

**PSYCHOANALYTIC PSYCHOTHERAPY  
WITH DEPRESSED OLDER ADULTS  
(A Qualitative Research Study)**

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A research thesis submitted to the University of  
East London in association with the Tavistock  
Centre for the degree of Doctor of Philosophy.

**June 2011**

## **ABSTRACT**

This thesis is a qualitative investigation of once-weekly psychoanalytic psychotherapy practised by the researcher over a period of one year with a sample of six patients, all of whom were over 65 at the beginning of their treatment and had been previously diagnosed by clinical referrers as depressed. The purpose of the study was to explore whether psychotherapy could alleviate their distress and enhance the quality of their later life. It was also to investigate if there were other reasons for depression in later life than the failure to mourn early losses.

In an earlier study I had applied the method of psychoanalytic infant observation to the study of aged adults suffering from dementia, both to learn about their states of mind and to study their responses to this kind of close observational attention. This new study brings my training and experience as a child and adult psychotherapist to bear on the experience of older adults.

I adopted a qualitative method of research, applying a form of Grounded Theory to the analysis of clinical data which I wrote up in detail after each clinical session. I sought to identify themes which explained the origins of depression in later life in otherwise well-functioning adults both from thematic analysis of the separate case studies and by comparing them. In a follow-up review meeting three months after the completion of treatment research patients completed a questionnaire which enabled me to assess the changes which had taken place as a consequence of clinical treatment. These results and the outcomes of the CORE measures, an independent assessment, indicated significant improvements in the states of mind of all the patients since the beginning of their psychotherapy.

The context for this qualitative clinical study is provided by a chapter which reviews the literature on the psychology and especially the psychoanalytic study of old age, identifying earlier theoretical contributions beginning with the work of Freud which were formative to my work. A central finding of my study was that losses, sometimes from childhood, remained the significant unrecognized sources of depression, and that enabling patients to reflect on aspirations which were no longer attainable could bring them relief from depression and a renewed interest in life. Most previous psychoanalytic writing in this field is based on single clinical cases. My study is original both in its systematic comparison of six cases of depression in old age and in its adoption of an explicitly qualitative research method adapted to clinical data. A further context for my investigation is provided by a chapter in which my research methodology is described. A chapter on the social context of old age is included, which takes note of the growing proportion of aged people in the population and the demands placed on social provision to meet their physical needs as well as their mental well being. The final chapter draws some further conclusions and recommendations from the study.

## Morituri salutamus

It is too late! Ah nothing is too late  
Till the tired heart shall cease to palpitate,  
Cato learned Greek at eighty, Sophocles  
Wrote his grand Oedipus and Simonides  
Bore off the prize of verse from his compeers  
When each had numbered more than four score years  
Chaucer at Woodstock with the nightingales,  
At sixty wrote the Canterbury Tales:  
Goethe at Weimer, toiling to the last,  
Completed Faust when eighty years were past.  
These are indeed exceptions, but they show  
How far the gulf-stream of our youth may flow  
Into the arctic regions of our lives...  
For age is opportunity no less  
Than youth itself, though in another dress  
And as the evening twilight fades away  
The sky is filled with stars, invisible by day.

- *Longfellow*

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## **ACKNOWLEDGEMENTS**

The research would not have been possible without the unstinting encouragement and support of my supervisors Prof Michael Rustin and Prof Andrew Cooper. I would also like to thank Dr Gianna Williams for her brief but influential clinical support. I am especially grateful to colleagues, clinicians and the administrators of the Cyril Couve Team and other staff members of the Adult Department of the Tavistock and Portman NHS Trust who provided a space and the patients in order to carry out my research study.

My sincere thanks to Mrs Sheila Miller who continually encouraged me throughout my training, supervised my previous research study from the clinical viewpoint and continued to be interested in all my undertakings in work with older adults.

Most of all I would like to thank the patients who participated in my research study. Without their cooperation this undertaking would not have come to fruition. My appreciation and sincere gratitude is conveyed to them for their unreserved trust in me with their intimate life experiences. I would like to say a special thank you to them.

My appreciation and thanks to all the professionals from the various NHS Trusts and other institutions who have been indirectly involved and who supported and encouraged my research by referring the participants.

Finally a thank you to my son, Julian, for his patient involvement with some of the technical computer skills so much needed for effectively presenting the thesis.



# INTRODUCTION

## RATIONALE FOR A QUALITATIVE RESEARCH STUDY

The main focus of my study was to assess whether there were reasons for depression in later life other than the known failure to mourn early losses using psychoanalytic psychotherapy as a research methodology. A further aim was to explore why older adults who had functioned satisfactorily during their working lives had become depressed in later life. The psychotherapeutic interventions of listening, reflecting and comprehending through inter-personal and intra-psychic activity have proved useful in understanding some of the emotional states of older people. The holistic, humane approach adopted was particularly appropriate with my research study cases as they seemed not to have experienced this form of prolonged professional attention previously. A qualitative research method using an applied form of Grounded Theory originally developed by Glaser and Strauss (1968) enabled me to observe and recognize states of transference during therapeutic sessions that would probably not have been captured by other methods.

There have been several publications on psychotherapy with older adults which rely on individual case studies, notably those by Segal (1958), Terry (2006), Davenhill (2007) and Quinodoz, D. (2010). These are discussed in the literature review in Chapter 2. The above authors did not use a formal research approach but treated their patients within their clinical practice. All these clinicians came to similar conclusions, that is that depressive states in later life are closely connected with the topic of Freud's insightful paper, 'Mourning and Melancholia' (1917), in which he wrote that the internal world of the depressed person is in identification with an object that is dead. He links this with the failure to mourn early childhood object losses. My research builds on this foundation as I also found that some of my patients' depressive states were closely linked with a failure to mourn early childhood losses.

Most psychoanalytic psychotherapeutic work with adults in Britain does not take place using formal research methods and this is even more true for

psychotherapy with older adults. Some clinical research is now being carried out by child psychotherapists as I will discuss later. Some short term psychological therapy studies, Alexander & Morgan (2003) and Evans (2004), indicated the usefulness of psychological therapies for people in later life. Therefore my research, set up using a qualitative methodology, including a comparative study across the sample of six case studies, is an original undertaking. I made some other crucial findings, grounded as hypotheses, alongside the recurring theme of the failure to mourn early loss. The most important 'clinical fact' which I discovered was my patients' yearning for lost experiences which remained constantly alive in their sub-conscious. They hoped and anticipated that these desires and longings would be miraculously fulfilled. The unattainable but ever present 'hope and desire' (Bion 1970,1993 143-145), which in reality was a false hope, remained a nagging ache and as one of my patients succinctly expressed it, felt 'like a lump in my chest'.

My thesis has identified significant other factors pertinent to depression in later life. Further to the constant desire for the lost object there is clear indication that in reality my patients were aware of yearning for something in an inexplicable and insolvable way. The 'nagging ache' was unidentifiable to them. Their original desires were definitely unattainable and the futility of their hope and resultant despair could not be sustained. I found that retirement brought on feelings in my patients that they were entering the final period of their lives and these thoughts exacerbated their need for the fulfillment of their unattainable desires. The fact they were unattainable made them panic and ultimately played a significant part in their depressive states. This dysfunctional and desperate state of mind was the significant reason alongside failure to mourn early losses for their depression and only became evident when their feelings were explored and exposed during the process of psychoanalytic psychotherapy.

The unique aspects of psychoanalytic psychotherapeutic interventions gave these patients the opportunity to relate and think about what was really happening in their minds, something which their medication could not help them do. Psychotherapy allowed them to acknowledge the impossibility of regaining what had been lost. Individually, at different stages during the treatment, they

were able to understand their distressed psychic states, reorganize their feelings and adjust their mindsets so that they could relinquish some of their hopes. Thereafter they felt some inner peace and were able to continue with their lives in a more productive manner. Obviously there were several other losses in connection with early object relations and failed mourning. Also, as expected with the ageing process, they experienced some physical impairment as well as concrete losses such as children, family and friends geographically moving away as well as losses through the death of loved ones. These were anticipated, life experiences to varying degrees and they could perhaps have been expected to undergo temporary states of feeling depressed. Conscious attempts to mourn these losses are different from those experienced as part of the early, childhood mourning process.

My research case studies were diagnosed by medical professionals such as GPs and psychiatrists as depressed and they were consequently medicated. Fortunately these professionals also realized that the patients needed more than medication to alleviate their problems. Anti-depressants helped maintain their external equilibrium and to a point suppressed their anxieties but did not reach the core of their depression. On the whole the patients gave the impression of being reasonably well in their outer lifestyle but suffered internally. Although most of them had good social lives with family and friends the yearning for the unattainable, desired experiences remained constant but hidden in their psyches.

### **MY REASONS FOR THE RESEARCH STUDY**

My interest in the ageing process and mental activity is longstanding, since my child psychotherapy training twenty years ago. At that time I undertook an innovative research study which aimed to extend the Tavistock model of infant observation by Bick (1964) to the observation of old people, over the age of seventy in geriatric wards. I published a report of my study in the journal *Free Associations* (McKenzie-Smith 1992, 355-390). The purpose of this study was to understand the emotional needs of older adults suffering from dementia. Similarly to infants and very young children, those older adults had difficulty

verbalizing their feelings. My original exploration was useful in thinking about supporting these older people through the close and receptive human contact that the observation provided. This work has been further developed in practice by current day clinicians and on teaching courses involving older adults: Terry (2006), Davenhill (2007), Ng (2009), as well as through the development of observations in institutions: Hinshelwood & Skogstad (2002), Datler et al (2009).

Following my training as an adult psychoanalytic psychotherapist I started working with adult patients both privately and in the Tavistock Adult Department. Some colleagues and practitioners who knew about my interest in older adults referred patients from this age group to me. I realized that most of these patients had led what were considered successful adult lives. The noticeable onset of depression came in later life for no obvious external reason, though they had undergone varying degrees of loss arising from both minor physical conditions and other more excruciating ones. From the initial assessment the immediately recognized feature was the failure to mourn some of their early childhood losses. But my previous experience of observation skills as a child psychotherapist with older people gave me insight into other dysfunctional mental activities. I recognized that these contributed to their depressive states. This inspired me to research a sample of six patients, combining the practice of psychoanalytic psychotherapy as a methodology with the qualitative research method of 'Grounded Theory'. As this method is used to assess the social sciences data, it seemed most practical to consider it for the assessment of psychotherapy sessions. I hoped that hypotheses would emerge which would go beyond the idea of the failure to mourn early losses.

The word 'depression' is amorphous in that it can mean anything from being sad to clinical and refractory depression. In my research thesis I have looked into the more subtle forms of depression in older adults. Perhaps retirement, an outer loss made them become more aware of inner losses. Psychotherapeutic intervention enabled me to get to the root of their depressive states and in my view supported them in enhancing their life styles by coming to terms with their unhappiness. It is possible that the treatment prevented a decline into more pathological states of mind.

## **SUMMARY**

The rapid growth in size of Britain's older population in the last two decades has brought about an increase in the number of people who are diagnosed as suffering from dementia. Could this condition have been alleviated if some of this population, who might have been mildly depressed at an earlier stage in their lives, had been given some reflective, person-centered support? This would need a further longitudinal study. As in my previous research findings I discovered that old people want to be listened to. Genetic factors cannot be ignored but is this, the only cause of dementia in later life? Many older adults who seemed to have led well constructed, normal and what is considered satisfactory lives, similar to my research patients, have become demented. Dementia is a physical illness and manifests itself in changes in the organic state of the brain. Consequently it has attracted numerous epidemiological research studies. But the wider spectrum of depression has not had the same impact on researchers, even though an Age Concern (2008) – now Age UK – document indicated that there are almost two million older adults in the UK alone who are depressed. What is regarded as normal treatment by medication is perhaps due to many professionals thinking of depressive states as part of the 'normal' degenerative process of ageing.

Perhaps Freud's (1905a, 257-268) opinion that psychoanalysis was not a viable treatment for people over the age of fifty, as 'the elasticity of the mental process on which the treatment depends is lacking', has influenced clinicians to believe that 'old people are no longer educable'. Freud was in his mid-forties at the time of writing this and was perhaps pre-occupied with his own death. However, he himself refuted this claim by remaining mentally alert and solidly produced new findings until his death at the age of 83 regardless of his long standing struggles with ill health. He said, 'one must try to learn something from every experience'. Although there has been a certain degree of professional inertia in clinicians until recently with regard to the provision of emotional understanding and support for depression in older people there is now a growing awareness that

more people are living longer and there are many who remain fully capable in later life. Thus public awareness of the need for appropriate provision for emotional support for older adults has grown. But even now there are limitations as to the number of clinicians who take on older adults for psychotherapy, as I will discuss later in Chapter 2. Perhaps ageing and the process of death and dying might feel too uncomfortable, threatening or intolerable for both clinicians and policy makers to mobilize them to confront these issues.

As stated previously my thesis has focused on not only the inability to mourn early dysfunctional object relations but on other issues that prevent the mourning process. By the process of an applied form of the qualitative Grounded Theory research method – of coding, categorizing and thematic analysis of the written-up data – it was possible to generate some themes as 'key facts' that I grounded as hypotheses for depression in later life. The most relevant findings were: the development of an ego-destructive superego, 'hope and desire' for the lost object maintained in the sub-conscious, and belief that early desires will still be fulfilled. This malfunction of the psychic process cultivated and encouraged a state of mental 'false hope' which was revealed during the course of the psychotherapeutic treatment. I will further show with reference to psychoanalytic theory how their dysfunctional mental processes remained in the background during their daily lives in order to protect needy parts of themselves.

The research study is entitled, *Psychoanalytic Psychotherapy with Depressed Older Adults: A qualitative research study*. My thesis therefore not only involves the use of psychotherapy but is also connected with other aspects of becoming old. Similarly to any other stage in the life span, in old age emotional well-being is as important as physical good health, but the ageing process brings about other needs for older adults which have to be provided for as necessary. This would include the thinking and provision from other areas for promoting an enhanced life style in later life. Therefore forays into other sources have been considered in connection with their thinking on the ageing process and these are discussed in the larger context of the psychotherapeutic work. A review of some of the external circumstances bearing on old age, such as government

and other social provision as well as the specific perspectives from the disciplines of psychology, sociology and gerontology are briefly discussed in Chapter 4. Each chapter will commence with a summary of the contents.

# 1 RESEARCH PLAN AND ETHICAL ISSUES

## Chapter Summary

- A brief outline on the organization of the clinical work.
- Application to 'The Joint UCL/UCLH Committees on the Ethics of Human Research (committee A).
- A brief discussion on CORE

## 1.1 CLINICAL SETTING AND ORGANIZATION

The research was carried out in the Adult Department of The Tavistock and Portman NHS Trust. This centre is a teaching and training institution for post graduate and diploma courses in child, adolescent and adult psychotherapy, social work and psychology. It is specifically distinguished for the treatment of mental health problems by the means of psychoanalytic and psychotherapeutic intervention to patients of all ages, but also offers other modalities such as systemic family therapy, couples work and therapeutic support for parents of children seen at the centre. On account of the specialist form of treatment only patients who are referred by professional clinicians from the local area are seen. Some patients from other authorities where this form of treatment might not be available are also referred to the Tavistock Centre.

The procedure for treatment is for the referred patient to be sent an assessment appointment by a clinician. Depending on the diagnosis and the availability of a suitable clinician the patient might be offered a one year period of once weekly sessions or intensive treatment involving three to five sessions per week for an unlimited period. There is no particular section in the department for people in later life. Older adults are part of the intake system, reviewed and allocated like any adult patient to one of the teams. My case studies were chosen because they had been diagnosed as depressed by their professional clinicians, suggesting that perhaps they needed therapeutic support.



In order to participate in my research study the patients had to fall into the following criteria for suitability:

1. They had to be over 65 and referred by professionals or clinicians who had diagnosed them to be suffering from mild depression.
2. They had to agree to be initially assessed for suitability for psychotherapeutic treatment by me or a colleague in my team. They had to be patients who had been treated for depression previously in ways that had proven unsuccessful or attended psychiatric units for a long time without showing any beneficial change. Patients who had frequented GP practices and were on medication but continued to be depressed were also included.
3. If they were found to be suitable and agreed to participate in the study they had to attend once weekly sessions over a period of a year followed by a review meeting approximately three months later. The context of my research study was explained to each patient. All the patients filled in the Confidential Document, specifically required by the Adult Department, prior to the commencement of treatment.
4. They had to complete a Consent Form (see Appendix 1) which made it clear that commitment as a participant for my research was optional and at any stage they could opt out. This would not alter the continuity of their sessions for the stipulated period. Included in the Consent Form was a request that the participants would allow important, relevant material to be used for publication or teaching purposes. They were assured that should this happen their personal details would be altered so their identities would not be known to readers of the study.

The accumulated psychoanalytic psychotherapy data from the treatment, usually written immediately after each session, was often rich and gave insight to the patients' 'inner state'. This was studied and discussed at varying points of the treatment, during supervision, with colleagues and afterwards for referral

purposes. The relevant processed facts and mental activities were noted and were useful when required to support the mental functioning of the patient. Not all of the content of every session was important but it was important to understand sequentially what the patient was conveying of their mental activities, to find patterns in the patient's internal state of mind. The more important, detailed data from some of the transcriptions for the purpose of my research are presented in Chapter 5. They were purposefully chosen to highlight links with psychoanalytic theory and to explain states of mind as experienced during the treatment that gave insight to mental dysfunction. The chosen vignettes identified and clarified some of the reasons for depression in my case studies. The study was also undertaken with the arrangement that the professionals who referred them would if necessary maintain and continue with care plan support. For example two patients in particular needed to attend Psychiatric Units for Older Adults for regular medication and assessment.

My operational and professional role as a trained psychoanalytic psychotherapist was adhered to at all times. The conventional clinical boundaries and the fifty minute sessions were maintained throughout the research. Nevertheless during these sessions I encouraged the patients to reflect on their thoughts and 'free associate' without feeling that I was going to be judgemental or critical, as would be the case with any other patient who came for psychotherapy sessions. Clinical principles and technique were maintained at all times but due to the age and physical needs of some of the patients, some appropriate minor management and practical adjustments were made as explained in Chapter 6 under the heading 'Findings and Discussion'.

