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Excursions in countertransference: treating complex trauma, structural fragmentation, and psychosis in a bipolar gay man

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ABSTRACT

This article chronicles an extended psychoanalytic treatment of a bipolar gay man who suffered from unremitting suicidal depression, mania, paranoid psychosis, and psychic fragmentation due to severe complex trauma and developmental deficits in attachment and cohesive self-structure. Following his initial hospitalization within an inpatient psychiatric facility after a suicide attempt, I present his course of treatment in outpatient practice over a four-year period that highlights the psychodynamics of the case, the treatment parameters, and the multiple crises that led to chronic suicidality, re-hospitalization, manic psychosis, and an eventual incarceration in prison for criminal theft and fraud due to an unconscious death wish and need for self-punishment for being homosexual. In atypical clinical honesty, I discuss the various countertransference enactments I engaged in as I struggled with the treatment, such as encouraging the permeability of the treatment frame, offering unsolicited self-disclosure, visiting his house, running personal errands, taking him to the hospital, giving him a gift, precipitously accepting and returning phone calls, engaging in lengthy, ongoing email discussions, and letting the patient run up a large debt. It is for these reasons that it becomes instructive to consider just how far one should go in the name of therapy. Implications for clinical discourse in countertransference are discussed.

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1. Introduction

It may be argued that most psychopathology is largely due *to developmental traumas* acquired in childhood that disfigure the personality with overdetermined degrees of specificity in symptomatology and erode healthy capacities for adaptation, attachment, affect regulation, and cohesive self-structure required to live a well-adjusted life (Mills, 2005a; Fonagy, Gergely, Jurist, and Target, 2002). Rather than view clinical disorders from a genetic, neurobiological, or organic framework that collapses the qualia of lived existential reality into causally reductive ontologies (Downing and Mills, 2017), clinical symptomatology and pathological manifestations may be conceived as failed attempts at compromise formation informed by developmental traumas that predispose the subject toward suffering and mental health issues later in life (Cassidy and Shaver, 2018). When trauma is acute, cumulative, complex, or extreme, the psyche is more susceptible to fragility, dysfunction, intrapsychic decompensation, and emotional crises that are clinical amplifications due to structural deficits in the self and the failure to cope based on earlier developmental configurations in object relations, self and object representations, psychic integrity, modulating affect, and unabated unconscious conflict tarrying in the shadows.

Since Freud introduced his trauma model of psychoneurosis (Breuer and Freud, 1893-1895), the field of traumatology has saturated the mental health landscape to the degree that trauma has become the contemporary counterpart to classical conceptions of neurosis. Today, trauma discourse is ubiquitous when considering the etiology of psychopathology across many clinical disorders and spectrums within and between different mental health disciplines, hence showing growing multidisciplinary trends in trauma studies that take into account childhood attachment deficits (Solomon and George, 1999), parental neglect and loss (Bowlby, 1988), abuse of all kinds, systemic familial, communal, ethnic, and religious violence, and the nefarious impact of terror (Knafo, 2004), forced immigration and diasporas (Beltsiou, 2016), geopolitical conflict and war (Stout, 2017), torture (Luci, 2017), and cultural genocide.

Within contemporary psychodynamic paradigms, the role of relational trauma (Schore, 2009; Mitchell and Aron, 1999), dissociation (Bromberg, 1998; Stern, 1997, Howell, 2005), affect regulation (Schore, 2016), and mentalization (Busch, 2008; Jurist, 2018) has taken

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center stage, hence informing the way we conceive of mind, the subjective psyche, social collectives, treatment interventions, and the therapeutic relationship. As a psychoanalyst, I will confine myself to this genre with the acknowledgement that there is much overlap in conceptualization, technique, and clinical praxis that many therapists share in their approach to treating trauma (Greenberg, 2020; Charles, 2012). Within the psychoanalytic community, trauma has a broad meaning and can apply to a number of clinical sequalae, syndromes, and pathologies from parental absence, lack, and deprivation to overt abuse, either discrete or prolonged, which may be secret and sequestered to personal private experience, or witnessed as objective occurrences, to the accumulative effects (Khan, 1963) of harboring protracted psychic pain. Although concrete traumatic events can interpose and revisit patients throughout their lifetimes, those who suffer from psychological vulnerabilities due to early compromises in psychosocial development and familial attachment breaches often have less resiliency (Fonagy, 2001), are prone to experience re-traumatization and mental illness, and generally have heightened reactions to stressful events as they grow older. In fact, parent-child disruptions in relatedness such as the ability to mutually reciprocate love, empathy, emotional attunement, validation, safety and trust, and confirmation of worth and belongingness can be experienced as micro-traumatic events that lead to cumulative psychic injury (Mills, 2005a; Crastnopol, 2015), compromised internal organizations, conflicted self-states, and clinical profiles that are precursors to developing adult PTSD.

