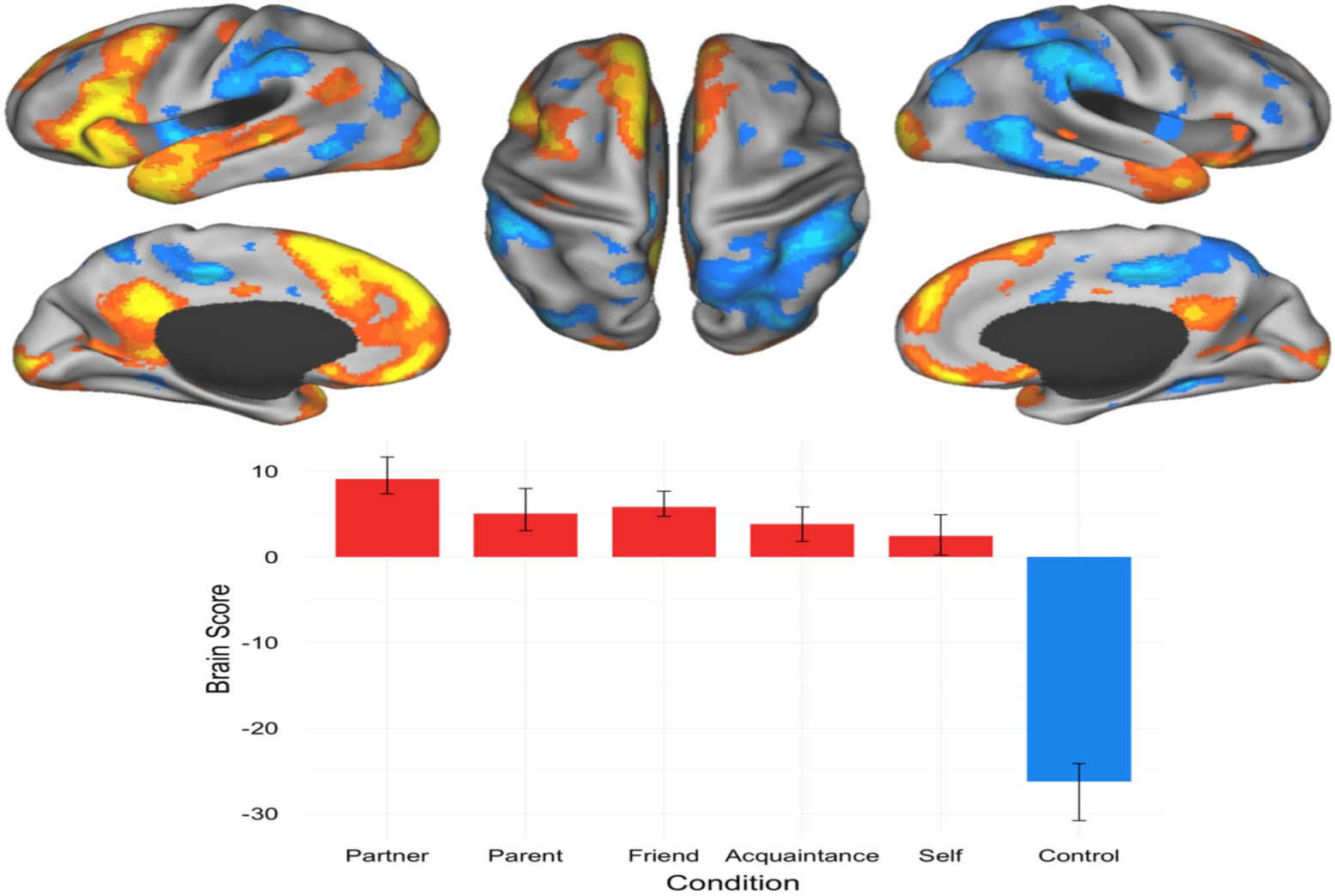
[The interviewer is asking about childhood disruptions of care: in this case parental divorce]

Did they divorce?