## **1.2 APPROVAL BY THE JOINT UCL / UCLH COMMITTEES ON THE ETHICS OF HUMAN RESEARCH (COMMITTEE A)**

During psychoanalytic psychotherapy sessions detailed personal accounts of the patient's life as well as their family and friends may be revealed and noted by the therapist. To encourage the patient to divulge important facts about their personal life a trusting relationship needs to be established. Therefore confidentiality is of utmost importance for ethical reasons and this has to be

acquired from the appropriate source. In order to carry out my humane and person-centered research study I applied to 'The UCL/UCLH Committees on the ethics of Human Research (Committee A). After an interview with a panel I was duly granted permission to go ahead with my research study in August, 2006 (Appendix 2).

(NB. During a final discussion with my supervisors I suggested that the original title did not seem appropriate for the qualitative research and was given permission by the Research Committee to change it to the present one).

### 1.3 CORE RESULTS

The CORE (Clinical Outcome of Routine Evaluation – see Appendix 3) has been designed to feed back the effectiveness of psychological therapies. It represents a well developed clinical outcome measure to assess progress, resulting from the treatment. The measure addresses global distress and is therefore suitable for use as an initial screening tool and outcome measure. Like most self report measures it cannot be used to gain a diagnosis of a specific disorder. The CORE outcome measure addresses the four dimensions of well-being: problem or symptoms, life functioning and risk factors. The graphs represent the patients' responses and indicate their emotional states.

The CORE Measure has 34 items on two sides of an A4 sheet making it easy to administer. The items in the measure are not regarded as a scale but as a clinical flag up to trigger more discussion of risk at the initial assessment as well as during treatment. Each item within the CORE Outcome Measure is scored on a 5-point scale, ranging from 0 (not at all) to 4 (most or all the time). The total score is calculated by adding the response values of all 34 items. The minimum score that then can be achieved is therefore 0 and the maximum is 136. The design of the form helps to tap into the 'core of patients' or users' distress and social functioning'. In addition items on risk to self and others are included. The risk items cover suicidal ideation and harm to self and others. Where an individual scores more than 0 on any item marked "R" this flags the need for attention by an appropriate professional clinician. For the purpose of my

research I found the CORE outcome measure useful in that I could be aware of the risk factor that might be evoked through the treatment.

My comparison with the CORE results (see Chapter 3) represented the patients' responses and indicated their emotional states at stipulated periods of their treatment, i.e. prior, during and at the end of the therapy sessions. The CORE Form is posted directly to the patient by the CORE Researcher of the department, including a self-addressed envelope, so that the form can be filled in and returned to the appropriate CORE department. The CORE measure provided an independent self-report check on changes in the patients' states of mind throughout the course of treatment. In the absence of a control group these changes cannot however be taken as absolute evidence for or against the effectiveness of the treatment.

#### **1.4 SUMMARY OF RESEARCH PLAN**

1. After the initial assessment the patients attended for 40 weekly sessions, each lasting for 50 minutes and one review session about three months later after the treatment ended.
2. The framework for the treatment was psychoanalytic psychotherapy with an inter-personal, intra-psychic, holistic and humane approach.
3. Keen observation and attention to transference, projection, projective identification and splitting-off processes were noted to clarify the mode of understanding involved in the qualitative research.
4. An adopted form of the Grounded Theory qualitative research method was used to process codes and categories that linked with psychoanalytic theory.
5. A study of the categories from across the domain of the research cases resulted in the identification of some similar themes which were noted as 'key facts'.
6. These defined 'key facts' were grounded as hypotheses for depression in later life.
7. Lastly a comparative study with the outcome of the CORE graphs showed significant developments in the patients' mental functioning.

## **2 A REVIEW OF PSYCHOANALYSIS AND OLD AGE**

### **Chapter Summary**

- A brief account of depression in later life.
- Some aspects of the Psychology of old age.
- Psychoanalytic theory associated with my research case studies.
- A literature review of psychoanalysis for older adults.
- A comparative brief discussion between psychology and psychoanalysis.

### **2.1 INTRODUCTION**

This chapter will provide a general discussion of depression in older adults, followed by an account of the psychology of old age and some essential psychoanalytic theory pertinent to the research study. Finally, a literature survey of provision in connection with psychoanalysis for older adults will be discussed and the chapter will end with a comparative study of the difference in approach between psychology and psychoanalysis.

The ageing process is unavoidable and impairment both physically and mentally is inevitable. Whilst some people become incompetent in various ways others continue to run marathons in their seventies or remain as creative and academically able well into old age. Is longevity only connected with the genes we have inherited or are there other factors? Sociologists, gerontologists, psychologists and psychoanalysts agree that the environment has some influence over our mental state and does have some impact on our behaviour. But can mental processes be altered for the better? If so how can they be altered? Therefore before discussing the contribution of psychoanalysis I will look into what the psychologists have to say about old age.

The pathology of depression is not always as easily recognized unless it is clinical, refractory or preceded by an intense traumatic experience that has led

to the depressive mental state. The symptoms with these cases are usually obvious and can therefore be more easily diagnosed. My research focuses on patients who were depressed in a subtle manner and whose depression was not easily detected. The patients had functioned fairly normally in their outer lives until or soon after retirement. The literature survey focuses on patients who are mildly depressed and whose depression prevented them from living a more fulfilled old age. Their depressive state was serious enough to warrant help from their GPs and accordingly they had been prescribed medication.

## 2.2 DEPRESSION IN LATER LIFE

The following studies on the subject of depression enforce the claim that Age UK (2008 4-6) made in its survey that about 2 million older adults were depressed in Britain. The findings further indicated that it was understandable that anxiety about death might increase with age.

*Depression is an illness that blights the lives of many older people. It is not "one of those things". Ignoring the problem is not an option: if not identified and treated depression ruins people's quality of life, increases the risk of other illnesses and can even lead to suicide. However the findings of the Mental Health Enquiry and the experiences of individual older people show that this alone cannot end the scandalous treatment of depression ... Depression in later life is very common but it is not an inevitable part of ageing.*

Similarly further studies indicate that 'Depression can seriously impair quality of life. Its incidence rises steadily with age and unfortunately goes unsupported. It may be associated with loneliness and the lack of friends, together with negative assessment of health' (Berg, Mellstrom, Persson, Svanborg, 1990)<sup>1</sup>. According to Hamilton (1960, 1980)<sup>2</sup> 'Depression may be assessed clinically or by the use of observer or self-rated scales', and the Hamilton Rating Scale for

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<sup>1</sup> **Berg, Maelstrom, Persson, Svanborg (1990)**. The Prevention of Disability in the Aged. In Journal of Scientific Exploration Vol 2

depression which 'is observer-administered and oriented more towards the behaviour and somatic features of depression is a better instrument for detecting depression compared with self rating scales.' The argument that Smith, Ahmed, Mehta, Hamilton (1971)<sup>3</sup> later make is that: 'The self-rating scales have the disadvantage of depending on literacy of the subject, ability to concentrate and the patient's wish to present him in a certain way. They are more concerned with depression as a mood state.'

Templar, Ruff & Franks (1971, 521-523)<sup>4</sup> devised a Death Anxiety Scale which 'as might be expected, correlated with depression as measured by the depression scale of the Minnesota Multiphasic Personality inventory and with global health assessment as measured by the Cornell medical Index.' They concluded that 'death anxiety is usually related more to the degree of personality adjustment and subjective state of well being than to reality factors.' Further research by them signified that, 'The scale is also sensitive to environmental events and the impact of interpersonal relationships.'

My reason for quoting the psychometric testing studies is to indicate how irrelevant they can be when one really wants to understand intra-psychic activity. External 'behaviour and somatic features' are obvious to diagnose but they do not give indications as to why the patient is behaving in a particular manner or explore that the depression might stem from some internal anxieties. The psychotherapeutic or person-centered psychodynamic method might be a slower process but explores more than the outer reality and provides in-depth access to internal distress and feelings as experienced by the patient. It might not always be what the older adult wants or be successful as a form of treatment but at least it gives the older person the opportunity to be listened to before suppressants are prescribed to alleviate the physical state. The tests might provide statistics and be useful to policy makers but I cannot envisage

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<sup>2</sup> **Hamilton M (1960)**, The Hamilton Depression Rating Scale: Has the Gold Standard Become a Lead Weight? *The American Journal of Psychiatry*. Revision and Overview: 161 2163 -2177

<sup>3</sup> **Smith, Ahmed, Mehta, Hamilton (1971)** The Benefits of Psychotherapy with Couples. *British Journal of Psychiatry* 115 947-958

<sup>4</sup> **Templar, Ruff and Frank (1971)** Death Anxiety as Related to Depression and Health of Retired Persons. *Journal of Gerontology* 26 (4) 521-523

how they can help the depressed older adults' internal state. Furthermore most psychometric testing focuses on the intellect and not on emotionality.

Degenerative states to varying degrees, both physically and mentally, are the inevitable experiences of most people towards the end of the lifecycle. Degenerative states were evident in my research case studies as I will discuss later in more detail. Amongst the many findings in connection with the ageing process and depression was that my subjects were unaware of why they felt depressed until they were able to share some of their feelings and experiences that they recollected during the therapy. Some of these 'memories and desires' went back to their early childhood. But an even more interesting development was their reluctance to relinquish some of their longed for desires. Klein (1959 247-263) posited this very significant feature of emotional states during adulthood in her paper: 'Our Adult World and its Roots in Infancy' (262):

*If we look at our adult world from the viewpoint of its roots in infancy, we gain an insight into the way our mind, our habits and our views have been built up from the earliest infantile phantasies and emotions to the most complex and sophisticated adult manifestations. There is one more conclusion to be drawn, which is that nothing that ever existed in the unconscious completely loses its influence on the personality.*

Klein came to this conclusion after noting that although both the paranoid-schizoid and depressive states of mind are part of normal processes for the infant's ego development, the infant requires the mother's capacity to contain her infant's persecutory anxieties. But if these early anxieties are excessive and not supported during infancy or childhood they can be denied at the time but remain in the unconscious. Comparative or associated experiences during adulthood can evoke some of these early experiences and influence one's reactions.

Some of these early repressed object-related experiences can be noted during



the transference when the patient regresses or recollects during the analytic session. The depressive states in my research patients were closely linked with their earlier dysfunctional object-related childhood. Bion's (1962, 1993 143-157) thinking further approached the subject of our internal states of mind in his discussion on 'memory and desire' and how this affected our adult lives which will be discussed in more detail later.

Further sources of the lack of psychodynamic provision for depression in older adults over the age of 65 have been highlighted by professionals from other fields. Shah and De (1998), cited in Evans & Garner (2004, 48):

*There exists a particular danger in late life depression that it may be considered as normal ... The depressed individual is at the end of their life and may have survived trauma that is inconceivable to a younger person. The individual may not seek treatment or may not be adequately treated and their detachment from others is not subject to intervention.*

Several questions arise from this: Why does the individual not seek treatment? Is this due to ignorance, lack of resources or are older adults conditioned to believe that this is 'considered as normal'? Perhaps this could also be due to the socio-economic status and/or lack of psychodynamic services for older adults.

Failure by carers to detect depression also occurs as Pollock, A. (2004, 30) indicated:

*A study of older people in Barking... showed that before their transfer to nursing and residential care homes more than 90% of residents had been diagnosed as having serious clinical depression. Subsequently case note reviews showed that despite their high level of need fewer than 10% received the treatment and care they required. Only GP services were provided.'*

My observation of older adults in geriatric wards (McKenzie-Smith, 1992, 387) noted:

*It seems that there is scope for improvement in the understanding of the feelings of the patients of the hospital in which I observed. It is a large, sophisticated, modern hospital. A number of the patients sit or lie down day after day unable to move or fend for themselves. One wonders if this is always from physical disability or perhaps rather from lack of stimulation... whether this is the result of an organic or inorganic cause. Had these people been given mental stimulation earlier perhaps some of them might still be alert.*

I did not use the terminology at the time but with hindsight I now think that many of those old people were depressed and not recognized as being so. This was not due to neglect because the patients were treated with care for their external needs, but the carers did not, or did not want to get emotionally involved with their depressed patients. Menzies-Lyth (1975, 76) wrote:

*In general the organization of the nursing service militates against close and prolonged contact between the individual patient and nurse ... [there exists] a sort of depersonalization of both nurses and patients.*

Although some current training requirements for care of older adults have dramatically changed to incorporate awareness of “inner states”, it seems that this factor has not become a relevant and much needed requirement for most professionals and carers.

Observation studies aiming to cultivate an awareness of psychological needs of patients have found a way into a few of the various caring institutions in both the public and private sectors. For example some hospitals, care homes, schools and other public workforce centers have opted to train staff to acquire the skills of observation in order to cultivate an awareness to provide for more than what is externally obvious. Obholzer (1989, 58), expresses the importance of

understanding the projective experiences as 'the nature and vicissitudes of inter-personal, inter-group, inter-institutional and international relationships.' Obholzer & Roberts (1994), Hinshelwood & Skogstad (2002), Alexander & Morgan (2003) have carried out further relevant studies in the field of observation of organizations, assessment and consultation in institutions to cultivate insight and perception. But observation of older people as a requirement for courses involving older adults in universities as well as in hospitals has not developed except with a few psychodynamic trainings. A more recent paper by Davenhill, Balfour, Rustin M.E. (2007, 129-144) conveys the importance of understanding the emotionality of people in later life. The booming growth of the older population and their emotional needs urgently necessitates some action from professionals to facilitate a more in-depth understanding to promote conditions for their well-being.

The DOH survey and reports by Crisp (2005a, 2005b, 2006) looked into depression in older adults. Crisp (2006) states: 'The dementias and depression are without doubt the major mental health problems encountered in older people.' Woods (1999, 73) points out: 'The prevalence of the dementias has been the subject of numerous epidemiological studies internationally.' Similar thoughts have also been voiced by Murphy (2000) Hepple (2004), Evans & Garner (2004), Davenhill (2007), Dartington (2010). The basis of psychodynamic intervention is to incorporate the understanding of the unconscious or what is more commonly noted as 'our feelings' in order to understand the psychic processes. Obviously not all older people might be willing to seek or use such support and although depression might be one small component of the several needs of the older adult, 2 million people cannot be ignored when they might be supported to enhance their lifestyles.

The emotional state of people during the ageing process is just as important as at any other stage of the lifespan as is conveyed and confirmed by Pollock's survey. If this kind of neglect is evident in residential care then what are the chances for depressed older adults living on their own? As stated in the Introduction the aim of my thesis is to study what might be causing older adults to become depressed at this stage of their lifespan. Keen perceptiveness might

be necessary to identify what lies beneath the façade of their external behaviour. There is more research in connection with dementia than for the larger variety of depressive states. Elderly people living on their own may lack the incentive or the drive to get motivated. A state of depression might only be detected if they see an insightful GP for some other physical ailment.

### 2.3 THE PSYCHOLOGY OF OLD AGE

The psychology of ageing covers a wide span from theoretical concepts to research evaluations connected with genetics, physical health such as disabilities, degeneration and cognitive neuroscience in relation to behaviour. For the purpose of my research study I will specifically concentrate on the psychology of the ageing process as linked with depression and as understood through psycho-social factors and emotional behaviour.

Aldwin et al (2001, 91-95) consider 'three broad types of psycho-social factors that may affect the rate of ageing: personality, religious beliefs/spirituality and stress and stress coping processes'. They go on to suggest that the personality includes, 'traits, beliefs, health and attitude affects of health, especially cardiovascular health ... Older adults are more vulnerable to physical stresses for a number of reasons ...all relating to physical ageing.' A further point they make: 'Some exciting new developments focus on personality processes that can be protective factors, such as emotional stability and use of control and optimism.' But they do not give details of how one focuses to acquire 'emotional stability or optimism'. Some further literature by Vaillant (2002) cited in Birren & Warner Schaie (2005)<sup>5</sup> studied the lifelong predictions of successful ageing. He came to the conclusion that there was no direct link between early childhood, adversity and longevity. In a smaller sample he did find an indirect effect that stressful childhood environments affected mental health in mid-life, which in turn related to ageing.

Levenson et al (2001, 99) suggest that 'a liberative model of adult development

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<sup>5</sup> Vaillant (2002) in Birren & Warner Schaie (2005) Handbook of Psychology of Ageing. 6<sup>th</sup> Ed. 91-95. Elsevier Academic Press

is about transcending the self'. They argue that the 'self transcendence aspect of wisdom develops from coping with stress, which may force detachment from previous sources of identity'. They further claim that 'correlation of self-transcendence with emotional stability and spirituality are associated with better health in later life' and think that the capacity to do so through detachment and wisdom may be necessary in order to accept the ageing process. But once more how the ageing adult goes about achieving emotional stability or mental well-being is unclear.

A positive approach comes from Woods (2006, 9):

*There was some reluctance to grasp that the range of techniques applicable to adult work could with care be extended to work with older adults. Recent years have seen an upsurge in the use of a wide variety of procedures, from behavioural to psychoanalytic, for individuals, families, and groups, more closely reflecting practice with younger people. A review of effectiveness of these approaches (Woods & Roth, 1996) suggests that in areas such as depression, outcomes are as positive with older adults as with younger people. While there are many areas for further research and development, there are no grounds for therapeutic pessimism on the basis of age.*

He also suggests that 'psychological approaches need to keep pace with advances in knowledge regarding problems of mental health in older people', recognizing that 'there might be deep-seated uneasiness by many younger professionals' and also 'personal revulsion to and distaste for growing old, disease, disability and fear of powerlessness, uselessness and death' quoting Butler (1963 65-76). Erikson et al (1986 141) stress the need to maintain an identity in old age and state: 'Part of the old-age processes of reviewing the sense of oneself across the life cycle involves a coming to terms with perceived mistakes, failures and omissions – with chances missed and opportunities not taken ... which may all along have remained part of an underlying sense of identity'. They continue to say that older adults would like to 'endeavour' to

integrate, rather than resolutely deny ... the life actually lived with the life anticipated in youthful fantasy and imagined over decades.' In other words they are saying that older adults would like to recollect and assess their past through some self awareness in later life.

