

Chronic pain clinic as a haven for difficult patients: the role of projective identification

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ABSTRACT

Difficult patients - or those with difficult personalities - are frequently encountered in the treatment of chronic non-oncologic pain, overburdening the doctor-patient relationship far beyond the complexities of their illness and treatment. The present review/experiential report discusses the role that projective identification, as a psychological process of communication, puts the doctor-patient relationship in within the multi-professional chronic pain team. The concepts of projective identification are reviewed both in their benign and their malignant forms. Two clinical vignettes exemplify each of them. Some situations in the setting of doctor-patient communication are presented in which projective identification appears and complicates the therapeutic relationship. Some recommendations are offered regarding the handling of patients that communicate mainly by means of projective identification, and some ideas are offered to the multi-professional team. In our chronic pain clinic, difficult patients as a whole seem to prefer to communicate by means of a malignant form of projective identification and present with immature types of personality organizations. Within the chronic pain teams, doctor-patient relationships (as well as relations among the professionals) can be enriched if projective identification is detected early and appropriately handled. Long-term psychotherapy is the treatment that should be chosen for such patients.

Keywords: Chronic Pain, Pain, Intractable, Projection, Identification (Psychology), Personality Disorders, Physician-Patient Relations

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INTRODUCTION

Teams that work with chronic pain patients generally face dysfunctional situations in the patient relating to one member (or more) of the team. In medicine, ways of improving the handling of these so-called difficult patients or problem-patients have long been discussed. It is estimated that 15% of physician-patient encounters in general medicine clinics are difficult or problematic.¹⁻³ For Hahn, difficult patients tend to present many psychosomatic symptoms along with an "abrasive" personality style that frequently places them in the diagnostic category of personality disorder.⁴

Chronic pain treatment, specifically non-oncologic chronic pain, is one of the specialties that most often attracts difficult patients, who tend to present anger, rigid personalities, and arrogant behaviors.⁵ The most severely difficult patients have already been qualified as "pan-symptomatic", for presenting a wide array of symptoms, in multiple and complex combinations, in addition to commonly externalizing anger towards their caregivers.⁶ Among chronic pain patients it is also common to see destructive behaviors such as threats and suicide attempts, self-mutilations, lack of adherence to the treatment proposed, and opiate abuse or dependence. Such patients are generally hyper-demanding and many health professionals feel exhausted when working in non-oncologic chronic pain clinics.⁵

Groves, one of the pioneers in the attempt to categorize difficult patients, proposed to group them into four subtypes:⁷ (a) patients who are dependent clingers, who seem to have never-ending needs for reassurance and appear eternally helpless; (b) the entitled demanders, who, initially docile, become aggressive and intimidating with time; (c) the manipulative help-rejecters, who usually cannot give thanks for the help they receive and are always pessimistic about their prognosis; and (d) the self-destructive deniers, who always seem to sabotage the treatment with their risky behaviors and/or systematic failure to follow instructions. In our psychiatric experience on a chronic pain team, we have met Groves sub-types frequently and identified a certain degree of overlapping among them. It has become increasingly clear that there is a common denominator in the mental functioning of difficult patients: the immature personality. Such immaturity seems

to lead patients to use extremely archaic, primitive relating mechanisms, typical of early childhood - with projective identification being the main mechanism.

The present article reviews the role of projective identification in the construction of difficult relationships between patients and physicians (or other professionals) on the chronic pain teams. Two clinical vignettes (fictional) are included to exemplify such projective identification. It is hoped that, with the text, the members of pain teams become more skilled at identifying the phenomenon early and handling it therapeutically (or in a less dysfunctional fashion) for the parties involved.

METHOD

The terms "chronic pain" and "projective identification" were combined in the search through the SciELO, MedLine, Embase, Cochrane Library, and Web of Science electronic databases.

Any article in Portuguese, Spanish, or English could be included, as long as it discussed a possible role of projective identification in the setting of treating patients with chronic pain. After reading their abstracts, only one was eligible, in accordance with the adopted inclusion criteria, and it was read in its entirety.

This first search strategy, due to having recovered a very small number of articles, was replaced by another strategy where: (a) the experience of the author is given, after two years of working as a psychiatrist on a team for chronic pain patients; (b) the texts of authors who mostly discussed projective identification in the health setting were verified for the gradual construction of a narrative review on the theme; and (c) two clinical vignettes are presented to show the projective identification operating in the context of patients with chronic pain being treated.

