CHAPTER THIRTEEN

The dynamics of containment

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The title of this chapter serves to capture a dimension of mental health care that I think we all know about at some level, albeit implicitly rather than explicitly. It refers to both the inner world and external reality and, crucially, the relationship between them. Transactions across this boundary generate the most primitive anxieties even in the relatively well, as we all know from the experience of moving house, moving country, or major changes in role. But what for others is a tremor is, for those who are mentally ill, more akin to the feeling of an impending earthquake, a psychic catastrophe that reawakens all the terrors of breakdown.

A supervisee brought the following material. A not very ill patient was late for her session. She described her journey. On the way she had a lovely walk; she met a friend, they talked; it was a beautiful day, wonderful scenery. And so she went on. The analyst thought of her as involved in a happy world, excluding him; he experienced himself as looking on at this happy scene, feeling that he had been kept waiting because, in comparison, he was rather uninteresting. He felt a pressure to make a comment conveying this to the patient. But instead he stayed with his uncomfortable feeling and refrained from making what he thought of as the expected interpretation. He remembered that

this patient was socially isolated, and very inhibited, dominated by a cruel superego that made her feel uninteresting and worthless. The analyst could now see that she had projected this superego into him and was trying to nudge him into an enactment that would serve to attack the pleasure she had experienced on her walk. Understanding this enabled him to contain the pressure and think about it, and this provided the possibility of development. For, as it turned out, the capacity to enjoy the countryside and her conversation with her friend rested upon important developments in the analysis.

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Mrs B suffered an acute paranoid breakdown and was continuously persecuted by the idea that "they" were coming to get her. She arrived on the ward, accompanied by her relatives, who were exhausted with trying to reassure her, to no avail. The charge nurse went to greet her, but as he arrived she was continuously muttering to herself "They are coming to get me . . . Cannot stay here . . . they will come . . . they are coming to get me."

"Who are coming to get you?" said the charge nurse, fixing her with his gaze.

"They are," she responded.

"Oh no they won't," he responded ". . . because I am in charge."

The patient immediately calmed down, seemed to feel understood and safer, and went calmly on to the ward.

These two anecdotes, one from an analysis, the other from an observation on a ward, serve to introduce my topic. The contexts were, of course, very different, but in both situations the capacity to contain something was essential to the therapeutic outcome.

Like many psychoanalytic terms, the word "containment" has both an everyday meaning and a more technical psychoanalytic one, the latter providing a deepening of the concept and also locating it within a theoretical structure and a model of the mind. Although it is clear that appropriate support—that is, containment—of mental health staff provides them with a basis of confidence and morale, which is perhaps one of the most vital therapeutic factors in work with the mentally ill, it is largely absent from all documents dealing with policy, strategic planning, and so on. This is increasingly

so as the "thinking" that underlies these projects degrades into performance targets, measured competencies, and the like.

Many years ago, when I was a young doctor working at the Maudsley Hospital, Alexis Brook (a well-known expert in the psychodynamics of institutions) came to give a lecture on the nature of institutions. He started by asking us "What is a hospital?" and we gave the predictable answers such as "a place where patients are looked after". After we had given various suggestions, he pointed out that something essential had been overlooked: a hospital is a place where *staff* get looked after.

This might strike us as strange and perhaps even indulgent, and the fact that it does so in itself reveals much about the lack of place for such thinking in our present culture. But it does indicate an important truth. That is, if the staff feel well supported and valued, they in turn will value their work, and so the patients will be well cared for. This brings to mind the model of a mother looking after a baby, who needs the support of those around her, such as the immediate family and social context, to provide her with a basis for managing the intense emotional engagement with her infant.

In approaching the concept of containment within a service, it is important to bear in mind the many different levels within the system, which interact with each other in complex ways. In the Introduction to the book, it was suggested that these different levels can be pictured as like Russian dolls, each outer system containing the ones inside. These levels may act to support each other, providing levels of containment within the system; alternatively, they can interact in more destructive ways.