Another source is Kvale (1985 171-196) who incorporated a hermeneutic perspective. He explained: 'The hermeneutic discipline implies an attempt to reflect the mode of understanding in the humanities as in analyses in literature, historical research as well as within theology and law.' Citing Radnitsky (1971), Kvale explains:

*Hermeneutic human sciences study the objectivations of human cultural activity as text with a view to interpreting them, to find out the intended or expressed meaning, in order to establish a co-understanding, or possibly even consent, mediate traditions, so that the historical dialogue of mankind may be combined and deepened.*

Erikson et al, Woods and Kvale progressively suggest that a more person-centered, reflective approach is required in order to understand the human, social and historical development of the individual as well as the outer behaviour patterns. This suggests that psychology should incorporate the understanding of the emotional aspects of people similar to that of psychoanalysis and psychotherapy. Although some psychologists do now adapt a more human science perspective pertaining to feelings and long standing experiences, many still do not consider the "inner state" and psychic activities as relevant to diagnose the cause of depression. Psychological research often pays more attention to the general environment and behavioural patterns to quantify and conclude results.

The focal aim of this thesis was to find out if psychotherapeutic intervention can alleviate depression in older adults who had led satisfactory working lives until retirement, before they were diagnosed as suffering from depression. In the next section I will discuss psychoanalytic theories relevant to my study.

## 2.4 A REVIEW OF PSYCHOANALYTIC THEORY LINKED WITH MY RESEARCH

### 2.4.1 The Unconscious Processes

A vast amount of literature on psychoanalysis has been produced by Freud, Jung and by many more recent writers. The practice of psychoanalysis or psychoanalytic psychotherapy is a unique form of intervention which aims to investigate and understand 'unconscious processes' regardless of age or sex. The technique has been modified and adapted for children through the form of 'play therapy'. What is meant by unconscious processes? The terminology was originally coined by Freud to express the internal psychic activity of the patient and not just the external evident reality. Unbearable, painful and adverse experiences cannot be annihilated so they are repressed. They remain in the unconscious. The basic intention of psychotherapy as an exploratory and reflective practice is to identify these repressed experiences within the analytic situation through the transference and countertransference processes. Freud (1915, 167-173) in his 'Papers on Metapsychology' said:

*We have learnt from psychoanalysis that the essence of the process of repression lies in not putting an end to, in annihilating, the idea which represents an instinct, but in preventing it from becoming conscious ... Everything that is repressed must remain unconscious ... Psychoanalytic work shows us everyday that translation of this kind is possible.*

Freud explains that during the course of early infantile and childhood psychic development, the individual experiences periods of psychic gain as well as losses. The ability to process these losses originate from internal feelings of containment acquired during the nurturing stage and continue in the form of healthy, mental development. Psychoanalysis suggests that all relationships stem from the infant's ego development. The process of accepting the unattainable and mourning it as a loss is crucial for mental well-being. Refusal to accept the true state or denial of the experience is detrimental for normal ego functioning. Basically these activities are related to all our daily experiences

throughout our lifetime. Our inner psychic state often reflects on how we cope with our everyday life experiences. Some negative, unresolved intrapsychic activities unconsciously influenced my patients' outer behaviour. Freud's paper "Mourning and Melancholia" (1917, 237-259) is fundamental to understanding the experience of loss. He described the process as that of shock and denial followed by a period of working through as one never relinquishes one's attachment to important objects willingly. When confronted initially with loss 'one abandons the reality instead of abandoning the object; a turning away from reality ensures the object is clung to through the medium of hallucinatory wish fulfillment'. The mourner reacts as if somehow the information is wrong and denies the experience.

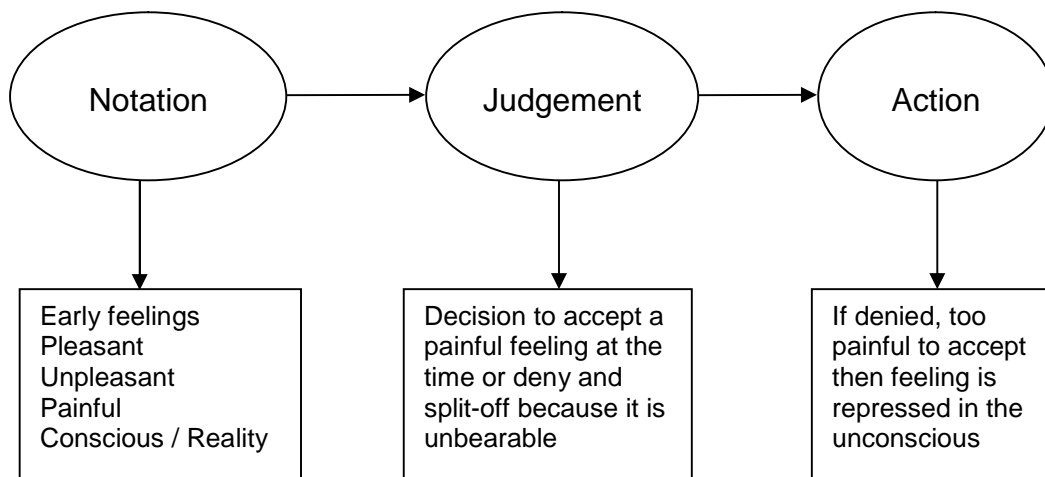
It is important to understand what is meant by the process of "mourning and melancholia" within psychoanalysis. Mourning does not always lead to a state of melancholia. When mourning the mourner is psychically experiencing and pre-occupied with the loss of the object. The mourner feels psychically impoverished until he comes to terms with the loss and accepts the situation. The time it takes differs with the individual before a healthy mental state is reached. Melancholia is a state of mind created when the mourner does not accept the loss. The emotional impact has been perceived but misconstrued resulting in the non acceptance of the lost object by the ego. Eventually when the loss is mourned through integration a healthy state is achieved. The process of mourning is necessary before the melancholia subsides.

During the psychotherapeutic process the denied activity may re-occur through the transference whereby the previous experience is re-activated, re-enacted and may eventually be mourned and integrated as a loss. After this process of mourning the melancholia subsides as the loss of the object is accepted and the patient comes to terms with the reality. I think the transference depends on the attitude of the patient. If the patient remains in denial or is resistant then there is more of a negative transference or none at all as the patient cuts himself off from any emotional experience. Some patients develop a transference relation to their psychotherapist after an initial assessment which I will discuss in the next chapter.



## 2.4.2 Aspects of early mourning and melancholia

Freud (1911) originally explained that the infant is all id and whilst in relationship with the other develops an ego which is the basis of our psychic existence or mental functioning. For a healthy mental state ego development requires continual processing of pleasant as well as unbearable experiences. Freud categorized this activity into three stages: 'notation', which is the original experience; 'judgement', making a decision; followed by 'action', the actual response or behaviour occurring in connection with the initial experience. Voluntarily or involuntarily all experiences are also stored in the vast unconscious as pleasant and memorable or if painful they are repressed as undesirable. Bion (1963) presented his thoughts on the subject by accepting Freud's view of memory and its relationship with 'notation' but explains the phase of 'judgement' as 'attention and inquiry' before taking 'action'.



**Figure 1: A Simplified Model of the Unconscious Process**

Figure 1 represents how I see Freud's description in three words – 'notation, judgement and action' – in a simple format of a very intricate and sophisticated subject – the unconscious process. This psychic mental activity continually happens throughout our lifetime with every experience.

If the ultimate action was to avoid the reality of the experience and escape into phantasy then the actuality was the denial of the experience and moving to the state of the 'pleasure principle' rather than remaining with the pain or

undesirable experience as termed as the 'reality principle' (Freud 1920). Continual denial and repression of the unbearable engenders a superego but the original experience remains in a passive state within the unconscious. At some stage other incidents might evoke these early feelings and can lead to depression or dysfunctional mental states. Bion (1967,1993, 112) explained the process as starting with a feeling, followed by thinking about the feeling and thereafter communicating or acting accordingly. If the action is to avoid and pretend that it never happened then a false premise is set up in the psyche because in actuality the real experience is being denied and an imbalance of the psychic equilibrium occurs. Consequently normal ego development becomes restricted and the mental functioning becomes distorted whilst the painful experience is consistently denied and remains as such in the unconscious. If the individual continues to behave in this manner then instead of ego development an 'ego-destructive superego' (Bion, 1993 93-109) develops which can be counter-productive to a healthy mental state as discussed in more detail below.

#### **2.4.3 Early attachment, separation and loss**

Melanie Klein (1935, 290-305) focused on the early experiences of the object (mother/caregiver) and the infant's feelings of security through dependency, attachment, separation and toleration whilst oscillating between integration and disintegration. She advanced Freud's original thinking on the early unconscious processes by linking them to her understanding of the manic-depressive states in infancy which required the processing of good and bad experiences. She explained that the immediate reaction of the infant is to despair when the mother is not readily available. How the baby processes this would depend on whether there is a secure relationship between mother and infant. Should the attachment be positive then the infant is able to tolerate the immediate lack of attention and the existing positive attachment enables the baby to tolerate the separation. She suggested that 'the child's pleasurable attachment to the breast develops into feelings towards her as a person', but also that it is 'very important for the child's future that he should be able to progress from the early fears of persecution and a phantasy object-relationship to the relation to the

mother as a whole person and a loving being'. In other words the child needs to psychically separate from the attachment to the mother and accept this loss through the mourning process.

Originating from Klein's thinking other researchers in the field further developed the concept of early object relations and attachment theory. Bowlby (1969) in particular presented the early mother/infant relationship as that of negotiating attachment, which progressed to separation and eventually to accepting loss. The mourning process is an essential entity for continuing a healthy mental life. He also said that the acquisition of 'a secure base' during infancy and childhood continued to play a significant part throughout our lifetime as these feelings are the foundation of future psychic growth and a balanced, emotional adulthood. Bowlby (1980) significantly added:

*There is today impressive and mounting evidence that the pattern of attachment that an individual develops during the years of immaturity – infancy, childhood and adolescence – is profoundly influenced by the way his parents or other figures) treat him ... Systematic research studies of socio-emotional developments indicate that the first five years influence the personality and behaviour of the individual throughout his life in dealing with attachment, separation and loss ... Deviant patterns and defences link with earlier experiences that definitely persist throughout the lifespan as a process of internalization.*

Current attachment theory generated from the origins of the early object relations and developed both in the UK and across the Atlantic by Schaffer & Emerson (1964), Spitz (1965), Ainsworth & Bell (1970) who described good attachment, separation and contained feelings of loss as important processes in the life of an infant. Dysfunctional, adverse conditions often cause emotional damage and resonate in some way during the adult lifespan. Their contributions were mainly made through intensive work with children.

In the analytic situation attention is usually given to a patient's early history in

one way or another. In my clinical experience of working with older adults, the separation and linked losses of early childhood became more prominent as the sessions progressed. Such concrete realities of the ageing process as loss of partners, friends, employment (through retirement) and physical impairment often evoked memories of past experiences that had not been mourned. Well repressed feelings and resentments connected with earlier experiences which had at the time been too painful to negotiate remained dormant in the unconscious and unresolved. But simultaneously some yearnings for the desired lost objects lurked in their subconscious in an inexplicable manner. This caused the depression or 'black cloud hanging over me' as one of my patients described this feeling. The psychoanalytic process slowly explored the well repressed emotionality that was connected to the current psychopathology. Patterns of insecurity and low self esteem, stemming from the feelings of being redundant were often connected to the underlying problem.

#### **2.4.4 Concepts of container and contained**

Bion (1993, 35-37) introduced the concept of the 'container' (mother) and the 'contained' (infant) to describe a process whereby the mother or caregiver contains the anxiety provoking projections of the infant by processing them into a more acceptable form. The communication or introjection made more digestible 'is that her love is expressed by reverie', hence the expression, 'maternal reverie'. In other words the mother is tuned into her infant's needs. However if the mother continually fails to contain the infant's anxieties then a state of 'meaningless fear' impinges on the infant's psyche and this is experienced as terrors that become 'a nameless dread' (Bion 1993, 110-119).

Contemporary clinicians have added to the original container-contained concept. For example Williams (1991, 3-14; 1997) wrote: 'It is rare to meet the phenomenon 'in pure culture' so to speak but it can happen that a child, at times a baby still desperately in need of containment, is exposed to the experience of being used as a receptacle (this word is more appropriate than container) of massive projections ... If the child is a recipient of the projections or the reversal of the container/contained; if early containment has not been available then the

tendency is to turn to an unreliable container such as an addiction during adolescence or young childhood.’ Briggs (1997, 50) describes the process as ‘concave and convex’, stating that: ‘The central issue for parenting in the model is the extent to which the mother offers a containing (concave) or not containing (flat/convex) shape in interactions with the infant.’ He adds: ‘Reverie or concave shape is the function of mother’s availability for receiving communication from the infant and through this being able to transform the emotionality.’

These early states of psychic mental functioning are important forces that shape our future personality. The necessity emotionally to accept all object relations as part of our life experiences, whether pleasant or adverse, is vital for psychic well-being. Dysfunctional, bad experiences have to be accepted for what they represented as the reality at the time. The original experience or the communication (notation) might have been experienced as painful and in actuality cannot be altered. The experience has to be borne however unbearable. An infant is perhaps not psychically able to contain the negative experience and requires the ‘maternal reverie’ to adapt to the experience. But crucial for psychic growth is that the remaining negative aspects have to be mourned as a loss and the desired experience relinquished.

My research patients conveyed not only the lack of containment but the reluctance to accept some of the negative activity experienced during their childhood and adolescence. They were aware of what they had desired and carried these yearnings in a state of ‘passive hope’ that their wishes could still be fulfilled. These factors played an important part in their depressive states as I will discuss later.

#### **2.4.5 Superego and its ramifications: fragmentation of ego, splitting-off and projective identification as a process of defence and creating an ego-destructive superego**

Freud (1923, 19 & 28-39) originally introduced the concept of the superego. He suggested that there is ‘the existence of a grade in the ego, which may be called the ‘ego ideal’ or superego’. He further discussed that ‘the superego is not simply a residue of the earliest object-choices of the id; it also represents an

energetic reaction-formation against those choices'. He explained that the ego represents the external world of reality, whilst the superego in contrast is the representation of the internal world. Much later Freud (1940, 23 & 275-278) wrote: 'A child's ego is under the sway of a powerful instinctual demand which it is accustomed to satisfy' and that if it is suddenly frightened by an experience which 'teaches it that the continuance of the satisfaction will result in an almost intolerable real danger' the child considers 'the reality of the threatening experience as dangerous and consequently the splitting of the ego takes over the fear of that danger as a pathological symptom and tries subsequently to divest himself of the fear in the process of defence.' He also expressed that a 'superego develops an extraordinary harshness and severity towards the ego'.

Klein (1946, 3 & 1-24) further developed Freud's theory of the superego by adding that the unbearable experience was not only split-off but projected into an object, attributing the denied experience as that of the other. Instead of tolerating and processing the experience the predominating "judgment" was non-acceptance and denial, bringing about temporary relief. By taking that 'action' the painful experience can be disowned outwardly but the actual experience remains in the unconscious in its original form. She identified the process as 'splitting-off and projective identification'; Bion (1967,1993, 93-109) suggested the 'dysfunction and antagonism between normal and abnormal forms of the superego'; Steiner (1993, 1-13) discussed the process as 'a psychic retreat that requires the analyst to process, collect and integrate the disparate elements of the self ... re-organization of the fragmented parts of the ego to create a SELF'; O'Shaughnessy (1999, 80 & 861-870) called the process an 'ego destructive superego' a term originally used by Bion; Britton (2003, 117-128) expressed this behaviour as 'amalgamating to not embodying the truth'. This kind of mental activity is a common feature and often recognized during the analytic process. During the formative years if the young child is continually undergoing painful, unbearable and intolerable experiences then the child is unable to structure normal ego functioning – a requisite for psychic growth – the capacity to sustain losses and mourn them is minimized.

## 2.5 PSYCHOANALYSIS AND OLD AGE

As indicated earlier for the purpose of this thesis I have selected a sample of over 65s specifically diagnosed as suffering from depression. Members of the sample had on the whole functioned normally in earlier life although two of the cases had been diagnosed as depressed for brief periods following some traumatic life experiences. They managed to come through their depressive states, continued to work satisfactorily and led fairly fulfilling lives until retirement. I will now review some literature reporting psychoanalytic interventions with older adults.

The earliest published record of psychoanalysis in connection with older adults is by Karl Abraham (1919, 113-117) and titled 'On the prognosis of psychoanalytic treatments in advanced age', followed by Chadwick (1929, 10 & 321-334) 'Notes upon the fear of death' and Kaufman (1937, 308-335) 'Psychoanalysis on late-life depression'. But one of the most significant clinical papers on psychoanalysis with an older adult is Hanna Segal's (1958, 39 & 178-182) paper, 'Fear of death – Notes on the analysis of an old man'. She reports an account of her work with a seventy four year old man, who was referred to her following his psychotic breakdown. In her paper she describes his analysis of eighteen months in three phases. This work connects with my theme of splitting-off parts of the self and being in denial. In some people intense childhood desires remain persecutory until they are recalled during the analysis and integrated or relinquished. I discovered with my research cases that these childhood desires were never mourned but remained as false hopes.