The concept of Projective Identification

The concept of projective identification was coined by Klein from the observation of non-verbal communication between a mother and her baby⁸ and soon applied to the therapist-patient relationship setting.⁹ When a baby shows discomfort (by crying, contorting, etc.) and his mother helps it to alleviate this discomfort (whether through breast feeding, providing warmth, or just picking it up, etc.), a circular communication is slowly

created between them. By repetition, such communication will be refined day by day and, if everything goes well in the process, the mother will know, after some time, what the baby needs - that is, an effective non-verbal communication code is founded between them. In other words, on the one side the baby signaled to its mother that it was suffering, and on the other side, thanks to her feeling anguished, the mother could diagnose the suffering and solve it.

Authors who deepened the understanding of this pre-verbal communication between mother and baby proposed the following equation:⁸⁻¹³ the suffering/anguish that belonged to the baby was separated from the notion of itself (the baby self) and became experienced by the mother; the mother started behaving - although unconsciously - as if the suffering was hers. That is, thanks to the identification of the other's suffering as her own, an effective handling of such suffering appeared. Meanwhile, the baby (the communication emitter or projector) can feel relieved and rest a little from a pain that seemed intolerable to it. In fact, the mother (communication receiver) for having a stronger ego, knows what to do to ease the pain/suffering/anguish of her baby. Therefore, the projective identification receives this name because the baby projected onto its mother something that belonged to it, and the mother identified with those projections as if they were her own and felt, thought, or acted accordingly.

The process that leads the child's psyche to organize itself separating good things from bad things (that is, gratifying experiences from frustrating ones) receives the name of scission or split.¹⁴ It is part of the early infantile experience to perceive - itself as much as the other - in a split, partial manner; the mother who gratifies is totally good; the mother who does not (for example, who moves away for a moment) is totally devalued as a dangerous object, totally bad. In the first months of life, it is in the interest of the maintenance of the baby's well-being that it not perceive that its opposite and radical impulses are directed to the one and same mother. That part of its own self or of the object (the other, the mother) that is experienced as being totally good, perfect, fully gratifying, is seen under the process known as idealization. The parts of its own self or of the other that are seen as bad or dangerous are being devalued. Idealization and devaluation are very common defenses in early childhood and, when the psychological maturing

does not occur, they can persist disruptively in adult life. Immature personalities tend to see the world in black and white. Many times, in treatment we see patients who idealize their physician to the extreme when (at the beginning of the treatment) they think they have found a friend who will save them from all their pains and existential woes - only to later devalue that physician totally when they feel frustrated, either with the treatment or with the "friendship".

Bion understood projective identification as a form of primitive communication between mother and baby that is capable of persisting in adult life in many interpersonal relationships, such as the therapist-patient relationship.¹⁰ For Bion, the concept is deeply associated with the fact that the child uses its mother as a temporary container for sufferings that are still intolerable to it. This notion is known as continent/content relation in the mother-baby interaction. Due to projective identification, therefore, the baby is able to maintain the fantasy of splitting off from all its unpleasant contents (hunger, cold, anguish, pain) and storing them in its mother. For Bion, as long as the mother is able to identify with her baby's anguish, "taking it" as hers and handling it, the baby has the time to digest its impulses and raw emotions, transforming them into thought; therefore, it is in this interval that the capacity to self-evaluate (insight) and think would arise and become stronger.⁹

Extending the concept of projective identification to the therapist-patient relationship, Bion postulated that when we are the target of projective identification (when we are receivers), similar to the mother, we need to function as a temporary container. In other words, if we want to effectively treat the patient, we need to have the tolerance to develop in ourselves the ability to store that which is projected onto us by the patient - no matter how execrable it may be - and to, later, return everything to the patient that was his, but softened and detoxified in a form that he can tolerate (for perceiving it as less dangerous).