2. Trauma as persecutory fragmentation

In previous work, I have highlighted the nature of trauma as being overdetermined, hence subject to multiple causal principles that scar psychic integrity and personality structure (Mills, 2004b, 2004c). What is fundamental, regardless of etiology, is how psychic trauma leaves its noxious haunting impact on the phenomenology of lived experience. With severe or excessive trauma, psychic structure is always fighting the encroachment and proclivity toward persecution and fragmentation. Patients with structural fragmentation often present in a constant state of agitation, hovering on panic and doom. When the self begins to fracture, it leads into an abyss of annihilatory, disintegrative, and decompensating inner experiences. Structural fragmentation corresponds with looming annihilation anxieties: anticipation of fragmentation induces annihilation panic, and the self begins to undergo a breaking-apart, a splintering of consciousness. Here patients descend into a spiral regression of persecutory and disembodied torment. Patients with this level of insidious regression may plummet into psychosis.

It is not uncommon for bipolarity to lead to psychosis, but bipolarity is often conditioned on attachment pathology and developmental traumata that predispose the person toward decompensation, manic defense, depression, and extreme affect dysregulation that eclipses reality testing especially when recurrent traumas are encountered in adulthood. The threat of persecution and fragmentation summons paranoiac and psychotic anxieties, further triggering annihilation panic, primitive splitting, and a fracturing of the psyche. As a result, the self becomes dislocated and hounded by the fear of deracination. When schizoid mechanisms fail, the self is imperiled by the return of projected persecutory fantasies, oppressive guilt, self-flagellation, and death wishes.

3. Synopsis of the case

At this point I wish to turn our attention to an extended case study of a four-year treatment with a 42 year old, epileptic gay man who has had a twenty year history of chronic, unremitting rapid-cycling bipolar disorder, has been hospitalized over a dozen times for his illness, and has had several near-fatal suicide attempts. I initially met and treated the patient as a clinical psychologist working in inpatient psychiatry of a general public hospital and continued in outpatient treatment after his release. In what follows I will highlight the key features of his developmental history and illness, parameters of therapy, clinical course of treatment, my countertransference reactions, and the atypical nature of working with extreme pathology caused by complex, complicated overdetermined trauma.

It may prove useful to give a terse overview of the patient's psychiatric history before delving into the course of treatment. Arvid was raised in a strict Evangelical Lutheran home environment, never shown physical warmth or affection by his parents, and was never told he was loved. He was beaten as a child by his father for the slightest infraction and was battered for years by his first homosexual partner who reportedly threw him from a two-story balcony, thereby fracturing his hip and pelvis, further triggering the onset of epilepsy. Arvid remains extremely conflicted by his homosexual identity, which he beliefs is a sin. After the break-up of a four year relationship, he became hopelessly depressed and suicidal. This was the longest and most significant relationship he had ever known: his partner's abandonment of him was for another lover, which Arvid construed was a reflection

of his inherent worthlessness, lack of lovability, and as punishment from God. He has been characteristically dysphoric, panicky, and intermittently manic, suicidal, and psychotic since he began treatment with me over four years ago.

Although I initially starting seeing the patient while he was hospitalized in residential treatment, he transitioned to my private practice after leaving the hospital. Arvid has been the most difficult and clinically challenging person I have ever treated on an outpatient basis, and my countertransference with him cycled just as rapidly as did his fluctuations in mood, suicidality, psychosis, and behavioral unpredictability. Over the course of my work with Arvid, I have violated many therapeutic caveats that in some circles would be considered sacrosanct, such as encouraging the permeability of the treatment frame, offering unsolicited self-disclosure, visiting his house, running personal errands, taking him to the hospital, giving him a gift, precipitously accepting and returning phone calls, engaging in lengthy, ongoing email discussions, and letting the patient run up a large debt. On the face of things, these actions may look palpably incompetent, which you may indeed conclude in the end. It is for these reasons that it becomes instructive to consider just how far one should go in the name of therapy.

4. Developmental and psychiatric history

Arvid was raised in a strict religious, Norwegian household: affection was never displayed yet hard work was expected. Although he spoke very little about his Scandinavian background, he did say this was important to understand about his parents as immigrants to Canada. He describes his early childhood life as replete with material necessities but bereft of interpersonal warmth and love. His mother was a controlling, depriving woman who demanded stringent conformity and would administer physical discipline by pinching and twisting his biceps or the skin under his arms until they turned black and blue. His father was a devaluing and volatile man who would deliver stern whippings with a belt strap during Arvid's early childhood that eventually turned into regular beatings with his fists from the ages of 12 throughout Arvid's university years. Despite the ongoing physical abuse and emotional torment that Arvid had to endure, his parents attempted to portray themselves as the pillars of their community. He learned to passively accept an imposed obsequious role out of fear, while stifling his inner rage through dissociative strategies and inversion, the reversal of destructiveness turned onto himself.