Segal says: 'The circumstances of his breakdown are relevant to my theme ... I suggest that my patient was unconsciously terrified of old age and death. His main defenses against this fear were splitting, idealization and denial.' In the first phase of the analysis there are several descriptive paragraphs of her patient's 'outer life activities' and biographical accounts of his past including his childhood. Through insight into his historical background she perceived that:

*Any feeling of persecution that pertained to his father was*

*immediately split-off and projected into his older brothers. In the background, there was a picture of an unloving cold mother. The feeling of persecution by her had been mainly transferred onto the various countries he lived in, which he completely personified, and invariably described to me as treating him badly, exploiting him and refusing to give him a livelihood.*

By the second phase Segal describes the analysis has having moved on to the patient being able to think about and accept some of her interpretations. She explains that: 'With this admission of these fears of persecution and punishment, he could overtly admit fear of death.' By the third phase of his analysis he was recalling more and more events of his early childhood and later history. His discovery that most of his family and friends had perished in the concentration camps whilst he had escaped left him 'unable to bear his depression and guilt' and he split-off these unbearable feelings and denied them by secretly drinking. In her conclusion Segal suggests that her patient had been unable in infancy, childhood and later to face his ambivalence and the resulting depressive state. This is a pioneering piece of analytic work with older adults and the beginning of its archive.

The point of going into some of the detail in Segal's paper is to demonstrate the importance of the inner world consisting of past experiences that remain in the unconscious and the long lasting impact these could have on the mental states of older adults. She was able to explore the reasons for his depression and thus helped her patient make better relations with his inner objects, come to terms with death and dying and continue to live a more fruitful life. Following his analysis he was able to emotionally support and nurse his sick wife.

After a period of dormancy of recorded analytic work with older adults, the eighties saw a burst of interventions. A few analysts worked with people in later life, not as a specialist provision but within their practice, and they subsequently produced papers on various aspects of this work: King (1974, 1980), Pollock, G. (1981), Wylie & Wylie, (1987). These publications were questioning whether successful psychoanalytic work could be done at this later stage of the lifecycle



and if techniques needed to be modified. Some analysts questioned whether the oncoming ending required a backward journey of reminiscence to earlier states of life experiences. Similar to Segal, Klein's followers thought there was the necessity to work through some of the experiences linked with early object relations that had been repressed.

King (1974, 23-37) wrote and presented a paper on the analysis of middle-aged and elderly patients, the theme of which was 'understanding of the nature of transference phenomena in the context of the life-cycle pressures of elderly patients, important dynamics, operating in these patients' that can become accessible during the sessions within the psychoanalytic process. She connected her findings with 'an increased understanding of the developmental processes in the area of ego functions and object relations and the effective implementations of these for mental health'.

A further paper (1980, 153-160) arose from her interest in Erikson's (1959) discussion 'on the impact of the experience of the life-cycle on the psychosocial development of the individual'. He had formulated and extended his seven stages of development to involve an eighth stage – integrity vs. despair (wisdom) – recognizing the potential of older adults. In this paper King addresses, 'some of the pressures which seem to operate as sources of anxiety and concern during the second half of the life-cycle', that is, retirement and/or loss of professional identity or work role, sexual potency, an awareness of one's ageing, possible illness and death and dying. She also includes that not having achieved goals could lead to feelings of inadequacy and depression.

King specified that there might have to be time limits to working with people in later life connected with financial difficulties. Perhaps she was thinking of patients who came to see her privately. But in fact for some older patients a restricted span of therapy might be most appropriate to their needs and affordability for this reason less of an issue.

Peter Hildebrand deliberately set up facilities to work with older adults both individually and in groups. He described this work in: 'Psychotherapy with Older

Patients' (1982) and 'Dynamic Psychotherapy with the Elderly' (1986). In 1995 he wrote about the ageing process from a psychoanalytic viewpoint giving some vignettes of older adults and their experiences of traumatic loss of loved ones. He supported his patients in mourning their bereavement. There are now some facilities and provision for older adults to be supported for bereavement counselling within some GP practice services.

Literature on psychodynamic intervention with older people has recently become more available with publications by Coltart (1991), Porter (1991), Hunt et al (1997), Terry (1997), Martindale (1998), Murphy (2000), Quinodoz, D. (2002 2010), Alexander & Morgan (2003), Hepple et al (2004), and Davenhill (2007), Garner (2008). On reviewing the above it transpires that most of the writers are clinicians from other designations than psychoanalysis. The exceptions are Coltart, Quinodoz, D. and Davenhill. Coltart (1991) has given a report of her work with one elderly patient. Davenhill (2007) edited a book in which she relates that: 'Older adults with problems of abnormal or failed mourning are very common in many of the people who are referred for assessment and treatment to old age and psychological therapies services.' She gives an account of her work with 'a man in his late sixties who was referred for help with his depression following the death of his wife who had been killed in a traffic accident while they were on holiday four years previously.'

Davenhill (2007, 73) links her findings to those in 'Mourning and Melancholia' (Freud, 1917) and discusses 'the internal world of the depressed person in identification with an object that is dead or decaying.' She goes on to indicate that her patient's depression was due to the death of his wife which he had not been able to mourn at the time. She linked this to Segal's (1958) paper in which Segal explained that her patient's depression arose from the incapacity to mourn the death of his father. Following Segal's contribution that psychotherapeutic intervention 'analyses such anxieties and defence mechanisms', Davenhill reported that her patient moved on to 'experience ambivalence and mobilize the infantile depressive position' enabling him to make mental adjustment and 'face old age and death in a more mature way'.

The most recent and extended accounts of this work come from Quinodoz, D.(2010), 'Growing Old, A Journey of Self-Discovery'. Her book covers a wide spectrum of issues concerning older adults. She describes her work with older patients who were seen for long term psychoanalytic psychotherapy and she also describes her own experiences of what it means to be a psychoanalyst growing old. Quinodoz , D. (2010, 41) relates:

*From childhood onwards we all know that we are mortal beings but that knowledge is purely intellectual and we accept it with more or less equanimity.' She goes on to point out: 'Everything changes, however, when we find ourselves close to death: that is quite a shock ... This is completely different from a purely intellectual form of knowledge.'*

She relates (136-137) that:

*A defence mechanism which, somewhat to my surprise, is very often encountered in the treatment of older people is projective identification (Klein 1946) ... When psychotherapists work with elderly people, it is important for them to know what kind of attitude to adopt with patients who have recourse to projective identification, otherwise they could find themselves drawn into an aggressive anxiety provoking relationship that goes round in circles.'*

This links with the point that Martindale (1989) made about older patients who are seen by younger psychotherapists.

Older people are sometimes seen for psychoanalytic psychotherapy once weekly or for a time limited period in the NHS. But the treatment still falls far short as an available service in comparison to established departments in the NHS for other age groups. This is confirmed by Hill and Brettle (2006) who describe:

*'the lack of appropriate psychodynamic and psychological therapies as a dimension of treatment ... although there are many who will benefit from such a procedure few are fortunate enough to gain access to this form of treatment*

The lack of provision is also confirmed by Evans (2004 28 (11) 411-414) who points out:

*The provision of psychological treatments of all modalities to older people is widely varied in Britain. The main difficulty seems to be lack of resources, but it would appear that inexperience with psychological therapies applied to older adults is also a factor. ... The needs of this group for psychotherapy were not met as well as those of younger people ... [it] is most marked in people over 65 years of age who are infrequently referred to psychotherapy departments ... There are experienced clinicians working within the NHS who see older adults as part of their professional skills but few are particularly trained to work with this age group whereas working with other age ranges require specific qualifications.*

Some professionals working with the older sector of the population have developed new ideas about aspects of emotional care which are required for people suffering from dementia or depression, but the much needed availability of psychological therapies is slow in being introduced as a necessary provision. Murphy (2000, 24 & 181-184) states:

*Sadly, a more realistic reflection on the present state of psychotherapy provision for this group [older adults] might be contained in the comment of one respondent that, "we just get forgotten" ... It seems timely to begin to hold them in mind.*

Ardern (2002 16) reports:

*The belief persists that this age group are either not worthy of, or do not benefit from psychotherapy. We can speculate on the reasons for this; older adults might be seen as psychologically too rigid to waste valuable NHS time.*

Can the lack of support for mental well being of older people as claimed by Murphy and Ardern have anything to do with the skeptical illusion that it is a waste of time as old people are going to die anyway? Fortunately a new awareness by professionals and initiatives taken by organizations such as IAPT (Improving Access for Psychological Therapies) is changing the attitude of some professionals and policy makers. Pertinent is Waddell's (1998, 195-212) insightful description of the importance of earlier life experiences and the impact they have on later life. She states:

*Yet it is often during the last decades of life that the capacity to sustain a mature state of mind is most severely tested. The question of whether or not it is possible to continue to develop remains as challenging as ever ... For the mental and emotional preoccupations related to physical decline, and to the fact that death itself is becoming more imminent, now have their own particular weighting. The extent to which these additional and major considerations spur, threaten or arrest emotional growth will very much depend on how securely an adult state of mind has been established in earlier decades.*

She specifies that the 'relative success or failure' to cope with the impact of the ageing process 'will depend on the struggles of separation and loss, in relation to mourning, absence, guilt or disappointment'. She also clarifies that the mourning is not only to do with the fear of oncoming death but will depend on the 'internal container' as the bereavement 'may be associated with the many losses that will, at this later stage, shadow normal life: loss of opportunities, for example, or of health and vigour, of political and professional ideals ... and support of children.' Although everything during one's lifetime is uncertain and

the only certainty in life is that one day we will die it is a taboo subject in most cultures.

Further confirmation of this long overdue need to understand the emotional life of older adults has been voiced by others such as Martindale (1989, 1998) on 'the aspects of dependency in later life that cause difficulties for some elderly persons and for their younger therapists'. Garner (1999, 18 & 276) succinctly states:

*Our internal world is peopled by figures and objects from our past which nevertheless interact with the present. There may be conflict between the demands of internal figures and our present needs. Our symptoms and personality have meaning which is hidden from us. The relationship with a professional who is sensitive to these ideas may be diagnostic as well as therapeutic.*

Biggs (2006, 97) discusses the subject of 'the mask of ageing' and that 'this is more concerned with external structures that shape or at least impinge upon one's sense of who one is. A new understanding is required of the older person's inner state. Junkers (2006 xiii) writes: 'ageing will embrace a period of life that is at least as long as the period of childhood' and suggests that older adults need more than the external support available. 'Davenhill (2007, 17) writes:

*One of the central tasks of therapeutic treatment is to enable the individual to reclaim areas of themselves that in fact they have done their best to get rid of, such as the capacity to become aware of and to feel love, hate, pain, grief, rage- and psychoanalytic psychotherapy in old age involves as much a fight as at any other point in the lifespan.*

All of the above identify similar characteristics of the ageing process connected with internal states of mind that care institutions fail to recognize.

### **3 METHODOLOGY: COMPATIBILITY BETWEEN PSYCHOANALYTIC PSYCHOTHERAPY AND GROUNDED THEORY AS A RESEARCH METHOD**

#### **Chapter Summary**

- A brief discussion on some current psychoanalytic research.
- Discussion on the concepts of transference and countertransference.
- A survey of some clinical research in connection with psychoanalytic psychotherapy as a methodology.
- This section gives an account of the compatibility of exploring the clinical data of psychoanalytic psychotherapy sessions by the application of the qualitative Grounded Theory method to generate hypotheses.
- Illustrative material from one case study is presented in detail.
- Discussion of the 'key findings'.

#### **3.1 INTRODUCTION**

From about the time Freud (1915) first postulated his theory on unconscious processes and their relevance to human behaviour he determinedly tried to structure it as a discipline that would conform to the rules of the natural sciences. However he discovered that psychological processes were being determined by the unconscious and could not therefore be investigated according to conventional scientific methodology. By 1925 he had shifted his thinking to define psychoanalysis as 'the science of unconscious mental processes'. Freud was never able to clarify and 'augment the status of psychoanalysis as a natural science due to the elasticity of the unconscious mental processes' (Bowlby 1980). Although innumerable and informative clinical papers on psychoanalysis have been produced research in the field is not as advanced as in some other areas to explore substantive areas of mental activity and behaviour. During the last two decades some child psychotherapists, such as, Anderson (2002), Philips (2003), Reid (2003), Midgley (2006) and Midgley et

al (2009) have made contributions by formulating some grounded hypotheses through their clinical work with children. In my view the use of this research method of clinical analysis based on Grounded Theory has recently been more fully developed in child psychotherapy than it has in the field of adult psychoanalysis in the UK. It is almost non-existent in psychoanalytic work with adults in old age.

The clinical work with people in later life discussed in Chapter 2, have not deliberately been set up with research studies in mind. They mainly identify the usefulness of psychodynamic interventions as a possible means to alleviate depression in older people. Facts from their accumulated, recorded sessions mostly with individual patients have been used qualitatively to explain some of the complexities of the impact of the ageing process. Some of these clinicians such as Segal, Hildebrand, Martindale, Quinodoz, D., and Davenhill discovered relevant factors and have promoted these significant findings as mainly to do with the failed mourning of early object losses.

Perhaps psychoanalysts have been reluctant to carry out research on a wider scale due to the many difficulties in doing this. Emotionality is never constant but changes from moment to moment. This state of flux, as well as the varying observations and interpretations by different clinicians may lead to difficulty with processing an outcome. But psychoanalytic theory is technically grounded in the identification of recurring facts of experiential data that occur in the analytic situation. In Chapter 2 I discussed some of the concepts that were recognized and identified as unconscious processes. I will now discuss two further very important and accepted concepts that have emerged in the field of psychodynamic work at some stage regardless of the age or gender of patients. These are the concepts of transference and countertransference, which have been accepted as grounded features of the analytic work and are essential for understanding the intrapsychic structure of the patient.

### **3.2 TRANSFERENCE AND COUNTERTRANSFERENCE**



Before discussing the conclusions that some clinical researchers have come to it would be appropriate to discuss the function of what is known as transference and countertransference. These processes are the underlying features of the psychotherapeutic intervention that develop during the humane, interpersonal relationship, and they are useful in obtaining intrinsic details and phenomena such as the patient's feelings, thoughts and behaviour from both present and past experiences. These details can make for key findings in order to understand the meaning of feelings for assessment within a qualitative research method. Resistance against the flow of psychic activity can create a negative transference towards the analyst.

Transference was initially brought to Freud's (1912, 97-108) attention in his work with one of his patients known as Dora. He explained transference as, 'new editions or facsimiles of the impulses and phantasies which are around and made conscious during the progress of the analyses'. Often some of the past experiences are re-enacted as if they were happening in the immediate present. The concept of transference from almost the beginning of the practice of psychoanalysis has been considered as an ally of the analyst in helping the patient overcome resistance. It is a subtle, inter-personal intrapsychic mental activity and can involve the interplay of unconscious phantasies. The transference is the unfolding and externalization of internal states of mind during the therapeutic process. Past experiences are often evoked through regression or recollected from memory. As these facts unfold the information thus gained through observation on the part of the analyst/therapist enables him/her to understand and interpret the situation. More often than not it is a relief to the patient to be able to share these disturbing thoughts and feelings with someone who understands.

The transference manifestations might also be of a pleasant nature that are more readily acceptable but not altogether desirable. For example the patient might have phantasies about his or her analyst that may be of a personal nature and feel reluctant to share them during the session. Analysts should be non-judgmental and will consider whatever is brought to the session in the transference and if necessary will interpret the patient's thoughts or feelings

accordingly. The transference might also be activated in a negative manner and the patient may feel antagonistic towards the analyst. 'Acting in' or 'acting out' depending on whether it takes place during the session or in the patient's external life are also common features as a result of what goes on during the therapy. Clinicians consider the factual experiences during the transference as important 'clinical facts' as described later in more detail. Since the augmentation of the transference process by Freud the subject has been discussed further by other authors (Klein, 1952: Joseph, 1985: Meltzer, 1968).

In my experience evidence of transference can be found as early as the assessment session although some analysts would disagree and claim that transference only transpires during full analysis, meaning a patient being seen for four or five times a week. For example two of my research patients, CF and DL, recollected and related some intimate details of past experiences during the assessment. This was indicative of the immediate trust and development of a positive transference. When patients first meet with a therapist they either may share personal, intimate feelings and thoughts that perhaps they had never disclosed before to anyone or they can be defensive and refuse to cooperate with the treatment. This initial trust or distrust in the transference I think plays an important part in whether they decide to launch on an unknown inner journey. Perhaps this is the precursor to the transference or negative transference that may develop further during the therapy. Positive transference is helpful in assessing the unconscious processes of the patient. Similarly the negative transference might be indicative of personal problems that arise, can also be interpreted during the session and be worked through productively. All my research case studies as well as my private practice patients have displayed both a positive transference and a negative transference during their once-weekly sessions.

Countertransference as defined by Heimann (1950): 'the analyst's emotional response to his patient within the analytic situation represents one of his most important tools for his work.' Countertransference is generally not revealed to the patient by the psychoanalyst because it might intrude upon the patient's free association in the transference. There is also the possibility that the patient's

material might arouse some of the analyst's personal and negative feelings, creating provocative and biased interpretations. The analyst might also identify something in common from personal experiences that can be supportive of a better understanding of the patient's dilemmas. However, analysts often include or discuss their countertransference during supervision or in their clinical recordings.

### **3.3 PSYCHOTHERAPY RESEARCHED AS A SOCIAL SCIENCE FROM A QUALITATIVE RESEARCH METHOD**

Historically there has been more emphasis on 'quantitative research with regard to the social sciences than that of a qualitative approach' as pointed out by Fonagy & Moran (1993, 62). They further say that 'social science practitioners of quantitative approaches focus on selected criteria through appropriate randomized controls that exclude the meaning and purpose of human behaviour'. By nature a human being is not just a physical object and therefore cannot be understood if isolated from his emotional activity. Qualitative data as accumulated by psychoanalysts can provide insight into the personality and give a fuller account of human behaviour. Although quantitative studies are useful in themselves they are not compatible with the investigation of unconscious processes that give access to intimate and confidential relationships important for analytic processing. Fonagy & Moran state:

*The psychoanalytic method provides access to unique data that may not be accessible outside of this long-term, intimate and confidential relationship. The method provides a standardized observational framework with an observer trained to minimally disrupt the flow of emerging material while remaining attuned to his or her own, as well as the patient's, emotional reactions.*

However, as they point out, quantification can be the route for a follow up from a qualitative study to categorize and assess the accumulated data. By this process a comparative study of similar clinical facts across the domain of case studies can be quantified to generate hypotheses as I have shown in Tables 2 to 6.

