Psychodynamic Systems of Residential Treatment: Another View From Riggs

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Abstract: Many patients lack the capacity to manage intense affects between therapy sessions, and as a result are caught in impasses as treatment becomes organized around fending off the next crisis or recovering from the last. Risk of suicide is often part of this presentation. Among the range of interventions that may help such patients emerge from impasse and treatment resistance is residential treatment, particularly psychodynamic residential treatment. We describe the role of residential treatment for such patients and offer an illustrative case example.

Regardless of theoretical approach, successful outpatient psychotherapy requires a capacity to use the relationship with the therapist and his or her technical interventions. In psychodynamic psychotherapy this includes the capacity to enter an alliance, to develop and use a transference, and to tolerate and learn from whatever degree of regression is part of the work. However, successful outpatient psychodynamic or other therapy also requires that a patient be able to function adaptively between sessions. Many patients in outpatient therapy lack such a capacity, and this has contributed to the growing problem of treatment resistant disorders noticed in our field (Plakun, 2006, 2011).

In response to the need for resources to help patients manage better between sessions, multiple approaches have been developed to support patients’ limitations in containing affects. This is why psychodynamic psychotherapists are wise to carefully negotiate and utilize the therapeutic alliance as a holding and containing device (Plakun,
2009, 2011), and this is how we use medications and groups, concurrent chemical dependency or family treatment, and what the skills training of DBT supports when it is added to outpatient psychodynamic psychotherapy. When patients cannot tolerate the affects mobilized in outpatient therapy sessions they may require acute hospital settings for relatively brief periods, but, too often, once the immediate crisis is past, returning to the outpatient therapy is like leaving the frying pan only to re-enter the fire. Unlike the situation several decades ago, long-term hospitalization is now quite rare, so there is often a revolving door experience of multiple short-term hospitalizations for such patients. Outpatient therapies can then become focused on the ongoing provision of support and/or ongoing crisis management that is always fending off the next crisis or hospitalization or recovering from the last—while the underlying work of therapy—and with it the patient’s progress—become stalled.

In the absence of the option of pursuing treatment in long-term hospital settings, alternative settings have been developed to provide more support between sessions over longer periods of time. These include partial hospital and day treatment programs, which are often helpful, but are also often not enough. For example, many contemporary late adolescent and young adult patients reach a developmental and treatment impasse as they struggle with the challenging tasks of separation and individuation associated with leaving home—often to attend college or after college as they struggle to enter the adult world as citizen and worker rather than student. For these patients managing between sessions means not just tolerating their affects, but also finding a way to function adaptively enough to live independently, to develop satisfying relationships, and to perform adaptively in work or school settings. Day treatment and partial hospital programs that leave late adolescent or young adult patients still living with their family of origin may unwittingly undermine progress by leaving such patients developmentally stuck at home with their “failure to launch” accepted as a fait accompli. Too often the additional support of a partial hospital or day treatment program fails to break this impasse for young adults because the treatment setting leaves them in the role of child still at home in the family, unable to adapt to the role of adult in the world.

This is one reason why residential treatment programs have evolved and make particular sense for the late adolescent and young adult population. Immersion in the developmentally supportive but simultaneously interpersonally challenging environment of a residential treatment program allows treatment to unfold from a starting point on the separated-from-home side of the developmental transition. Even when this physical separation occurs, however, there are often power-
ful underlying ties to the family that perpetuate symptomatic behavior and, if not fully addressed, leave patients feeling unable to exercise greater authority over their lives. The designated patient within a family system may be in a role that spares others from facing difficult issues (Schwartz, 2007). In such cases, the patient’s ability to change may depend on family members’ openness to changes in how the family system operates. Alternatively, the patient may need to face and grieve what is not possible within the family so as to be able to create it with others.

There are several types of residential treatment programs. Some are organized around provision of resources in relation to a particular symptom, like chemical dependency or eating disorders. Some are contemporary extensions of “moral treatment,” operating from the notion that a caring environment of concerned peers and staff will provide the necessary support to help a patient rejoin the stalled developmental process, maintain substance abstinence, and find his or her way into a work role and better relationships. Often these residential programs include an expectation the patient (sometimes intentionally recognized as “guests” rather than clients or patients, as at Gould Farm in Monterey, MA) will do work on behalf of the treatment community, for example helping prepare group meals or farm labor in rural residential treatment settings.

Some residential programs carefully include a therapeutic community milieu with large and small group work and thoughtful structures for providing peer feedback, thus maximizing patient responsibility and including an expectation of competence as an aspect of treatment. A few such residential treatment programs also include intensive psychotherapy in addition to a therapeutic milieu. As a hospital based continuum of care that begins treatment with virtually all patients at a residential level of care, the Austen Riggs Center is arguably the oldest, most sophisticated, most successful and best known of the latter group of residential programs offering both a complex therapeutic milieu and intensive individual psychodynamic psychotherapy. Although Riggs might have looked like a dinosaur 30 years ago as long-term inpatient treatment faded from the scene, it turned out to be a mammal because of its unusual commitment to a fully open setting that maximizes the freedom—but with it the responsibility—of patients. The commitment to patient freedom respects the developmental achievements of people who come to Riggs, and the associated expectation of high enough functioning to warrant that freedom—even in patients struggling with suicide as a symptom. This stance provides a powerful counterbalance to the regressive pulls of being in an institution over lengths of stay ranging from six weeks to many months. It also facilitates a useful and
often successful approach to suicide not simply as a dangerous symptom, but as an event with interpersonal meaning in the transference relationship (Plakun, 2009). In fact, in our work with suicidal patients, 75% of whom were free from suicide as an issue in their lives at mean 7-year follow up (Perry et al., 2009), Riggs stands for the notion that safety is not a function of locks and restriction, but of negotiation of an alliance and achievement of a sense of community.

Residential treatment programs have also proliferated in response to recognition of the growing problem of treatment resistance (Plakun, 2011, 2012). Despite our field’s hope that patients will present with a single disorder that responds to a single treatment, we are learning that most patients suffer from multiple concurrent disorders. For example, 78% of the large, multi-site STAR*D study sample of patients with major depression also had comorbidity or suicidal ideation that were associated with lower rates of treatment response, worse outcome, and that would have excluded them from most randomized trials of medication or other treatments (Wisniewski et al., 2009). We are learning that comorbidity, especially personality disorder comorbidity (Skodol et al., 2011), and histories of significant early adversity (Nemeroff et al., 2003) increase the likelihood that patients will fail to respond to treatments developed and demonstrated to be efficacious in carefully selected populations without comorbidity (Plakun, 2012).