Various authors have proposed a didactic form in three steps to understand projective identification:¹⁵⁻¹⁷

- (a) the projector has the unconscious fantasy that, being able to lodge a painful feeling (such as anxiety or shame) within another person, this will result in those feelings becoming more tolerable;

- (b) the projector exerts a subliminal pressure on the receiver, so that the latter experiences the projected feeling as his own, and will think and react accordingly;
- (c) an affective resonance is created between those involved: the affective state of the receiver now mirrors that of the projector; there is a blurring of boundaries between the two, so that it is no longer known to whom those intolerable feelings of anxiety or shame originally belonged; if the receiver knows how to act on the contents projected (instead of simply being altered by them), the projector will be able to take those contents back (in a form metabolized by the receiver) and the blurring of boundaries is cleared.

This dissection of the projective identification process shows how different it is from a simple projection.¹⁸ In a projection, there is no blurring of boundaries between the identities of the projector and receiver, nor does the latter feel pressured to identify with the contents projected onto him, or to think or behave accordingly. That is, in the projection, the receiver neither participates, nor is altered by the process. For example, a racist individual can project onto a neighbor from another ethnicity various of his own character flaws - but the neighbor does not even know that. There is no blurring of boundaries between them: quite the opposite, in the projection, the projector insists on seeing himself as different from his neighbor, and better than him.

It is fundamental to keep in mind that, in early childhood, it is normal that the baby use projective identification to rid itself of discomforts that its immature ego cannot yet store and process (pains, anguishes, sufferings). However, if the individual becomes an adult and still uses projective identification to communicate with another person, we are facing a pathological situation - and one very commonly found in chronic pain treatment.

"Benign" and "malignant" projective identification

In a review article, Clarke points out that projective identification may serve to build a more empathic communication between the projector and receiver, but may also serve as an attack from the projector against the receiver.¹⁹ This attack notion was the one most emphasized by Klein, who understood that

through projective identification, the small child established the prototype of an aggressive relationship that served to control, damage, or possess its mother.⁸

The question has been well explored by Rosenfeld¹² and Ogden²⁰ in the relationship setting of adult patients and their therapists. The "benign" form of projective identification results in the refinement of empathic communication between patient and therapist (Scenario 1). However, the "malignant" form only helps the patient to expel everything he feels as execrable (frightening, spoiled) within himself, using the other (the therapist) as a garbage can. In this second case, the patient seems to use the therapist without considering him as a person (without seeing him), for what is interesting is the quick evacuation of everything that causes pain or discomfort to the patient. Certainly, in the first months of life, the mother is used as this type of receptacle. The difficult patients we have seen in the treatment of chronic pain also seem to make regular use of their physicians and therapists as this type of receptacle. Scenario 2 shows a clinical vignette that exemplifies a situation of malignant projective identification that was well handled by the consulting physician.

Projective Identification in the Treatment of Chronic Pain

We find very difficult patients in treating chronic pain. The careful observation of these encounters reveals that, many times, the therapeutic capacity of the health professional is challenged and may be seriously compromised by malignant forms of projective identification. Below, we indicate a few frequent situations:

1. The patient that idealizes his physician or treatment too much

Professionals on pain teams often face patients who idealize them in an extreme way or intensely idealize the treatment that is proposed. A few of those professionals may wonder whether they should offer friendship as a counterpart to the trust being placed in them by the patient. Some even wonder whether they should give their personal phone numbers to the patient or accept their gifts, etc. Unfortunately, the patient that makes a vicarious use of projective identification usually alternates moments of idealization with moments of devaluation - both extremes, since the patient perceives the world in black and white, splitting his experiences so as to allocate everything that is "good" to him and

Scenario 1. Clinical vignette of "benign" projective identification

A psychiatrist describes that he was astonished during the first consultation with patient A.C., 45 years old, while she told him her story. Two years earlier, she had lost her oldest child while he was swimming in a dam and disappeared right in front of her eyes. And during the entire past year, she had cared for her other son who was going through the evolution of a metabolic disease. She had given him the final care, at home, waiting for him to die in her arms. The psychiatrist noticed that she talked about it in a monotone voice, while he felt more and more oppressed, almost to the point of breaking down in tears. In the following sessions, he noticed that he had served as a first confidant for his patient's pain, who was now, little by little, able to speak with more emotion about her recent tragedy.