Over the last 20 years or so, important changes have occurred in the NHS and more widely in the public sector. In the earlier period, the outermost level (i.e., government) was distant, and, though it clearly had a determining effect, it was relatively—at least manifestly—unobtrusive. Now, however, it is ever-present, hovering like a kind of menacing superego penetrating into every pore of the relationships within the system. Whereas intermediate management structures previously could serve as buffers, absorbing pressures from above and containing them, they now act as fully porous conduits distributing anxiety that is amplified as it resonates throughout the system, flooding those at lower levels in such a manner that they cannot carry out their task. A previous government Inspector of Prisons described similar processes within the prison service (personal communication). On visiting a

prison, he asked the Prison Governor what he regarded as the main aim of his prison. The Governor answered immediately, "To reach my performance target of saving over one million pounds before the end of this financial year."

So what do we mean by the term "containment"? The need to contain things in the mind is part of our ordinary common-sense psychology: "keeping things in mind", "keep your hair on", "look before you leap" are well understood idiomatic expressions that emphasize the importance of thinking instead of acting and, more than this, the value of sustaining even unpleasant states of mind and resisting the pressure to "do something" at least long enough to allow their nature to become known, reflected upon, thought about. We all recognize these capacities and value them as part of everyday life, but psychoanalysis has given these terms a breadth and depth. Since the beginning, psychoanalytic theory has stressed the centrality of sustaining thought and resisting the temptation to act, as so well captured in Freud's (1911b) quotation of Shaw as the capacity "To be able to choose the line of greatest advantage instead of yielding in the direction of least resistance."[1] One of Freud's most remarkable attributes, perhaps characteristic of very great minds in general, is the extraordinary development of the capacity to think and to sustain this painful process over long periods, without peremptory closure.

When we say "thinking" rather than "acting", it is important to bear in mind that there are two different kinds of action. There is external action, and here we may think of that type of action which, instead of being the outcome of thought, serves as a replacement for it. However, Freud also put firmly on the map a new kind of action that similarly serves to obviate unpleasant or difficult thoughts—*internal actions* (see Wollheim, 1971). These actions would include defence mechanisms such as symptomatic forgetting, denial, repression, displacement, minimizing significance, and so forth, all serving to restrict what can be thought. Central to the psychoanalytic endeavour is its capacity to widen the possibility of what can be thought about—that is, contained in mind. The psychoanalytic method of free exploration of all that comes into mind serves exactly this purpose.

The work of Melanie Klein considerably extended our understanding of the internal factors that might support the mind's capacity to think. She described how in early life the world is largely divided in a simple binary way between good and bad.

This is a method of dealing with powerful anxieties that cannot be tolerated. Unbearable thoughts and feelings cannot be contained within the mind and are instead projected, creating a frightening external world. As the child establishes a secure relation to a good, albeit idealized, internal object, his anxiety lessens, and a qualitative change occurs in his way of being in the world. The feeling of internal security removes the need for such violent projection, and so his world, internal and external, becomes more integrated. Integration, however, brings profoundly painful feelings deriving particularly from the awareness of separation and feelings of guilt.[2] But if these can be borne—that is, contained within the mind—this lays the basis for feelings of confidence, faith in the world, and development. Every new crisis in life provides further opportunities for development, but it also brings with it the possibility of regression into illness and more paranoid-schizoid ways of functioning.

Central here is the distinction between the depressive position, a state of mind characterized by its capacity for integration and containment, and the schizoid mode of functioning, where reflective thought is severely compromised by the mind's urgent need to deal with overwhelming anxieties.

A particular strength of the Kleinian account of human development is that the theory of the depressive position links the capacity to bear mental pain with the capacity to sustain empathic identification with the other, and thus concern for his or her sufferings—in other words, to enter a moral world. This moral world centres on a relation to reality, internal and external, and a struggle for truthfulness.

