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Only connect— the links between early and later life

Margot Waddell

. . . Last scene of all,
That ends this strange eventful history,
Is second childishness and mere oblivion,
Sans teeth, sans eyes, sans taste, sans everything.

[Shakespeare, *As You Like It*, II, vii, 163–166]

These are the final words of Jaques's disquisition on the Seven Ages of Man in *As You Like It*. His reflections are prompted by an (off-stage) encounter with Touchstone (Duke Senior's clown), a meeting that is described at the beginning of the same scene. Jaques is exceedingly taken with Touchstone. He delightedly reports to Duke Senior and the outlawed court the "motley fool[']s" pronouncements on "how the world wags":

And so, from hour to hour, we ripe and ripe,
And then, from hour to hour, we rot and rot;
And thereby hangs a tale

[II, vii, 26–28]

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The “tale” is the most significant of all tales—it is that of the human condition. A central theme in this play, as in many of the comedies, relates to the necessity of incorporating the reality of endings (i.e., of loss, of relinquishment, and ultimately of death) into the spirit of beginnings, and of potential beginning into the sense of an ending.

The “tale” that Shakespeare so often re-tells, explicitly and implicitly, is, at its barest, that of the importance of encompassing debility and death in any story of renewal. The straightforward statement is that “second childishness and mere oblivion” are facts of life that, at every stage and age, must be recognized and understood, not sequestered and denied, if any genuine development or understanding is to occur.

The inextricable relationship between beginnings and endings is one that I shall be tracing in quite literal terms, in order to link together the ways in which psychoanalytic theories, clinical experience, and observational work with early “childishness” may contribute very immediately, even practically, to an understanding both of “second childishness” and of how to work with impaired and enfeebled states of mind. As is made so clear in *As You Like It*, ripening and rotting are, in one sense, a straightforward matter of time, of chronological time, and although time is absolute—the next hour follows the last (Touchstone’s assertion that Jaques is so taken by)—yet, as life in the Forest of Arden makes so clear, the important issue is what you *do* with those hours. In terms of development, the psychotherapist is always aware that at any age what matters is what the hours *mean*, and how they are spent, in relation to the possibility of furthering or prolonging psychic growth, or of limiting and foreclosing it. In this sense, time is *not* absolute, for the extent to which we “ripe and ripe”, only to “rot and rot”, is dependent on the indissoluble relationship between physiological/neurological and psychological factors—between body/brain and mind. As a person physically deteriorates, early problematic psychological constellations, if unresolved, are likely to be replayed; infantile defences, if underlying anxieties remain unmodified, are re-erected; childlike needs, if unmet, resurface. These things tend to occur the more as coping abilities fall away, and raw, even abject, dependency asserts itself.

It is a full century since Freud established that a person could become mentally, even physically, sick for emotional and not just organic reasons—an idea that prompted a furious response from the medical establishment, to be met by Freud’s famous statement: “I understood that from now onwards I was one of those who have disturbed the sleep

of the world" (1914d, p. 21). A hundred years later we are nowhere near as far as we should be in understanding the emotional component in what are considered the organic origins of psychiatric, developmental, and behavioural disturbances. Within psychoanalysis, perhaps the most significant of the theoretical innovations have been Wilfred Bion's elaborations of Melanie Klein's conceptual framework—in turn rooted in Freud's. Bion explicitly linked emotional and cognitive deficits and thus initiated a much more extensive and confident basis for exploring deeply troubled—indeed, psychotic and schizophrenic—adult states *and*, of especial significance, areas of developmental disturbance in infants and young children. Bion's psychoanalytic model now underlies much current thinking about the nature of troubled child and adult worlds, and their roots in the emotional deficits and traumas of infancy and young childhood. Work with children's fractured mental states (e.g., Rustin, Rhode, Dubinsky, & Dubinsky, 1997), and, in particular, areas of developmental arrest, has yielded extensive understanding not only of the puzzling conditions themselves—for example, of autistic and Asperger states—but also of the non- or *undeveloped* aspects of all ordinary personalities and, as I am suggesting here, of the troubling mental states of the very old.

In many areas, the draw of the organic, medical explanation for such states still remains strong, and, of course, with the very elderly the actual deterioration is real and has to be taken centrally into account. But latterly neuroscience is itself coming up with evidence that strongly supports the research and intuitions of the so-called folk psychologists, those of us who have long recognized the complex intimacy of the links between cognitive and emotional deficit, between organic impairment and affective disorders, between the functioning of the brain and of the mind. The issue is not only that the brain affects the mind, but that the mind affects the brain (e.g., see Schore, 2001).

With some important exceptions, little psychoanalytic work has been done towards a greater understanding of the predicament of the very elderly—work of a kind that might harvest the insights of those most skilled in understanding the mind's capacity to grow and develop and also its propensity to become stuck, deformed, or fragmented. Those who have worked with the more severely disturbed adult patient, and also, in particular, those involved with the disordered and arrested development of young children, will be drawing on clinical and observational skills that are centrally relevant to the present problems.

The psychoanalytic picture of middle and late life stresses the way in which a person's ability to face loss of all kinds, ultimately death, is rooted in very early capacities to bear psychic reality (e.g., see Jaques, 1965; Waddell, 1998). There is a sense—to draw on George Eliot—that

“It is never too late to become the person you might have been.”

This chapter addresses that time in life when it *is* too late, in any obvious sense, and yet when the quality of mental and emotional life may still, if only very temporarily, be rendered a lot more bearable, meaningful, even enjoyable, than is often recognized. Those same models of work with early infantile and childlike states which have contributed to an understanding of the “later years” are particularly pertinent to the last years—those of “second childishness”—especially in relation to the joinings and fracturings involved in organic impairment, whether as a result of cortical vascular trauma (strokes) or of Alzheimer's Disease, or of senile confusional states more generally. (A distinction between any or all of these different states is very hard to make.)

Case description: Mrs Brown

I shall recap on a vignette that I have recounted elsewhere (Waddell, 1998, pp. 8–10)—that of 89-year-old Mrs Brown and her husband, Eric. Basing my thoughts on detailed descriptions by their family, I shall then trace their lives further as, over the following two years, Mrs Brown steadily lost her lively, creative, and enquiring mind to the depredations of Alzheimer's.

The vignette described how Mrs Brown had become painfully jealous lest her recently widowed friend, Gladys, be simply waiting for her (Mrs Brown) to die so that Gladys could move in with her husband, Eric. The emphasis was on how swiftly Mrs Brown became beset by a persecuted certainty of betrayal and abandonment by her husband.

This certainly bore all the hallmarks of an infant or young child's jealous belief of having been supplanted in the affections of the person who matters most. The child is forced to realise that that most beloved person also has important relationships with others, be it their partner or their children. Mrs Brown was unable to hold in mind the kind of person she knew her husband to be. She ignored the real Eric and saw only a polarised and persecuting version of what she feared. It was as if she had lost her capacity for depressive concern and had become caught up in a paranoid–schizoid state,

one that was more characteristic, in development terms, of a three-months-old baby than of an 89-year-old adult. In this state of mind, Mrs Brown could turn even the most loyal and caring figure into a fickle tormentor. [p. 9]

It may be helpful to clarify what is meant here by the Kleinian terms “depressive concern” and a “paranoid–schizoid state”. Aspects of the first are characterized by the capacity to bear separateness, to understand things from the other’s point of view, to tolerate another person or interest temporarily coming first. The second state, by contrast, is dominated by a persecutory fear of loss or displacement and a defensive need for omnipotent control. The seeing of things in extreme and unmodified terms—all good, or all bad—is also characteristic, often resulting in imperious and demanding, or abject and terrified, behaviour. The distinction between the two is beautifully drawn by George Eliot in *Middlemarch*, written in 1872. Eliot contrasts those who can recognize that someone may have

“an equivalent centre of self, whence the lights and shadows must always fall with a certain difference”

With those who

“take the world as an udder to feed their supreme selves.” [*Middlemarch*, chap. 21]

At this point, the source of Mrs Brown’s anxiety was fairly clear to any sensitive and attentive observer. She could still be reassured and given some peace of mind. Her ability, even then, to take an interest, albeit selectively, in “how the world wags” to a large extent remained. At times she would talk about death and recommend that her children be preserved from what she referred to as a “*too* ripe old age” (implicitly drawing an interesting contrast with what she clearly considered to be a reasonably positive “ripeness” in a *degree* of old age) and be allowed to rot a bit earlier than she herself, for she hated what she called “dying bit by bit”.