Scenario 2a. Clinical vignette of "malignant" projective identification with improper handling

B.D., 45 years old, was monitored in a large university hospital for many years, with diagnoses of tendinitis, lumbar sciatic pain, fibromyalgia, adenomyosis, endometriosis, Crohn's disease, irritable bowel syndrome, and cephalgia. In addition to the Pain group, she was also treated for Gastroenterology, Gynecology, Rheumatology, Neurology, and Mastology. She was forwarded to a psychiatrist to be evaluated "urgently for endogenous depression, suicidal ideation, panic syndrome, and bipolar disorder". On the first psychiatric visit, she also claimed to have insomnia, breast lumps, lumps in the uterus, having had cancer treatment, and almost having had thrombosis in the leg. She said she felt pain for as long as she could remember. She had attempted suicide various times, had had psychiatric treatment with a physician "friend" and no psychiatric hospitalization. She had been abusing benzodiazepine for years. She had episodes where she got lost in the streets, coming to in places other than her destination hours later. Her relationship with her husband and two sons was dysfunctional, marked by almost daily verbal altercations. She referred to past childhood traumas, including neglect and physical and sexual abuse. The psychiatrist noticed that her medical records were confusing and that there was no confirmation of some of her diseases: for example, there were many normal colonoscopies. In the psychological exam, the patient had a childish contact, poorly structured suicidal ideas, verbiage, anxiety, and irritability; there was no mood depression or anhedonia. The psychiatrist found no corroboration for the panic syndrome or bipolar disorder diagnoses and speculated a borderline personality disorder. In the following visits, the psychological exam was maintained and the psychiatrist noticed that the patient had difficulty following prescriptions; she also brought no family member for an objective anamnesis as had been asked of her. During one month when she would not have any visits with the psychiatrist, B.D. appeared at the ambulatory clinic and requested to be "squeezed in". During the consultation, she insisted on the doctor prescribing benzodiazepine again, because the prescribed sedative did not make her sleep. In a shorter consultation, the psychiatrist acquiesced. On the next visit, the psychiatrist forwarded B.D. to psychotherapy and confronted her with her own difficulties in following rules (for example, using the medication erratically or not bringing a family member to the objective anamnesis). Two weeks later, the patient came to the clinic alone and very anguished, asking for another "squeezed in" visit. The physician, however, could not see her, for there were too many other patients waiting for previously scheduled appointments that day. Showing an excoitation on the wrist, the patient started to cry and accuse the physician of being insensitive and not seeing her degree of fragility due to her pains, problems with her husband and sons, and her wish to commit suicide. She showed a small forwarding letter from another physician in the institution (who did not know the case) asking that her visit be "squeezed in". Finally, seeing that the physician would not see her that day, she bent down to his ear and asked him (in a lower tone of voice, but still crying): "How could you? Do you think it is normal for a patient to be thinking of suicide all day?" The physician answered he did not think it was normal and that was why he had forwarded her to multiprofessional treatment, including psychotherapy, in the psychiatry department. When B.D. left the room, the psychiatrist noticed that an altercation had happened between them; and that he had felt anguished with the sensation of having been discovered and threatened by a patient in his own work place, in a day he was not thinking of her; he noticed his anger for the patient and feared that she had noticed it. After seeing one or two patients, an employee at the reception told him that B.D. was complaining about him to the Management, which increased his anger even more. In the following days, the physician could not sleep and felt like calling B.D. many times. He noticed that he feared being punished by the hospital's management and that the patient might already have committed suicide.

everything that is "bad" to him in separate compartments. In our opinion, on pain teams, professionals should be very careful not to "wear" the super-hero costume completely - no matter how omnipotent they may feel - for, many times, there will be a free fall from the position of savior to that of a tormentor of the suffering patient. In their relationship with these patients, the experience of the physician as a savior (omnipotence) was, in general, projected onto him by projective identification. This physician may start acting with extreme affection towards a specific patient (a "special" patient), allowing appointment exceptions, for example, or even trying difficult interventions that he has never practiced. Even if this professional does not become a target after a fall to the role of tormentor, it is likely that another member of the team is already being violently devalued by the patient, which may lead to divergences in the work team.²¹

2. The patient who is capable of enraging the physician

When a member of the pain team finds himself containing an excessive rage he feels for the patient, it is quite probable that he is identified with bad, spoiled, repulsive, and destructive aspects that the patient has projected onto him through projective identification. In some instances, the professional experiences the exact brutal rage that had once belonged to the patient. The process may have begun because the patient made the physician feel devalued and/or has openly devalued the treatment that the physician was offering. It is noteworthy that the patient does not do this on purpose or consciously, but because his discomfort for harboring a destructive rage is intolerable to him, and he once again needs to separate himself from bad things to remain the bearer of good things or to deserve something good (that is, to prevent his

destructiveness, in fantasy, from destroying his good contents). A physician who finds himself angry or anguished - in the place of a patient who is unemotional and unshakeable in his own complaints - is one of the most common scenes in the treatment of chronic pain.