Residential treatment with a therapeutic milieu and intensive psychotherapy offers to treatment resistant patients an experience of immersion in a setting rich in diverse treatment resources. Such settings provide patients and therapists with the support needed to deal with the difficult negative transferences that are often part of working with patients who have not yet achieved the developmental capacity to hate the one they also need and love (Plakun, 2006). Further, such settings maximize the possibility of detecting, analyzing, and utilizing the inevitable transference-countertransference enactments that are part of work with such patients (Kayatekin & Plakun, 2009). Indeed, much of the therapeutic power of psychodynamic residential treatment comes from its capacity to detect, analyze, and utilize interpretively enactments, and negative transference and countertransference more comprehensively than is possible in outpatient settings.

In this article we will present a case illustrating several key features of how treatment is conceptualized and carried out in the residential treatment program of the Austen Riggs Center. We will highlight the unique opportunities the open, psychodynamically oriented residential treatment setting offers. In particular, we will discuss how certain patients—those with dual diagnoses, histories of trauma, and other early adversity—benefit from participation in an intensive psychother-
apy situated within the broader context of a therapeutic community program. We will demonstrate the therapeutic value of recognizing and enhancing patient authority, conceptualizing symptomatic behaviors as meaningful communications that require translation, and harnessing human relationships as powerful agents of change.

A few words about the treatment program at Riggs are in order to provide a context for what follows. Riggs is a not-for-profit, hospital-based continuum of care that treats about 65 patients. Virtually all patients found to be appropriate for admission enter a residential level of care. The first 6 weeks, which for some patients constitutes the entire length of their Riggs treatment, consists of intensive evaluation and treatment during which patients are assessed from multiple perspectives even as they are immersed in a treatment setting with an intensive milieu and four times weekly individual therapy with a doctor on the staff. This initial period culminates in a 2 hour case conference that the patient joins for about 20 minutes to shape the discussion, and where the assessments from the individual therapy, nursing and community perspectives, family evaluation, projective testing and medical and psychopharmacologic perspectives are presented and integrated. Although some patients return to outpatient treatment after these 6 weeks, most stay longer, with the median length of stay about 5 months, and then move through a range of step-down programs from less staffed residential programs to day treatment and an intensive outpatient program.

Given the focus of most health insurers on behaviorally oriented outpatient treatment or brief inpatient treatment geared toward crisis intervention, few insurers cover treatment at Riggs. It is unclear at this writing whether implementation of the Affordable Care Act, with its mandated parity and exclusion of quantitative and non-quantitative limitations to mental health treatment that are not also used in medical and surgical care, will increase insurance coverage for residential treatment in policies sold on insurance exchanges. Although about 30% of Riggs patients currently have insurance pay for all or part of their treatment, the majority of patients pay out of pocket. The all-inclusive cost for the evaluation and treatment phase is about $1,200 daily. For patients who stay beyond the more expensive phase of initial evaluation and treatment, the average patient pays about $750 for the average day, including all room and board and therapy fees, but excluding the cost of medications, which are usually covered by a prescription drug benefit. Fee reductions are offered based on need, and this can make this kind of treatment accessible to patients who could not otherwise afford it.
About 60% of Riggs patients are women, with the average age in the late 20s, though patients range from 18 to their 60s and beyond. The average patient meets DSM-IV criteria for six disorders, 80% with a treatment resistant mood disorder comorbid with a borderline or other personality disorder, though comorbid substance use, eating and anxiety disorders are frequent, as is PTSD (Plakun, 2006). About 15% of patients have psychotic spectrum disorders.

Treatment at Riggs and other comparable residential settings is structured so that patients are able to broaden their involvement beyond the therapeutic dyad, and to integrate these engagements into complex understandings of themselves and their troubles. Patients interact with one another and with staff through numerous offerings in the therapeutic community program, including patient government, process groups, and DBT informed coping skills workshops. Additionally, they have individual meetings with a social worker, psychopharmacologist, and nurse, and when indicated, a substance use disorder counselor and dietician as well. There is also an activities program where patients assume the role of student rather than patient, learning woodworking, fiber arts, pottery, painting, and acting. This breadth of potential engagements allows patients to titrate their involvement with their therapists as they experiment with other aspects of themselves across the institution. The dispersal of transference elements also reduces some of the pressures therapists face when working alone with highly symptomatic, impulsive, and destructive patients. In turn, this helps therapists maintain their role and focus on the relational pressures, communications, and meanings embedded in symptomatic behaviors, as opposed to rushing to manage crises or being rendered a helpless bystander (Shapiro, 2009). Lastly, working closely with colleagues who possess confirmatory and alternative perspectives on a given patient also allows therapists to more readily face how unique features of their own psychologies might be interacting with those of their patients in enactments that perpetuate or even exacerbate the patients’ difficulties.

Individuals break apart and disperse transferential representations of self and other for a number of reasons. Sometimes this results from fear that hateful feelings will overpower loving ones and therefore must be kept separate to preserve what, or who, is good. A patient might split a transference by participating in courteous conversations with the therapist he depends on while brutalizing other members of his treatment team between sessions. Fear that loving and hating the same person might destroy the scarce resources therein necessitates such disparate behaviors.

Some patients have never experienced sufficient safety and attuned responsiveness to build what then might be dismantled. Rather than
engaging in splitting, they present diffuse states of arousal not yet organized into discrete feelings of self in relation to other. Indeed, others and the patients’ own unbounded longings and aggression are so terrifying that contact is mostly avoided. By providing a range of environments with varying degrees of interpersonal interaction, structure, stimulation, and support—for example, community meetings, opportunities to work on campus at the greenhouse or Montessori nursery school, social outings with other patients, learning alongside others in the activities program, and multiple levels of care that adjust a patient’s proximity to nursing, degree of independence, and so on—such patients are able to calibrate their engagement and arousal. Through establishing contexts for tolerable interpersonal distance, they can move into the critical work of identifying feelings and building a greater sense of coherence so that they might take on the challenges and opportunities associated with broadening and deepening their involvements.