This chapter explores that later stage, when ordinary communication had ceased to be possible for Mrs Brown and the central issue had become the struggle with an ever-recurring collapse of the characteristics of depressive-position thinking back into a much more paranoid–schizoid state. Unlike previous years, when Mrs Brown could swiftly re-emerge from a persecutory state, she was now in danger of remaining cut off from those about her by the seemingly impossible roadblocks of extreme old age—roadblocks to memory, recognition, or

shared meaning. She was becoming cut off not only from others, but also from herself.

This is a poignant picture. Yet my point is that even *these* states may be much less impenetrable than they seem, as the following brief examples indicate. There is increasing evidence that the anxieties and mental disturbance of later years are often quite specifically linked to the nature of early emotional struggles (e.g., see King, 1999). As the foregoing vignette suggests, in Mrs Brown's case there seem to have been underlying oedipal difficulties that had never been resolved, despite many decades of steadfast marriage and familial devotion. Following Bion, Segal, Britton, and others, the psychoanalytically minded are especially alive to the ways in which the very early capacity to form symbols (and therefore independently to think) is rooted in the ability to bear separation, to cope with the loss of the phantasy of sole possession of the caregiver, and to tolerate being, at times, excluded from the primary pair. These are tasks of early infancy and childhood. Such capacities for "triangular" relationships—capacities that begin to develop in the first year of life—are, in turn, dependent on the relative security and mutual understanding of the primary dyadic relationship between infant and caregiver—usually the mother.

The very early managing of triangularity has much to do with later ways of negotiating oedipal constellations of whatever kind. If these earliest interactions are too disturbed, the development of thinking may itself be impaired, as well as emotional and social capacities, and a person may, for ever after, be struggling with the pains of love and loss, with fears of rejection and exclusion.

Many aspects of so-called senility offer close resemblances to early disturbances of thinking, relating, and communicating. For present purposes I shall focus on a limited number of the many relevant psychoanalytic and developmental concepts: from psychoanalysis, those of projective identification, reverie, container-contained (processes and mechanisms that, in my view, belong quite as much to the last year of someone's life as to the first), and, from the field of developmental psychology, those of, for example, "joint attention skills" and "gaze monitoring". In the first or the ninety-first year, or in any year in between, cognitive and emotional growth in the individual depends on the quality of emotional exchange between self and other. Whether in extreme youth or extreme age, a person has the impulse, one might even say necessity, to project feelings from the self into the other—be it in order to communicate those emotions or to get rid of them. Much depends on whether the person acting as "container" can tolerate the

disturbing projections and still go on thinking about the meaning of the experience.

It is when verbal communication is not yet developed on the one hand, or is all but lost on the other, or when it is put in abeyance by psychological catastrophe, that a caregiver's capacity to render meaningful the raw data, or *sensa*, of experience can determine the difference between "ripening" and "rotting". Following Bion's model, it is the mother's mental and emotional capacity to render the raw elements of the bodily and feeling states of her infant manageable, bearable, and thus comprehensible to the infant that enables him or her mentally and emotionally to develop. This capacity of the mother's was called "reverie" by Bion. The emotional intensity about which the baby is unable to think is projected into the feeding, nurturing, caring aspect of the mother—the "breast". The taking-back-in of that passionate, disturbed emotionality now, because it is unconsciously understood and thereby rendered amenable to meaning, forms the basis in the personality of a sense not only that emotional states have a shape and a form—and are not some long, utterly bewildered, terrifying internal or external scream—but also that the function (originally the mother's of bringing about that transformation) can itself become part of the developing personality. This process, what Bion calls alpha function, is a therapeutic one. A later carer, too, can provide a setting and a mental attentiveness that renders him or her available as a thinking, containing presence whose functions can be internalized.

To return to Mrs Brown. What little her family knew of her childhood was that she suffered (like Bion and so many others) the emotional deprivation of being born in India during British Colonial rule, to be raised by others, albeit initially lovingly by her ayah, and sent off to school in that unthinkable distant place, "England". Mrs Brown scarcely knew her mentally disturbed, sadistic mother (for so she was described), nor her adored but remote, and often absent, father. Her childhood fate was to be constantly uprooted, relocated, re-disrupted, and denied any consistent care or attention. During her youth and adulthood, she had drawn on the resources of class and education to find ways of socially accommodating to what was expected. Yet she had never felt personally secure.

Mrs Brown once confided to one of her daughters the painful details of her own mother's fierce—almost delusory—jealousy of, and competition with, what she felt was too close a relationship between her husband and daughter from very early days. Soon after the husband's early death, the mother seduced her daughter's young lover.

Mrs Brown felt for ever scarred by this betrayal and by the loss of a man to whom she was, at that time, so deeply devoted. She described herself as constantly having struggled, even as a child, to conceal her terrors over exclusion and her tendency towards "self-relegation", as she put it, to the league of those who "service", by contrast with those who "exercise power".

It is certainly true that fear of abandonment and inability to bear separateness are characteristic of dementia sufferers, and that these persecutory states of mind increase with organic impairment. It is nonetheless striking that, in Mrs Brown's case, it was precisely the complexity of the triangularity, and the assaults of jealous rage and anxiety, that caused her particular distress. The horror of being pushed out and replaced had undermined her confidence since early childhood and had never quite been laid to rest. In advanced years, as she lost her acquired social skills, it was these same old infantile insecurities that began to reassert themselves, with an intensity that was scarcely manageable.

I shall briefly discuss a few commonplace situations in which Mrs Brown's relatives' capacities for containment enabled them to render inchoate, or apparently random, fragments of communication not only meaningful, but also of evident support in maintaining contact, and even in re-forging old links, thus momentarily reigniting the embers of a former self.

The situations describe Mrs Brown in her ninety-first year. She had lost the capacity to remember or to think in any sustained or obviously recognizable way. She was becoming averse to anything new, and often to life itself. She had long been losing words, except for the most formal or learned, habitual response. These were the last to go—the relatively mindless attention to proper enquiry and concern: "You must be so tired", "Did it take you long to get here?"—a lifetime of practice in "how-very-kind-of-you"—the *mores* of polite society. She could still take her cues for response from details of her companions' expression and intonation, based on her exceptional sight and hearing, which remained blessedly unimpaired. This ability of hers often obscured how little she was in fact understanding.

As has long been established in the context of infants and children, changes of surroundings or of caregiver cause anxiety, and with Mrs Brown it began to be acute. The understanding accorded to the very young over matters of separation from the loved and dependable one, or from the familiar setting, has, as yet, had little impact on the care of the elderly. For them, too, searing and destabilizing "homesickness"

for the site of psychic security can set in within an instant of any alteration of context. One of Mrs Brown's much-loved daughters unexpectedly arrived to stay for the weekend. The setting was immediately different. Mrs Brown looked at her husband with intense anxiety: "Are we still at home, Eric?"

At some point later that day, Eric got up to leave the room. In his turn challenged by his own forgetfulness, he paused halfway to the door and clasped his hands behind his back, indicating self-irony as much as frustration—his characteristic pose when having lost track of *his* original purpose. Mrs Brown pointed to his hands and gazed at her daughter with what was later described as "almost youthful delight". Insistently she pointed at Eric's posture, her finger crooked for emphasis. Her daughter said, smilingly, "Yes, good old Dad, he's forgotten something." Mrs Brown laughed. Eric collected himself again and left the room, shutting the door behind him. Mrs Brown looked suddenly terrified: "When is he coming back? Where has he gone?" "I think he's remembered something he wants in the kitchen. He'll be back in a moment." Mrs Brown remained anxious. Her daughter wondered aloud, "Would it help if he told you what he was doing, and where he was going, so that you would know?" Her mother nodded.