Church was a regular event in order to keep up social appearances, so Arvid was brought up to observe his faith. As a result, he became a very religious teenager; but this was juxtaposed to his increasing realization that he was homosexual, thus causing immense psychic torment, depression, and suicidality associated to feeling that his sexual impulses were unnatural, immoral, and sinful. Arvid became sexually active in his early university years, then lived with a partner for the remainder of his academic studies. During this time he was battered on a regular basis and was thrown from a two-story balcony by his lover who was a volatile alcoholic, thereby fracturing his hip and pelvis. Shortly after that he began having sporadic twitching fits followed by passing-out, and would periodically wake up to discover himself in a cold bath. This pattern got progressively worse and developed into grand mal seizures. He simultaneously began to undergo significant changes in his mood and temperament characterized by extreme fluctuations in affect ranging from intense suicidal depression to disjointed feelings of euphoria. He was diagnosed with epilepsy and manic depression during his early twenties and had several subsequent hospitalizations due to his illness.

Arvid had attempted suicide on numerous occasions and was once in a coma for 6 days following a heavy overdose during an alcoholic bender. On another occasion, he was found unconscious in a closet in his apartment barely alive. Despite these moments of crisis, he was able to work effectively for over 10 years after graduating from college, but his illness became so insidious that he had to go on medical disability, which he has remained on ever since. For over 20 years he has been taking myriad medications for his seizures, mood, and anxiety symptoms to help stabilize his condition, but he has largely been treatment resistant. He even had a series of right unilateral ECT treatments, but with minimal success.

5. Forays into countertransference

Although countertransference has been a ubiquitous topic among psychoanalytic discourse (Maroda, 2004; Tansey and Burke, 1989; Hirsch, 2008), we are unaccustomed to seeing detailed descriptions of excessive countertransference in the literature, presumably out of fear of judgment, embarrassment, reproach, or ridicule coming from colleagues (Mills, 2004a). In order to be able to discuss what really happens in the consulting room with verity and integrity despite my less than flattering enactments, I am willing to take that chance so we may displace any silent taboos and open up a permissible space for candid professional disclosure and reflection.

I first met Arvid in one of my therapy groups when he was on the inpatient psychiatric unit of a general hospital following an overdose. I had agreed to take him on as an outpatient when he was well enough to leave the hospital because, at the time, I recall thinking that if he did not get the appropriate form of long-term individual therapy he needed, he would in all likelihood succeed in killing himself. In retrospect, this was my first identifiable countertransference reaction – I was going to be his savior. Most patients where I worked in inpatient psychiatry were the chronically mentally ill who came in and out of the hospital like a revolving door. As soon as they were stabilized and doped-up on meds, they were discharged with little follow-up care. Most never sought individual therapy simply because it was not encouraged by their psychiatrists, was not available, nor was it financially feasible unless one had the means to seek it out on their own. I distinctly remember thinking that I would probably have profound regret if I were to hear down the road that Arvid committed suicide and I had done nothing at the time to try to help him. Waiess (2000) tells us of the propensity to have countertransference reactions of protectiveness while working with homosexual patients. Not only did my savior fantasy correspond to his acute state of need and helplessness, which I witnessed during his vulnerability in the hospital, but it ironically echoed his religious preoccupation with sin that I felt was doubly condemning. The fact that I have been an ardent atheist since adulthood did not help the countertransference (Mills, 2005b, 2017). Arvid had a right to be saved not only from God but from himself.

6. Early phases of treatment

Arvid has been actively yet intermittently manic, psychotic, suicidal, and medically unstable since I began seeing him in therapy. Simply put, it's been a hell of a ride for both of us. Our first session was fraught with crisis. Less than three days after his discharge from the psychiatric unit he was informed that his uncle had died and that his then current partner of three years was seeing another man while Arvid was in the hospital. Arvid was already feeling suicidal over being devalued by estranged family members at his uncle's funeral for being gay only to have a bomb dropped that he was likely to be abandoned by his partner whom he sensed was planning to leave him in just a matter of time. Arvid contracted for safety and we initially began a three-day a week treatment until his suicidality had sufficiently become more tractable. During this time, the majority of our treatment had centered on symptom management, affect regulation, the furtive aftereffects of his previous abuse, and exploration into his long-seated developmental traumas. Arvid admittedly told me the details of his very traumatic history of chronic childhood neglect, physical battery, and emotional devaluation by his parents, which at this time in therapy manifested as an experientially depleted, empty core self-structure. His bipolarity only exacerbated his shifting self-states from depleted to more manic and fragmentary organizations.

Arvid shows a pattern of unconsciously seeking out people in his adult life that use, hurt, and abuse him, which involves a compulsion to repeat his early traumatic experiences. Moreover, because he has profound dependency longings and needs for acceptance, interpersonal affiliation, and succorance, he would often submit to personally demeaning and exploitive acts by those who would take advantage of him. This became readily apparent with his then recent partner who had been using him for money, lodging, and sex, as well as other so called 'friends' who had apparently manipulated him into buying them expensive gifts he could not afford. As Arvid began observing these patterns more directly, this mobilized more feelings of rejection, worthlessness, and unlovability that plummeted him into deep emotional pain and deprivation of never being touched, hugged, or held by his parents as a child. Because of the abuse and lack of affection and interpersonal warmth he experienced growing up, he felt he did not know how to love or connect to people. He had an intense aversion to non-sexual physical touch, which spoke to his inner void and extreme anaclitic anguish informing his attachment deficits. His depression and feelings of worthlessness were magnified by the intense shame and cowardliness he experienced in not being able to confront those who had used and hurt him, which he masked as silent (disquieted) rage, apathy, passive aggressiveness, and the hostile inversion of destructive impulses turned on himself.