One way of conceptualizing the rich array of presentations one sees in a residential treatment setting is through the lens of multiple transferences. For example, a patient’s seemingly disconnected ways of being with other patients and members of the staff might demonstrate different facets of how he or she conceives of him or herself in relation to different family members and, when considered together, to the family system as a whole. Our patients often come from families in which parents and parent substitutes have struggled to come together around the task of their child’s development, instead unwittingly grappling with their own unresolved difficulties with dependency, identity formation, and agency. By engaging seemingly disparate ways in which patients interact with authority figures across contexts, opportunities emerge to take up the consequences of fractured caretaking and rigid family role delineations.

However, merely creating opportunities for a person to externalize their object world is not adequate, nor does this distinguish Riggs from other residential treatment settings. The crucial difference is in what we consider data, and then how we conceptualize and work with it. As Muller explicates in Reflections on the Open Setting (Muller, 1992), all behavior at Riggs is regarded as public and addressed to someone, and thus all of it has communicative potential when an effort is made at translation. Prior to pursuing the work of translation, though, ciphered, fragmented bits of communication, as well as the individuals behind them, must be “held” and “contained.” Winnicott introduced the notion of holding to describe crucial aspects of the relational environment a mother provides her infant (Winnicott, 1965). He used the term “holding” to refer to how a mother takes her child into her mind and arms in a manner that enables the child to build a sense of coherence and sep-
arateness, and also to playfully experiment with less structured ways of becoming a person. Bion introduced the related concept of “containment,” which refers to how a person collects, tolerates, and helps organize the inchoate thoughts and feelings of another so that over time they can be returned in a more bearable and useable form (Bion, 1962).

Residential programs like Riggs provide a wide range of contexts for holding and containment. Therapists, social workers, nurses, activities program instructors, and members of community, dietary, and support staffs work individually and collectively to take in patients’ experiences in a thoughtful, empathic manner. The differences between these roles and their associated contexts are crucial, as they mark varying discursive and behavioral environments. Among other dialectics, the degree to which patients’ dependency needs are met and their authority and responsibility engaged varies by role and context. When in therapy, for example, a patient enters a particular discursive field that tends to be less structured and thus increasingly colored by powerful unconscious motivations, presumptions, and interpersonal schemas. However, when interacting with dietary and support staff the same patient’s role as citizen and community member moves to the foreground, altering the discursive parameters and behavioral expectations. And, finally, when participating in the activities program, the individual is in the role of student, which among other things demands tolerance of working alongside other students, filtering utterances inappropriate to the learning task at hand, and managing supplies and tools safely and responsibly. The staff works individually and collectively to bring together information gathered in each of these settings such that the richness and complexity of an individual’s presentations, capacities, and vulnerabilities are recognized and thoughtfully addressed.

In addition to holding, containing, engaging patient authority, and providing a coordinated network of relationships and services, residential programs like this attend to the multigenerational history of each patient and the transgenerational meanings of symptoms. Detailed personal and family histories of each patient are collected and offer therapeutic stories that become part of a guiding psychodynamic formulation (Schwartz, 2007). Family meetings are held to learn how each member conceptualizes the patient’s troubles, and to create a space for thinking about psychopathology as rooted in family and social contexts. In the following case example, we will illustrate how these theoretical components of a psychodynamic residential treatment program come to life in the treatment of a patient. The patient is an amalgam of patients treated by both authors, but is written about from the first person voice of the therapist’s experience. Fictional names have been used and details altered in order to maintain confidentiality.
CASE EXAMPLE

Mark, a divorced, unemployed, 25-year-old high school graduate, sought treatment at Riggs because of longstanding depression, volatile interpersonal relationships, and a history of suicidality including two recent attempts. He spent the first 6 months of his 2-year treatment in the component of the Inn Residential Program that emphasizes group work. This program provides 24-hour nursing support while patients also use peers and groups to contain and learn about their symptomatic behaviors. He then stepped down to the Lavan Residential Program (LRP), a residence that is a short walk from the Inn and main campus. Here the focus is on developing interpersonal skills while also taking on responsibilities of independent living, including managing a budget with housemates. After a few months in LRP, Mark stepped down to the Day Treatment Program (DTP) for most of the remainder of his stay. In DTP patients maintain their involvement in 4-times weekly psychotherapy and work with their psychopharmacologist and social worker, but gradually reduce the number of days they participate in offerings of the Therapeutic Community Program, such as patient government and groups. In turn, DTP patients turn their attention to deeper involvement in the local community by volunteering, working, or attending school. Toward the end of his treatment, Mark briefly stepped up to a higher level of care utilized when there are questions about a patient’s program, and when they temporarily require increased contact with nursing staff and peers.

On admission Mark’s diagnoses were as follows: major depressive disorder, single episode full remission; posttraumatic stress disorder; borderline personality disorder (principal diagnosis). Though Mark did not carry formal diagnoses in childhood, early precursors of his later troubles will be presented in his developmental history below.

Mark, the youngest of five children, was raised in the Midwest. He has one sister 4 years older, and three brothers, 6, 8, and 10 years older. Mark was two weeks premature, weighed 5 pounds at birth, and spent the first several days of his life in an isolette in a neonatal intensive care unit. He relayed a story he had heard from his siblings about how, despite the fact that he was to have limited contact with family members after coming home from the hospital, his sister took him from his crib and held him in her room. Mark’s earliest memories were of checking to see whether his intoxicated mother was breathing, and of his siblings excluding him from conversations because he was “just a baby.”

Mark described his mother as anxious, often intoxicated, and either intrusively involved or neglectful. He said little about his father other
than that he was mostly absent and, when present, prone to sudden eruptions of anger that left everyone in the home quaking. By contrast, Mark reported being very close with his maternal grandfather, whom he experienced as kind and emotionally responsive. He died of cancer when Mark was 5.

Beginning around age 5, Mark left his room most nights and slept in a window seat by the stairwell in the hope his parents would leave their bedroom for a drink of water and happen upon him. He dreaded being in his bedroom because his sister routinely entered in the middle of the night and began molesting him while he was sleeping. The incest began when Mark was 6 and continued until he was 14; it ended when he forcefully pushed his sister away in response to one of her advances. Initially, she fondled his genitals, but later inserted objects into his rectum as well. As Mark entered adolescence he and his sister exchanged oral sex; Mark recalled ejaculating and being terrified his sister would get pregnant despite the fact that he knew this was impossible. Socially, Mark had few friends and started feeling like “a total freak” once the incest began.