In this simple set of interactions, one can trace the almost moment-by-moment shifts in states of mind so characteristic of the infant or young child. The shared, humorous understanding between mother and daughter of the meaning of Eric's gesture of uncertainty occurred within an assured sense of available and communicable meaning. The daughter was able rightly to interpret her mother's mood, gesture, and gaze and to articulate it—much as a sensitive therapist might speak to a wordless child, or a parent to a baby. It was clear, however, that when the door shut, Eric's unexplained absence made his wife feel utterly cut off from her base and as terrified as any infant registering loss of the object, and feeling, as a consequence, overwhelming abandonment and dread: "He's gone . . . He's never coming back . . . I'm all alone in the world . . ." and so on. What was needed, and what, as a result of her daughter's observation, subsequently became a habit in the household, was some simple explanation of the kind that a mother might offer a young child: "I'm just going to do X; I'll be back in a minute." Mrs Brown's emotional state could be described as shifting from depressive to paranoid-schizoid and back to depressive again, in a way that was exquisitely related to the psychically disturbing experience of being, at one moment, safely held within a shared triangular psychic structure (husband–daughter–self) and, at the next, feeling severed

from her source of safety and, as a result, in some kind of emotional free-fall.

Mrs Brown's unresolved oedipal anxieties, and the associated guilt, fear, and longing, had, despite impressive social accommodation, nonetheless persisted throughout her adult life. As her social defences—and, more importantly, her memory—fell away and actual mental impairment compounded the underlying emotional difficulties, she became anguishingly prey to her tormenting jealousy and increasingly incapable of negotiating the hazards of relating to more than one other.

Her son recounted an occasion on which, just before lunch, his mother was sitting by the fire with a glass of wine beside her, but not, as yet, her customary once-daily cigarette. Son and husband were holding an animated conversation. As so often, they included her, but only by eye contact. Her son observed his mother agitatedly reaching for a matchbox. As she struck successive matches with her right hand, her left hand moved, scarcely perceptibly, towards her mouth. She would glance at the "couple" with apparent irritation, shake the match to extinguish it, and cast it into the fire. This occurred many times over. Her son, who was observing these details while yet discoursing with his father, came over to her, smiling: "Is it that by lighting a match, you think that the cigarette you are hoping for will somehow materialize?" Mrs Brown looked uncertain, smiled, and then nodded as if in affirmation. (What he did not register was the likelihood of his mother's unconscious wish to extinguish or burn up one or other of her rivals.)

These examples particularly bring to mind a recent study, "Me, You and It" (Burhouse, 1999), looking at the significance of "joint attention skills" and of "gaze monitoring", which is effectively what was going on here between Mrs Brown and her husband and son. Anna Burhouse brings together concepts from cognitive psychology, child development research, and psychoanalysis, with her own work of observing young infants. She focuses, in particular, on impairments in the formation of triangular mental space with special reference to the severe mental difficulties characteristic of the autistic spectrum. Many aspects of this research have an important bearing on the understanding of the kinds of mental problems associated with the very elderly, as the following examples indicate:

Lost for words, Mrs Brown would characteristically point to a focus of stimulation and interest and then look to a secure companion, as if sometimes anticipating a shared response. At other times, more anxiously, she would look for confirmation or enlightenment. When she

encountered an emotional presence of mind that could appreciate and engage with the substance of her communication, or when she could find a meaning where as yet there was none, she was able to make something of it—to enjoy the fact that something had been understood. This was particularly the case when she seemed to be wishing to articulate her sense of beauty—that of the sky, of birds, or of flowers—aspects of the natural world that were among her few remaining sources of interest. Almost as if holding a wand, she would wordlessly and gently sweep a wafting hand in the direction of some object that attracted her. This would be followed by an intense and often quizzical look at a companion, and back again to the bird or flower, and then, in turn, back to her companion. When she sensed that the meaning of her gestures was articulated in simple terms—“Isn’t the evening sky absolutely lovely”—Mrs Brown would break into a smile, with a kind of serene pleasure.

These were, indeed, moments of intense communication between herself and one other. But when a third factor was involved, things were different. The following incident was described by her son. It occurred on a day when Mrs Brown’s jealous anxiety about exclusion had already been aroused. The occasion of this disturbance was a card addressed to Eric from an elderly widow, wishing him a swift recovery following a recent medical problem. Mrs Brown was to be observed staring at the card, opening and shutting it for quite long periods of time, and repeatedly muttering to herself, “Love from Lily”—the words written in the card. She seemed to become irritable at Eric’s temporary, unusual debility and was herself more physically dependent than usual. At one point, she limped across the room, leaning heavily on her frame. Eric was observing her. He looked stricken and sad but was unable to help. When he said to her, “Mind the carpet” (meaning “Don’t trip over the carpet”), she commented crossly to her son, “All he can think about is the carpet.” She proceeded on her way, looking back every few steps to scrutinize her husband’s face—half mocking him and, it almost seemed, half jeering. Was this change of mood related to trying, as a defence against her anxiety, to gang up with her son against her unusually fragile husband?—seeking to make Eric feel useless (“He can’t help”), to crow, for once, over *his* helplessness?

The next day, husband, wife, and son were in the kitchen. Mrs Brown was sitting holding a yellow checked washing-up cloth. There was a bit of rubbish lying in front of her on the table. She pointed to it questioningly, as if to say, “Where does this go?” and looked at Eric. Misunderstanding her “question”, and thinking that she was referring

to the rubbish, Eric replied, slightly impatiently, "Over there!", nodding towards the bin. His wife stared at him uncomprehendingly—seeming to know that something was wrong, but not being able to work out what it could be. She demurred. Fleetinglly she glanced down at the cloth, and then at herself: "That's a terrible thing to say!" (clearly thinking he had meant that she herself was a piece of rubbish). Ignoring this comment, Eric insisted irritably, "In there, in the proper place!" She looked unhappy and continued to dither, arousing further irritation in her husband, who quite suddenly left the room, without, on this occasion, the emotional resources to pause and try to understand what the problem really was. Later, Eric found the yellow cloth carefully folded and placed on top of the bin. Recalling the incident, he described himself as feeling very guilty: his wife had so wanted to be obedient, to do the right thing, but had been unable to sort out the muddle between the rubbish, herself, and the cloth. She had tried to follow instructions but was mystified by her residual sense that the yellow checked cloth was *not* something that should be put in the bin and nor, indeed, was she herself—although her life-long tendency to feel like rubbish had temporarily taken on a concrete reality for her.

The following morning, Eric had to go to hospital for the day for a further check-up. Despite having been carefully prepared for his departure, Mrs Brown was intensely anxious, repeating angrily, "He didn't say he was going. He didn't tell me." There was an exceptionally strong wind blowing that day, and Mrs Brown stared into the garden, distraught at the swaying, cracking branches of the nearby trees. She turned to her daughter with an air of a terrified child and said, pleadingly, falteringly, "Home [*long pause*] . . . Where's home? [*another long pause*] Take me home . . . *please*." Instead of swiftly reassuring her ("You *are* at home, Mum. Look, here are the flowers I bought this morning!" or some such thing), her daughter tried to understand something of her mother's state of terror. She talked to her quietly about the crashing and the banging. She remembered that her mother had also been terrified on the night of the mighty 1989 storm, telling her afterwards that she had thought it wartime again. She suggested that her mother might be feeling that she was back in London, that the War was on, and that "Home" meant the Old Brompton Road flat. Mrs Brown looked momentarily puzzled and then murmured "Yes. [*pause*] . . . But I can't see anyone with guns out there." As her daughter drew the curtains and talked to her mother about why the high wind in the trees felt so distressing, the old lady's anxiety began to subside. It

was as if the room became itself again in her mind—not an alien place where she was stranded and desolate.

In their different ways, these examples show how glimmers of light can be thrown on the nature of impaired and confusional states. One facet of the picture which these glimmers reveal is the fact that, whether in infancy or in old age, development runs unevenly, that the situation is not quite as Touchstone had described it—a steady process of ripening, followed by a steady process of rotting.