3. Physicians who are paralyzed by the fear-obligation-guilt triad

Some patients, through projective identification, are able to overwhelm and paralyze their physicians and therapists with fear (especially the hyper-demanding patients); with guilt (by therapeutic failures): or with obligations not completely fulfilled towards the patient (for the patient did not improve totally or did not improve as expected with a certain procedure). Forward coined the expression FOG for those patients (Fear-Obligation-Guilt), creating an acronym as a reminder that the professional overwhelmed by "fog" can see less and less the path to be taken to conduct his patient's case. With his sight hindered, the physician may chronically consider himself "responsible" for the ineffectiveness of the treatment. The author postulates that these patients are formidable in their capacity to operate emotional blackmail, silently and subliminally creating (and nurturing) this triad of uncomfortable feelings within the physician's psyche.²²

4. The physician on a string

Similarly to the baby who makes its mother never end her chores and move away from him, many patients sadistically are able to control their physicians and therapists. Many physicians find that, days or even weeks after their visit, they are still thinking about how to solve the patient's sufferings (even when they are with friends and relatives in activities not related to their profession).²³ Sometimes, a clean bill of health needs to be postponed due to the ghostly appearance of a somber and inexplicable worsening in the clinical presentation of the patient. The feeling of being controlled by the patient is one of the most uncomfortable to a physician. It is as if, in spite of the physician's decision-making intelligence, there were another alien, strange intelligence hovering over the physician-patient duo. This intelligence seems to be in command and to control everything that works and does not work in the course of treatment. In fact, the need to control the other (the other who cares) is central in the projective identification process: when an

individual places aspects of himself on another person, he will also control the behavior of this other person to maintain the illusion of still being the owner of the aspects that have been projected.²¹ Bohmer points out that projective identification is a way to communicate by "impact", as well as with suicide threats and self-mutilation.¹⁶ To feel under somebody else's control has an impact and it is crushing, for the physician suddenly finds himself deprived of his freedom and of his right to make choices on anything, including to continue treating a specific patient. The need to control the other systematically can be identified in the patient's initial visit and can be confirmed with an objective anamnesis (collected from relatives or friends of the patient). The problem is that, as we have seen, most physicians who deal with chronic pain forgo the objective anamnesis.

5. Frustration as a guaranteed outcome

Teams that care for chronic pain patients are periodically frustrated, disappointed with therapeutic strategies that seem perfect (sometimes, even heroic), but that always end up being ineffective to the patients.^{24,25} The professionals in those teams generally forget to examine the following equation: while the frustration is experienced by them, the patient rests free from it and does not need to deal with it. However, in order for the treatment to work, the patient needs to internally process the onus of his burdens, recognize the limitations that the disease brings, accept his duties in the fulfillment of the medical recommendations, and plan a way to live well, even while managing his sufferings. In other words, while the patient is simply evacuating his complaints onto another person (his physician or team), he does not need to deal with the real presence of intrapsychological suffering. And if the physician or team tend to live that frustration in place of the patient, a third step will be missing from the projective identification (to return to the patient that which is his and that needs to be tolerated by him, after being softened by the presence and continence of the therapist or team).