Mark was guarded when asked about his sexual development. He identified himself as heterosexual, but said his sexuality was a confusing topic given his history of incest. Mark masturbated for the first time around age 15, but had no particular images in mind when masturbating and did not feel aroused. He had his first sexual relationship at the end of high school. Though he initially panicked around intercourse he eventually spoke with his girlfriend in general terms about the incest; she responded sensitively and supportively and they had mutually enjoyable intercourse. Two years after graduating from high school Mark’s girlfriend broke up with him because of his emotional volatility.

Mark took a job at a retail store and his parents helped finance his living expenses. He changed jobs frequently because he often spent weeks at a time collapsed in his bed watching television reruns; periodically his parents intervened and “literally dragged [him] out of bed.” Though close with his next older brother, Mark had little contact with his other siblings, refused to see his sister, and generally avoided his parents. At age 21, while intoxicated at his father’s company party, Mark was escorted away by family members after he blurted out his sister had molested him. Months later, his parents told him to “forgive, get over it, and move on.” Mark also had one conversation with his sister who stated that she felt bad about what had happened and hoped they could put it behind them.

Mark spent the next several years isolated and inundated by memories of his sister sexually abusing him. He began outpatient therapy, but, despite liking the therapist, Mark felt unable to speak freely about
his history. He became acutely suicidal and was briefly hospitalized several times. Ultimately, Mark made two serious suicide attempts by overdose of prescribed medications, but was unable to provide any context for these to his therapist. Mark stated that he had carefully planned the attempts to ensure he would not survive, but that strangers had interrupted him by chance and intervened. After numerous failed medication trials and his sense that he could not safely address his history of incest using outpatient resources, Mark sought admission to Riggs for immersion in a residential treatment environment.

In addition to the life history I collected from Mark in the first weeks of his treatment, Mark’s social worker spoke with his parents to gather information about the family over the previous two generations, which was then shared with Mark and me. Mark’s mother was one of five children. She reported being “raised by [her] siblings” and said she always imagined her children would “take care of one another.” Her own mother died of cancer when she was 5, but she quickly remarked that she and her siblings supported each other and did not have much reaction to this loss. She stated that her father provided for the family and her mother had been loving and available to her siblings and her. While Mark’s mother acknowledged consuming alcohol regularly, she denied any family history of substance use disorder, serious psychiatric illness, or suicide attempts.

Mark’s father, a real estate developer, was an only child. He reported being close to his mother growing up, but reported a distant relationship with his father. He had trouble making friends and longed for siblings, primarily to help him feel less lonesome. Mark’s father acknowledged having an unpredictable temper, but added that he had an enormous number of responsibilities and merely got “stressed out” from time to time like anyone else. He stated that his marriage was “picture perfect,” and that he could not understand why Mark was having so much trouble, particularly in light of all of the financial support he gave him and how successful his siblings were. Mark’s siblings held prestigious jobs and presented “ideal families,” though Mark suspected underlying chaos and dysfunction.

Mark presented for initial therapy sessions with a clipboard. He clutched it anxiously when coming to the end of his list as though desperate for another one to appear. He itemized daily tasks and responsibilities and seemed panicked when there was space for freer conversation. Though amiable in my presence, he interacted aggressively in the community, scolding and criticizing other patients and devaluing staff members. Several times a week he told nurses he was leaving treatment, though he did not share this plan with me. In an early hour I said, “You’re keeping this space with me tidy but are explosive next
door and teetering on the edge of ending our work.” Mark replied, “No shit,” and proceeded to comment on my intellectual sluggishness and general unhelpfulness. He returned to his clipboard and muttered: “It’s okay. I’ll work this out. I’ll take care of it,” to which I added, “On your own.”

Mark talked about feeling alone his whole life. He cursorily referenced the incest and then associated to his father coming home from long days at work and the kids scurrying “like vermin.” I suggested to Mark that his use of the word vermin implied something wild and offensive. He agreed and added that he felt that he and his siblings had infested their father’s life, with the exception of his sister, whom his father prized. A few days later Mark reported screaming at a group of patients for being “fucking idiots,” and I commented on how he was engaging the Riggs “home” as his father. He said he felt powerful in his role and used a dismissive hand gesture. I said I imagined he had seen that a lot growing up, to which he replied, “All the time.” We discussed his rapid movement from a position of vulnerability and terror about being the victim of aggression to becoming the agent of destructiveness.

As his psychotherapy unfolded I learned how Mark was engaging across the residential program’s multiple contexts. On a multidisciplinary treatment team I talked with colleagues about their experiences with him. Riggs treatment teams consist of a senior nurse, social worker, members of the community and nursing staffs, substance use disorder counselor, psychiatrists, and psychologists (Krikorian & Fowler, 2008). A team leader and assistant team leader oversee team functioning, and work to balance management responsibilities—for example, matters related to a patient’s level of care, paperwork, and treatment planning—with interpretive work, including identifying enactments, unraveling the meaning of splits on the team, and clarifying transference and countertransference dynamics. This distinction between management and interpretation is not so sharply defined in practice, as complex psychological and interpersonal dynamics often cleave to seemingly unambiguous management aspects of patient care.

A central aim of teams is to integrate information into a dynamic formulation that is continually revised and builds a textured narrative of patients’ inner worlds, drawing both from their individual and family histories as well as from what emerges in our interactions with them and with each other. This includes reflection on how members of the team are mobilized in order to consider ways in which we might be joining and re-creating family and social roles important to the patient’s difficulties.
Over the first several months of Mark’s treatment, I received the following reports at team: Mark had been elected to a leadership position in the patient government and was carrying out the role with impressive sensitivity and aplomb; he was building a dinner table with seating for seven (notably, the number of people in his family of origin) in the woodworking department of the activities program and, though prone to hostilely excluding peers, he was an earnest, responsible student; in group settings Mark alternated between feeling ridiculed and verbally attacking other group members, and he regularly commented on the incompetence of the staff consultants.