From the incidents described, it is possible to see how helpful to an understanding of the opaque mental states of old age might be the skills of those who work with similarly opaque mental and emotional states in childhood. Such professionals have a very particular experience of the power of infantile transference, of the way in which a mother's unconscious registering, reflecting, and thinking gives *meaning* to the infant's world—a meaning that is communicated in her responsive care—or of how, in the language of developmental psychology, “gaze-monitoring” may yield insight into an infant's needs and intentions. By the mechanism of projective identification the baby/child/elderly person who cannot understand, think, or talk about his or her fragmentary or fragmenting experience may nonetheless be able to engender in the caregiver some version of that basic experience. If, as we have seen, the caregiver can offer a mentally receptive state of mind, conscious or unconscious, the communication can be received, modified if it is one of pain and rage, appreciated if one of love and pleasure, and re-communicated, whether in more manageable or in reciprocal mode. The caregiver's mind functions as a container for, and a sorter of, the projected emotional fragments, which, as a consequence, become “the contained”. Care of the elderly—those so often lacking the capacity to speak, yet so intensely riven by extreme emotional states—requires a painful reversal of the original pattern of container-contained (the young now struggling to offer states of reverie to the old).

We are familiar with observing how the behaviour of the baby is fostered by its relationship with its primary sources of love and care, but the foregoing describes the same sort of value of receptiveness to elderly as to infantile emotional experience. The turbulence of feeling—whether of joy, frustration, hopelessness, rage, fear, pleasure, persecution—is quite as intense as in the old as in the young and tests the caregiver in equivalently extreme ways. In these situations the carers, too, have much to learn and may themselves be enriched. As Rustin and Trowell (1991) say: “The capacity to contain and observe

emotionally powerful psychic phenomena is the basis for knowledge of oneself, and for that contact with psychic reality which is at the core of an authentic personality" (p. 244).

Mrs Brown was fortunate to have, in Eric, a loving, sensitive, and deeply patient husband who had an unusual "untrained" capacity to bear his wife's states of mind. She was also fortunate to have children who were, in their different ways, experienced in the so-called caring professions. They were "good enough" at knowing when her insistent pointing to an object indicated, for example, a request or a plea for enlightenment; or whether it asserted a demand; or whether, by contrast, it was a communication of affect in a situation of shared intimacy. At such times of inwardness with her specific state of mind it was possible to observe a distinctive renewal of cognitive capacities in Mrs Brown's now very limited range. That is, despite in all obvious respects "rotting", Mrs Brown was still able, however briefly, to "ripen"—to a point that could, at times, even feel like a momentary late flowering.

Each time this occurred, it was as if mental pathways that had seemed to be totally overgrown, or mysteriously to diverge where once there had been a single track, had for a moment cleared or miraculously re-joined (and doubtless this was literally the case). For her, as we have seen, the times of greatest anxiety were those of being unable to tolerate feeling at the lonely point of the oedipal triangle, fearing that two others could come together only if one, usually herself, were excluded. Unable to speak or to think clearly at such times, Mrs Brown would seek, as in the cigarette incident, primitive reassurance (as if from breast or dummy). At other times she would become angry and, on occasions, abusive. To hold mentally these latter states required immense emotional resources on the part of her carers. They had to bear their own impatience, anger, even hatred, as part of their love.

The kinds of interaction described above became more and more rare as Mrs Brown's Alzheimer's made ever more destructive claims on her mental capacities. She deteriorated physically, became wholly dependent, and was increasingly silent. Eventually, this protracted "second childishness" yielded to "mere oblivion". By the time that point was reached, the "mere" of Jaques's account seemed less stark and challenging, and more appropriate than first reading suggests. For after so long a struggle in life, Mrs Brown's death seemed, to her loved ones, and almost certainly to herself, to be a matter of lesser importance, a comparatively easy thing. She had had enough. She had lived out Jaques's "last scene of all".

No truce with the furies:
issues of containment in the provision
of care for people with dementia
and those who care for them

Rachael Davenhill

Geriatric

*What god is proud
of this garden
of dead flowers, this underwater
grotto of humanity,
where limbs wave in invisible
currents, faces drooping
on dry stalks, voices clawing
in a last desperate effort
to retain hold? Despite withered
petals, I recognise
the species: Charcot, Ménière,
Alzheimer. There are no gardeners
here, caretakers only
of reason overgrown
by confusion. This body once,
When it was in bud,
opened to love's kisses. These eyes,
cloudy with rheum,*

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*were clear pebbles that love's rivulet
hurried over. Is this
the best Rabbi Ben Ezra
promised? I come away
comforting myself, as I can,
that there is another
garden, all dew and fragrance,
and that these are the brambles
about it we are caught in,
a sacrifice prepared
by a torn god to a love fiercer
than we can understand.*

R. S. Thomas, "No Truce with the Furies" (1995, p. 9)

This chapter examines some of the unconscious factors involved in the silencing of debate at a particular point during the 1980s and early 1990s regarding the provision of long-term care for people in later life suffering from dementia. Particular attention is paid to factors internal and external that led to the decimation of local authority and NHS provision in this area and to a shifting of care into the private and voluntary sector in such a way that much of the time there seemed to be a malignant mirroring of the deteriorated mental state of the very people whom such services were meant to help.

There is indeed a kind of double jeopardy for the dementia sufferer in which the person is not only having to bear losing his or her mind but is also at risk of being treated mindlessly, which this particular period of history and the issues contained within it serve to highlight. The pervasive, unremitting pressure of a stance based on the denial of need had a major impact on the area of long-term care, with its sustained denial of the reality of ageing, of death, and of distress. This denial of reality took shape in a concerted attack to decimate those structures that formally existed within the welfare state to address and deal with extreme need. This led to a destructuring of services to people in later life, with a shift in local authorities to privatize residential and nursing home services often in a precipitate and unplanned way. The jury is still out in terms of whether history can be learned from or not in the longer run, with most readers being aware that the recommendations of the Royal Commission (1999) into the provision of long-term care have still not been implemented.

The welfare state and old age

The development of the welfare state in Britain attempted to address need throughout the lifespan from “cradle to grave”, with the Beveridge Report of 1948 representing hope—hope for cooperation and renewal, and of altruism and reparation, following the long nightmare of the depression in the 1930s and the Second World War. Inevitably its construction also contained within it an idyll—total care, for all, for ever—and what we know from psychoanalytic theory is that idylls don’t last. However, this is quite different from holding to an ideal, and the ideal inherent within the construction of the welfare state was that there should be some equitable form of social and health care provision for all citizens in need, which would be funded by a system of national insurance throughout the span of every adult’s working life.

As life expectancy increased, so too did public expectations regarding social and health care delivery systems in terms of what could be provided. Timmins, in his outstanding book *The Five Giants: A Biography of the Welfare State* (1995), highlighted the increasing difficulty for people now requiring public sector services in later life:

Not for the ones who are relatively healthy or well provided for in terms of income and family support and have a brief illness at the end of life before dying, but . . . those who died slowly and forgetfully when first capital and then some of the next generation’s income vanished into longer term care which, during the 1980s the NHS no longer provided on a sufficient scale to match the growth in the numbers of the elderly. By the 1990s the Welfare State’s collective smoothing of income across the life cycle with people paying in through tax and national insurance during good times to receive in bad or at times of heavy burden—i.e. when children appear, or pensions or long-term care are needed . . . the concept of cradle to grave which many of us grew up with had begun to shrink. From the late seventies onward, Julian Grand commented that “The Welfare State had been hit first by an economic and then by an ideological blizzard”. [p. 503]

The Audit Commission Report, *The Coming of Age*, pointed out “that the growth in the number of people aged over seventy-five and eighty-five in recent years has been taking place at a time of significant change in the way that continual health and social care are funded . . .”. During this time, the most dramatic reduction in the areas covered by the NHS was the long-term care of older people. In the early 1980s, the

bulk of care for people in later life was provided directly by the public sector, whether through the NHS, through social services, or through the housing departments.