In this chapter I am making the argument for my research that the method of traditional psychotherapy I have practiced and writing-up the process notes soon after the sessions with my case studies, can be understood as 'a methodology representing the hallmark of nineteenth-century clinical medicine, which used clinical observation and phenomenology as its primary research tools' (Fonagy & Moran, 1993). For the purpose of the research I systematically observed, identified and thematically analysed the psychic activities and emotional aspects of depression in older adults. In the literature review in Chapter 2 I gave examples of some clinical work carried out by analysts with older adults within their practice. My research study was deliberately set out to address older adults diagnosed as depressed through the means of psychoanalytic psychotherapy as a methodology supported with the qualitative method of Grounded Theory.

My key aim was to structure an understanding of psychodynamic activities of older people and thereby assess whether the depression stemmed only from unmourned early object related losses or whether there were other factors involved. I realized that my innovative attempt at validating psychotherapy with this kind of patient was not going to be an easy task, but hoped through the application of the 'Grounded Theory' research method to the clinical material I might be able to understand what caused their depressive states. The focus of the research was to investigate whether the perceptions, insights and observations associated with analytic theory could be extended to produce findings other than the already accepted one of the failure to mourn early losses. Other interesting, notable and important features were observed during the transference situation in connection with depression. These are identified and included as grounded hypotheses for depression in later life.

An adopted form of the qualitative research method of Grounded Theory was chosen for two important reasons. Firstly this type of research required the understanding of the nature and meaning of psychic activity in older adults that would have proved difficult to assess through a quantitative method. Secondly a person-centered and reflective qualitative research method 'is invaluable to obtain detailed phenomena such as events, thought processes and outcomes

that would otherwise be difficult to identify, extract and understand through more conventional research methods' (Strauss & Corbin 1990). As a clinician the qualitative method enabled me to codify and categorize from the patients' accumulated written out data advantageously without having to be confined by the rigid scaling of answers, as happens with many questionnaires. Nevertheless quantitative methods were useful to tabulate repeated categories and identify them 'key facts' in support of the main method.

### **3.3.1 Clinical Facts**

Intermittently research forays have been made by psychoanalysts working with adults or for people in later life. Since Freud there have been numerous publications connected with the complexities of emotional life within the clinical setting. In the *International Journal of Psychoanalysis* (1994, 75) a group of psychoanalysts contributed to a symposium on the theme of, 'What is a clinical fact?' based to a considerable degree on their clinical work. Although several views were put forward in the symposium, the writers generally agreed that unconscious processes can be identified by qualitative means and established as clinical facts to help authenticate psychoanalysis as a research methodology. The psychoanalytic researchers argued that psychic states noted during the therapeutic situation are clinical facts and discussed methodology and method, by looking at processed extracts of recorded clinical material and using this as evidence. Here is a brief review of some of the papers that are based on factual experiences during the analytic work with their patients.

Quinodoz, J-M (1994, 963) pointed out:

*The characteristics of psychoanalytic clinical facts are that they are observable and communicable and that they have at the same time a fixed and a transformational aspect.*

He goes on to discuss the meaning of the term 'clinical fact' as something that has been a subjective experience of a patient and is noted as such. He argued that in other words it is a psychic reality. He distinguished between a scientific, concrete and observable fact and a specifically psychic clinical fact. He further

stated:

*I consider that the class of psychoanalytic clinical facts can be subdivided into those falling outside the psychoanalytic situation and those which take place within the psychoanalytic situation; the latter are psychoanalytic clinical facts proper.*

He identified the point he was making with some vignettes from sessions of his work as an analyst. He clarified that not all clinical facts communicated by the patient are valuable, 'but everything that arises on the manifest level in the psychoanalytic situation can be regarded as having potential unconscious meaning in the analyst-analysand relationship.'

Tuckett (1994 1160-1180) described a clinical fact as being that which is acquired within the session and outside the analytic session as communicated by the patient. He based his research on validating the activities within the analytic setting with a patient, clarifying what he saw as 'true' and distinguishing between a 'notion' and what is 'actual'. He further validated his clinical findings from outside the session when in discussion during supervision and with colleagues. He made the argument that, 'the merit of an observation depends on a combination of the quality of careful thought that is put into reframing its specificity and the reasoning process linking it to an underlying concept that those who are to be convinced find resonant.' Observation is an important hallmark of psychoanalysis and particular attention is given to this throughout the treatment.

Another contributor was O'Shaughnessy (1994 939-947) who used the material from her clinical work with an adolescent. In her paper entitled 'What is a clinical fact?' she discussed analytic technique and methodology by looking at extracts from her data and determining what components were clinical facts. Using this as her basis she argued that 'clinical facts, materially transient, are unexpectedly durable' citing examples from Freud. She claims, 'At the outset allow me to state that there are scientific clinical facts'. To support her hypothesis she presented clinical recordings from three sessions with a 14

year-old boy arguing about what a fact is, then, discussed clinical facts noted during the psychotherapeutic session as being facts that contributed to the scientific study of the mind.

Other clinicians like Cartwright (2002, 210) have argued that 'psychoanalysis is not only a theory but a methodology in itself, developed specifically for exploring unconscious processes.' He went on to add that, 'analysis can yield valuable insights about a particular research topic in the space of a few interviews.' Similar to Kvale (1985, 171-196), discussed previously, Cartwright collated data from narrative recordings. They incorporated some of the thinking from the hermeneutic perspective and interpreted the repeated data findings as 'clinical facts'. Kvale determined that the 'hermeneutic philosophy of a holistic humane approach embodies all aspects of a person's lifetime experiences' and therefore relates closely to that of the process of psychoanalytic psychotherapy. Cartwright stressed: 'Context refers broadly to the host of factors, internal and external, that come to bear on the way an individual communicates and how the communication is understood'. He explained that, 'analysts interested in the hermeneutic nature of dialogue emphasize both intrapsychic and external influences of meaning'. Both are stating that valuable psychoanalytic insights into intrapsychic processes associated with phenomena of historical, cultural and behavioural experiences unfold in the transference or through recollection during the analytic situation.

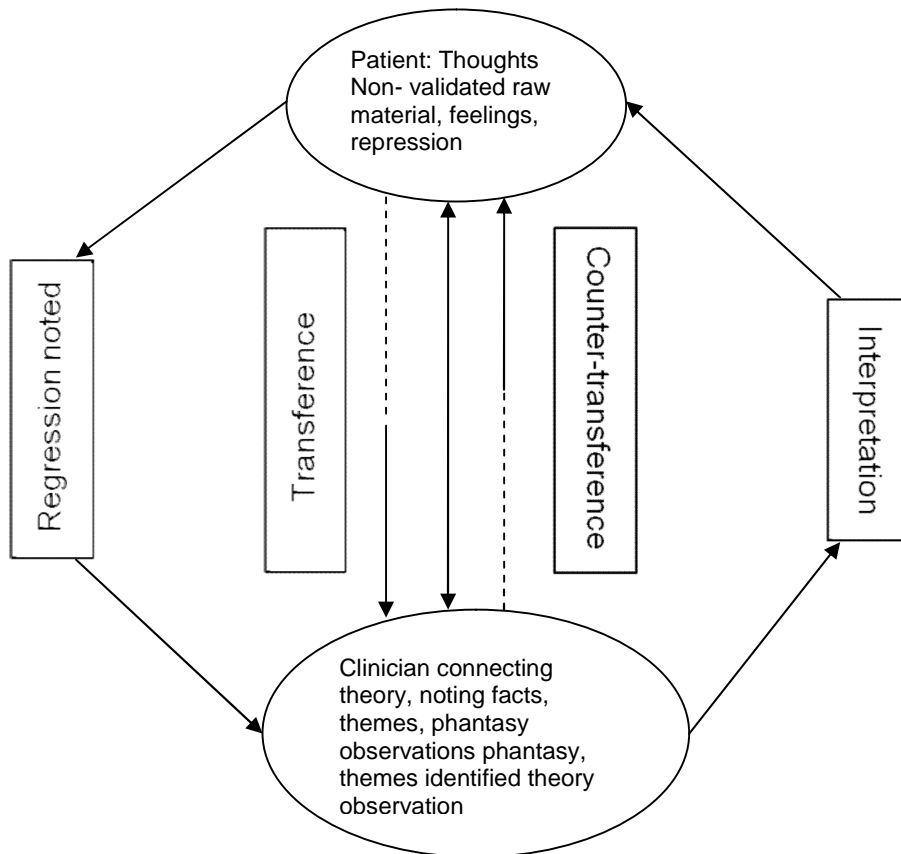
Rustin (1997 527-541) pointed out that: 'patterns of repetition make possible differentiation and comparisons between states of mind ... analytic settings enable grounded inferences to more holistic accounts.' These are invaluable conclusions in connection with research for adults and helpful in further understanding some of the emotional states of our patients.

In several aspects the above examples represent my approach by the means of psychoanalytic psychotherapy as a research methodology. At the commencement of the psychotherapeutic treatment the therapist has no psychic facts. The attainment of these is brought about by working in the psychoanalytic framework and the formation of a long term emotional and trusting relationship. The stability created in this interpersonal and humane

relationship enables the patient to communicate facts that can be organized and contextualized as clinical facts and grounded as hypotheses.

### 3.3.2 A brief description of psychoanalytic psychotherapy

The above clinicians have argued that the practice of psychoanalysis as a methodology can be assessed for establishing some clinical facts by a process of perception, the interpretation of the transference and recognition of repeated themes in the sessions. The two diagrams below illustrate the methodology that the researchers have adopted.



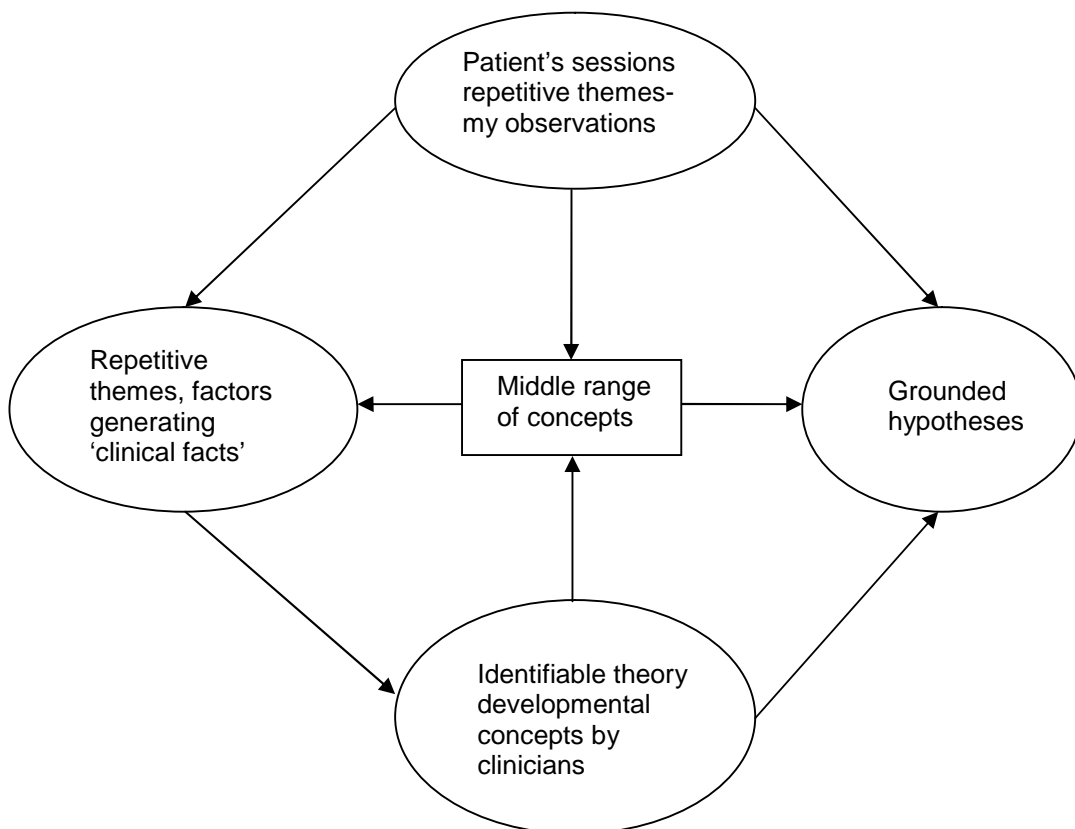
**Figure 2: Within the session**

In this diagram I have tried to illustrate the complex process of psychoanalytic work. When a patient comes to a session he/she is encouraged to free associate with respect to his activities, feelings and thoughts. The unprocessed material as indicated by the top oval is listened to and thought about by the psychoanalyst. The transference and countertransference becomes activated at



various stages of the therapy. The analyst not only listens but observes gestures, nuances and other bodily movements carefully, making a mental note of the relevant information, and records these after the session. Appropriate interpretations connected with psychoanalytic theory as shown in the bottom oval of the diagram are made whenever possible. The process goes around in a circle from the patient's material including repressed and recollected information to clinician and back to the patient.

More often than not the patient might refer to the same feeling or incident but each time, say it differently. The choice of words might differ but the gist of the content often remains the same. When some of these intense and associated feelings or experiences are understood they are interpreted by the analyst.



**Figure 3: Outside the session**

Figure 3 is an illustration of what occurs outside the session. The patient's raw, recorded material is taken to supervision or to a team seminar to think about it with colleagues. The material is studied for repetitions and other factors in order to understand what the patient is conveying from the unconscious. Not all data

is relevant or understood. Often this is correlated with identifiable psychoanalytic theory. The repeated processes as discussed previously are considered to be clinical facts.

As a researcher I have adopted and applied the qualitative Grounded Theory method to the clinical data. The core of my research is based on the data that was written-up after each weekly session of psychotherapy with the sample over a period of a year. In Chapter 5 I have given descriptive accounts of the more notable sessions as written-out soon after the relevant psychotherapy sessions with the six case studies. During the course of the year's treatment, numerous interesting facts and experiences were brought into the therapeutic session. Some were of more importance than others and amongst them some very intimate feelings were revealed and assessed.

To illustrate how the method of Grounded Theory was applied to the psychotherapy sessions I have chosen two written-out sessions from each stage of the therapy (noted as early, middle and late) of one case study (GS), to illustrate some of the findings by this qualitative method. Further examples of four sessions each from a different patient respectively have been supplied in the appendix to illustrate how the Grounded Theory was applied to the process notes of all the patients. Tables 2-5 in Chapter 6 further illustrate the progress of the treatment and demonstrate some of the findings of the comparative study across the domain. Significant and identifiable unconscious mental phenomena are also tabulated and discussed later in Table 6. These findings have been acknowledged and established as 'key facts' for depression in later life.

Before discussing my findings or the key facts derived from my study I will commence with a description of the qualitative Grounded Theory method I adopted to come to my conclusions. The generated themes linked with psychoanalytic theory are highlighted as the clinical facts and grounded as hypotheses for depression in later life, further to that of the already accepted reason as the failure to mourn early losses.

### 3.4 THE APPLICATION OF GROUNDED THEORY TO PSYCHOANALYTIC SESSIONS

#### 3.4.1 What is Grounded Theory?

Grounded Theory was originally used to develop a method of qualitative research in connection with the social sciences for generating theory from data by Barney Glaser and Anselm Strauss (1967) 'during their investigation of the institutional care of the terminally ill'. They argued that by the induction process, Grounded Theory identified a systematic emergence of theories. Pidgeon (1997, 75 & 79) pointed out:

*Their approach to qualitative research is particularly suited (though is by no means restricted) to the study of local interactions and meanings as related to the social context in which they actually occur. It therefore has considerable potential for psychologists and has been used in areas as diverse as social psychology.*

He further suggested that 'the issue of grounding involves not simply the appreciation of a particular research technique but also questions of an epistemological nature (that is, questions regarding the assumptions that we make about the very bases for our understanding).' He further identified the method of Grounded Theory as a:

*Progressive, discovery-based research by highlighting the role that qualitative methods could play in the neglected activity of generating new ideas ... to demonstrate how such qualitative research could be systematic and yet simultaneously help to stimulate highly creative work.*

Researchers in similar fields of sociology and psychology, Strauss & Corbin (1990), Denzin & Lincoln (1994) and Charmaz (1995) have studied the qualitative method of analysing from data to determine original theories. They employed the Grounded Theory method to collate informative data from the

context of sociology and psychology to support their grounding of theories. Charmaz (1995 1-22) points out that the researcher is involved in a systematic method of conducting research that 'begins with an inductive approach'. The researcher is engaged in 'simultaneous data collection and analyses'. She also points out that the method goes beyond induction because 'its strategies lead to making conjectures and hypotheses and to checking them. Therefore the researcher engages in deductive reasoning as inquiry proceeds'.

Charmaz, who is a leading contemporary interpreter of Grounded Theory methodology, acknowledges that researchers may well have a perspective to begin with from which their analyses are developed. This is a revision of Glaser and Strauss's original (1967) position which was that Grounded Theory analysis should be free of prior theoretical presuppositions of any kind. Probably this development arose from the later extension of Grounded Theory methodology well beyond its origins in sociology. Once it became used as a method within other disciplines (such as psychoanalysis in the present case) it became clear that different background theoretical assumptions would be likely to influence empirical observation and the selection of material for analysis. Similarly, Rustin (2009, 1-5) said: 'Its fundamental idea is that theory needs to be derived by induction and inference from the relatively unstructured data which can be collected by qualitative researchers making use of such methods of data collection'. He further argued that:

*Grounded Theory in psychoanalysis is not a purely inductive process undertaken without preconceptions ... interesting ideas can be shown to be identified in a flow of material, and can, in a process of reflection, be linked with a wider context of psychoanalytic ideas*

From what the above researchers have said it can be concluded that Grounded Theory is an inductive as well as a deductive procedure comprised of four basic and important stages: 1) memo-writing or note-taking; 2) coding and sorting; 3) categorizing into themes and 4) generating and grounding hypotheses.