6. The physician "behind the eight-ball"

We have heard colleagues comment on how they feel in a tight corner while trying various therapeutic strategies that generally end up being ineffective to chronic pain patients. A few complain that the patient himself always seems to have a negative expectation

in relation to any therapeutic proposal the physician presents. The eternally ineffective treatment is closely connected to what was said in the previous item: as long as the frustration is experienced by somebody other than the patient, no treatment can work. A treatment that works means a discharge from the clinic. That is, the possibility of the end of having someone outside serving as a receptacle for the patient's anguishes and frustrations is frightening. These patients seem to be people who never can say they are well. Saying they are well is terrifying because it announces distancing, abandonment, loneliness. Many times, the physician seems to notice, in the patient himself, actions that sabotage the treatment. For example, failure in following recommendations, missing scheduled appointments, forgetting prescriptions or exam printouts, etc. With time, the physician starts feeling impotent with the case. It is necessary to recognize that, through projective identification, this impotence is also lodged by the patient inside his physician (originally, this impotence and helplessness facing life's inherent discomforts belonged to the patient). Authors who study the contact with difficult people usually call such setting a "no-win situation".^{26,27} We have observed a few patients who, already on their first visit, manage to leave the physician or therapist in a no-win situation: the physician, after listening to an avalanche of complaints, feels paralyzed, avoids looking at the patient much, preferring to look at the computer screen or at the papers he is filling out, hoping to escape from the situation, asking for doubtful consultations at other clinics or for more sophisticated exams. In our clinical meetings, we call this the "straw doctor" sign,²⁴ to point out that the doctor is at an impasse, stuck "behind the eight-ball". It is interesting to remember that Bion, when talking about projective identification, drew attention to the fact that it could attack the receiver's ability to think, destroying any chance of a useful relationship between patient and therapy;¹⁰ and that Rosenfeld indicated that the fusion of identities between the projector and the receiver created a "confusional state" that delayed or paralyzed the therapist, leaving the therapy ineffective.¹²

7. Contagion through catastrophizing

In recent years increasing attention has been given to the phenomenon of catastrophizing presented by chronic pain patients.²⁸⁻³⁰

However, we found only one author who pointed out a possible link between catastrophizing and projective identification.³¹ We found that catastrophizing derives from splitting: any bad aspect, any suffering or discomfort is seen as being extremely bad and dangerous - a threat to survival. The catastrophizing patient will try to extirpate from himself (split off) the notion of any such threat due to the impression that it could cause dissolution of his self. We have seen innumerable chronic pain patients complain of problems lodged in a certain part of their body as if that part of the body did not belong to them. In this way, the patient appears to talk of his pain, but not experience it. In addition, catastrophizing is contagious. It is contagious in part because we were all born with a physiological apparatus to defend ourselves from threats to our survival. In other words, it is hard for someone not to respond with extreme anxiety to seeing someone falling apart in desperate, catastrophic suffering. In short, the catastrophic thinker manages to contaminate the other with his desperation, whether verbal or non-verbal (by projective identification).

Therapeutic considerations and recommendations to chronic pain teams

When comparing what happens in the physician-patient interaction in the treatment of chronic pain with the description of projective identification theorists, it is difficult not to see how much they have in common. Klein postulated that through projective identification the small child establishes the prototype of an aggressive relationship that serves to control, damage, or possess the mother.⁸ For Hanna Segal, in projective identification, parts of the self and of internal objects are expelled and projected onto an external object, which becomes possessed and controlled by the parts being projected, becoming identified with them.^{11,32} In the words of Ogden, "the unconscious intersubjective alliance present in projective identification can have qualities that to the participants sound like abduction, blackmail, seduction, hypnosis".³³ For Julia Segal,¹⁹ the projective identification can be used as a destructive attack, with repulsive, crazy, or intolerable parts of the patient's self being elicited in another person to destroy the other's comfort, peace of mind, or happiness. Joseph suggested that the projector operates a subtle jab to exact a response from the other person.¹⁹ Rosenfeld wrote that projective

identification can be used as a means of control in order to provoke in the receiver the appearance of an object concerned with the projector.¹² Gabbard pointed out that patients who abuse projective identification generally manipulate, persuade, coerce, flatter, and seduce members of the team caring for them, while trying to obtain the satisfaction that is interesting to themselves.²¹ These descriptions (keywords in italic) are quite consonant with the feelings experienced by those who take care of difficult patients in a chronic pain clinic. Two decades ago, these patients were still frequently found in psychiatric ambulatories. Nowadays, they seem to have migrated to pain, rheumatology, orthopedics, psychiatric, physiotherapy, and rehabilitation clinics. In part, this change may have happened because these patients started being dismissed by psychiatric ambulatory triages - it is known that these patients are not too responsive to pharmaceutical treatment.