Well I don't know if he divorced [her] or not but all I know is that he left her in a sense that he told her about his companion as he called her and erm to cut a long story short I blamed him for her demise because the last flicker of flame in her belly had been extinguished.

Attachment and the building of relationship

- Time, depth and mutuality
- Mentalising and reflection on the other's mind
- Attachment needs to be flexible: distance regulation
- Rupture and repair: relationships are not always comfortable or easy!
- Attachment bonds involve care giving and care eliciting i.e. not all bonds are attachment bonds
- But early attachment security has a significant influence on adult attachment to peers/partners AND to parent infant attachment



From: Dissociable patterns of brain activity for mentalizing about known others: a role for attachment

Soc Cogn Affect Neurosci. 2017;12(7):1072-1082. doi:10.1093/scan/nsx040

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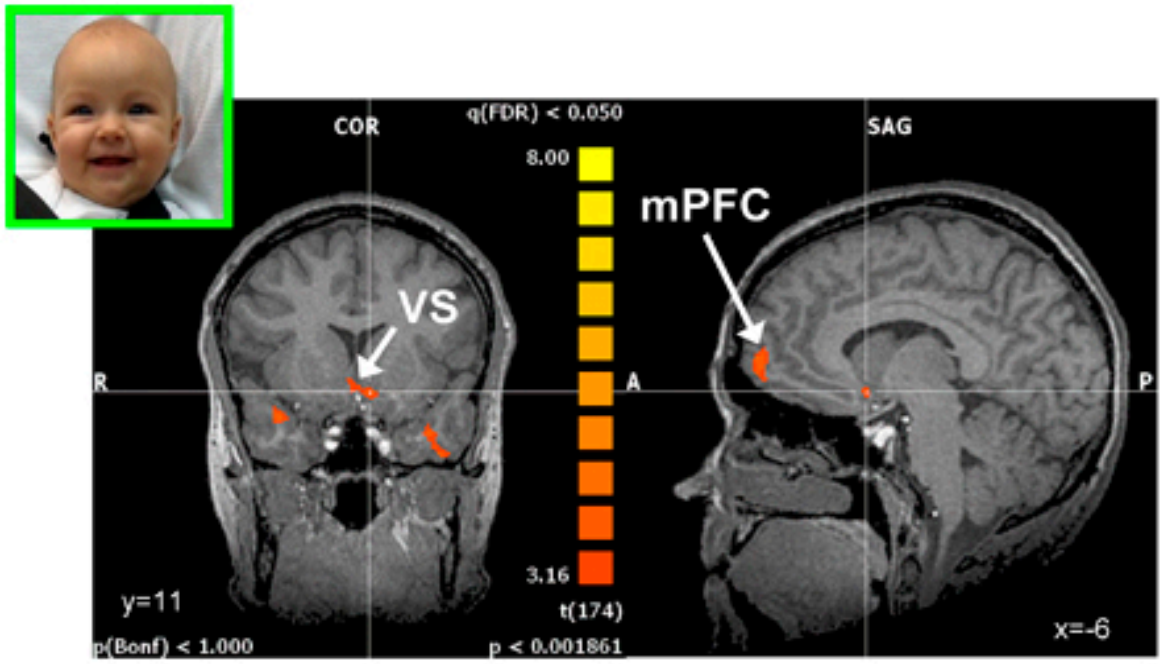
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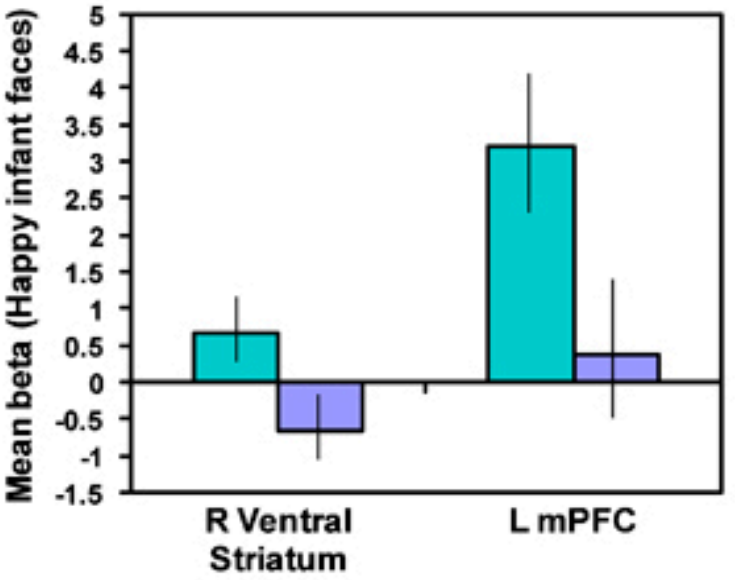
Mean beta (Happy infant faces)
5
4.5
4
3.5
3
2.5
2
1.5
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-0.5
-1
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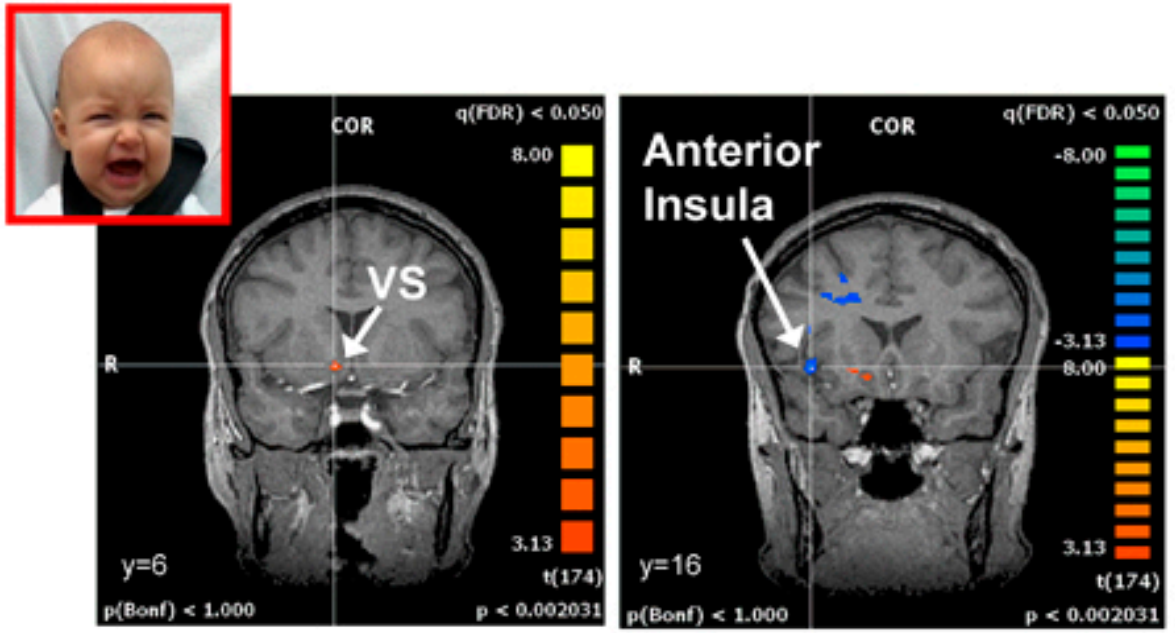
R Ventral Striatum
L mPFC