When his partner dumped him, he became suicidal and vacillated between dysphoric states of profound sadness, despair, rage, and hate directed toward all those who had ever hurt him. Arvid began noticing rapid-cycling changes and was becoming more manic as the sessions progressed. Partly as a defensive need to flee and escape from his unabated pain, and partly as a felt attack on his psychic integrity, his mania was both liberating yet enslaving, eventually opening up into an abyss of fragmentation. Arvid was in constant crisis. He called me incessantly in suicidal panic, or in order to seek my reassurance and mollification. He moved in with his widowed mother, but could not stand her devaluations, invalidation of his illness, and the associations to memories of his bereft and abusive childhood years, so he moved into his own apartment, only to feel even more alone, empty, and tormented.

We spent months attempting to work through the pain and vulnerability over his loss and dejection, attempting to shore-up the devastation from the only person he loved. Sessions were filled with intense sobbing and regression. Then he started missing appointments, got confused about the days and times, and became physically ill. The only thing that purportedly gave him any sense of pleasure or comfort was his dogs. He had four Scottish terriers and one was a show dog. One day he phoned in a suicidal crisis and I insisted that he come to my office. When he arrived, he looked and smelled as if he had not bathed for days. He informed me that he had taken all his dogs to the Humane Society and was preparing to go to his family's isolated cottage in order to kill himself. Apparently, his former partner had just called and told Arvid that he had never loved him.

7. More countertransference enactments

There were several incidents where I was feeling I had to constantly put out fires. Countertransferential reactions ran rampant. I relied on basic cognitive-behavioral interventions in order to manage the crises, then I wanted to refer the patient to a cognitive therapist thinking I was not adept at such strategies. I even tried a trial of EMDR (Eye Movement Desensitization and Reprocessing), which provided some temporary relief, but that proved equally ineffectual. I consulted with his psychiatrist and other colleagues, and was convinced to hang in there despite feeling helpless and frazzled, introprojective emotive states I absorbed from Arvid like a sponge. Although he had many psychiatrists over the years, and had been labelled with a litany of diagnoses, the credibility of some remained dubious. He was generally medicated for symptom management, which was constantly changing, the corollary of which produced destabilized presentations in mood and symptomatic manifestations. Because of his decompensation, I not only allowed but I encouraged the permeability of the treatment frame. I welcomed Arvid to call me when feeling impulsive or unpredictable so I could pacify or talk him down, and these mini phone sessions or 'windows,' were increasingly used for containing purposes. I spoke to his mother and his previous partner in order to appeal to their sensibilities and empathy for Arvid's fragile state. But nothing was working.

Arvid had gone off all his medication because he was cognitively disheveled and convinced that nothing was helping, and this just precipitated his deterioration. He began having several seizures a day and was growing increasingly more confused, disoriented, and out of control. He told me that he woke up at 3am to find himself standing on a peer overlooking Lake Ontario in his pajamas in the snow with no shoes or socks on. If he wasn't going to kill himself, his unconscious certainly was. The holidays were approaching, and I was scheduled to take my annual vacation and would not be back until after the new year. I was encouraging Arvid to make contingency plans to leave his dogs with friends or relatives so he could return to the hospital during my absence, but he refused. Then he called stating that his mother allegedly told him that she has hated him for the past 20 years (since coming out of the closet), and his ex-partner just phoned to tell him to kill himself. Arvid wished he was dead so he didn't have to feel the pain. I told Arvid I was coming to get him to take him to the hospital and I was not going to take 'no' for an answer.

I drove to Arvid's apartment and helped him pack for his stay. We then loaded the dogs in my minivan and drove to a kennel to have them properly cared for, then to the store to get some personal toiletries before taking him to the inpatient unit. Arvid disclosed more about his past and his inner conflicts during that hour drive than in over thirty hours of therapy. There was a bond developing between us during these poignant moments. Despite his regression and decompensation, I began to feel he was truly letting me into his inner world and was hopeful that a trusting and secure connection was possible. Before I went on my holidays, I decided to give Arvid a Christmas gift hoping it would serve as a sort of transitional object during my absence. It was a small hourglass that a former patient had once given me as token of appreciation. 'It takes time,' I said; 'Healing is a process.'

After Arvid's stabilization and discharge from the hospital, we began the arduous process of working-through his traumas and affective devastation over losing his partner. Arvid had a pathological dependency and masochistic attachment to him, an obsessional need to cling to an abusive internal object. His ex-partner was calling four to five times a day only to debase, reject, and harass, but Arvid continued to receive his calls. Like his relation to his father, mother, and past partner who battered him, Arvid could not give up his dysfunctional connection to abuse. During a session, Arvid confessed that he had recently slept with his former partner after a seductive phone conversation, only to be discarded once again the next morning. Arvid would speak frankly about how 'I will kill myself, it's just a matter of when.'