Although the above account provides a framework for understanding the development of the capacity for containment, it does so only implicitly. It was Bion who moved this function from implicitness to explicitness, bringing to the centre of psychoanalytic scrutiny the process of containment itself, which is closely bound up with his model of the development of thinking. "Thinking" in Bion's sense expresses the capacity to contain thoughts in the mind.

Bion's model rests upon an understanding of a dynamic relation between two psychic elements: the "container" and the "contained". He provides us with a phenomenology of the vicissitudes of this relationship and an account of their development. Bion's model of container–contained not only refers to processes in one individual, or even between two, but has a much wider reference to

group, institutional, and social processes in general. Certain types of social structure, for example, serve to provide containment of violence, whereas other types promote it.

Having established the model of containment, different types of failure of this relation can be studied, and this is perhaps most easily explicated in terms of group functioning.

Any group acts as a container both of the people who are its members and of the field of thoughts and emotions that these individuals bring. Bion (1962a, 1970)[3] studied the fate in a group of a new idea that is felt to be disturbing, communicated to the group by an individual, whom one might think of as the messenger. There are a number of possible outcomes:

- The group may exclude the new idea. Here, the container extrudes the contained—the messenger is expelled because the message he brings cannot be borne.
- The group may succumb to the dangerous idea but dissolve its identity. Here, the contained destroys the container.
- The group may accept the idea but crush it and strip it of its nature, so that its unique qualities are destroyed. Here, the container suffocates the contained.
- The group may *adapt* to a new idea, be changed by it but exist in a dynamic relation with it. Here, the container and contained have a symbiotic relationship, which might lead to growth and development.

These processes are exactly mirrored at the individual level. In this, the container is an individual mind and the contained is a disturbing thought or feeling—which suffers similar outcomes. Expulsion of the idea occurs through projection, creating a paranoid world; cutting oneself off creates dissociative states and feelings of unreality. Breakdown occurs when thoughts and feelings simply cannot be managed. The patient may say he feels he is "falling to pieces".[4] In a certain sense, this is an accurate "endopsychic perception", for what is being described here is the experience of a powerful force impacting on a rigid container that is then felt to shatter into fragments.

Where the new thought/emotion can be thought about and held in mind so that it can become known, the container and contained are affected by each other in ways that can promote development.

Bion suggests that the origin of this capacity is to be found in the mother–infant relationship, but the detail of this need not detain us here. What is essential is that this model provides a kind of prototype of mental functioning both within the individual and in relation to those around him or her.

The disturbed patient is afflicted by thoughts and feelings that he or she cannot manage and is thus impelled to act upon all those around him or her. The way these interactions are managed will have important implications for both the patient and those involved in the patient's care. Good mental health professionals know this and carry out this work quite intuitively—for example, as in the situation cited above where the nurse intuitively contained the patient's paranoid terror without challenging it.

With this theoretical background in mind, we can start to build up a picture of the factors that might support containment and those that, on the other hand, might undermine it. Crucial here are the quality of the support structures at various levels that can provide the basis for feelings of morale and confidence in one's role. As discussed above, menacing superegos hovering in the corridors will have the opposite effect.

Where containment fails, the result, not infrequently, is enactment—that is, action replaces thought. This may find expression in irrational management plans.

> Miss B, a young married woman, was internally dominated by a cruel, primitive superego, which she felt watched her every move. She experienced any attempt at self-control as in the service of this superego, and so she could not distinguish between it and ordinary ego functions that sought to protect her from danger: in other words, the ego masqueraded as the superego. This resulted in a wholesale projection of her sane awareness of the danger of her actions into her analyst. Left free of any concern for herself, she took increasingly dangerous risks—such as driving while under the influence of sedatives—with what appeared to be complete equanimity, while her analyst grew increasingly horrified as the momentum of her self-destructiveness gathered pace. She said that she experienced the ending of sessions as "like a guillotine". This was a very apt description since, having projected important ego functions into her analyst, she left the session in a "headless" state. The situation deteriorated to such an extent that it became necessary to admit her to hospital.