### **3.4.2 The compatibility of the method of Grounded Theory to psychoanalytic practice**

Psychoanalytic psychotherapy as a method is a technique that involves the analyst to note inter-personal, intrapsychic transference and countertransference activities of the patient during a session. Observation of behaviour, mannerisms and any other important facts that give insight to the patient's personality are noted. The usual clinical procedure is to write up sessions in literal detail, soon afterwards, but adding reflections in a way which corresponds to the 'memo-writing' of the grounded theorists. This results in the accumulation of a massive amount of very rich, raw material from the noted verbatim sessions. By exploration and concentration for the 'elucidation of meaning' (Kvale, 1985) from this humane approach, enriched with the patient's emotional experiences, one gains access to the intrapsychic life of the patient. Therefore the quintessential point of the treatment is the analyst's inductive study of the collated data, enabling her to code and filter categories linked within the terminology of psychoanalytic theory. Progressively the researcher identifies and filters some 'clinical facts' that have been closely linked with the patient's anxieties and the ultimate cause for the depression. This process of the induction of themes from the sessions may enable analysts to discover or formulate new concepts and theories. This qualitative method of assessment by clinicians has given rise to a great deal of theoretical development in psychoanalysis, often presented and justified through the evidence conveyed in clinical papers.

As aforementioned Sigmund Freud the inventor of psychoanalysis spent almost a life time trying to establish his work as a natural science. Only more recently some contemporary researchers and especially child psychotherapists have recognized that they were using a qualitative method very similar to that of Grounded Theory in assessing their area of work from a social science perspective. Psychoanalysis could be considered as a creative art that awakens internal, dysfunctional parts of the psyche to change and stimulate positive psychic functioning thus leading to the improvement of the positive aspects of the mind. Intuitive deduction through the transference is comparable to an artist

who begins with a blank sheet of canvas. At the beginning of analyses the patient's inner state and characteristics are an unknown quantity. Things emerge and the analyst uses her acquired tools to intuitively develop a picture. Similar to the artist the psychoanalyst creates a portrait of the patient showing him what he looks like. This in turn helps the patient to look at himself, think about his characteristics and develop the genuine parts of himself to acquire a more positive personality and become a 'new person'.

The compatibility of Glaser and Strauss' innovative discovery of Grounded Theory and psychoanalysis came to be seen as both illuminating and useful. Forays into this method by psychoanalysts appeared and were discussed earlier, one of which is by Fonagy & Moran (1993, 66). They argued in their discussion for the support of qualitative research that there were three essential requirements:

*the researcher should attempt to support conclusions using data from multiple sources; aim to formulate hypotheses to permit the derivation of appropriate counter examples; finally qualitative research should clarify the personal connection between the researcher and the researched and the possible threats to objectivity that may then ensue.*

Child psychotherapists: Anderson (2006), Midgley (2006, 2009) and Quagliata (2008) have since exemplified the usefulness of data analysis by the method of Grounded Theory to generate hypotheses from their clinical findings. Anderson (2006, 330) claimed:

*Clinical research using Grounded Theory produces theory that is grounded in the data and can provide explanations, prediction and applications directly applicable to the clinical setting.*

She described Grounded Theory and child psychotherapy as 'well suited partners.

In my thesis I have endeavoured to indicate the compatibility of the Grounded Theory method for investigation of psychoanalytic psychotherapy sessions with depressed older adults. The systematic inductive and deductive process to identify and explicate what was happening during a clinical session has generated some new theories for depression in later life other than the failure to mourn early losses. The summary represented below identifies some of the major similarities between Grounded Theory and psychoanalytic practice. The compatibility of these two methods as a qualitative research tool is too striking to be ignored.

### 3.4.3 Comparison of Grounded Theory and the psychoanalytic technique

<b>Grounded Theory</b>	<b>Psychoanalytic Technique</b>
1. Memo-writing or note taking during an interview	Writing up of the session soon after it ended
2. Collecting and coding of data	Collated data scrutinized to identify theoretical concepts that are coded
3. Categorising	Categorizing the recognized concepts and linked with theory for itemizing as 'clinical facts'
4. Generated new theory grounded as hypothesis	New 'clinical facts' grounded as generated hypothesis and grounded as new theory

Grounded Theory researchers might argue that psychoanalysis is not entirely an inductive process as analysts incorporate the transference and perceptions as they evolve but as pointed out earlier Charmaz claimed that 'beyond induction, strategies lead to making hypotheses and to checking them - the researcher engages in deductive reasoning as inquiry proceeds.' Therefore as a psychoanalytic psychotherapy researcher I found that the Grounded Theory method was most suitable for the investigation of depression in older people. The sorting and coding from a comparative perspective across the domain of my research case studies resulted in further categories and themes other than my focused aim which I describe in Chapter 6.

The full analysis of the year's accumulated data from the forty sessions of each case study's notes cannot be described in detail or repeated on account of the stipulated length of the thesis. It is only feasible to present selected exemplary samples from the material. Tables 1-3 indicate some of the findings in the three stages of the treatment (early, middle and later) in line with the respective breaks such as Easter, Summer and Christmas. To represent a systematic approach for the qualitative investigation I will present the clinical material from an earlier session, a middle session and a later session of each stage, of research case study (GS). An applied form of the Grounded Theory method was used to discover themes associated with the individual's psychic states.

In the first column, what was said by GS is repeated from the verbatim material of the session written out soon after it ended.

The second column represents the recognition and identification of the points made in connection with the unconscious processes and coded by the researcher similar to that of the Grounded Theory approach.

In the third column identifiable and significant themes are categorized as key facts or clinical facts and are grounded as new theory.

#### **3.4.4 The application of Grounded Theory to the psychoanalytic treatment of a case study (GS)**

Further details of Case Study GS in connection with the reasons for his referral, assessment and sessions are given in Chapter 5. This section is indicative of how his treatment was qualitatively investigated and progressively processed by the applied method of Grounded Theory in order to explore some reason(s) for his depression in later life.

<b>Noted from Patient's Written-out Data</b>	<b>Recognition of themes sorted and coded</b>	<b>Thematic analysis leading to categories of 'key facts'</b>
<b>Early stage: Session 1</b> Initially I introduced the subject of it being a preliminary meeting. Unexpected and angrily,	Unprovoked anger. Why? Very different to his gentlemanly manner	In-depth, intense anger. Internal anger asserted inappropriately.



'I do not understand all this about a preliminary meeting!'		
'I do not know if a woman would be able to understand me. I am a classical musician of Western music. I find it difficult to envisage you understanding this part of me or my homosexuality'.	He sounds as if he is prejudiced. Assumption: as an Asian I do not appreciate Western classical music. Is he a racist? Definitely angry. And was this towards me or was it in the transference?	Still angry and arrogant. Was the arrogance a 'cover up' for other feelings?
To my calmly pointing out his assumption of me without knowing anything about me, he responds: 'I am glad you are being so direct with me. My previous therapist was a man and he did not want to know about my homosexuality.'	Indication of some doubt. Showing mistrust of his own capacity and signs of doubt	Perhaps exterior manners are a facade. Internally perhaps a weak personality. He was presenting a 'false self' as a veneer to cover up vulnerability.
Towards the end of the session and my being unusually but fairly firm with him he says: 'Perhaps coming to you is my 'karma'... my fate. I would like to come and see you. I need to sort myself out. Besides, I like your style.'	Response to my firm manner brings about a change of attitude. Almost pleadingly he noticeably changes. Showing a pleasanter side to his personality.	Split personality, oscillating from anger to being calmer and friendly. Was the initial anger being 'acted out' without any control?
<b>Session 6</b>		
Beginning with a dream about going under mother's skirt and frightened by a serpent. Led to speaking about his feelings towards his mother. 'My mother was unbearably close and suffocating. But as soon	Mother either overbearing or non-caring. Interested in her need and desires.	Not a very supportive object. Competitive with her child. Dysfunctional relationship.

as my playing excelled hers I felt abandoned.'		
Long pauses during this session. Softly and tearfully: 'She only liked me for what I could give her.' Recalled her pushing him away during his adolescence. He loved curling up against her to speak to her. She started to become cold and aloof. He added, 'My father was always a stern, unemotional and an unrelenting workaholic. He had no time for my musical talent. If anything he was disappointed in having a sensitive son, he would have preferred a macho one.'	A very poignant account of some early experiences he recalled. He felt unloved and rejected by both his parents. Sensitive to rejection of his talent. No support from either parent.	Emotionally felt isolated and lonely. Strong yearning and desire to be loved remained active and alive in his psyche. Definitely not been repressed but very much in the sub-conscious.  To avoid the reality he psychically shut himself away. Developed a narcissistic personality by presenting himself as not needing anyone.
<b>Session 9</b>		
He volunteered that he had been storing-up a whole lot of anti-depressants over the years. One day he hoped to make his own 'champagne cocktail'. Later in the session he went on to tell me about his oldest friend, Jeremy, almost twice his age who had befriended him when he first arrived in the UK. Jeremy was an unemotional man. Took no interest in his musical talent. He related a dream of being in Diana Washington's beautiful room, a singer he	Suicidal ideation as volunteered by his GP. But had not actually attempted to kill himself. Best friend so similar to his father both in age and characteristics. What was the attraction as it was definitely not a homosexual relationship?  He was beginning to approve of me. Felt more relaxed during his	Despair in not being able to gain the love or interest in his talent from Jeremy (replacement father). The yearning or desire for fulfillment of a desperate need must be achieved.  Reflecting a positive transference

admired very much.	sessions and spoke openly about his feelings.	
<b>Middle Stage</b>		
During the break he sent a letter to the head of Dept. complaining that I was useless and he did not want to see me again. He requested that he wanted to be seen by a male therapist.	I was shocked. Puzzled by his change of mood and he made me feel useless. I felt angry and reluctant about seeing him again to discuss his feelings about me.	Recognized his reaction to the break. He was angry with me
<b>Session 13</b>		
Commences with: 'I was dreading that you would say you did not want to see me anymore.' Jeremy had also let him down over the Easter break as well. I missed not coming to the sessions. The letter was an ill-judged one posted on the spur of the moment.	My countertransference of feeling unwanted, rejected, unloved. My feelings changed towards him. I felt sympathetic and agreed to continue seeing him.	I became the parent(s) who had rejected him. I had a helpless child/ adolescent in the room. Yearning to feel wanted. Jeremy, the surrogate father, repeatedly let him down, like his own father did. An unconscious mechanism at play i.e. setting up a state of false hope.
<b>Session 20</b>		
At this stage he became more involved with his therapy. Shared some of his innermost feelings and thoughts. Many came through his dreams.	Had stopped all medication for his depression. No back pain. Looked healthy and a little more relaxed. Still wary and at times defensive.	
A dream he related about a long journey across from east to west spanning large areas of water. Frightened but also assured that he would reach his destination. A feeling of arriving home.	Although his situation was not altogether ideal, he was asserting himself more. Finding a new state of confidence and most of all trusted me to help him achieve his goals..	More self esteem. Needing people and less arrogant. Making links with his past situation and seeing the futility of trying to gain what was lost forever. The beginnings of making the internal, emotional journey.
<b>Session 24</b>		
Throughout this term of the therapy he oscillated		

<p>between being grandiose as his confidence grew and at times needy and emotional. At the latter times he recalled and explored huge areas of his childhood and adolescence.</p>		
<p>I can see now that my father provided for us materially but maintained a 'macho front'. I can never recall my father even placing a hand on my shoulder in a friendly, fatherly way. Emotionally: 'When he sold his business he arranged from me to buy a Steinway piano in London. I could not believe his generosity although I would have preferred him to have acknowledged my talent when I was younger.'</p>	<p>Accepting the past for how it had been. Appreciating his gift as a token of love.</p>	<p>Making reparation by being understanding and accepting some of it for how it was.  Mourning the loss and relinquishing the desire for 'it to happen'.</p>
<b>Later Stage</b>		
<p>He had missed two sessions on account of some intense recording he had to do. He had failed to perform previously just before he came to see me. These were anxious days both for him and me.</p>		
<b>Session 26</b>		
<p>I was both amazed and relieved. He looked really happy. His opening sentence: 'Well I have done it. The recording went extremely well. The CD should be out for Christmas. The sopranos and baritones congratulated me ... the</p>	<p>A changed personality in many ways. Was able to achieve. Not particularly perturbed by Jeremy's coolness but still longed for his talent to be appreciated by father.</p>	<p>Perhaps a lot less narcissistic and less dependent on Jeremy appraisal. Less needy in a mature way. Not as melancholic as he used to be.</p>

<p>director was highly enthusiastic.’ Jeremy on being told barely congratulated him and expressed no real warmth towards his achievement.</p>		
<b>Session 29</b>		
<p>As he walked in I could see that something was worrying him. ‘I have always been a loner from a long time ... as an adolescent I felt different. It was a little better during my university days but I felt I was never really a part of a group. I now find myself wishing I could be with people. I meet people regularly at the club but feelings of being alone come back strongly. I feel so lonely.</p>	<p>He is with people and objectively not alone but there is an inner state of feeling alone</p>	<p>Not loneliness in the sense of being physically isolated but unable to be part of a group on account of a state of internal aloneness. As a child he acquired an ego-destructive superego to survive because it was too painful to accept the reality. When his parents could not give him the love he yearned for he pretended he did not need anyone. He could cope on his own.</p>
<b>Session 36</b>		
<p>He was keen to go on with therapy sessions and wanted to know if I would take him on privately. Although I could sympathise with his feelings. I had to be firm about our one year plan. I gave him the appropriate referral source to find another therapist. He was disappointed and said, ‘I felt reluctant to come today. I feel there is no use in coming if this cannot go on.’ He agreed that things had moved on and his lifestyle had changed for the better. ‘Gone too far now to go</p>	<p>Ambivalent feelings. Naturally uneasy about our relationship coming to an end. But could also see what he had gained and how once the personality had developed positively it remained with the patient. He could only move on.</p>	<p>The therapy had changed his personality for the better. The limited one year period of the treatment proved to have brought about some positive aspects to his lifestyle. There was room to explore further if not with me with someone else.</p>

back there! Would rather be where I am right now, as it feels good!		
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### **3.4.5 Key facts derived from the treatment of psychoanalytic psychotherapy as exemplified by the application of the qualitative method of Grounded Theory in connection with case study GS**

The above systematic and thematic analysis by the application of the qualitative Grounded Theory method to the verbatim sessions of case study GS highlighted the following 'key facts'. The generated clinical facts linked with psychoanalytic theory have been grounded as hypotheses and given as reasons for his depression.

#### **Key Fact 1 – arrogance a front for feelings of insecurity**

His arrogance expressed most vehemently and especially at our first meeting was not directed at me personally. Psychically in his phantasy and in the transference his immediate reaction was to identify me as the weak mother, who would not be able to gratify his internal need. He unconsciously came to the session with expectations. From my appointment letter he would have known that I was a woman but this was internally not acknowledged. His arrogance was also a contradiction of his emotional state of internal feelings of inadequacy that had resulted from early dysfunctional containment. According to him his mother had not been able to provide emotionally to make him feel secure. In his state of mind a woman could not provide adequately for his psychic well-being. He came to his first session with expectations of finding a containing 'father figure'. To avoid the mental pain he denied the reality. Psychically in the transference he associated me with his weak mother who was unable to gratify his internal need for containment.

To quote him: *How, could a woman understand me! I am a homosexual!! Jeremy never listens to me.*

#### **Key Fact 2 – poor object-relations leading to feelings of not being contained during early childhood**

His dysfunctional early childhood had resulted from not having any sustaining

and supportive object during those vulnerable years. I concluded that the desire for parents, who loved and acknowledged his talent, had always remained alive and active in his psyche and had definitely not been repressed. All his overtures to acquire this, first with his peer group during adolescence, then at university and later with Jeremy, proved unsuccessful. At the time of retirement an end was in sight. He could not tolerate the pain of not having experienced his desires and he lost all hope of achieving fulfillment. He felt that life was not worth living and had suicidal feelings. He had not been able to mourn repressed, early object-related losses because he still expected them to be gratified.

### **Key Fact 3 – development of an ego-destructive superego**

From very early childhood he psychically denied the reality as it felt too painful to accept. By the time he reached adolescence he was emotionally stuck and still yearning for recognition from his parents and especially his father. Over the early years he had developed an ego-destructive superego to avoid the painful reality. The retirement aggravated and intensified his internal need for the desired lost object. Therefore the crux of his depression centered on the obsessive yearning for the lost object. It was an insatiable need that lurked somewhere in his conscious life without being understood. Intrapsychically he denied the reality and survived on a false premise that he could cope and did not need anyone. For psychic self-preservation he had developed a 'second skin' Bick (1968) as a defence against the painful early negative experiences resulting in a narcissistic personality.

### **Key Fact 4 – feelings of aloneness**

His internal state was one of desperation and hopelessness. Retirement, professional impotence and the feelings of aloneness were some of the combined circumstances that activated the internal despair and his depressive state became overtly apparent at this stage of his life. He realized that within himself he had always been a loner and admitted *I have felt lonely since my adolescent days*. In the outer world GS had several friends but was never really close to them, as they were either women, whom he could not have a sexual relationship with or as he said that he was attracted to the ones who were

married to a friend. His continuous search for a father figure, ironically led him to people like Jeremy or the composer, who turned out to be unemotional and they both had similar personalities to his father. He felt a permanent state of 'lack or loss of companionship' (Townsend 1974) resulting in an internal state of aloneness.

#### **Key Fact 5 – a development of some awareness of his problems**

Through the therapy sessions GS developed an awareness of his psychic state which led to recognition of his denial of reality and his inability to accept the past for what it represented. This transformation took place because for the first time he was able to think about the unspoken unrecognized desires and was able to accept the truth. The positive change in his mental attitude enabled him to function satisfactorily once more. He regained the ability to perform musically and was able to successfully help with the recordings.

#### **Key Fact 6 – termination of taking any medication or suicidal ideation**

An interesting development, resulting from the treatment was that he had stopped taking any form of medication for his depression or his back pain. There were no further suicidal thoughts soon after the commencement of therapy and no further back problems. He felt and looked healthy.