Mark’s psychopharmacologist brought her work with Mark to team meetings to find meaning in the complex reactions he had to taking medication—a perspective we call “psychodynamic psychopharmacology” (Mintz & Belnap, 2006). Mark told his psychopharmacologist he could not imagine being able to address his anxiety and depression. He added that busyness had provided the most reliable form of relief from his suffering, and that he was becoming more anxious in the context of slowing down in psychotherapy and talking about his history of incest. Mark often made medication requests of his psychopharmacologist, only to refuse the medications suggested. When she pointed out this pattern to Mark, he associated to having a stomach ache as a child and briefly considering knocking on his parents’ bedroom door. Instead, he ran to the bathroom, where he vomited and ultimately slept on the floor. Mark’s psychopharmacologist observed the combination of pain and fear about asking for help, which left him alone with his suffering, and she wondered whether this explained Mark’s ambivalence about help in the form of medication. This conversation helped Mark establish a more open dialogue with his psychopharmacologist about his fears of being intruded upon by medication, and fears that, should he ask for help directly, there would be none coming. In his psychotherapy, Mark linked his fear of intrusion to his sister’s sexually abusive penetration of him. He also said he dreaded “applying learning retroactively,” by which he meant that, in asking for help now and receiving it, he could have asked for it in childhood, and, therefore, was responsible for both the incest and his suffering. They eventually negotiated a regimen of daily lamotrigine 200 mg and escitalopram 20 mg, as well as quetiapine 25 mg once daily as needed for agitation. Though he was hesitant to take the quetiapine because of an association he made between drowsiness and vulnerability, he found it useful during periods of heightened agitation and insomnia.

Family meetings provide a context through which to understand how the “treatment resistant” patient may carry particular meanings and functions for each family and its members (Schwartz, 2007). In
families with histories of trauma, how generations have used one another to accommodate and make sense of overwhelming experiences may become clear. During initial meetings Mark’s parents focused on whether he was participating in treatment and meeting measurable signs of progress defined by his father, who chided him and demanded that Mark show evidence of concrete changes he was making in his sleep schedule, for example. Mark’s mother remarked on the hospital grounds and offered saccharine words of encouragement that Mark responded to despondently.

Each patient has one primary nurse, referred to as their Nursing Care Coordinator (NCC), who works especially closely with them throughout treatment. Mark initially dismissed the nursing staff as unhelpful. They experienced him as fiercely competitive for attention, but disparaging of it as soon as it was offered. Mark spoke with me about how “the two buildings have nothing to do with each other,” referring to the patient residence and the medical office building where he met for psychotherapy. He went on, “You make all the money but are clueless and nurses sit around eating and chatting instead of actually taking care of patients.” This picture resembled his childhood experience where his mother was nearby but intoxicated and his father away working. Taking Mark’s description as relevant not only to his history, but also to his current experience of us, we talked on the treatment team about our work together and in relation to him.

Enactments may serve as the primary cause of impasse or the primary engine for change in psychotherapy, but to achieve the latter outcome they must be detected, analyzed, and utilized as opposed to merely being repeated (Plakun, 2007). The treatment contexts and approaches at Riggs help therapists detect enactments in a number of ways, most of which stem from communication between staff members and the work of patients and staff in the Therapeutic Community Program.

One day the senior nurse observed that I was uncharacteristically hard to collaborate with because I seemed too busy to take the time for even brief conversations between team meetings. She and others on team had the sense there was something deeply significant but imperceptibly private occurring in Mark’s psychotherapy. Mark’s social worker said this reminded him of a conversation he had with Mark’s parents about privacy in the home, in which they said privacy was essential for children and they would have needed to violate it to protect them.

As team members wrestled with this enactment and our different roles in it, we discussed the importance of privacy and the risk of it becoming a rationalization for neglect. Through team discussion I was also able to see ways I had drifted into an isolated dyad with Mark. Turning away from team members and treating the dyad as sufficient
potentially highlighted an aspect of the incest wherein parental figures made themselves and were rendered unnecessary. In team discussions we could all join Mark’s perception of difficulties in how the two buildings, and the people within them, were interacting around his care. In turn, Mark elaborated on his childhood sense of disconnected parents and how he waited to be found rather than seeking them out. Following detection, analysis, and interventions based on unpacking this enactment, Mark gradually approached nurses more directly for support following emotionally tumultuous meetings with me, and ultimately developed a close relationship with his NCC.

In their meetings, Mark’s NCC provided supportive interventions with a focus on containing and reducing his unbearable arousal. They identified such strategies as journaling, listening to music, and reading that gave Mark some relief from his overwhelm, and discussed ways of implementing them before he spiraled into interpersonal destructiveness and relapse. Mark and his NCC also recognized that the activities program offered a relatively benign environment where he found relief from the strains associated with other aspects of his treatment. In this role as student Mark was reminded of learning how to fish from his grandfather, and he assumed a different stance in relation to his academic history, recalling important teachers who had helped him feel safe and held in mind. In the activities program Mark exercised many of his adaptive capacities, which balanced regressive pulls elsewhere.

There is a range of group offerings at Riggs that augment psychotherapy. Some orient patients to the treatment and resources at Riggs, while others facilitate interpersonal communication and promote peer support by identifying and elaborating upon members’ shared experiences, and still others address how individuals inform and are reciprocally shaped by group processes that contribute to role delineations that can be both orienting and stifling (Elmendorf & Parish, 2007). Since Mark’s discharge a DBT skills training group, which explicitly teaches patients skills to tolerate affects, has been added as well. All these groups share an emphasis on patient authority and the mutative power of human relationships.

Mark became an active member of multiple groups during his stay, loosening his stance of counterdependent self-sufficiency through meaningful exchanges with peers and staff. He learned that he was not alone in his struggle to integrate his vulnerability and aggression, or in his remarkable strengths and profound difficulties. Mark also explored his competitive feelings and tendency to dismiss staff members and attempt to take over their responsibilities. Some groups came to represent his family, and Mark learned about a role he often occupied as the alone
and unseen child who was susceptible to transgressing boundaries as a way of securing contact that he felt unable to access otherwise.