> On the ward she behaved in a very provocative way to the nurses. She would leave the hospital without telling them where she was going, leaving them with an overwhelming anxiety that she was about to carry out a very self-destructive attack. For example, she might say, seemingly calmly, that she was "going to the shops", as if this was a quite ordinary and banal event, while at the same time conveying that she would be near the pharmacy where, by implication, she might buy some paracetamol. At other times, she would telephone the ward from outside but not speak when a nurse answered and would then hang up. The nurses found this unbearably tantalizing. This resulted in an escalation of the need of the staff to control her, and she was restricted from leaving the ward. The situation then further deteriorated, and the nurses became worried that she might carry out a serious attack upon herself at any moment. In the end, she was restricted to a small room where she was continuously observed. She then became acutely anxious and declared in a terrified voice, "I can't stand this place. I'm being imprisoned."

The patient has "actualized" (Sandler, 1976) her inner situation. What started out as an inner conflict between aspects of herself, an intra-psychic situation, has now been transported into a conflict between herself and the nursing staff—namely, an interpersonal situation. The superego that watches her all the time is of course inescapable, but temporary escape is achieved through projecting it elsewhere in this way. It is not her own superego but, instead, the nurses on the ward who are felt to be imprisoning her.

It is also important to note that the patient's provocative manner did engender a good deal of hostility towards her, which was never really owned by the staff. Although keeping her under continuous observation manifestly served a wish to protect the patient from suicide, I think it also, at a deeper level, satisfied a hatred that had been recruited in the staff and that was associated with some excitement.

These situations are not uncommon. Many patients use admission to psychiatric wards to provide themselves with an immediate context for these projective procedures, and this is particularly the case in suicidal patients. Although, in the last instance, no one can be absolutely prevented from committing suicide, it is easy for staff to become identified with an omnipotence that dictates that it is entirely their responsibility. They come to believe that they are

the only ones who are capable of *really* understanding the patient. The determination to save the patient acquires a religiosity, the staff believing themselves to be specially selected for this mission. Hostility that is denied and split off to this extent can quite suddenly return and with a vengeance, breaking down any residual capacity to contain it. Yesterday's poor suffering patient, who only needs help and understanding and constant support, becomes tomorrow's hopeless case, who should be immediately discharged or given high doses of medication or even ECT. Such measures may even bring an apparent improvement in the patient, one based not on any real development but brought about through the gratification of the patient's need for punishment, relieving him or her, temporarily, of the persecuting omnipotent guilt.

It was Tom Main (1957)[5] who originally studied these processes in detail, showing how the splits in the patient's mind are re-lived in the ward as divisions among the staff. The "saintly" group, described above, who endlessly suffer on behalf of the patient and who believe the patient to be only a victim of his or her damaging early relationships, have their counterpart in another group of staff who see the patient only as manipulative and "attention-seeking", who must be "confronted". The extent to which such processes enact the split aspects of the patient's mind is the extent to which the possibility of the system's containment of them has broken down

Where these staff disturbances remain unacknowledged, the situation can quickly escalate, with catastrophic results as the container—the ward—suffers a kind of institutional breakdown. It is important not to underestimate the effects of this kind of catastrophe on the staff, most especially in terms of persecuting guilt and feelings of worthlessness.