### **3.4.6 Conclusion**

The obvious overall reason for GS's depression was the failure to mourn his early losses, but as conveyed by the systematic application of the Grounded Theory method and close observation, other subtle reason for his depression were also noted as discussed above. The research model closely indicates the compatibility of the use of the qualitative research method as appropriate to discuss themes that link with psychoanalytic theory. The key facts thus determined above were at the root of GS's depression.

- 1) Dysfunctional early childhood object relations.
- 2) Failure to mourn early childhood losses because of the denial of painful reality and continuation of yearning for the lost object.



- 3) Development of an ego-destructive superego for self-preservation that created a narcissistic personality often presented as arrogance.
- 4) Retirement instigated feelings of loss of hope and evoked feelings of aloneness in the outer reality as well as in the inner state resulting in depression.

I am not by any means claiming that the year's psychotherapy sessions had completely worked through all of GS's problems. This I think would be an impossible task even with long-term intensive work. But the psychoanalytic psychotherapeutic intervention supported him to look at some unbearable and dysfunctional characteristics of his personality, acknowledge them and helped him change positively. The efficacy of the treatment was the recognition of his long-standing and dysfunctional attitude of desiring what could never happen in the present time. The conscious knowledge to accept the past for how it was and relinquish it as unattainable resulted in some positive changes. For example he stopped all medication for depression, his suicidal thoughts and back problems ceased. A dramatic change was that he was once more able to perform as a pianist which definitely enhanced his lifestyle.

The questionnaire (Appendix 4) filled by the individual at the end of treatment also indicated that without exception the participants felt that psychotherapy helped them change their lifestyles for the better. (To maintain privacy the reports cannot be included).

## **4 THE SOCIAL CONTEXT OF OLD AGE**

### Chapter Summary

- The social context as relevant to my study
- The current demography which is bringing old age into new prominence as a sphere for social problems that require new policies
- The changing conceptions of well-being
- The current ethos and social provision for the ageing population

### 4.1 INTRODUCTION

Throughout the thesis the emphasis has been on mental well-being or the understanding of internal states by the means of psychotherapeutic intervention. Before addressing what I mean by well-being I will briefly look at the picture of ageism from some of the other perspectives. In order to have an overall picture of the current ageing population it is necessary to discuss some other issues connected with older people other than from a psychodynamic perspective. Provision for people in later life is a topical subject for government departments as well as other academic disciplines such as the medicine, pharmacology, sociology, gerontology and psychology. The tendency from most of the above is to cater for much needed external comforts but to neglect the inner state of individuals. This situation is perhaps due to a lack of funding or unawareness that there might be more to a fulfilled lifestyle than physical and material well-being.

As the older population expands social adjustments are required to cater for the many demands that already exist and ones that will inevitably arise. There is a growing concern that this is not happening for several reasons. However, many older people who live fairly fulfilled and satisfactory lifestyles. The last two decades has particularly been a bonus to many providers in the travel and cosmetic industries who have found new markets in the growing number of older people. For the latter these amenities have been supportive and given

many a new lease of life. Through travel many lonely, older people can now socialize if they wish to and have opportunities for developing new relationships and friends.

#### 4.2 THE DEMOGRAPHY OF THE OLD AGE POPULATION

The massive growth of the older age population in the last two decades has become a prominent subject for discussion by governmental agencies and various other authorities. Demographic studies indicate that there are going to be many more old people as a proportion of the population, particularly in the relatively rich Western nations. Several factors contribute to this: firstly the inauguration of the Welfare State during the post-war years generally provided a much improved standard of living; secondly the implementation of the National Health Service created the amenities for the monitoring of general health problems. The baby boomers born after the war are more educated and independent than previous generations. They also had smaller families, resulting in a situation of the number of births not keeping pace with that of the number of people living well into old age. Consequently there is the sense of a widespread risk that there will not be enough people of working age to provide for the fast growing older sector. A survey by Evandrou for Age Concern UK (1997) – now the merged Age Concern and Help the Aged – suggested that ‘in 2010 there will be approximately one million more people, aged 60-65 than in 1995’. A more recent survey by Age UK (2008) indicated: ‘By 2025 there will be half a million more again and in 2031 there will be 60 people of pensionable age for every 100 people of working age. – double the number in 1991.’

Statistics compiled during Liam Byrne’s term as Minister for Care Services in the Labour government demonstrated that:

*By 2007 there will be more people over 65, than under the age of 18. The over 85s are the fastest growing segment of the population, set to double in number by 2020. We should celebrate this. An ageing population is not a burden – it’s a benefit. Older age should be a time to enjoy the rewards flowing*

*from years of service to the community... (2006)<sup>6</sup>*

The following chart gives an idea of the conceivable growth in the older population.

	1901	1931	1961	1991	2001	2021
<b>MALE</b>						
Birth	45.5	57.7	67.8	73.2	75.4	77.6
1 year	54.6	62.4	69.5	73.8	75.7	77.9
10 years	60.4	65.2	69.9	73.9	75.9	78.1
20 years	61.7	66.3	70.3	74.2	76.1	78.2
40 years	66.1	69.3	71.4	75.1	77.2	79.3
60 years	73.3	74.3	74.9	77.7	79.5	81.4
80 years	84.9	84.7	85.2	86.4	87.2	88.2
<b>FEMALE</b>						
Birth	49.1	61.6	73.6	78.7	80.6	88.2
1 year	56.8	65.3	75.1	79.2	80.9	82.8
10 years	62.7	67.9	75.4	79.4	81.1	83.1
20 years	64.1	69.1	75.6	79.5	81.2	83.1
40 years	68.3	71.9	76.3	80.1	81.7	83.5
60 years	74.6	78.1	78.8	81.9	83.3	84.9
80 years	85.3	85.4	86.3	88.3	89.1	90.1
Source: Government Actuary's Department.						

**Table 1: Expectations of life at selected ages for men and women, 1901-2021**

Table 6 shows the improvement in expectation of life at selected ages for both

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<sup>6</sup> **Byrne, Liam MP (2006)** (Minister for Care Services) In DOH Report: *A new Ambition for Old Age* 'Next Steps in Implementing the National Service Framework for Older People' by Prof. Ian Philp.

men and women. In 2021 when the post war babies of the 60s begin to retire, the Government Actuary Department predicts that men will live on average for a further 21.4 years and women for 24.9 years. This compares with 17.7 and 21.9 years respectively for men and women aged 60 in 1991.

Contrary to a claim Byrne also made, that old people should be able 'to enjoy the rewards flowing from years of service', many older people of this generation have lost heavily in connection with pension funds. The estimated financial contributions they had made to pension schemes have either collapsed or not kept pace with inflation and the current cost of living. Some have lost substantial amounts of their savings as a result of collapsed banking corporations. They had hoped that this extra finance would help maintain a good quality of life in old age. The perceived problem is that many occupational pensions will become unaffordable in the future, since people are living for more years than originally anticipated. Currently large numbers employed in the public sector like the NHS, Education and civil servants are concerned with some of the policies that the Coalition Government intends to implement.

However, although there will be many more people living to advanced ages, there are also many who are currently in good health and enjoying the extension to the life span. Some are still employed even after the retirement age and perhaps there are others who will also see the rising age of retirement as justified. The retirement ages of 60 and 65 were set when people on average lived only a few years beyond retirement. As the above statistics indicate even with a projected rise in the retirement age people on average are still likely to enjoy more years of good health post-retirement than their predecessors.

The recent financial crisis and consequent cuts in welfare spending are likely to make things more difficult for many but there are positives as well. Many facilities offer concessions for senior citizens and free travel passes have improved lives. The current government policy instigated by David Cameron's 'big society' theme will presumably favour more voluntary self-help activity to enhance the lives of older people in later life. Further organizations might develop to include psychological services as already experienced via IAPT.

#### 4.3 CHANGING CONCEPTIONS OF WELL-BEING

The current provision for intermediate care is without doubt well meant but the identity and values of the individual recipients seem to have been ignored. Byrne stated: 'I am determined to raise standards of care for older people ... Prof Philp recognizes that along with this must go changing the often negative culture of attitudes towards older people so they are valued and respected.' (Preface to DOH report, by Philp 2006). The booming growth has necessitated not only a change in attitude but essential changes in the framework and provision to cater for the varied demands that exists within the older population. Evandrou (1997) pointed out that contemporary retired people 'are more informed about their rights and more vocal in their demands'. In spite of these sentiments why are there two million depressed older adults? Age Concern/Age UK (2008)

Pollock, A. (2004, 157-199) questions 'the National Health Service today, as well as the credentials of the people who are now at the helm'. Her conclusion is that: 'Its senior managers now include people with no training or experience of public health or the principles of health care delivery.' She goes on to suggest that there is a lack of insight as to what needs to be delivered especially from the internal, emotional perspective. The good intentions of the original implementation of the NHS had not anticipated among managers that fifty years on the demands of the current older population would not only unavoidably raise the overall costs of treatment for external comfort but would also create the need to extend the social care system to include emotional well-being.

The theme of emotional well-being has been referred to throughout this thesis. It is therefore appropriate to discuss Maslow's (1968, 1999) humanistic approach to psychology:

*If we wish to help humans become more fully human, we must realize not only that they try to realize themselves, but that they are also reluctant or afraid or unable to do so. Only by fully appreciating this dialectic between sickness and health can we*

*help to tip the balance in favour of health.*

Therefore the conceptions of provision need to change to incorporate non-material and internal dimensions such as emotions. During their long lives many older people have acquired a clear knowledge and evaluation of what they think is the right thing to do for themselves and to others. They feel disoriented and troubled by impinging institutionalism or professionals who think they know better. This is often true in the case of physical illness but nevertheless the elder's need to be understood emotionally is just as relevant. Maslow further stated: 'Human beings often resent being rubricized or classified, which can be seen by them as a denial of their individuality (self, identity). They may be expected to react by reaffirming their identity in the various ways open to them', confirming the point made by Pollock and my understanding of the emotional needs of older people.

#### **4.3.1 The social context of the life cycle**

An official government prediction (Govt. White Paper 1997) stated that the number of old people aged 60 and over will reach 17.5 million in 2026. An increase of nearly 50% compared to that of 11.9 million in the same age category in 1991. This is due to the retirement of people born during the baby boom period between the post-war years of 1946-1950 and during the early 60s. The consequence of this state, as Glennerster (1995, 224) pointed out, is that: 'The ambition or dream of the Welfare State was to cater from the 'cradle to the grave'; a totality of care for physical and mental well-being for the needy.' Although this was a well meant intention of the forties it has not been realized. The policies have not kept pace with what it means to be growing old in the twenty first century.

Fraser (2009, 1-2) stated:

*The Welfare State is a concept which historians and sociologists alike have found difficult to define. Like socialism it has meant different things to different people. 'What the*

*historian notices most about the place of the Welfare State in the history of social policy is that it is very much a time bound concept ... The Welfare State was the end product of a very long historical process.' Figuratively as indicated earlier, the numbers given by the government in 1997 are proving to be correct but historically government policies have not kept pace with provision for the rapidly growing older population.*

He went on to say that the present democratic society is asking for a different mode of social provision, which 'the individual can utilize without loss of dignity and free from any taint of patronage ... a changed political climate requires a changed system of welfare which has to incorporate the egalitarianism of the current older population.' Therefore an ideal world for the older population would be a welfare state of a democratic nature with social freedom as essential.

Pollock, A. (2004, 158- 159) pointed out: 'The image of older people as a burden on the rest of society has been enforced in the recent years by scare stories about the "demographic time bomb" – the idea that as people live longer welfare systems are no longer sustainable'. In her view this has confused policy makers. She further says: 'Almost one-quarter of all pensioners in the UK live below the poverty line' (noted from Goodman, Myck & Shepherd (2003)<sup>7</sup>. Policy makers consider many older people as no longer economically productive and therefore to be a burden on the resources of the state and the working population.'

She added:

*Of all the areas of social policy, care for older people is perhaps the most riddled with inequalities and injustices. Unlike hospital care and education, which are organized and*

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<sup>7</sup> **Goodman, A. Myck, M. & Shepherd, A (2003)** *Sharing in the Nation's Prosperity? Pensioner Poverty in Britain.* Institute for Fiscal Studies, London 2003.



*funded on collective principles, primary responsibility for the care of frail older people is not borne by the state but is largely left to relatives and friends who care for them in their own homes. This largely invisible workforce amounts to some 5.7 million people providing care for older people. About 800,000 are providing unpaid care for fifty hours or more.*

Sharkey (2009, 49) pointed out that in 1993 social service authorities took the lead in organizing and financing the role of care, but a local government report in 1997 indicated that a large number of vulnerable old people in need of financial assistance were going without because they found the system impossible to access.

The argument that all the above authors are making is that the Welfare State is no longer as viable as it was. The necessity for changes to be made is crucial for the current well-being of many older people in later life. Although the inauguration of the Welfare State was no doubt well meant and optimistic at the time many of the policies have now become dysfunctional and redundant. Pragmatic changes are necessary to meet the current demands. It is necessary to add that in connection with provision for those who are not as needy as the vulnerable elders the NHS is a boon. For example children and adults suffering from chronic illnesses such as diabetes, asthma, high blood pressure etc. are entitled to free medication.

#### **4.3.2 The sociology of the ageing process**

During the post-war period the welfare state focused very much on childhood, the ethos being of an improved space where a child could grow and live both in physical and mental health. Consequently education became compulsory and the school leaving age was extended to sixteen. For centuries young adulthood was seen as a prime time in the lifecycle but there was no definitive distinction between childhood and adulthood. As we note in old paintings and from the literature children were not really differentiated but seen as young adults in dress and manner. During the Edwardian period books especially for children

became available and gradually childhood was recognized as an earlier distinct stage of the life cycle. Adolescence was defined as a stage between childhood and adulthood when mental processes had to be confronted and the move into adult life had to be negotiated. Inner conflicts pertaining to early childhood as well as current struggles of the time had to be worked through to establish an identity into adulthood.

Adolescence is a developmental period of various stages of both physical and mental change. These are: early, when moving from latency to puberty; middle, as physical demands require mental negotiating; finally, the later stage of being conscious of entering adulthood, Blos (1962), Meltzer (1973), Anderson & Dartington (1998), Waddell (1998). The introduction of further education as a facility for the mass population and not just the privileged was a new departure. Consequently the sixties saw the emergence of late adolescence as a distinct life stage, demanding its own social space through the cultural impact of 'flower power', rock and roll, punk fashion and even drug abuse. Adolescents demanded to be heard. It was during the sixties when adolescence was recognized as a special stage of a person's life time. Erikson (1966, 281-307) originally pointed out that the lifespan was made up of seven stages but he later added an eighth stage: old age. The recognition of adolescence in some ways prefigured that of old age. Provision for the dynamic need of each age group generally depends on the expectations current at that particular time. The striking increase of the longer life span is a fact and needs to be noted as requiring appropriate redistribution of facilities for healthy survival.

Degenerative processes are obviously more common in old age than in earlier phases of the life-cycle but for reasons of both external and internal well-being we need to open up and reconstruct the now extended lifespan as an opportunity for further development and not merely a time of anxiety. However in old age one requires additional inner resources to perhaps change or relinquish longstanding habits. Perhaps expectations need to be renegotiated as Erikson et al (1986, 135) point out: 'Societal circumstances and stereotypes concur in suggesting that with increasing age the individual is likely to

experience diminished competence and success, according to the evaluative criteria used in earlier stages of the lifecycle.’ They go on to say that some older adults ‘have always considered themselves “superior” and have great difficulty integrating this element of realistic identity confusion.’ One conclusion of my research study is that despite the fact that childhood, adolescence and young adulthood are generally times for growth and stimulation whereas the ageing process can bring physical and mental degenerative states every opportunity should be available to encourage the aged to enhance their lifestyles and avoid lapsing into depression.

One should not lose sight of a huge proportion of older adults who have led very satisfactory and fulfilled life styles. Whether they feel superior to their peers or not they should be given opportunities like any other members of society. The larger older population is now a fact and as statistics show it is here to stay. In connection with these dilemmas one could take up the argument made by Rustin (1991, 42) noting that current attitudes towards older people can range from ‘benevolence to begrudging injustice’. In his discussion on ‘social justice and injustice’ he cites the thinking of Turner (1969)<sup>8</sup> who debated the difference between ‘injustice and misfortune’.

*A misfortune is a lack or a happening against which we have no right to seek remedy. An injustice on the other hand, is a condition which should not occur and we can make claims on others to see put right, if it does.*

Conditions once seen as misfortunes seem to have been redefined as injustices. This is now happening in regard to some of the avoidable sufferings of the old.

Gerontological researchers and others have argued that especially in a society with a large ageing population provision for the old is as important as for any other age-group. Edmondson and Kondratowitz (2009 1-20) discuss the

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<sup>8</sup> Turner, R. H. (1969) *The Theme of Contemporary Social Movements* British Journal of Sociology XX 390-405.

prominent need now for 'establishing a 'humanistic gerontology' perspective, the term as introduced by American research scholars, Moody and Manheimer.'<sup>9</sup> They stress the fact that, 'human activities (including gerontology itself) cannot be understood without taking seriously the different ideals, values, norms and goals that give actions intelligibility and meaning.' They add that this requires appropriate motivation over and above observation to influence current day policy makers, to address and deliver for the growing older population.

Edmonson & Kondaratowitz (2009 2) further point out: 'While other major issues are crucial to the exploration of older age – power, social structures and cultures, politics and the economy, physical and health related questions – they need to be explored without losing sight of the human persons concerned.' They go on to discuss the necessity to 'devise a 'human gerontology' outlook whilst being aware of deficiencies and shortcomings in the gerontological research agenda.

Phillipson (1998, 13-14) on the same subject of the older person's individuality critically drew attention to three main areas:

*First from political economy, there is awareness of the structural pressures and constraints affecting older people, with divisions associated with class, gender and ethnicity ... Secondly, from both a humanistic as well as a biographically oriented gerontology, there is the concern over the absence of meaning in the lives of older people, and the sense of doubt and uncertainty which is seen to pervade their daily routine and relationships ... Thirdly from all three perspectives, comes a focus on the issue of empowerment whether through the transformation of society ... or the development of new rituals*

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<sup>9</sup> **Moody, H (1989)** *Gerontology with a Human Face* in L. E. Thomas (Ed) *Research on Adulthood and Ageing: The Human Science Approach*. New York State, University of New York Press 227-239.