Other patients provided a critical function in Mark’s treatment, expanding the range of transference paradigms he was able to take up and learn about, and providing him invaluable feedback and support. He made good use of a resource provided through the patient government called the Task Committee (Elmendorf & Parish, 2007). This group of elected patients and one or two staff consultants meets twice a week to talk with patients who have run afoul of community behavioral expectations or acted in ways that are problematic for themselves and/or other community members. Mark met with this group several times regarding his angry outbursts. Other patients told him they wanted to know him better but found him unpredictable and frightening. Some commented on how unsafe they felt around him because it felt as though “anything could happen.” They also acknowledged relishing his explosiveness because it sometimes expressed what they were feeling but were too cautious to say. Though he initially dismissed their comments as irrelevant and stupid, over time he was able to link them to a position he had occupied in relation to his parents. He talked with other patients about how fearful he was of being hurt and used, which often prompted him to lash out, and he remembered how terrified he felt as a child when those around him were intoxicated and his father erupted in anger. Mark also described his difficulty knowing who he was, and his related fear that he and others would merely find a damaged and uninteresting person if they got to know him better.

In his psychotherapy Mark faced similar fears, but he gradually described experiences of being overpowering and in physical pain as his sister penetrated him, sometimes with her friends involved. He also shared memories of feeling close, connected, and soothed by her presence, which contributed to the disorganizing nature of this experience. In one hour I lingered on Mark’s comment that all his troubles started with incest. When he replied that nothing of significance occurred before then, I reviewed his birth, the climate of his early childhood, and the death of his grandfather.

Mark suddenly withdrew. He missed several sessions and when present appeared incapacitated and lifeless. He swiftly extinguished moments of connection and showed no interest in reviewing the moments leading up to his withdrawal to learn more about what had informed it. In response, I noticed myself either pressing more actively than usual for lively interaction or retreating myself. When I withdrew, Mark anxiously pursued me with stories and associations that I found fascinating but difficult to take up with him. I commented on this pattern and my sense that only one person in the room could be alive.
Mark associated to his mother’s alcoholism and said that as a child he felt charged with the tasks of emptying her bottles and bringing her in from the cold when she passed out in the yard. These scenes generally ended with him struggling to enliven her for fear she had died. Mark returned to a prolonged state of collapse, again missing appointments and resigning from his position in the patient government. I offered the idea that Mark and I were caught in an important story concerning his relationship with his mother; at times I was in Mark’s childhood position trying to bring his mother into life, while at other times he was doing this with me.

In contrast to never feeling connected to his mother, Mark regularly experienced closeness and tenderness with his grandfather. Mark sobbed as he recalled long walks with his grandfather on a nearby farm, sitting on his lap trying to catch his breath through peals of laughter, and quieter moments talking over breakfast when it was just the two of them. He went on to talk about his grandfather moving in with the family while battling cancer. Mark described his withering body and brutal cries of pain, and how Mark avoided contact with him during the final days of his life. We explored the timing of this devastating loss and how it coincided with his mother’s age when she lost her mother, and preceded the incest between Mark and his sister, which potentially contributed to the confusing blend of pain, longing, and soothing therein.

At this point in his treatment the word incest had not been used. When Mark started to speak of being raped and molested he stopped himself and remarked on his need for “a different word.” He said the words he had been using were accurate in terms of how they captured the violence inflicted upon him by his sister. However, Mark had recently been considering the word incest because of his growing awareness of how the entire family, himself included, were implicated in what had occurred and continued over so many years. Mark talked about how sexual contact with his sister was sometimes soothing and helped him feel less alone, which in part kept him from ending it sooner. He considered how other family members claimed they had no idea the incest occurred despite the fact that he and his sister were often slamming doors in the middle of the night and he routinely turned on the television or noisily prepared a snack in the barely conscious wish for someone to intervene. Mark also explored his sense that his parents had refused to parent their children, instead leaving them to one another. This work proved incredibly difficult for Mark and he repeatedly interrupted it with more familiar accounts of his sister as a monstrous figure responsible for everything, or targeted himself as guilty and despicable.

In this context I learned from team members that Mark had been verbally abusing a female patient, following her around campus and
aggressively entering her room. Mark did not share this with me and I again found myself in a bind. On one hand, I wanted to hear directly from him rather than introduce material brought to me by others, and on the other I was reticent to postpone engagement about something potentially destructive not only for Mark, but for another Riggs patient as well. Patients and other members of staff had been clear with Mark that his behavior was unacceptable, but as his therapist I occupied a unique position relative to the transference meanings of his actions. I shared my dilemma with Mark and suggested I was in the position of the uninvolved parent failing to mind my children. Mark cried and then angrily stated that his parents were clueless. He also acknowledged not coming to me directly with information and how this placed me in a challenging position.

Several weeks later I left for vacation. Over the weekend before my return, Mark attended the high school graduation of a family friend with his siblings and parents. Though he rarely consumed alcohol because he feared developing a drinking problem as his mother had, he got drunk and called his mother a “blind bitch.” Mark did not return to Riggs for his Monday appointment. He called me on Tuesday and said he was not feeling suicidal, but added that Riggs was a terrible place and nobody could help him. He then angrily demanded phone sessions with me. I replied that I wanted to talk with him about his request and my refusal to meet it in person during his 8:30 A.M. appointment the following morning. He said he doubted he would see me the next day. When I asked whether he was feeling suicidal presently, he assured me he was not and that he would return to Riggs sometime over the following week. I stated that I planned to see him the next morning.

Mark arrived the next morning at 8:31. He told me he had lied and had been acutely suicidal over the previous few days, and had called several patients and told them he was going to end his life. As I listened, I felt betrayed and angry, and I noticed how Mark’s pattern of undisclosed suicidality with his outpatient therapist had now entered his work with me. I also imagined I was feeling Mark’s anger at me for going away. He told me I seemed angry. I confirmed this was the case. He screamed, “You left my fucking treatment!” I clarified, “I left for vacation. You left your treatment.” Mark slid back in his chair and spoke about what a terrible, worthless person he was. I suggested he was placing badness between us to interrupt our exchange of strong feelings. Mark then spoke of being furious with me for leaving him so alone with unbearable feelings, and for not demonstrating the least bit of regard for him.