8. The turning

A turning point in the therapy emerged when Arvid's pain over abandonment and loss was converted to anger. He began to distance himself emotionally from his ex-partner after he was able to consider how manipulative, sadistic, and exploitive his partner had been,

e.g., using him for money, lodging, and support under the guise of love. Once he was able to view more realistically how disturbed his former partner was, this mobilized rage as a primary defense against his suffering, which turned into a need for revenge. Arvid purportedly reported his ex-partner to the police and to creditors for fraud, which provided some relief and satisfaction as he kept me informed of the criminal investigation. What had once been a treatment peppered by times of intense therapeutic impasse and psychological upheaval leading to psychotic depression, suicidal uncertainty, and a tenuous grasp of reality, was beginning to remit and level off into pockets of functional adaptation. During this time, the patient was able to trust and open up to me more about his traumatic past and the affective aftermath it left on his psychic structure.

After being on disability for over ten years, he told me that he had secured a stress-free part-time job, and moved into Toronto in order to be connected to the gay community for support and social interaction. I convinced him to consult another psychiatrist and a neurologist for a second opinion about his medication regime, and modifications were made including adjustments in his lithium levels. I felt we were making some progress: his symptoms were stabilized, he was not suicidal, he was working and living autonomously, and was socially involved with others. Furthermore, I felt he was slowly internalizing me as an empathic soothing selfobject: he called my answering machine to hear my voice when upset rather than needing to speak to me directly, was less inhibited in his disclosures during the session, was able to address our developing relationship, was more tolerant of examining his defenses and the emergent transference, and was reporting more experiential qualities of daily living. On the face of things, he was getting better, so it seemed.

Then Arvid started getting high again. He was going on uninhibited spending sprees, engaging in foolish business ventures, and acting-out sexually. He was indulging in unprotected sex with many strangers, was frequenting gay bathhouses, participating in orgies, and had one ephemeral fling after another, including with a man named 'John.' His mania served as a feeble attempt to flee from the anguish of mourning the loss of his former relationship and dealing with his past trauma; but his one-night stands and destructive hypersexuality only triggered more internal upheaval and feelings of worthlessness, loss, and inner emptiness.

Then I discovered that Arvid had been lying to me. Certain aspects of his narratives were contradictory so I confronted the discrepancies. He had no job nor did he move to the city. I now had reason to question his entire story, not knowing what was fiction from fact. A breach in trust and in honesty was orchestrated by the patient, but why? Arvid confessed that since I had been so available to him throughout all his crises, he felt beholden to show me that he was doing better in my eyes. He felt a sense of guilt and obligation to be more functional than he really was, and by pretending to live a life through such fantasized achievements, it provided him some temporary escape into satisfaction. I have no doubt that my countertransference was fueling this dynamic, a sort of reverse projective identification where the patient felt compelled to internalize my fantasies and adopt a role responsiveness in order to fulfill my wishes that he get better, and hence pacify my anxieties. Examining the transference and our 'real relationship' only created more feelings of shame and self-reproach for disappointing me, which in retrospect signaled the beginning of his downhill plunge.

Arvid started acting-out more impulsively and became more reckless. He was spending money he did not have and was giving it away to friends. Refusing to turn his finances over to his mother, he claimed that his apartment was burglarized (which I later found out was a lie) and he was in danger of being evicted for violated boarding codes for harboring too many dogs. His seizures were more frequent and he had two minor car accidents, thus necessitating me having to encourage his physician to report him to the provincial Department of Transportation for endangering other people's lives. When his license was revoked, he was furious. He was angry with me and the world, and temporarily refused to continue treatment. Consequently, he rapidly decompensated.

9. The downward plunge

Arvid became paranoid and actively psychotic. One day he came to session palpably agitated with florid hallucinations, stating that 'they' did not want him to speak to me any longer. 'Who are they?' I asked. 'Bill and Fred, they are sitting right beside you.' Bill and Fred were incarnations of previous lovers, one protective and one abusive. Each were dialectically at war with one other, projections of Arvid's divided self. Bill wanted him to fight while Fred wanted him to die. Arvid was internally splintered, disoriented, and was fragmenting more by the day. His hallucinations and delusions persisted despite a change in his medication regime. I got his mother involved with some success. Then Arvid's psychosis gave way to unremitting paranoia and delusional persecution: people were watching him, following him, trying to poison his food, so he stayed cooped-up for days, didn't eat or bathe, and

neglected his dogs. Friends of his were on a suicide watch: they took turns staying with him in order to get him through his plight. Then one afternoon, Arvid called to tell me goodbye. I couldn't talk him down nor could I get him to agree to come to see me or to go to the ER. His hallucinations and feelings of persecution were simply unbearable. When he hung up the phone and would not answer when I attempted to return his call, I had no other choice than to call the police to have him hospitalized.

While coming off of his manic psychosis, Arvid was criminally charged with theft and fraud. He claimed that he had no recollection of his activity and pursued criminal diversion under the mental health code rather than face a trial. During this time, his psychosis leveled into generalized paranoia and fear, and he preferred to seclude himself and avoid the world as a protective refuge. He dissociated through much of our sessions and was internally preoccupied with his hallucinatory experiences, refusing to accept them as delusional psychotic projections. He had constructed in his mind the presence of more benevolent protective figures to get him through the uncertainty of his impending court case. He reported having increased seizures and had several serious falls. I was concerned that he had incurred a concussion given his psychosis entailed synonymous symptoms.