Splitting and projective identification have been pointed out as the main functioning mechanisms of patients with severe personality disorders, especially the borderline disorder.^{21,34} Various authors have reported the extent of the association between borderline personality and chronic pain,³⁵⁻⁴¹ with many cases erroneously diagnosed as depression or bipolar disorder.⁴² Our experience of two years working on a chronic pain team has revealed that 70% of the patients referred to us for psychiatric evaluation can be diagnosed as having borderline disorder and/or narcissistic personality disorder.²⁴

Through projective identification, the difficult patients we have seen continue doing what they did to their mothers: capturing the attention of another person to have the guaranteed proximity of a receptacle that contains his pains and anguishes. Some patients behave, either with the psychiatrist or pain specialist physician, like a "complaint machine gun", which is an effective way to overwhelm the other person with anguishes (especially if that person has a good listening capacity). Overflowing complaints, many times in a continuous stream, are the "bad" parts of the self that the patient is trying to get rid of, attributing the suffering to some part of their body that contains this or that disease. It is unlikely that the patient with get better, for he needs the "disease" to make those expulsions of the "bad", dangerous, or rotten parts of his self.

A few recommendations can be given for when the projective identification occurs in

the chronic pain teams. The most important recommendation to the team regards training them to detect the projective identification. The professional who can talk with his peers about a patient that is being emotionally burdensome is at a lower risk of exhaustion or of reacting in a dysfunctional manner. For example, the physician who shouts at a hostile patient almost certainly has been captured by projective identification: all the patient needed, at that moment, was to see his own anger being acted out by the physician (instead of seeing it within himself). There are dysfunctional ways of reacting that the physician must avoid, such as making those patients "run the medical gauntlet", going from one department to another, from an exam to another, intervention after intervention. Generally, the physician who proceeds in this way has already stopped listening to the patient for some time. Many times, to be actively heard is what the patient needs the most. In teaching hospitals, it is also important to remember that difficult patients must be seen by the most experienced professionals and not by the younger or less experienced. Where there is a hierarchy, it is common that these patients be "referred" to the team's newcomers, residents, interns, or volunteers.

As for the patient, the most important recommendation is not to delay referring him to a deeper treatment, which is psychotherapy. The patient, who is a prisoner of an incipient phase (pre-verbal) in the formation of his personality and still communicates with infantile mechanisms such as splitting and projective identification, can only be helped by a bond that is strong enough to allow the resumption of growing towards adulthood, with the main characteristics of maturity: taming of impulses, thinking anchored in reality, insight, coherent verbal communication, tolerance to the limits presented by the other, and respect for life in society. Intolerance for adulthood also helps to explain a phenomenon that we have seen in our sample of patients with chronic pain: very high rates of inadequacy to work life, absenteeism, leaves of absence, and early retirements (many times with questionable justifications). Various treatment approaches have been used, such as therapy focused on transference (psychoanalysis), dialectical behavior therapy, or therapy based on mentalization.^{34,35,43} A randomized one year-study comparing three techniques for borderline patients showed an advantage in favor of a therapy focused on transference.⁴⁴

When access to psychotherapy is not possible, it is important to remember that any professional in the team that has a good capacity for active listening can become the elected therapist for the patient, since he may offer himself as the temporary container the patient needs. However, it would be highly interesting if this professional have some training in dealing with the feelings lodged into him by the patient (see items 1-7, above). If the duly trained professional knows how to perceive he is the target of projective identifications, he will have more chances of applying the third step in the projective identification process: to show the patient that he is still there, the same as before, despite everything that has been violently projected onto him. Winnicott called attention to the capacity the mother (and therapists) must have to survive the attacks from the baby (and the patients).⁴⁵ When the baby/patient perceives that the anger or anguish projected was not enough to either paralyze or destroy his mother/therapist, he has the possibility of reintrojecting his destructive impulses in a softer manner. This allows him to suspect that he also will not be pulverized by such destructiveness. Many of the patients in a chronic pain clinic suffer unconsciously from what we call first order fears: fear of annihilation, fear of being dissolved by their own hatred, and the terror of being abandoned and/or, in fact, being dead. Winnicott spoke about these brutal experiences of the child, initially calling them unthinkable anguishes and, later, primitive agonies.⁴⁵ For Winnicott, some other terrorizing experiences were also part of this set of pre-verbal agonies, such as fear of falling into emptiness by the force of gravity (not being held by the mother), the disconnection between the self and the parts of the body (anguish for not being able to control his own body), and the experience of not knowing his way (for the clues that come from reality do not seem real).