> Ms C was referred to be considered for admission by a psychiatric team who had become very worried at the possibility of her suicide. From what I could gather, threats of suicide had become one of her principal modes of communication. When I went to meet her in the waiting room, she had the air of someone who is very seriously disturbed. She was sitting in the waiting room with her head bowed low, and she apparently did not see or hear me arrive. I had to attract her attention. What ensued was a very disturbing experience. For much of the time, she disowned any knowledge about herself, claiming she had come "because they sent me". When I commented on how difficult she found the interview, she replied with a defiant air, "Well anyone would in this situation, wouldn't they?"
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> Throughout the interview I felt acutely aware of her dangerous suicidality, while she remained almost entirely cut off from it and apparently superior. However, when I pointed out that she was doing everything she could to stop me from helping her and went on to say that she might succeed, she looked at me, smiled, and said, "You've pulled the rug out from under my feet." She added that getting treatment was "her only lifeline". Although in a certain sense this was true, what I want to convey here is the way that, right from the beginning of the consultation, it was I who was to carry responsibility for her condition. The waiting-room situation where I had to try, in a rather awkward way, to attract her attention was emblematic of what was to transpire. When she said to me that getting help was her lifeline, this was not a moment of contact and reassurance. It filled me with anxiety. I felt that if I didn't accept her for treatment then and there, it would be me who was pulling away the lifeline, me who would be responsible for her suicide. She had projected her wish to live into me, and now I, as the representative of that wish, was being taunted with the terror of her suicide. I carried not only the responsibility for her life but also the threat of an omnipotent persecuting guilt. The smile was a smile of perverse triumph at my impossible position. It did emerge later that this was an enactment of an internal situation in which she herself felt continuously threatened and mocked. Any reference that she made to mental pain was quickly followed by a contemptuous attack on the part of herself that experienced this vulnerability, which was labelled as "whinging and whining".

A marked feature of this kind of situation, where perverse elements are so predominant, is the presence of negative therapeutic reactions. Just when the patient has made some real progress, there is a sudden deterioration with a real risk of suicide. It is as if the progress that brings awareness of the extent of disturbance and vulnerability provokes a furious counterattack by an internal organization that regards this contact with sanity as a betrayal (see Rosenfeld, 1971). It is important to distinguish this sort of negative therapeutic reaction from that where the pull towards suicide is

primarily a result of unbearable guilt and despair, which has different management implications.

> Ms D at first appeared rather similar to Ms C, in that she, too, filled the staff with unbearable anxiety as to her suicidal capacity. Although at first perverse psychopathology seemed to predominate, this gave way to a more clearly melancholic picture. She had made innumerable mutilating attacks on her skin by slashing it. Her skin seemed to represent her sexual body, which she regarded as disgusting. She felt full of "bad disgusting thoughts", particularly of abusing children. She felt that she could only rid herself of this identification with her abusing parent through quite literally cutting it out of her body. She had managed, however, to spare her face and hands, and this appeared to represent a limited capacity to hold on to something good in herself. However, once on the ward, she tended to project into the staff all awareness of these good aspects of herself, while she herself sank further and further into a melancholic state. The fact that in this case the staff felt able to maintain a belief in her—that is, to contain it—despite being constantly provoked, turned out to be of great therapeutic importance. Here, the primary motive for projection outside herself of her wish to live was more for "safekeeping", perverse mockery being much less evident. After some improvement, she, like Ms C, also showed a marked negative therapeutic reaction and became more acutely ill. Although there were some perverse elements, the predominant difficulties arose from the unbearable psychic pain. Here, the staff were called upon to contain her wish to live and the intense feelings arising from her awareness of the damage done to her good objects, which to some extent really was irreparable.

I would like to close with an example that I think shows how different levels within a system can serve not to mitigate the disturbing effects of a particular patient but, instead, to amplify them as they resonate through different levels within the system.