Private nursing and residential homes started to be funded through a system of social security payments, leading to an enormous expansion of residential and nursing provision in the independent sector, with residential beds increasing by 242% from 1983 to 1996. A further shift came about with the NHS and Community Care Act in 1990, which was formally introduced in 1993. This required local authority social service departments to become lead agencies for arranging social care. However, as the Audit Commission Report pointed out, previous changes had left two knock-on legacies. First, a reduction in the role of the NHS, and second, a growth in the role of the independent sector. As the commission wrote, "Neither of these changes was planned; they happened by default as a direct result of the increase in social security payments. They represent major shifts in policy that have never been debated or agreed." In the White Paper *Social Services: Achievement and Challenge*, Stephen Dorrell moved social care policy radically further to the right by suggesting that social service departments should shift into the sort of purchaser/provider split by then familiar to those of us working in the NHS. What this meant in practice was that rather than social services themselves providing residential and home care services for older people, they should concentrate on purchasing services. This was underlined by the explicit government directive that 85% of residential care was to be moved over into the private/independent sector. There seemed to be a malignancy of thought in connection to those who were young following the war, had paid tax and insurance throughout their working lives, and who were now in need of nursing and residential care, with the non-debate on the provision of long-term care and help for people in later life as long-stay wards closed, local authority homes closed, and older people were often shunted—literally overnight, with no preparation—into private homes. The stifling and silencing of debate around long-term care seemed to me an example of the death instinct in action, with silence, inertia, and inaction replacing thought. During this period, mortality rates among the very old in this country rose as a direct result of the precipitate movement of frail older people, and these rates highlighted the deadliness underlying the blind eye of a policy that impacted on the most vulnerable.

Dementia and the relocation effect

In thinking about the unconscious factors that may be involved in the sudden movement of vulnerable older people, I want to draw an analogy with gardening. What would lead a gardener to uproot the most vulnerable shoots and transplant them into another part of the garden, when all the gardening books indicate that such plants do not transplant well, adapt poorly to new conditions, and usually die? And for “vulnerable shoots” in the area of later life, research would indicate the most vulnerable to be people over the age of 80 with severe dementia (Bourestom & Pastalan, 1981; Robertson, Warrington, & Eagles, 1993). This research resides in the exploration of what has been referred to as the “relocation effect”—a relatively benign description—or “transplantation shock”, which perhaps conveys more realistically the experience of older people who find themselves suddenly being moved from one form of long-term care to another without preparation. I shall not go into these studies in detail, but in summary they show that advanced age, poor prognosis, and confusional mental state are strong predictors of mortality following any move, and that intensive preparation before, during, and after any move can have a significant impact on the mortality rate (Danermark & Ekstrom, 1990; Novick, 1967; Schulz & Brenner, 1977).

The first three months following any move are the most dangerous in terms of increased mortality rates in those patients with dementia who are over the age of 80, and the human cost of precipitate closure is immense. In Britain, examples have included the deaths of eight of twenty-four elderly mentally infirm patients following their transfer from Park Prewitt Hospital to nursing homes in 1994. Five died within twenty-two days of the move (*The Guardian*, 12 March 1997). In 1995, three elderly women with learning disabilities died within eighteen months of being moved from Dovenby Hall in Cumbria to private nursing homes. Some of these women had lived in the hospital for the previous forty years. Everyone was clear that in this case there was no criticism of the quality or care at the nursing homes; it was the impact of removing the women from a stable environment which had led to the deaths. Staff were not allowed to accompany the women into the new homes to ease the transition of leaving (*Independent on Sunday*, 19 March 1995).

Research in this area shows that where a closure involves disruption to staff and residents, with minimal awareness or sensitivity as to the impact such a closure and move may have, then mortality rates

among residents increase. Research also gives clear evidence as to how closures, if unavoidable, can be handled effectively. This involves both residents and staff taking part in extensive before and after resettlement programmes and in them both being moved as an intact unit (Novick, 1967; Robertson, Warrington, & Eagles, 1993). The continuity of care that familiar staff provide is extremely important for people with dementia. Each staff member carries a huge store of knowledge and, hopefully, understanding of each individual resident's needs, which may be learned through experience over many years. To move residents without any continuity of staff care is akin to kicking the crutch away from someone who cannot walk very well. That is why sudden relocation to a new setting, with new staff and insufficient preparation, is both dangerous and life threatening for people with dementia.

The external pressures leading to the political undercutting of integrated service provision in the public sector have been excellently delineated in the 1997 *Coming of Age* Audit Commission report. Throughout the 1980s and 1990s a policy of individualism was taken to its logical extreme, with the area of long-term care experiencing the way in which "Service interests are pursued in isolation, one service pursuing its own aims quite separate to the other, and often forced into competition both within the service itself and also across other sectors. Some area of policy change have led to benefit in one sector at cost to another" (Timmins, 1995). This policy held within it an attack on anything that was weak, needed constant monitoring, care, and attention, or was at constant risk of deterioration and death—and it is possible to recognize the older person in the later stages of dementia in such a description. It seemed that the welfare state and all it represented had been subject to an unconscious and at times quite conscious attack based on a denial of need and dependency. The politics of individualism, taken to the extreme and pushed into national long-term planning, ultimately held within it an omnipotent phantasy. This phantasy took the form of a belief that the individual is self-made, can provide all, and is in a position to make use of free choice at all times. Both the British Psychological Society and the Royal College of Psychiatrists were clear in their response to the previous government's document *A New Partnership for Care in Old Age* (DOH, 1996) that most proposals seemed to take no account of the fact that people making immediate choices about residential care are often at their most vulnerable point in the life cycle and are quite likely to have a degree of cognitive impairment or some form of mental distress and/or physical illness.

The more deadly response to being aware of need is to get rid of it. Steiner draws attention to this in his introduction to Hanna Segal's book *Psychoanalysis, Literature and War*:

This hatred of reality and its replacement by omnipotent phantasy is clarified by Hanna Segal in her discussion of the two possible reactions to states of need. One is life seeking and object seeking, leading to an attempt to satisfy those needs in the real world, even when necessary, by aggressive striving. The other has as its aim to annihilate the experience of need and the mental pain which goes with it, hence the self or the part of the self capable of experiencing pain is attacked along with the object which gives rise to the awareness of need. . . . Segal emphasises that both types of reaction to need are present in all of us but the balance varies and represents to her the conflict between the life and death instincts. [Steiner, 1997, p. 5]

If "self" and "parts of self" are replaced with "patient" or "society", then it is possible to see pretty clearly why the most vulnerable individuals—those with dementia, for example—get dislodged so quickly from the social mind's eye and why those in contact with such individuals within the NHS or social services, or carers, who attempted to articulate the problem of need have also had such a rough handling.

Issues of containment in dementia

The crisis in the area of long-term care for older people in this country arose in a climate within which the then prime minister, Margaret Thatcher, could say as a matter of course that "there is no such thing as society, only individuals . . .". Contrast this with Joan Riviere, addressing the impact of loss and death on the psyche in a 1952 paper striking in its humanity: "there is no such thing as a single human being pure and simple, unmixed with other human beings; each personality is a world in himself, the company of many. . . ." Before this, in what could be a searingly accurate account of the meaning of the dementing process to the individual and to those who care for him or her (although she was not addressing the area of old age specifically in this paper), she writes:

It is true that people as well as animals are known to pine away and die when their loved ones vanish. We are not concerned here with material realities only; death is not only a matter of whether the breath leaves the body and the heart ceases to beat. That is one item of the experience of death, it is true; but is that all that death means

to us? It is probably the most important factor in death because it is irrevocable, and thus all else that death means becomes irrevocable: namely, the cessation, the disappearance, so comparatively sudden, of a living existence, an entity, a person, a personality, a most complex and composite structure of attributes, tendencies, experiences, memories, idiosyncrasies good and bad, as well as the body they belong to. It is all this which disappears; from one moment to the next it was here and it is gone. So when one fears one's own death, it is all this which one will lose, one's "life"—in both senses—one's present breath of life and one's "past life" out of which one's identity is constituted. [Riviere, 1952, pp. 316]

Kitwood (1990b) suggested that the area of working with people suffering from dementia includes confronting organic impairment and the great difficulties there may be in consciously articulating any psychological conflicts. He thought that in dementia,

the problem . . . is not simply that of damaged brain cells, but also of damage to the psychological self and the good feeling that would sustain it. It is, I believe, quite correct to regard unattended dementia as a semi-psychotic state. . . . Dementia is envisaged as a break in cohesive awareness, a failure of the process of consistent symbolisation, so that the person has lost his or her bearing in the world, and is invaded by feelings from within. . . . [p. 49]

He observed that when organic deterioration occurs there may also be a breaking down of the individual's lifelong defences that leaves the person exposed and vulnerable to episodes of catastrophic anxiety and rage.