Though Mark had not acted on his suicidal feelings, we talked about how he kept himself mostly alone with them. In telling other patients
he was going to end his life, Mark symbolically turned to siblings rather than parents with his distress, longing, and rage. I, in turn, again occupied the position of the unapproachable and unusable parent. We discussed these aspects of the enactment and Mark struggled most around the question that emerged about his responsibility. In returning to my statement about him leaving his treatment, we considered his decision to break from our agreement that he would let me know if he felt suicidal, all the while acknowledging how challenging this agreement was for him to uphold, given his history and terror of “burdening” his parents, and in the transference, me, with his dependency and despair. The issue of responsibility recalled his work with his psychopharmacologist and his fear that responsibility would be applied retroactively, leaving him unduly burdened with total responsibility for incest.

Over the next few months Mark made several requests for me to change appointment times; in a few instances he asked to meet after standard Riggs therapy hours. This brought us back to his request for a phone session and his feelings about my refusal to meet it. Initially, Mark said it was evidence that I did not “really give a shit,” to which I replied, “as though caring is demonstrated by breaking from our usual, agreed upon structure.” Mark commented on items in my office, left his chair, and proceeded to pick several up. He put them down in different places and I remarked on his handling of my space, and by extension me, as an object he could do with as he pleased. I raised the possibility that this represented a search for a firmer limit. Mark apologized, returned the objects to their original places, and spent the next number of weeks talking about his wish that firmer limits had been set by himself and others long ago.

Mark appeared more stable and confident in subsequent weeks and began planning for his future. He stepped down to a lower level of care and took on greater independence relative to managing his medications, preparing meals, and spending less time using individual meetings with nurses in favor of more time with peers. As he advanced in a number of areas, however, he struggled with paralyzing bouts of shame and a number of dreams involving beautiful faces “spoiled” by blemishes, and stylish furniture with cracks and wobbly legs. These dreams, the first of his treatment, seemed to reflect a developing psychic structure. They also suggested his sense of being damaged and ashamed despite his gains, and expressed concerns about the sturdiness of his progress. Mark also associated to the table he had built and commented on how it looked more perfect than his actual family.

In therapy Mark suggested we bring his siblings into family meetings, including his sister, to discuss incest in a textured way that was not simply about blame and victimhood. As this was being discussed
in Mark’s therapy, his parents started canceling meetings and asked for proof of his progress, as if they dreaded the possibility of these discussions unfolding. In this context Mark again became volatile in the Riggs community. He talked with me about feeling abandoned by his family again and shared a wish to destroy them by destroying himself, “except for the fact that they would not really care.” I talked with him about being on the edge of destroying his treatment if he did not rein in his aggressive behavior.

In families with suppressed incest histories it is our experience that addressing the incest in family work, even when it has already been acknowledged by family members, is a delicate but also potentially transformative treatment opportunity. Efforts to bear the loss, longing, rage, guilt, despair, and chaos that come with facing incest collectively raise the question of whether the family system can hold and contain what it could not previously. In this family, facing its incest history challenged previously fixed roles of perpetrator and victim, of aloof parents and out of control children by making more complex the factors contributing to incest, and how it may have been an unconsciously determined solution within the family system as well as a serious problem. In a family meeting around the time of Mark’s initial thinking in individual therapy about bringing the incest into the family work, his father made an argument for discharge, highlighting “the facts of the case,” such as “exhibits A, B, and C.” I acknowledged the difficult place Mark’s parents were in as they measured Mark’s treatment against select markers they had identified as a good return on their investment. I also noted that Mark’s father had used courtroom language, and wondered whether it was tied to anxiety about blame; he shouted back that discussing incest was all about blame, and that Mark had supports at Riggs while the rest of the family did not. However, he proceeded to speak more openly than before of the strain of raising so many children and how he often felt overwhelmed. When he told Mark how much he cared about him, Mark replied that rather than to blame, he wanted the family to talk together about “all kinds of feelings that haven’t been expressed.” Mark’s social worker reiterated that he was available to talk with Mark’s parents between meetings, and that if they felt in need of additional support he would be glad to make referrals.

Mark’s parents said they were ready to accept Mark’s invitation for future meetings, potentially with his siblings, but then cancelled two more appointments. When we addressed their frequent cancellations at the next meeting they attended, they stated that they could not continue with the meetings as they found the subject matter overwhelming. Shortly thereafter, they set a firm financial limit for Mark’s treatment.
They were not ready to accommodate his request that they find a way to speak the unspeakable.

In the final month of Mark’s treatment we focused on reviewing his work at Riggs, crafting a discharge plan, and saying goodbye. He struggled talking with me about the end of our work, often sobbing in sessions and unable to speak. He told me he feared losing himself with the end of his psychotherapy and repeatedly expressed his temptation to leave several days early without saying goodbye. I interpreted our ending as comparable to his experience with the death of his grandfather.

Once this connection was made Mark talked about feeling less alone, and added that for the first time he found himself carrying other people in mind as soothing figures he could turn to in moments of emotional distress. Despite Mark’s articulateness and insight accompanied by powerful affects, he also momentarily returned to paralyzing shame and provocative suicidal threats. As I engaged this behavior in sessions he openly shared his anger and desperation about the end of our work. He said the more relevant factor, however, was his parents “turning their backs again.” In addition to his anger at them, Mark proposed that completing suicide might help bury a family trauma, relieving himself and family members of the pain of facing it together. Further, he sometimes thought they would only see him through his suicide. We talked about how he only survived past suicide attempts through unanticipated interventions. I linked this to his childhood wish that his parents would stumble upon him in the middle of the night to care for him when in need, and interrupt his damaging sexual involvement with his sister.

Mark’s serious ongoing risk for suicidal behavior was also addressed in final family meetings. Despite this risk and against my recommendation, his parents refused to finance further residential treatment at Riggs or elsewhere, stating that they had invested an enormous number of resources and were not satisfied with the results. However, they also tearfully acknowledged being unable to fully join him in his request to discuss the incest and said they had a better appreciation of how devastating this felt to him.

Mark ultimately constructed a discharge plan relying on money his father had invested for him. He openly talked about a resistance he felt to working, because in his mind doing so would relieve his parents of the only remaining scrap of responsibility for him. Mark interviewed several therapists and decided on one before leaving, and also planned to attend groups in a day treatment program. In his final session with me we shared a moving goodbye.