> Mr F was a 38-year-old eastern European man who came from a very severely disturbed background, though he disowned knowledge of this himself. He was admitted to hospital after a series of episodes of self-harm, including self-cutting, overdosing, and a serious attempt at drowning which required resuscitation. The diagnosis was of "treatment-resistant depression".
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> As he was clearly a very difficult patient to manage, I was asked to carry out a consultation with the team. I learnt that Mr F was relentlessly negative, saying that he had nothing to live for, that his life was entirely meaningless. Mr L, his special nurse, saw it as his job to persuade him otherwise, but without any success.
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> Special care was provided for the patient on a daily basis. In discussion, it emerged that there was, so to speak, a "politically correct" way of talking about him—that is, as someone who was very ill, suffering, who needed special care. But there was another, much more negative view, which it was very difficult to own.
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> However, as it became possible to talk more freely, the staff spoke of the hatred that Mr F stirred up in them. The nurse who was "specialling" him described how he himself had to arrange all his meetings with the patient. The patient would reluctantly agree to come, but always added, ". . . if *you* think there is any point". The staff felt extremely burdened with the day-to-day responsibility for keeping him alive, and they found it very difficult when the patient said he enjoyed being on the ward; he said it was "like being in a country spa". It also emerged that a number of the nursing staff worried more about this patient than any other patient and, furthermore, that this worry invaded their personal lives to the degree that even when they were not on duty they thought about him and even phoned up the ward to make sure he was still alive. Each of them felt very alone with this worry, as if it were their own very personal responsibility.
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> The crucial moment in discussion came when the senior consultant, Dr J, felt able to describe her distaste at a scene she was frequently exposed to when the patient's wife visited the ward. They would exhibitionistically caress each other sexually in the middle of the ward. This was done just sufficiently to make it clear what they were doing, but not so much that it could be censured. We understood this in the following way. The very public excited "intercourse" that was taking place on the ward made manifest the malignant continual "intercourse" that was taking place between the patient and the staff. Projecting his wish to live to the degree that the staff continually felt responsible for

keeping him alive had become a source of addictive excitement for Mr F. This excitement seemed to derive from two sources: from being rid of the burden of his wish to stay alive, but also from a perverse triumphant mockery of that wish, which the staff had to suffer, since the wish was now located in them.

As I have discussed, some patients, having projected their wish to live, feel relieved and can allow others to help them. In this situation, it is the nurse's (and it is usually the nurse) capacity to contain—that is, to hold on to—this vital aspect of the patient that proves of greatest importance as regards therapeutic development. But this is not the case here, where there is a more malignant relationship. The more the staff own the patient's wish to live, the more the patient, so to speak, is free of it. It is typical of these patients that they tend to overwhelm the staff's capacity to cope, to the degree that anxiety about the patient so invades their personal life that some may even feel that they cannot have holidays. In this situation, the container is so severely damaged by that which it is called upon to contain that it can no longer function, and if this goes unrecognized the results will be steady deterioration of the patients and staff on the ward.

In order to be able to provide appropriate care for a patient like Mr F, it is necessary that those looking after him do *not* feel that they, individually, have to take full responsibility for whether he lives or dies—that is, that care is taken so that no one person is subject to this omnipotent demand to contain the uncontainable. While it is, of course, inevitable that staff will end up feeling this to some extent, the point here is that this must not be supported externally. Precaution needs to be taken so that no individual member of staff is psychologically isolated with the patient, and this can be achieved by ensuring that the team regularly discuss their involvement with the patient. This is vital in order to avoid the splitting processes described by Main (1957), where different staff members come to contain widely split-off aspects of the patient. For example, one staff member is idealized while another is denigrated, or one staff member is drawn into unrealistic hopes for the future of the patient while another sinks into despair.

There was, however, a further difficulty in the situation described, and this derived from the more general context. There had been a suicide in the hospital within the last year, though on a different ward (but a patient under the care of the same consultant). As far as I could gather, there was nothing to suggest that this could have been avoided. However, the formal enquiry that dealt with the matter had been extremely difficult. The consultant told me that she had to explain in her report what she would do differently in the future to avoid this outcome. She told me: "In reality I felt there was nothing I would do differently, as I believed we had done all we could. But there was no place for this idea: it was assumed that there must have been a failure in the way the patient was managed." Here, one can see how the external system, in insisting that the staff were at least to some extent responsible for this outcome, acted to support the omnipotent persecution that was so evident—each member of staff felt that if Mr F did kill himself, then the responsibility would be laid at his or her door. As we looked further into this, we discovered that the patient himself was aware of this, since the person who had killed himself was known to him.