b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Anterior Insula
COR
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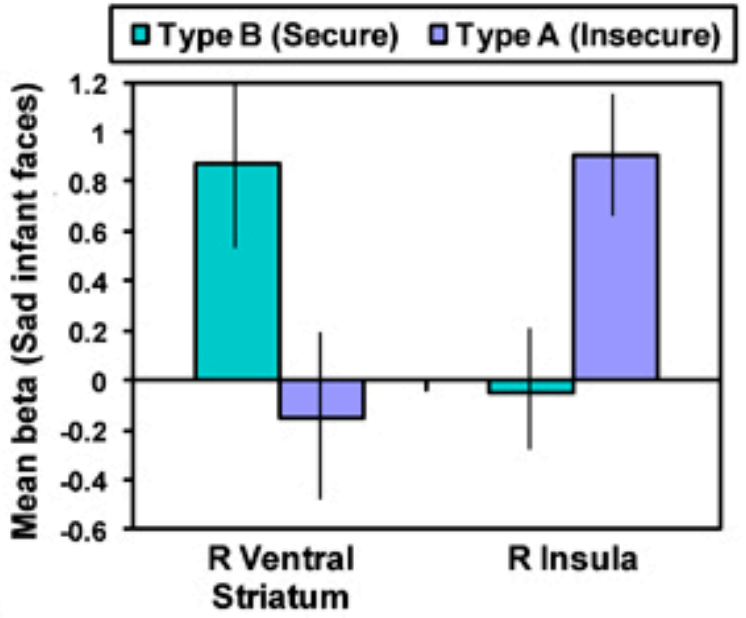
Type B (Secure)
Type A (Insecure)
Mean beta (Sad infant faces)
1.2
1
0.8
0.6
0.4
0.2
0
-0.2
-0.4
-0.6
R Ventral Striatum
R Insula

So how could this help us think the relationships that cause an ‘Ailment’ in staff?

- Likely to involve people (both staff and patients) who have experienced attachment insecurity as children; possibly attachment disorganisation
- Emotional neglect and deprivation can cause disturbances of attachment like this
- Poor reality testing; idealisation and denigration of others; oscillating vulnerability and grandiosity
- Inability to self-soothe when experiencing fear, ambiguity, loss, rage and envy
- Become preoccupied with (and confused about) the boundary between themselves and others
- Poor mentalising of others means failure of caring relationships; increased hostility towards carers

Suffering, self-deception and power

- Many people who seek and provide mental health care are suffering
- But they may be mistaken about the origins of their suffering and beliefs about how it can be ameliorated
- Manifest and conscious narratives of suffering co-exist with less conscious narratives of anger and grievance
- Both are ‘true’ or have ‘truthiness’; but deception and error are also possible, which leads to suffering
- The transformation of suffering is key to all psychotherapies
- But some kinds of suffering can be entrenched: especially if embodied

A toxic trifecta in 21st century NHS

- The patient is a customer who is always right
- Complaints mean that staff have got it wrong for the patient; weaponised deprivation and disappointment
- If someone is seeking care which is not available to them as adults, this leads to frustration
- But targets, pathways and fear of complaints means that staff do more and more
- Mirroring grandiosity and entitlement
- BUT the organisation joins in to insist that the patient is always the passive partner; and has no agency in recovery
- But then unconsciously rejects patient who doesn't get better as 'doesn't meet criteria for our service', 'doesn't want to engage', ' is too risky for our service' (!)
- E.g the NHS Trusts who send all suicidal patients to a Third Sector charity

Are there people we cannot help?

- Who bring their despair and hopelessness and rage to services to enact a battle that we must lose?
- A high risk battle: often related to eating/not eating; direct attacks on self or others; '*malignant alienation*'
- The refusal to give up childlike states of mind because that means entering a world of adulthood where other people's minds are real and must be engaged with
- Holding on to omnipotence and fantasy; and denigrating care that is offered
- Forcing carers to watch their suffering
- The woman who refused to eat unless she was anaesthetised

What do we need to do?

- Do an updated version of 'The Ailment' as a study: e.g people who self-harming repeatedly in long term private care
- Look at new versions of this kind of malignant relationship between carers and care seekers
- Keep being curious: study attachment dynamics, mentalising and unresolved anger
- Protect ourselves! Attend reflective practice or provide it for all those (patients and staff) who are caught in these kinds of relationship
- Maintain awareness and acceptance that some people may not be able to be helped
- Is there a kind of palliative psychiatry to be offered? A key theme in medically assisted dying