Some weeks following his discharge, Mark purchased acetaminophen and initiated an overdose. However, he interrupted his overdose,
called his therapist and the local emergency room, and was treated medically and released. A few days later Mark telephoned me. Mark told me he took action to end his life because he was enraged with his parents for putting a financial limit on his treatment when he had called for deeper family engagement around the incest. He stated that he wanted to hurt them but quickly realized this would solve nothing, and that for the first time in memory he did not want to die. Mark told me he thought about me as he began ingesting the acetaminophen. He reflected on the deep attachment he felt to me and how painful it was to end our work together. Mark also considered the conversations we had about the blending of this loss with the death of his grandfather, and how he was vulnerable to feeling left in the world unequipped, alone, and uncared for, though he also realized this was no longer true. He apologized to me for initiating the overdose, which he viewed as an attack on our work, as well as a protest against it ending, and reported he planned to engage these issues with his new therapist.

**DISCUSSION AND FORMULATION**

Mark entered treatment haunted by traumatic experiences of neglect, loss, and incest. He presented as intelligent and competent, but also bellicose and interpersonally destructive. Possessing little capacity to tolerate, identify, and make use of his feelings, they burst forth in ways he struggled to manage, leaving him alone, confused, and ashamed.

Mark entered the world isolated. His prematurity at birth kept him from immediate contact, and the contact that followed involved his sister touching him as a baby even though he was “not to be touched.” This foreshadowed later incest, which started in the context of Mark losing his beloved grandfather, a loss resonant with Mark’s mother’s loss of her own mother in latency. Mark’s mother had relied on her siblings to manage her grief and dependency needs, and she assumed her children would do the same. It is possible that Mark’s mother looked to her children to rely on one another so as to hold off the unprocessed mourning she would otherwise encounter were she faced more directly with their longings. Though Mark found contact and soothing for unmet pregenital needs through his sexual involvement with his sister, he also encountered violation, pain, confusion, and crippling shame. The incest exacerbated pre-existing terror about turning to his parents with his needs, as he came to feel both his needs and manner of attempting to address them were despicable.

In treatment, Mark easily drew others in with his intelligence and charm, but just as quickly obliterated them with rage and contempt.
Each time his wish for interpersonal closeness was roused he extinguished it, which held off intolerable longing and fear of exploitation, but also perpetuated his isolation. Mark’s volatility involved mimicry of his aggressive father, in relation to whom he struggled to secure resources for connection, identification, and guidance. It also operated as a reversal of his passive role relative to his sexually aggressive sister. Further, Mark’s hostile, bullying presentation amounted to a brittle effort to secure a position in the world as a son and as a man, though both were constructed on compromised foundations of absence and violation that left him with a hypertrophied, stereotyped posture of masculinity.

When viewed through the lenses of split and multiple transferences, Mark’s involvements with other patients and team members could be taken up within his psychotherapy as aspects of family and personal stories, as well as a commentary on his present troubles. Mark depicted childhood scenes of neglect in which it was left to himself and his siblings to sort through, or more often to inflict, what was unbearable. These scenes were clarified as we noticed his experience of me as the unavailable parent, the overstimulating sibling, or Mark himself in relation to one of these internalized representations of important others. In the role of parent, he experienced me as failing to connect with my colleagues in the service of his development, thereby highlighting his childhood difficulty locating a functional parental pair. In the countertransference, I unwittingly joined his perception with a complementary withdrawal from my colleagues that confirmed his expectation, and likely stirred further anxiety about becoming a pair that is detached from any representative of the third (Muller, 2007).

Through identifying and interpreting these transferences and enactments, Mark began to feel seen, and came to see himself more clearly. He developed an improved ability to name his feelings, to risk bringing them into his psychotherapy, and to attempt to discuss them with his family. This work was particularly challenging around issues of blame, responsibility, and suicidality. Loosening his stance as purely a victim of abuse opened the possibility to consider his involvement and the roles of family members in a shared trauma. This courageous work taxed not only Mark, but other family members as well, and ultimately led to the financial limit his parents set.

Though his suicidality did not resolve entirely by the end of his treatment, it was modified in significant ways suggestive of a more promising outpatient course. For the first time, Mark interrupted his post-discharge suicide attempt and actively sought help. Rather than having no one in mind and no context for thinking about his suicidality, which was the case in previous attempts, he thought about me and was able
to identify precipitants to his overdose. Perhaps most significantly, he stated that for the first time in years he did not want to die. He also seemed ready to face his grief that the family he had, with its limitations in terms of enduring more open discussion of the experience of incest, while not the one he hoped for, was one he could live with.

CONCLUSION

Mark’s case illustrates the benefits of immersion in a comprehensive psychodynamic residential treatment program for an emerging adult treatment resistant patient with comorbid mood and personality disorders. The case example demonstrates that intensive individual therapy may be conceptualized as a necessary but not sufficient ingredient to emerge from impasse with such patients. Beyond individual therapy, the perspective of a treatment team, supportive engagement from nursing staff, family work, participation in groups, opportunities for involvement in community government and work roles, and ongoing feedback on and contextualization of behaviors allow for the dispersal and then gathering back up of intense positive and negative transfers, and support the therapist’s ability to detect, analyze, and utilize enactments to deepen the work. Mark’s case offers the sobering lesson that change in one individual may lead to dysregulation of the rest of his or her family system if its members cannot face their shared history in a new way. It also raises important questions about how best to support family members as the process of unpacking the designated patient role reveals troubling and sometimes unbearable experiences for all family members. This is a complex topic extending well beyond the scope of this article.

As is often the case, discharge occurs not when therapeutic work is complete, but when a patient is able to utilize outpatient therapy more successfully because of insight into enactments and impasses, achievement of a greater capacity to tolerate intense affects in and between sessions, and commitment to the terms of the therapeutic alliance, including keeping himself safe or letting someone know if he cannot. Even in cases like Mark’s, in which suicide is not fully resolved as an issue, it may be enough if suicide has moved from symptom without context to an action the patient understands and limits through internalization of the terms of the therapeutic alliance. Such an achievement allows suicide to be contained within the therapy, where its meaning and associated affects can be explored without eruption of a full suicidal crisis that leads to hospitalization and potentially to the end of the work or of the patient’s life.
Though access to such comprehensive programs is limited by the reimbursement priorities of an overwhelmed health care system, there is reason to believe that for many patients such treatment offers the best hope for emerging from impasse, chronic crisis management, and treatment resistance.

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