Concluding comments

It has been my intention to show that containment is a central part of all work with psychiatric patients. This is, as I suggested, implicit in all our work, but the psychoanalytic account of this process, particularly as developed by Bion, offers us a proper theory and model of the dynamics of containment and indicates what kind of processes might support or obstruct it.

A World Health Organization study in the 1950s compared a number of different psychiatric hospitals in terms of outcome. The different outcomes did not seem to result directly from the treatment approach but were more linked to an indescribable quality that they termed "morale" (WHO, 1953).

It seems to me that in our current health service the professional occupies a very beleaguered position, one that is very damaging to morale. As I described in the Introduction, in earlier times the immediate context of patient and mental health worker could, to some extent, be insulated from anxieties emanating from higher up in the system. This situation has now radically altered. While the previous state of affairs led to some realistic concern about the tendency to pass responsibility upwards through the system, the current situation has brought a different kind of problem, which is

very much more damaging. The capacity of the outer/higher levels within the system to contain anxiety has been very seriously undermined: a minister sneezes and, somewhere on a ward, a nurse finds herself, so to speak, rushing for a handkerchief. Performance targets, constant systemic upheavals, and anxiety about survival cause anxiety to flood downward through the system, considerably damaging the possibility of therapeutic work. Nowhere is this tendency more destructive than in the consequences of the marketization/commodification of the NHS which is currently gathering pace.

Elsewhere (Bell, 1996), I discussed the manner in which the commodification of the public sector made manifest a peculiar form of thinking, which I characterized as "Primitive Mind of State". In this primitive world,

> There are "good" hospitals or schools and "bad" ones. The "bad" ones will be destroyed because they will not get the custom of the mythically empowered consumer, while the "good" ones will survive. The only way the "bad" ones might survive is by transforming themselves and becoming "good", something that is their own responsibility; and they can expect no help from the nanny state to get them out of the mess they have got themselves into!
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> There really is something very persuasive about this sort of argument—it appeals to our wish to live in a simple world of "good" and "bad". The question of a careful exploration, and understanding of why a particular hospital is "bad" does not really arise: it is bad . . . because it is bad. A careful exploration would introduce all sorts of unpleasant complexities which go against the simple appeal of "taking your custom elsewhere". One might cite the effects of chronic starvation of resources, lack of opportunities for staff development, chronic severe depletion of that vital ingredient for any therapeutic life, morale. "Good" and "Bad" become, in the transitory shifting nature of the market forces, categories existing only on a horizontal plane that is in the here and now—they have no history. "Good" must survive; "Bad" will go to the wall—as it deserves to. In this primitive world, the market-place is deified as the only source of human freedom and responsibility. [p. 54]

The ruthless primitive morality evinced here has the qualities of an archaic superego structure; for those working in health services, their daily existence is characterized by the experience

of constant threat. Under pressure to meet targets, and to make cuts, forced to sell themselves in a world where the representation of services takes precedence over their reality, they find themselves flooded with the constant anxiety of survival. This is a world where, as Mark Fisher (2009) has so aptly put it, "All that is solid melts into PR."

It can sometimes feel as though there is an unholy alliance between the pressure coming from above and pressure coming from the newly "empowered" customer (patient)—the mental health worker feels caught in the jaws of this pincer movement. Of course, it is a very good thing that patients are becoming more active in their own management, but it needs to be noted that this "empowerment" of the consumer/patient does not extend to having any say in the cutting of resources or having to accept a postcode lottery of services. Sometimes this "empowerment" can slide into something more perverse, particularly where complaints procedures can unwittingly provide opportunities for a more destructive part of the patient to wreak vengeance upon the staff.