The professional in Scenario 2a saw himself captured by the projective identification when he realized he had lost his temper with the patient telling her that he could not "squeeze" her in between his scheduled appointments. He spent many days thinking he had acted out an anger that might not have been his, but the patient's. He remembered various texts about the subject and concluded that probably it was the patient who, since early childhood, had seen herself as too small to contain the anger that occurred, for example, when she was left alone or could not

obtain from the other person all the gratifications she expected. Moreover, he lost sleep for many days, expecting a phone call from Management asking for explanations or informing him that the patient had indeed committed suicide. When he found out the patient had not committed suicide, but instead, had made a formal complaint with Management, he spent a few days angry again - and thinking of how to terminate his work with the patient and refer her to another psychiatrist. The vignette (Scenario 2a) clarifies that only when the psychiatrist read a text still unknown to him on projective identification⁴⁶ he remembered that to really serve as a container to the patient's fury, it was necessary to continue treating her and show that he had survived her attacks. Only in this way could he serve as a container that metabolized the extreme anger that belonged to the patient. It was the only way he could make the anger less dangerous - so that the patient reintegrated that anger back, as being hers again, but now less toxic to her own self (third step in projective identification). It is noteworthy that the skit dispenses with words and interpretations (and actually could be damaged by them) because what is important is happening on a pre-verbal level of communication between patient and therapist.

The patient (Scenarios 2a and 2b) was being clinically treated by the psychiatrist, with regular visits and a focus on improving symptoms by using medications. In an ideal setting (psychotherapy focused on transference), the work could have gone much farther and may have encountered some of the ancestral anguishes of the patient. The therapist could have shown the patient that, in going to the Management, she was asking for help from a bigger figure (maybe a parental figure) and had tried to damage her physician's reputation as a way to avenge herself. He could have shown her that her anger had been so voracious that she had tried to destroy her therapist or cause him to be fired from the hospital. He could have shown her that when she was relating to people who did not gratify her, she also felt impulses to either destroy such persons, or destroy the link that she had with them. And finally, behind all that physical suffering that had made her go on a pilgrimage of hospital departments for years, there was a dull, antecedent ache that could not be physically located nor communicated with words because it was indescribable, unspeakable - because it was an unthinkable anguish (primitive agony).

Scenario 2b. Clinical vignette with an alternative to improve the handling of a "malignant" projective identification case

After a few weeks, the psychiatrist was warned that he would have to defend himself against a complaint that a patient had made with Management. While preparing his defense, and still feeling very angry, the psychiatrist decided that he could no longer continue treating B.D. and that it would be better to refer her to another psychiatrist - after all, she had complained to Management about him, damaging his reputation. However, after reading an article on projective identification, the psychiatrist felt less anger towards the patient and noticed that he had recovered his capacity to "welcome" her suffering complaints. He also realized that his wish to terminate the treatment with the patient, discharging or referring her, could be the reflection (as in a mirror) of the feeling the patient had for him: that he be fired from the hospital. Being free from the pressures of projective identification through insight, the psychiatrist decided that he should continue treating the patient and that the visits could even help her to reintegrate her own anger as less destructive (since it had been metabolized and softened by him). That is, that the third step in the projective identification could now be taken.

As Bion said, there is an enormous difference between feeling pain and experiencing pain: only the latter can lead to growth.¹⁰

It is possible that physicians from different areas might be talking about the same patients, but using different terms: "pan-symptomatic",⁶ "multisomatizers",³ and patients who suffer from "pan-pain".⁴⁷ There are health professionals and insurance companies that consider chronic pain as an intractable condition.²⁵ If we are correct in the considerations of the present article, it is indeed possible that many of the medical efforts and material resources that are now used to treat chronic pain patients are being spent misguidedly (poured down a hole). Long-term therapy, being capable of changing dysfunctional personality traits, would be the preferred treatment for difficult patients who communicate through projective identification, whether they are found in a chronic pain clinic or in any other clinics.

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