Dementia will always have a deeply tragic aspect, both for those who are affected and for those who are close to them. There is, however, a vast difference between a tragedy in which persons are actively involved and morally committed, and a blind and hopeless submission to fate. [Kitwood, 1997, p. 69]

Caregivers, whether immediate family or staff in residential or nursing homes, have a crucial function in containing those split off and deteriorated aspects of the person they are with, often at great cost to themselves. Why at such cost? Because, on the one hand, there is the need to mourn the loss of, in many cases, a lifelong partner. But, on the other, the process is complicated because it is not a loss in the more usual way, through physical death, but having to witness over time the incremental loss of self-awareness in the person he or she knew and who knew him or her. Clare, Baddeley, Moniz-Cook, and Woods (2003) refer to the "quiet revolution" that has taken place in dementia

care in recent years with research providing strong evidence that early interventions individualized for the person with dementia and their families are effective in the short and long term, and there is a growing body of work on early-stage dementia indicating that psychotherapy can be helpful (Cheston, 1998; Husband, 2000).

Sinason (1992) described working with a man in late middle age with an early dementia whom she saw for psychotherapy sessions at home, drawing on her long experience in the field of learning disabilities. She thought that the facticity of the organic deterioration had to be acknowledged and that, while this was not transformable, the emotionally caused impairment remained open for change. When organic deterioration is severe with a resultant loss of capacity in the individual to mentalize internal objects, then there is a clear limit to the role that formal psychotherapy can play. However, psychoanalytic ideas can continue to inform a detailed understanding in thinking about the challenges of developing structures for intervention that will contain both the patient and those who care for them. Hildebrand (1982) described the way in which the carer eventually takes on the role of "auxiliary ego" for the older person with dementia, in which the care may be involved in a daily struggle to translate and make sense of the individual's distressed and at times bizarre communications, often conveyed through projective identification, which tends to replace ordinary language (see Waddell, chapter 11).

While, at the very end, the person with dementia may have very little or no awareness, those left behind are still having to live with something very painful. At the very beginning and the very end of life there is an immense dependence on the main caretaker, and this is more acute in the advanced stages of dementia. At the beginning of life there is a fragile and developing ego that has the potential to develop and be worked with. In severe dementia, there is not even that advantage, and survival does then depend on the capacity of the caretaker to remain in ongoing contact with and support humanely the older person in what carers have often described as a living death. This is often spoken about by people in the early stages of dementia following diagnosis, where the individual may retain, for quite some time, ongoing levels of self-awareness and a capacity to reflect on past, present, and future, including the painful knowledge that one's own self-awareness will diminish over time as the mind becomes irreparably damaged.

The difficulty in the later stages of dementia is that, in terms of internal containment, no robust mental structure, in a dynamic sense,

with a sustained capacity for self-awareness and thought, is left. The immediate care of the person with dementia is with the family or professional carers, such as nurses, doctors, and health and social care staff, the latter often poorly paid and unsupported, who are then left holding those elements of the person they care for in memory—the person he or she once were, and yet are in daily contact with the person he or she is now, which is “not their old self—not themselves at all”. Given that the basic mental apparatus no longer holds firm, the ego is emptied out—there is a weakening, a draining out of the ability to process, to articulate, to think, to understand. A reversion eventually takes place to a reliance on basic instinctual rhythms—to do with voice, taste, touch, movement, smell, and so on. That is why the maintenance of a live, consistent rhythm of routine with well-supported carers is so important. The current fragmentation of services, which I explore in more detail at the end of this chapter, means that caretakers are often left alone in a dyad with the older person, with an inadequate “third” in terms of a containing institutional or service structure that can take in the needs of the caretaker as well as the older person. If the emotional needs of staff and family members are not actively attended to, we know there can be terrible miscarriages when abuse, both physical and mental, of older people takes place, as we know it does with babies whose parents do not have sufficient internal or external resources.¹

Conceptual overview

The development of psychoanalysis in Britain in recent years has particularly concerned itself with the impact of very early experiences and anxieties on the formation and development of personality. I want now to consider the psychoanalytic concepts of projective identification, containment, and countertransference, which are linked in important and complex ways. Building on Freud and Klein’s work, Bion further developed the concept of projective identification, and this has contributed greatly in terms of our capacity to understand “the nature and vicissitudes of inter-personal, inter-group, inter-institutional and international relationships” (Obholzer, 1989, p. 58).

Projective identification describes a psychic mechanism, occurring in very early infancy, that can be a defence against and a communication about very frightening and disturbing anxieties and feelings that the infant is unable to express through language (Bion, 1962; Klein, 1946). The instinctual response of the infant to a bad experience is to

try to get rid of it by projecting it out into a person in the real world (specifically the mother or main caretaker). The mother then has the possibility of experiencing some of her baby's feelings and anxieties in a very immediate way. Here projective identification can be seen both as a form of unconscious communication and also as a means of getting rid of something that the infant finds difficult to bear. How, or whether, the projections are received and responded to by the mother depends on many factors.

Bion (1962) suggested that in order to respond to the baby's distress, the adult has to be able to take in, experience, and transform (or "detoxify") the distress so that the baby is enabled to reincorporate the feelings in a benign form. The baby senses that its needs have been understood; it has the experience of being contained and feels that its distress has been alleviated. This is an active interaction between infant and mother that is ongoing. However, if the infant experiences the mother as unwilling or unable, for whatever reason, to receive, assimilate, and transform its projections, then this can lead either to the infant making ever more frenetic and violent attempts to "get through" to the mother, through an increase in projective identification, or, alternatively, giving up in despair.

The capacity to sense needs accurately, to experience within oneself the anxieties and feelings of someone else, and to understand these and respond to them in an appropriate way finds its prototype in a good-enough relationship between a mother and her baby, but this relationship is potentially present in every human relationship. This process is an important aspect of what is known as countertransference (Heimann, 1950) and can be an extremely useful tool in helping us to understand the subtle communication that can occur in the therapeutic and other relationships. The next section gives examples of the importance of containment for those who care for the person with dementia, whether family or staff member.

Carers

The role of caregiving is an enormous challenge and strain, particularly where there are preceding ambivalences in the relationship. Increasingly there is recognition of the support that those caring for a family member with dementia need, which will include everyday support and keeping the structures of the carer's everyday life in place where possible, with consistent periods of respite care. As longevity increases, it is no longer uncommon for people in their sixties

and seventies to be the young old caring for parents in their nineties. A brief consultation over two or three meetings can sometimes be extremely effective for caregivers where the everyday strain of taking care of their relative may affect the capacity to take care of their own internal needs. The consultation gives an opportunity for the internal dynamics of the presenting situation to be understood and thought about in more depth:

Mrs Y came for an extended consultation and said she felt depressed and exhausted with the day-to-day pressures of caring for her 80-year-old mother, who suffered from dementia. She was in her sixties and had enlisted her daughter, then in her forties with a young family of her own, to help her with the care of her mother. As Mrs Y described her daily life caring for her demented mother, it was easy to understand how exhausting the sheer physicality of the task was for her. Part of the work of the consultation was to try to understand more about why she felt driven to provide all the care herself, and also driven to ensure that her daughter did the same. Mrs Y said that her depression had escalated at the point her mother started to refuse food, either knocking it off the tray or spitting it out. My patient conveyed an intensity of complaint and grievance about this, which we were able eventually to link to her experience of severe postnatal depression following the birth of her daughter, when she felt invaded at times by both suicidal thoughts and thoughts of wanting to kill her baby. It transpired that the baby had refused to take the breast in the first few weeks of life, and no help had been forthcoming to support the mother–infant couple. Her focus of complaint was connected to her deep resentment of her own mother, who at that point had been highly involved in her own career midlife, whom she felt had not been available. I was eventually able to take up the phantasy of a mother who was allegedly reparative, in terms of the way Mrs Y felt she had to take on all the care of her mother but was, in fact, imprisoning her own daughter with guilt in enlisting her to take part in the duty of care, as she felt imprisoned and persecuted by an internal mother for whom nothing was good enough, however dutifully carried out.