Then bizarrely, the patient came to session in an angry demeanor, talking in a different voice and under a different name. He appeared crazed and tough, unlike his more typically passive, meek, and helpless comportment. Claiming to be another person named Hal (his alter-ego he wished he could be), the patient explained that Arvid could not cope, so *he* was taking charge of things before Arvid killed himself. Hal told me that Arvid was charged with another count of defrauding a merchant and had to give a deposition to the police the next day. By the end of the session, Arvid had reconstituted and Hal had disappeared. Arvid began to sob but managed to gather his defenses enough to examine the practical tasks that were needed in order to cooperate with his lawyer and prepare for the criminal investigation that lay ahead.

10. Carnival

Arvid managed to evade prosecution of his charges, and over the next two years we explored more directly his self-destructive path, his passive aggressiveness and failure to take personal responsibility for his life choices, his death wish and sadomasochistic need to suffer, his incessant complaints toward family members and the self-sabotaging role he plays, his fixation with loss and lack as a failure to mourn, his physical abuse and anaclitic deprivation during childhood, and his persistent oscillation between apathy and self-pity associated with unresolved trauma. Treatment with Arvid could be characterized as a protracted carnival ride – intense, turbulent, and abrupt, punctuated by moments of calm before the scream. Over this time period, Arvid was profoundly depressed, intermittently hypomanic, manic, and psychotic, unpredictably suicidal, had disrupted his medication schedule several times, became detached, and grew increasingly more fragmented. His alter-ego returned, this time as another part-self, and confessed again that Arvid had been lying to me. Unable to speak about it directly in the first person, he was afraid of losing me, and hence sheltered me from many things as a need to protect the specialness of our relationship, afraid I would abandon him if he were to be completely honest. Although there was clearly an erotic component to the transference, even perhaps influencing a psychotic transference, this was never directly acknowledged due to the competing array of associations pressing for attention. A new delusional system had taken seed in this split off-ego organizations as he assumed the role of the fantasized defender – his self-ideal – what he would like to be (via identification with me). Attempting to understand his deliberate deception and dishonesty, he had been moving away from me in order to protect me from his bad self, as well as protect himself from his erotic and affectional feelings toward me.

As Arvid became more religiously preoccupied, he could not escape the affective self-certainty that he was evil and living in sin for being gay, a sin so sordid that he believed he could only be forgiven by God through death. Doing everything he could to destroy himself, he was brought up once again on more fraud charges and spent a week in jail. When I met with him after his release, the temporary incarceration paradoxically helped mobilize self-preservation strategies for survival and partly satisfied his punitive superego injunctions. I was concerned that Arvid was not getting the best legal representation he needed. His attorney was a fresh graduate with no experience handling mental health cases and had contacted me with his own anxieties about my patient. I gave Arvid a referral to a respected specialist in the region and he got better legal counsel.

During the months before the trial, Arvid's symptoms had stabilized. He took some time away at his family's cottage with his dogs for an interim reprieve where he reportedly experienced periods of solitude,

contentment, and quiet reflection. During this time, I was available through electronic mail exchange and provided him ongoing support. The Internet in many ways is an impersonal phenomenon despite being highly intimate: Arvid was able to communicate more openly and uninhibitedly – akin to free association – without the social pressure of having to censor or modify his self-conscious thoughts. His email communications were always unedited and often full of run-on, tangential spontaneous thoughts or confessions, which were more or less coherent amalgamations of fused inner experiences.

There was a progression in his correspondences from gratitude to more panicky, agitated, disoriented, suicidal, and psychotic associations eventually leading to helplessness, dread, and ominous fragmentation as his trial date approached. My responses were always laconic yet encouraging and optimistic. I offer below just a few sentences of Arvid's unedited communications:

> Email 1: I just wanted to say thank-you for your support. I do not feel that I am really worth anyones time and effort, it always amazes me how much you seem to care.

> Email 3: Things are just starting to push their way back into my mind. I really do not think that I am going to be able to withstand court and going to jail. I have pretty much decided that I am going to disappear before then. I think you know what I mean by that without me saying anymore. I do promise that I will attend my next appointment with you first, but I am just tired of my life and I think you have known that for quite some time.

> Email 4: It is too bad that my other illnesses have gotten in the way, I think you and I could have had some great sessions. There is so much that I want to tell you, but have always been afraid. I am always afraid of losing someone that I care for. You have been good for me and have tried to show that I am worth something. I thank you for that, I really am not worth anything, I wish that I had the courage to kill myself.

> Email 6: I am holding together, but I am not doing very well. I don't even admit to my mother when I am getting confused, I don't understand anything on the television. I have never wanted to admit it, but I will tell you, I hear strange messages from the television, I cannot stand music, because I get too many messages from there. I cannot believe I am telling you this, I do not want this discussed in court, this is between you and I. I also have some friends, you would call them imaginary, I wouldn't. Please don't hold this against me, I was never going to tell you this. I keep it under control most of the time, I am finding it more and more difficult living with my mother, I am sure she is going to figure it out sooner or later. Please do not pass this on, I want this to be our secret. I am very good at keeping it under c!!ontrol.