Insisting that mental health personnel accept a level of responsibility that is quite unrealistic seems increasingly to be a part of mental health policy. Such policies, based less on thought and more on the wish to project unmanageable anxiety into those faced with an already very difficult task, sets the scene for a deterioration in the real care of these patients. Management plans come to serve the function of defending the self against any possible blame, rather than enabling acceptance of the complexities of the task. An attitude of enquiry is transformed into a preoccupation with protecting oneself from the inquisition.

Beyond any other factor, staff morale, which creates the foundation of the staff's capacity to contain, is the vital therapeutic ingredient, a morale that needs to be robust and, as I have explained, not dependent on any individual patient getting better.

One last caveat. In the above I have emphasized the necessity of space for thought, whether at the individual, group, or institutional level, but I am not suggesting some kind of endless reflective thinking without action. We should not think instead of acting, nor act instead of thinking—that is, we should not think "action-lessly", nor act "thought-lessly". But, as I have suggested, our capacity to think, to contain what needs to be contained, depends upon a multitude of factors functioning at different levels within the system.

I would like to end by quoting from a poem of Bertolt Brecht's, which I think describes some of the features of a container that can stand the blast of experience:

In a dream last night
I saw a great storm
It seized the scaffolding
it tore down the iron cross-clasps
What was made of wood
stayed and swayed.

Notes

1. I am reminded here of a patient who was compulsively attracted to love objects whose overriding interest derived from the fact of their availability (the path of least resistance) as opposed to their worth to him (maximal advantage)!
2. It needs to be borne in mind that this is not a sequential process and that the appearance that this is the case is only an artefact of writing which is necessarily linear, whereas in reality these different aspects of the depressive position are all bound up with each other.
3. What follows is based on Bion's model but is derived from a number of sources. The works cited (Bion, 1962a, 1970) are the main references to Bion's theory of the relation "container–contained" but do not refer to all the vicissitudes discussed here.
4. The term "endopsychic perception" is used by Freud (1911c [1910]) to refer to the minds perception of its own activities.
5. Tom Main considerably advanced our knowledge of the processes that are required for containment in an institutional setting. He was fond of saying, "Don't just do something, stand there"!

REFERENCES

Anzieu, D. (1989). Beckett and Bion. *International Review of Psychoanalysis, 16*: 163–169.

Armstrong, D. (2005). *Organization in the Mind: Psychoanalysis, Group Relations, and Organizational Consultancy*. London: Karnac.

Barkun, M. (1974). *Disaster and the Millennium*. New Haven, CT: Yale University Press.

Barratt, R. (1996). *The Psychiatric Team and the Social Definition of Schizophrenia*. Cambridge: Cambridge University Press.

Bell, D. (1996). Primitive mind of state. *Psychoanalytic Psychotherapy, 10*: 45–58.

Bennetts, L. (2001). One nation, one mind? *Vanity Fair* (December).

Berke, J. (1979). *I Haven't Had to Go Mad Here*. London: Penguin.

Bick, E. (1962). Child analysis today. *International Journal of Psychoanalysis, 43*: 328–332.

Bick, E. (1968). The experience of the skin in early object-relations. *International Journal of Psychoanalysis, 49*: 484–486.

Bion, W. R. (1952). Group dynamics: A review. *International Journal of Psychoanalysis 33*, 235–247.

Bion, W. R. (1954). Notes on the theory of schizophrenia. In: *Second Thoughts: Selected Papers on Psycho-Analysis* (pp. 23–35). London: Heinemann, 1967. [Reprinted London: Karnac, 1984.]

Bion, W. R. (1956). Development of schizophrenic thought. In: *Second Thoughts: Selected Papers on Psycho-Analysis* (pp. 36–42). London: Heinemann, 1967. [Reprinted London: Karnac, 1984.]