Through this brief example I want to highlight the importance of the consultation for containing the patient's own hatred towards her mother, who, she felt, had abandoned her again. In her mother's spitting out of meals, an earlier trauma had been revived for Mrs Y of her

daughter as a baby refusing to feed. Mrs Y was having to try to contain her mother's increasingly fragmented state of mind, as well as her own. She had come for the consultation at the point that she had found herself wanting to hold a pillow over her mother's face, in the same way she had once found herself in a very depressed state wanting to suffocate her own daughter as a tiny baby.

* * *

The following detailed observation undertaken by a member of the old age course at the Tavistock highlights the strains for both residents and staff in a dementia unit:

The observation took place in a specialist unit for people with severe dementia. Nearly all the residents had lost their capacity to speak and were physically unable to do things for themselves. The observer arrived at the unit and sat at a table where there was a clear view of the main lounge. Mrs G was lying on a big sofa in a foetal-like position with her back facing away from the room, wearing an old cardigan, brown tights, and slippers. She was asleep and breathing heavily. Her hair was messy. A table with a newspaper on it was next to the sofa where she was lying. A nurse told the observer that Mrs G had only moderate dementia, and was unable to walk independently and talk, but had been moved into this unit as she had been very disturbing to the other residents in the next-door unit where there were no, or very early onset, dementia patients.

Mrs G woke up briefly and turned round to face the room. She shut her eyes again. Meanwhile, another resident from the dementia unit came in and asked if there was a spare newspaper. The nurse said yes and gave her the newspaper on Mrs G's table.

Mrs G immediately opened her eyes, looked at the table, and shouted:

"I haven't got a paper now!"

Then she shouted, "What a noise!"

Her face was screwed up, and she looked very unhappy. A nurse went and sat next to her and asked if she was OK. Mrs G screwed her face up and tutted. The nurse went to get up, but Mrs G grabbed her and said, "Don't leave me—it's lonely."

The nurse said she would sit a while if that is what Mrs G wanted. She sat with her for about thirty minutes, and Mrs G slowly relaxed, closed her eyes, and went back to sleep. When the old lady was asleep, the nurse got up to start getting dinner ready. After about ten minutes, she said to the care assistant, "You had better wake Mrs G up so that she can get ready for lunch."

The care assistant woke up Mrs G and told her it was dinner time.

Mrs G said "Dinner time, is it? What are we having?" She was trying to sit herself into an upright position.

"Beef stew."

Mrs G said, "Disgusting."

She went back to lying down again and looked unhappy. Suddenly she became very anxious and said, "Where's the toilet, I'm going to do it . . . I can't stand up, my legs have gone."

The nurse went over and said her legs were tired because they'd been up all morning, and they would be OK once Mrs G started walking.

"Will you go with me?" Mrs G said.

She seemed terribly anxious, and the nurse replied, "Yes of course." She helped Mrs G to stand, and they walked slowly to the toilet together, the nurse talking quietly with her as they went. Mrs G seemed to become more stable on her feet and calmer in herself.

After going to the toilet, the nurse brought Mrs G back to her chair and then went to get her dinner from the kitchen. On her return, she put it in front of Mrs G, who looked at it and said, "That looks like a pile of shit. I'm not eating that shit!"

She pushed the plate away, and it nearly fell on the floor. Mrs G kept repeating, "It's bloody rubbish, shit it is, shit!"

She lay back down again. The nurse came over and asked her to sit up and she would get her something else. How about a sandwich? Mrs G did not answer. The nurse took away the plate of stew and bought a sandwich over. Mrs G looked at it and said

"What's this? More of your shit?"

The nurse said that it was an egg sandwich, at which point Mrs G threw it on the floor.

The nurse asked her if she wanted any rice pudding.

Mrs G said, "What, does it not have jam?"

"It can do", the nurse replied.

"OK", said Mrs G.

When she was given the rice pudding, she moved her spoon up and down in it, then crashed it down and said, "It's shit."

She looked very unhappy and went to put her head back on the pillow on the sofa. The nurse asked her if she would like a cup of tea, and Mrs G looked at her for a while. The nurse paused, then asked for a care assistant to carry on distributing tea to the other residents. She then sat down next to the old lady and gently took her hand. Mrs G started to cry. She closed her eyes and kept crying.

At one level we can see in this observation the difficulties of mixing different levels of disturbance. Mrs G's real distress seemed to start when the newspaper was removed—the newspaper connecting her to the world of no or only mild deterioration. She was then left perhaps full of an indigestible awareness of being surrounded by what she may become—silent and immobile, like so many of the other residents in this unit for severe dementia. It is possible to see the nurse's concern and kindness in her contact with Mrs G, but this is not enough. The nurse also needs knowledge. This cannot come from within; as she, like any nurse or care assistant working in this setting, is bombarded with shit and despair and resorts to the concrete solution of feeding and toileting. The shouting starts again when Mrs G is woken up and offered dinner. Mrs G asks to go to the toilet, but everything is still shit. She seems to feel persecuted by something awful being aroused in her yet again and makes it clear she wants to get rid of something by asking to go to the toilet. What she actually needed was for something to be returned in the form of her newspaper. The newspaper that was taken away served to represent the less deteriorated world Mrs G was still capable of inhabiting, which was stolen away from her when she was moved prematurely to the unit with more deteriorated residents. When the newspaper was taken away, she rightly complained that this was shit.

The truth of the matter is that she was in a very shitty situation and had to close her eyes in despair as the only way of protecting herself from having to perceive again the situation she now finds herself and over which she has no control. Through close observation it could be seen that Mrs G's escalation of distress followed the removal of the newspaper that connected her to the world of more normal functioning. Just as something had settled, she was then offered food again. But it was not this sort of food that sustained her at this point. What she needed was a mind capable of taking her in and thinking about her state of mind as well as body. The observer was able to think this through with the support of a supervision group after the observation itself had taken place. However, not unusually on the unit being observed, there was no forum at all in which the nurse could talk about and process her experiences, and the opportunity for a real understanding of what had occurred with Mrs G was lost.

In her paper "Mourning and Its Relation to Manic-Depressive States" (1940), Klein commented that "Through tears, which in the unconscious mind are equated to excrement, the mourner not only expresses his feelings and thus eases tension, but also expels his 'bad' feelings and his 'bad' objects, and this adds to the relief obtained through crying" (p. 359). In the observation of Mrs G, what is immediately striking seems to be her verbal defecation—everything, she says, is shit. However, this isn't a meaningless evacuation but is accurate in terms of the situation she finds herself in, and it needs a receptive container to take in and make sense of what she is protesting about. Klein thought there was a continual oscillation and interplay between the external world and the internal world. The above example serves to illustrate one of the extreme external circumstances affecting an unseen percentage of older people who are moved into residential or nursing homes in an unplanned way. By the very nature of an unplanned admission, the person being admitted is often unknown. It is still extremely common to find that very little attempt is made to get to know the individual, to the degree that even the most basic of histories do not appear in the case notes kept by many nursing homes.

Often very primitive psychic processes occur in settings where staff are working with patients with severe psychological disturbances. If people, functioning psychologically at an infantile level, sense that their feelings have not been "taken in", experienced, understood, and responded to satisfactorily, then they may feel aggressive and destructive and may react to others around them in such a way. Staff who are

involved with people experiencing such disturbances are themselves likely to experience similar aggressive feelings, since the people they are working with often find their state of mind too unbearable to tolerate and, through the mechanism of projective identification, project the unwanted feelings into the member of staff. Whether these painful and potentially destructive feelings are acted out, or are transformed by the staff member, is central to the quality of care that can be given. However, the power of such unconscious projections mean they are sometimes particularly difficult to contain. If there is some capacity to experience, understand the meaning of, and respond to these projections constructively, then it may be possible to avoid acting out feelings of, for example, hatred, cruelty, or hopelessness in a destructive way.