> Email 9: I am sorry to dump all of this on you. I really respect you as a doctor, but I feel like I can trust you as a friend. I told you once of my secrets, there are many more for us to break through. Once again thank-you for caring.

> Email 14: I always counted on my faith in God and I have totally lost that, I realize that I am to blame for all of this and that I need to be punished. You try so hard to help me, which I do appreciate, I think you and my mother are the only ones that care what happens to me. I honestly don't. I wish they would give the death sentence for what I have done. I never lied to you, I honestly do not remember a ting. I just want to plead guilty, even if that is the worst thing to do. Once again thank-you from the bottom of my heart.

> Email 16: My voices and paranoia are getting stronger all of the time, I do not want that discussed with anyone but you and I.

> Email 20: All I can think about is running or killing myself. I think that I am at the most critical point that you have ever known me. I am not afraid of death and I am very well prepared. I worry about my mother, and dogs of course, luckily she has become very attached to them. I will not go to jail for something I did not do. How is that going to look for the other charges, I will be just digging my own grave, I might as well get it over quickly.

> Email 23: You have been the most patient and kind doctor I have ever known. You I [*we are merged*] think know that you have been the only one that I have ever trusted into the iner circle of my thoughts and you were just starting to get there. In many ways we are alike surprisiling, except I do not like to let people into what is really happening in my life. Belief me I have done a lot of analzing of myself, the problem is none of it makes sense to me. I came from your typical upper middle class family and we had everything. The only thing that I can [*notice the slip*] figure is that I consider love to be something that you must give to someone in the forn [*as in fornication*] of something material. I hate to touche even to shake hands but it does not bother me during sex. I don't know why I am telling you all of this now, I have probably told you before. Maybe it can help you close the chapter on me. I think I have been a waste of your time. I think that I have been a waste of all the wonderful people

that have tried to help me. Fine they may have found a physical problem, but I can promise you there is a hell of a lot more.

Arvid and I prepared for his testimony in our final session. This is an email he sent just prior to his court date:

Email 25: I want to thank you for being such a kind and understanding man, sometimes, most of the time I consider you my only real friend. I promise this will not be happening tonight, Wednesday, Thursday, I cannot promise about Friday morning. Please do not call hospitals, that would make matters worse, I would look more guilty, and it would just delay matters and the outcome would be the same anyway, this has just come sooner, do you actually think I was going to go through an entire court scene. I am embarassed to look in the mirror. How can I stand in court while they read charges against me, even the ones that I deserve. I believe I am getting the final punishment in life that God has put on me and that is death.

I helped the best I could in Arvid's defense. I wrote letters and reports for the Crown and testified in court on his behalf. Arvid had a total of five felony charges including fraud over $5000, perjury, and obstruction of justice. My expert testimony was the deciding factor. The judge was acerbic during sentencing but agreed that Arvid needed to maintain his established psychological and medical treatment regimes, which prison would not afford. Arvid was sentenced to eighteen months of home incarceration with many stipulations, including continuing his treatment with me. But Arvid's death drive (*Todestrieb*), need for punishment, and self-destruction was too cosmic. He violated the conditions of his home incarceration within twenty hour hours of leaving the courthouse, was subsequently re-arrested, and then placed in a minimum security prison for the remainder of his sentence. At the time of his incarceration, he had an outstanding therapy debt of over a $1000. When Arvid did not show for his scheduled appointment after his sentencing, I sent him an email asking him to give me a call to reschedule. This was Arvid's last correspondence to me before his re-arrest:

Email 26: Hello, I do not know whether I will ever be able to speak to any analyst again in my life. That judge opened up an entire new perspective of the way I look at myself, and it is not a good one. When he stood there and told everyone especially me that I was a con artist and a thief, that I do things that are only for me, he basically killed what was left of my soul, so I do not see any reason in trying. I unfortunately pointed out to the probation officer that they cannot force me to go to a doctor and she almost had a fit. Unfortunately she is applying to the courts to have that changed, she pointed out that if they force me to see you that they have to pay. My mother has your money ready. She is not aware that I am no longer seeing any doctors, at first I thought that I would go without pills as well, and I realize that the doctors will only renew [prescriptions] for so long. Right now I don't trust any doctor, I believe that you helped to get my ass out of a jam but were you right?, after listening to that judge I am even more convinced that Hell is my future. I cannot call right now, I need all of the quiet I can get otherwise I will explode.