Whether working with individuals, groups of patients, or staff, workers are often in the “front line” in trying to make sense of complicated forms of communication. For the person in the later stages of dementia, symbolic or verbal communication may be difficult, and the more primitive preverbal mechanism of projective identification will operate more forcefully. If there is no forum in the individual or the institution in which countertransference feeling can be processed and understood, then a valuable source of information with regard to the patient will be lost. There is also a very real danger that the worker will become overwhelmed by the level of projection and will become therapeutically less effective or will act in some punitive way towards the older person. The cost—in terms of burn-out, resignations resulting in a high vacancy rate and turnover of staff, and the concomitant reduction in quality of care for the patient—can be enormous.

Menzies (1959) carried out extensive investigations as to the function of institutions in containing anxiety. She thought that organizations, in the struggle against anxiety, developed socially structured defence mechanisms, the characteristics of which help the individual avoid the experience of anxiety, guilt, doubt, and uncertainty. What is known for certain from her work is that the structure within which the staff and the individuals they care for find themselves either can fail or can help to support the everyday work and struggle to contain the projections of more disturbed states of mind. While there is an emphasis on person-centred care for people with dementia, the lived experience of many older people and their carers is the way in which dementia seems to obliterate the possibility of real thought being given to the individual as a person. I would suggest that, in part, this is due to

the projection of intolerably fragmented states of mind into the carer, whether family member or clinician. From my experience and that of other colleagues working directly with older people and running work discussion groups for staff working in old age services, it is clear that a knowledge of the individual's history and past, present, and current relationships can be extremely containing for the carer in enabling him or her to take in and make sense of otherwise inexplicable communications. Person-centred care for patients has, in my view, to be yoked to person-centred care for staff, whereby their experience in working in old age settings can be taken seriously.

The next example describes the problem of faecal smearing and incontinence in a patient suffering from a psychotic depression. It highlights the importance of ensuring that, as part of the working day, sufficient time is provided in which staff can really talk to each other about the challenges of the work and the feelings that are induced:

A mental health worker described the dread of all the staff who had to look after Mr X, an 82-year-old man who had come in as an emergency admission. Every night he would defecate and smear himself, his bed, and the walls of the room. The staff were beside themselves with rage and had taken to sedating him heavily and avoiding entering the room at night. When we went further into this in the supervision group, it transpired that none of the staff knew anything about the old man. As is very common with sudden admissions, no history had been taken, and there was nothing at all in the case notes beyond the date of admission. Slowly, over a number of highly charged discussions, the staff group were able to think about the possible meaning of the incontinence as a concretization of failed mourning. They agreed to take turns sitting with Mr X after supper, trying to articulate some of his inarticulate distress about the shitty situation he found himself in, overwhelmed by the sudden move from his home, but also overwhelmed by the rapid movement in the onset of the loss of his mind, where he found himself unable to communicate verbally. He remained a challenging resident to care for, but with a consistent approach by the staff group, particularly through the night, an approach that emphasized regular and reliable contact with Mr X, although he remained occasionally incontinent the faecal smearing eventually stopped. It seemed to me that the level of intolerable internal persecutory anxiety experienced by Mr X diminished to some extent, and that, in turn, lessened the degree of violent projections into

staff and rendered more manageable their feelings of sadism in the countertransference.

This example looks at one of the external hazards of old age: the difficulty of being catapulted suddenly from one environment to another, a problem that we saw above in both in Mrs G's move and in Mr X's unplanned admission to the nursing home. It also touches on one of the internal hazards of old age, in terms of the dementing process, that hooks into one of the most primitive annihilatory anxieties of infancy—the fear of falling into the abyss of “nameless dread” and never ultimately returning from it.

The role of the visiting consultant

In working with staff in nursing and residential homes, old age psychiatrists or clinical psychologists are often called in to see particular “problem patients” at the point at which staff in the home feel they can no longer care and wish to discharge the resident. The task of the visiting clinician then is certainly to see the older person as requested but, just as importantly, to see, listen to, take in, and think with the staff about both their own and the patient's distress.

Dr P said that she had received a telephone call and urgent letter of referral asking her to see a 79-year-old man, Mr L, because of his “demanding and aggressive behaviour”. The complaint was that he constantly rang the bell next to his bed and was bed-bound through his own choice. The last straw had come when he had lashed out and kicked a young member of staff who was pregnant, after which the home issued him with an eviction order, but there was nowhere for him to go. Mr L had been in and out of hospital a number of times and had been diagnosed as having chronic obstructive pulmonary disease. His wife had died two years previously, and he had found it increasingly difficult to cope. Mr L said that he agreed with the view of his two daughters, who said that he had always been difficult and over-dependent on his wife and that it would be best for him to move into residential accommodation. He had sold the house and moved almost immediately after his wife's death, but he now expressed confusion as to what had happened to the house and its contents. His wife had collected little china figurines, and he repeatedly said, “I don't know what happened to all the figures.”

When she arrived at the home, Dr P said that the staff greeted her with enormous relief and said that they needed something to be done urgently and that unless she, the doctor, could sort Mr L out, he would lose his place in the home. Dr P was taken immediately to the side room where Mr L sat up in bed with an oxygen mask covering his face. The room was bare other than the bed, a commode, and an oxygen cylinder, and Mr L had a neglected appearance. He took the mask off and told Dr P that he thought the home was OK and that he particularly liked the food. He said he had always been a bit anxious and found it difficult to breathe sometimes. He'd been in hospital with the heart problem for six months before moving back into the home. He thought the staff sometimes stole things, and he commented that if they came when he called then he wouldn't use the bell all the time. After fifteen minutes, Mr L said he felt breathless, and Dr P said she felt dismissed when he put the oxygen mask back over his face and turned away. Dr P visited him again and learned more of his history. His early memories were dominated by the Second World War, in which he recalled hiding under the table during the blitz and his mother taking in an elderly neighbour whose home had been shattered. He thought his mother had been too charitable and that people took advantage of her. He married in his early twenties, and his wife died after their marriage of over forty years.

Here we can see that both the staff and the patient are right. The staff are right in feeling that the doctor needs to do something urgently. Dr L felt under enormous pressure to come up with some magical goods and cure Mr L in some way. In fact, what the staff needed was someone to take in the urgent pressure they felt under. Part of Dr P's role was to balance the needs of the staff and the needs of the patient, to feel confident in working with the staff group as well as seeing the patient. The patient is right, to some degree, in believing that the staff are stealing. While there was no evidence at all that they were actually stealing the patient's possessions, it was true that his dignity had been stolen and, in his neglected appearance, it was clear that he was being robbed of being taken in by another person. This was confirmed when the doctor subsequently discovered that although Mr L used the oxygen mask regularly, the cylinder had in fact been standing empty for over three weeks.

A direct repetition of the earlier childhood trauma seemed to be taking place in which the patient's house had been blown away. In the

residential home, Mr L was surrounded by staff who were unable to respond to his call, representing the busy mother who, Mr L felt, was preoccupied with all the neighbour's problems, not available to take in the little boy's fears and anxieties about his world shattering as the bombs dropped. The death of his wife, the pressure to sell his home quickly, and the current eviction order were all bombshells threatening to leave him homeless. As well as the external reality, his poignant query that he didn't know where all the "figurines" were also reflected the way in which he felt he had lost contact with any good internal object. The challenge for the doctor was to think about how she could give a home to so many uncontained feelings both in the patient and in the staff, and for that she, too, needed room to think the situation through in supervision.

Note

1. A 2004 survey of 700 nurses by the Community and District Nursing Association, *Responding to Elder Abuse*, found that 88% had encountered elder abuse at work. Verbal abuse was most common (67%), followed by emotional (51%), physical (49%), financial (34%), and sexual (8%). The person carrying out the abuse was most likely to be a partner (45%), son (32%), daughter or other family member (29%), paid carer (26%), nurse (5%), or other (4%).