He always signed his name in the following way:

all the best

Arvid

☺

11. Conclusion: making a difference?

What do you do when the treatment frame has been broken? How do you go back to re-instituting limits and boundaries when the therapist has dissolved traditional parameters for treatment and even encouraged permeability in the frame? Some clinicians would say this therapy was doomed from the start, and some may even say that the patient is not capable of treatment in any conventional way. If there was a mismanagement of this case, it may be due to the general criticism that I allowed the patient to violate all established boundaries. Was this because of my own countertransference, of being sucked into destructive borderline manipulations and needy-dependent projective identifications to rescue Arvid from his own internal hell? Was my desire to be his savior through therapeutic availability too much for my patient to bear? I wonder if the patient would have continued treatment if I had not been flexible and malleable in the frame. Would he have succeeded in suicide? Would the classical or Langsian analyst have much success with such a patient if strict observance of the frame was a stringent requirement? How far would other clinicians go? Would they have been able to do better; and if so, what would make the difference?

I am quite certain that this type of traumatized, attachment disordered patient needed my availability in order to feel some modicum of trust and attachment, but whether it was too much or too little I have no way of knowing. My impression is that he hated himself so much and hurt too deeply when given my gift of availability, one he could not receive – and in fact needed to repudiate in order to reinforce his own destructive convictions – so much so that his compulsion toward death overrode his wish to cultivate and sustain the emotional closeness he had always been deprived of yet yearns to

have fulfilled. The motivations of his criminal actions are undoubtedly overdetermined: he stole because he felt entitled to receive that which he was always denied (viz., the symbolic surrogate of love through material possession, an echo of his childhood). But such entitlement is poisonous and caustic; in the end, he punishes himself for the need to be loved.

This persistent impulse to abrogate and sabotage interpersonal warmth and happiness in the service of destructive repetition substantiates the concept of the death drive through circuitous interventions: he unconsciously orchestrates his death by having others (society) continue to oppress him, a return of his own actions, punishment from the law. For Lacan (1977) the name of the Father is law of signification – a signification of the phallus as lost or negated, hence castrated – *jouissance*. Arvid's father was a tormenting violent brute who hated his son for being gay. He gave no love, only negation. Arvid did not form an attachment to his parents, and sexuality is perceived to be his only positive way of engaging with people. But Arvid's own sexuality is what he must negate as did his father. Arvid perennially castrates himself. Could Arvid have unconsciously equated his father with the Christian metaphor of God as the ultimate Law, the law of negation, of lack – death? Would an analysis of this possibility do anything to repair his deficit psychic structure? Would it ameliorate his self-loathing, anaclitic depression, and emotional pain? Would it help him to accept his embodied facticity and form more authentic relationships with others?

When I have consulted other colleagues on this case, most say that they would not have taken this patient on. My fantasy is that anyone treating Arvid would hope that he would drop out from treatment in order to assuage their own discomfort and responsibility to act. I am guilty of this. Although Arvid was out of the closet since his university days, I felt closeted, trapped, sentenced – bootstrapped to this man for the rest of my life, as if it is out of my hands. But it is a duty I freely choose, an obligation to care. Despite the personal taxation this case has had on my emotional life, I maintained my commitment to Arvid when he was released from prison. After being sufficiently punished for his transgressions, he is now 'reborn' and 'no longer of the gay persuasion,' at least for now. Some would say I'm a fool, that my countertransference has consumed and infected the treatment, and that I would do best to refuse to see him any further, and instead refer him elsewhere. I would view this as a cop-out. More auspiciously, perhaps some would say I am virtuous to continue to be so dedicated, a virtue I could do without. But perhaps this commitment is what he truly needs in order to surmount his pathology, a therapist that will not reject him no matter how chronically ill or egregious his actions, a fantasy we may all harbor. Either we accept our responsibilities to care for others no matter what the personal cost may potentially be, or we adopt less of a standard; but regardless of one's own human limitations or moral principles, we at least need to be honest with ourselves about what we value.

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Notes on contributor

Jon Mills, PsyD, PhD, ABPP is a philosopher, psychoanalyst, and retired clinical psychologist. He is on Faculty, Postgraduate Programs in Psychoanalysis & Psychotherapy, Gordon F. Derner School of Psychology, Adelphi University, USA; Department of Psychosocial and Psychoanalytic Studies, University of Essex, Colchester, UK; Emeritus Professor of Psychology & Psychoanalysis at Adler Graduate Professional School in Toronto, CA and ran a mental health corporation in Ontario, Canada. Recipient of numerous awards for his scholarship including 4 Gradiva Awards, he is the author and/or editor of over 25 books in psychoanalysis, philosophy, psychology, and cultural studies including *Debating Relational Psychoanalysis: Jon Mills and his Critics* (Routledge, 2020); *Inventing God* (Routledge, 2017); *Underworlds: Philosophies of the Unconscious from Psychoanalysis to Metaphysics* (Routledge, 2014); *Conundrums: A Critique of Contemporary Psychoanalysis* (Routledge, 2012); *Origins: On the Genesis of Psychic Reality* (McGill-Queens University Press, 2010); *Treating Attachment Pathology* (Rowman & Littlefield, 2005); *The Unconscious Abyss: Hegel's Anticipation of Psychoanalysis* (State University of New York Press, 2002); and *The Ontology of Prejudice* (Rodopi, 1997). In 2015 he was given the Otto Weininger Memorial Award for Lifetime Achievement by the Canadian Psychological Association.

Informed consent statement

Informed consent was obtained from the subject involved in this study.

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