**Manheimer, R (2007)** *Becoming Historical to oneself*. *Journal of Ageing Studies* Vol. 22 No. 2 177-183.

**Manheimer, R (2009)** *Gateways to humanistic gerontology*. In *Valuing Older people, A humanistic approach to ageing*. Ed. Edmondson, R. & Kondrawitz, H. J. 2009 283-287

*and symbols to facilitate changes through the life-course.*

With further regard to well-being the 'human' as well as 'biographically oriented gerontology' does incorporate the emotional impact associated with earlier dynamic childhood experiences but the question arises as to whether the unconscious processes or associated repressed feelings are also recognized.

For example early experiences of loss often occur through dysfunctional nurturing during infancy and might not be remembered. These can have an adverse impact on the state of mind at any age. Obviously memories and desires are stirred up but can human biographical interviews reach this inner psychic state? There is no doubt that these interviews are useful and helpful and do support the individual's distress. The point I am conveying is that psychoanalytic psychotherapy can access the intrapsychic structures at a deeper level. Contrarily, I do acknowledge that not all psychotherapeutic treatment is successful in gaining access to the psyche when defensive mechanisms become involved. Older adults may have to come to terms with their progressive physical degeneration and perhaps mourn the death of loved ones in order to sustain a healthy life style. Inevitably everyone experiences mourning during their lives but losses that have been denied and repressed previously may need to be re-experienced. One may need to come to terms with one's past in order to achieve a fulfilled life in old age (Parkes, 1972; Maris, 1974). Lily Pincus (1981, 32-33) succinctly wrote:

*To understand why a good, happy and fulfilled old age is achieved by some, and not by others, old age must be seen, not in isolation or in generalised terms, but as a part of the individual life-cycle... Living involves constant changes, and each change, each giving up of a familiar situation for an unknown new one, can lead to a crisis... For the greatest need of human beings, from the first to the last breath is to make and maintain significant personal relationships. The ability to relate is the key to life and growth.*

In a similar vein Erikson (1966, 281) noted that early positive nurturing by the

mother/caregiver reflects on the personality throughout the rest of one's lifetime:

*because she has become an inner certainty as well as an outer predictability. Such consistency, continuity and sameness of experience provide a rudimentary sense of ego identity which depends, I think, on the recognition that there is the inner population of remembered and anticipated sensations that impinges on everyday activity*

Similar to Pincus and Erikson, Klein (1959, 240-263) suggested that our adult world is influenced by our earlier life experiences. Her understanding was that good early experiences reflect on behavioural characteristics during adult life. Paradoxically, negative and early dysfunctional experiences can also have a powerful impact on an individual's life. The argument is that not only must the needs of biological development be met but for an infant to function adequately a containing, emotionally nurturing environment is also necessary. Dysfunctional early nurturing has continuing effects in the present and may leave a residue of dissatisfaction and an incapacity to cope with later negative experiences. Psychological therapies provide an incentive and space to understand, recollect and incorporate losses and negative experiences both of a physical and emotional nature.

Implementing social justice will vary according to the demands of the individual depending both on the mental and physical state of the person. Even the more severe disabilities like dementia may require a deeper understanding of inner states by care staff if they are to be able to provide sensitive care. Quality care cannot be administered without seeing the individual as a whole. It requires provision for both external physical comfort as well as an understanding of emotional states and the impact and effect of dependency at an intrapsychic level.

Nichol (2009, 249) asks: 'Does eldership mean anything in the contemporary West'? He makes a comparative study in contrasting cultural contexts with accounts of 'traditional eldership as practiced in Guatemala, New Zealand and

Samoa going on to compare them with understandings within the European population in New Zealand and Great Britain'. Nichol's perception of the British group who participated in the study was that they had 'declared a belief in 'creative' ageing' but 'rejected eldership as an identification, while affirming a belief in later life development and contribution'. Perhaps this is an opportunity for the evaluation of some other cultural traditions and values in the context of services towards older people. Of course ethnic culture and traditions are ingrained from birth and not easy to re-introduce into Western society but perhaps respect for the elder is an important value that can be re-negotiated.

Another discussion of the recognition of eldership comes from Hunt (2005 187) who says: 'Much of the Western population's attitude on ageing is in contrast with other societies both past and present. For example in the case of rural China strong affection and respect for the elderly still remains. The elderly continue to maintain considerable control over the social and economic lives of their adult children while in their latter years they would expect to be supported and cared for by their adult children.' The interesting point about Hunt's emphasis is that the practice is maintained in rural China, suggesting that values in the industrial and developing cities are changing and long-standing traditions are perhaps being abandoned.

A more global study of the humanities has encouraged researchers to look into 'processes in ordinary later life [by means of] documented in-depth, life story study [of] informally recruited older people' (Clarke & Warren 2007 235). They go on to clarify: 'Using biographical approaches to capture the life stories of ordinary people we can understand more fully the ways in which diverse experiences and attitudes *throughout life* may affect individual circumstances and colour perceptions in old age'. They further make reference to Blaikie (1999) who suggested that: 'Biographical approaches allow for the possibility that the later decades need not be a period of sickness and decline but neither are they characterized by health, liberation and 'refurbishment.'

#### 4.4 COMMENTS

The central theme of my research study is emotional well-being in later life. Is it a misfortune or social injustice if two million older people are depressed and not given appropriate treatment? Obviously there are intricate mental processes involved which are not entirely connected with external physical losses. Poverty in old age perhaps once seen as a misfortune now comes to be seen as an injustice and rightly so. Furthermore, depression and other mental ill health difficulties should not be seen merely as unavoidable misfortunes but as social problems to which solutions can and should be found. This is the link the IAPT programme is making, which argues that depression and other mental illnesses require public attention and action. The point is being made that the condition itself is not unjust but the lack of treatment is. Two million older people have not chosen to become depressed.<sup>10</sup>

Often clinical work with older adults is related to un-mourned early losses that have remained unresolved or unrelinquished in the unconscious. The original diagnosed state of depression in later life is often symptomatic of a desperate need to come to terms with incomprehensible feelings that have been stirred up. These feelings are generally associated with some painful experiences of past lost objects. A current loss might re-evoked these anxieties. A re-activated, unresolved and repressed loss from early memory combined with a current loss can feel unbearable and lead to the onset of depression. Medication in the form of anti-depressants helps to alleviate the depressive state but does not resolve the problem. Appropriately IAPT is canvassing for more psychodynamic interventions as a provision for chronic physical disabilities such as diabetes, high blood pressure and other debilitating conditions.

Quinodoz, D. (2010, 1) asks: 'How could one define the work of growing old?' She goes on to answer: 'In my view it consists of an attempt to take stock of the

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<sup>10</sup> **Rustin (1991)** has noted that a 'difficulty in implementing such a diffuse conception of social justice is that the nurturing of development through relationships and understanding ... requires above all sensitivity to the individual case.' To actualize individual needs becomes more complicated and requires 'discretion, autonomy and variation in each instance'.



whole of our internal life-history, in order to relate the end of our life in the overall path we are following with its beginning and its end. This implies that we 're-construct for ourselves our own internal life-history.' She further states that, 'The desire to find some coherence in our existence becomes more and more pressing as the end draws near.' My argument is that older people can achieve and fulfill this need with the support of a person-centered and humane psychological intervention as I demonstrated by the use of psychoanalytic psychotherapy as a method.

The current social environment is not always conducive to the presence of an older generation of society who are here to stay. These people are often not given the opportunity to maintain individuality or an identity that many would like if they had a choice. Many are, well balanced, physically fit and look forward to enjoying a long life. To some extent amenities are already in place like 'The University of the Third Age', as well as the holiday market and free travel as earlier discussed. These are some of the many provisions available to support well-being if the elderly person is capable of utilizing them. However there are many elderly people who are not and the care of the emotionally needy could be changed for the better.

To summarize the contribution of the sociology of ageing it seems to be that older people are constantly bombarded by changes. Their quality of life fluctuates according to their physical and mental well-being, their socio-economic status and social provision. In the spheres of medicine, sociology, gerontology, psychology and psychological therapies the ageing process is being re-thought in reference to demographic changes. But there seems still a long way to go in order to establish the acceptance of this distinct phase of life as happened with adolescence in the sixties. Doubtless adolescence is a vibrant time in comparison with old age and physical dependency for the mentally alert older adult often feels undermining. It might be easier to be in denial rather than accept the reality. Biggs (1997, 564) refers to this as the 'mask of ageing' and a 'social masquerade'. He pointed out:

*The social mask, in other words, not only restricts self*

*expression, it also protects parts of the self that are vulnerable to social forms of attack. Once it is recognized that later life is also a period in which significant social constraints are placed on self expression the importance of a continued role of social masking as protection becomes more clear. In effect the psychodynamics of later life include two contradictory processes. On the one hand elders have the capacity to express a broader and more integrated sense of self in more flexible and symbolic ways but on the other this holistic self must be protected from an inimical social environment.*

No doubt these subtle complexities add to the dilemmas of providers. Recognition of the necessity to understand more than the biological process of ageing and a humane exploration of the self might support older people to live an enhanced lifestyle. Perceptiveness, a general sense of awareness and intuition are required to detect the often unspoken feelings of older people. Often this is not straightforward since the younger professional's fear of the dependency of older patients and the older adult's anxiety that the younger carer might not understand him or her can impede good working relationships as Martindale (1989, 67-75) conveyed.

The question is how to persuade or influence policy makers to make use of these insights. Perhaps suitability of provision has not kept pace because of structured dependency and the inability to see further than the narrow path of external requirements. Providers lose sight of the individual's personality and internal structure of mind. Attitude towards ageing requires change, as Daatland & Biggs (2006 223) suggest, recommending that diversity be recognized in 'contrast to the prevailing obsession with similarities and central tendencies'. They add: 'Gerontologists may have observed and documented that there are divergent pathways of ageing and substantial differences among older persons, but they have also tended to retreat to normative models as templates for theorising.' Insights into the inner needs of old people have been offered in recent writings from medical, psychological, sociological and gerontological spheres as discussed (Pollock, A; Woods; Fraser; Sharkey; Biggs; Blaikie;

Phillipson) but still fall short in terms of implementation by policy makers and providers.

The realization by policy makers that old age with a long post-retirement phase is an increasingly substantial part of the life cycle is now necessary. New positive possibilities and hitherto little recognized areas of distress have to be taken into account. There needs to be a conception of total well-being, involving not only physical and material provision but also a mental health dimension if suffering and unhappiness in old age are to be lessened.

## 5 CASE STUDIES

Betwixt and between, I am stuck and time is stuck with me. Time used to open out, serene, shimmering with promise. If I wanted to hold a moment still, it was because I wanted to expand it, to get its fill. Now time has no dimension, no extension backward or forward, I arrest the past and I hold myself stiffly against the future; I want to stop the flow. As a punishment, I exist on the stasis of a perpetual present, which is not eternity but a prison. I can't throw a bridge between the present and the past and therefore I can't make time move.

Eva Hoffman

(Lost in Translation, 1989)

No matter what, I want to continue living with the awareness that I will die. Without that, I am not alive. That is what makes the life I have now possible.

B. Yoshimoto

(Kitchen, 1988)

Let us not waste our time in idle discourse! Let us do something, while we have the chance! It is not every day that we are needed. Not indeed that we personally are needed. Others would meet the case equally well, if not better. To all mankind they were addressed, those cries for help still ringing in our ears! But at this place at this moment of time, all mankind is us, whether we like it or not. Let us make the most of it, before it is too late! Let us represent worthily for once the foul brood to which a cruel fate consigned us! What do you say?

Samuel Beckett

(Waiting for Godot, 1949)

## **Chapter Summary**

- Brief introduction to the treatment management and practicalities
- Recorded verbatim sessions of the six patients giving the more important and relevant material to indicate some of the facts as noticed during the treatment
- The material of each case study has been divided into sub-headings as: reasons for referral, assessment, treatment and end of treatment, CORE results and an overview
- The results of the independently conducted CORE has been included for the purpose of a comparative study
- The final, overview section represents a summary of the material linked with psychoanalytic theory to show how the clinical facts were derived to generate hypotheses

## **Introduction**

The forty weekly psychotherapy sessions were by a review meeting three months later. Patients completed a questionnaire (see Appendix 4) giving a self-assessment account of their point of view about the treatment. As aforementioned all six patients attended regularly and were well aware of participating in a research study. They had given permission for publication with due reservation to identity.

Before giving some relevant accounts of the verbatim recordings to indicate the impact of psychotherapy on my research case studies I will briefly describe the reasons for their referral followed by the initial assessment session. Obviously due to the immense accumulated material what I deemed the more important treatment sessions for my research purposes are given here. Many sessions full of irrelevant anecdotes and triviality, interesting but not relevant for my study, have not been repeated. The review appointment provided an overall assessment of the year's psychotherapy including a discussion of the self-

assessment questionnaire. Regardless of their feelings at the end of therapy all the case studies were most appreciative of this opportunity to be listened to for perhaps the first time in their lives from a humane and holistic perspective.

At the end of each transcription I have summarized the important findings from a clinical viewpoint as linked with psychoanalytic theory. These findings were ascertained either during the session (inside) or at presentation or supervision (outside) the session and have been identified as 'clinical facts'. The comparative studies in Chapter 3 on the qualitative research methodology used these 'clinical facts' generated during the psychotherapy as grounded hypotheses for depression in later life.

## **5.1 KW (AGE 77)**

### **5.1.1 Reasons for referral**

KW's Consultant Psychiatrist, Dr R, at the Unit for Older Age Psychiatry, decided to refer him to a colleague, Dr A, for a second opinion. Dr A described KW as 'a loner' who regretted not having had the opportunity to utilize his intelligence in a more productive way. Dr A also said that KW was preoccupied with ageing and projected his hatred of the ageing process onto professionals. Although he looks ten years younger than his chronological age and is physically fit KW conveyed strong feelings of wanting to die stating *that it is too much of a struggle to carry on surviving*. Dr A thought that KW continued to bear some deep rooted grudge against his parents, particularly his father. He has remained 'a lost boy who was significantly living a life of existential emptiness rather than clinical depression'.

KW had been on medication for most of his life. In his thirties he had two incidents of attempted suicide resulting in a mental breakdown and was hospitalized for almost six months. He has not been suicidal since and he indicated that he has no intention of attempting suicide again as he described himself as 'hopeless at being successful.' His medical history repeatedly stated that there was no organic reason for his depression although he had lifelong

difficulties in interpersonal relationships. He has had long-standing contact with psychiatric services and does respond to supportive medication.

### **5.1.2 Assessment**

A senior colleague from the team who assessed KW initially agreed with the diagnosis made by the referrer. Furthermore it was discovered that KW not only hated his father, whom he saw as the perpetrator of all his emotional problems and academic deprivation, but also that there had been a close, enmeshed relationship between him and his mother.

He had been in just one relationship with a man ten years his junior which lasted about twelve years. It had been a very rocky relationship and he ended it but they have remained good friends ever since. He had up to then never been in any intimate relationships. This was the time he experienced a breakdown and made two unsuccessful suicidal attempts whilst abroad and had to return to the UK.

KW has held onto various jobs successfully but left them when he chose to. He had no difficulty in finding new jobs and had been independent financially until he retired. He stated that all his life he had felt incompetent and found it difficult to fit in with any group.

### **5.1.3 Treatment**

#### **Session 1**

At our first meeting I faced a reasonably well dressed much younger looking more physically fit man than I had anticipated, who had a fairly distinguished presence about him. Although his manner was polite, reserved and unemotional he greeted me warmly and held out his hand. After the preliminary introduction and discussion regarding my research and once more establishing that he wished to participate he sat with a blank expression on his face. He was non-

committal and waited as if he needed some instruction to proceed. I appreciated the difficulties of the initial meeting with a stranger and encouraged him gently:

Although this is not alien to you, it must feel difficult to know where to begin with a stranger. Dr. A had probably explained to you why he thought it would be useful for you to see a psychotherapist. Perhaps we can think and work together about some of the issues that you are unhappy about. With your cooperation I might be able to address some of your unpleasant or distressing feelings. Some of this might stir up painful associations.

Although he was seated diagonally from me he looked out of the window, misty-eyed and expressionless. Then he softly volunteered:

*As you know I had therapy when I was in my thirties, but I was in a group and I hardly said anything. I felt inhibited and I did not find it useful. It was for three months at first and I said that I did not wish to continue. I can't see it being of any use now either. But I promised Dr. A I would give it a try as long as it was not a group.*

My heart sunk at this opening attitude and I realized that he was going to be hard work. I said that I appreciated his reluctance after that experience but maybe as he had agreed to come we should see what progress he could make. According to the contract he is not bound to continue if he does not wish to and could opt out of the research if he did not wish to continue as a participant. This would not change the agreement that he could continue coming for the year as agreed. Perhaps this encouraged him to feel less constricted because he gave a little chuckle and said:

*I have been a psychiatric patient all my life! So why not take this on? I can't lose by it. But, I can't see it doing me any good!*

My response:

So anything goes as long it is some kind of professional psychiatric care that



takes on the responsibility of your mental needs. It seems as if you leave it to others to make decisions for you.

I wondered if I had said too much too soon but he responded with:

*You can put it that way. I have made myself become dependent all my life. Nothing is going to change that now! It is far too late!*

I felt dismissed. There was silence and I was afraid of letting it go on for too long because if possible I wanted to keep him engaged. Tentatively, I suggested:

Sounds like a soft option!

To this he looked thoughtful, shuffled his feet around, clenched and unclenched his hands and looked directly at me for the first time:

*Now that you put it like that it does sound as if I settled for the easy way out. What was I to do? I was only sixteen. I could not challenge at that age. I had to do what I was told. Adults knew better. But it is too late now! This should have been offered to me many years ago. Perhaps, when I was in my thirties! It is too late now!*

He paused and exploratively I repeated and asked:

Only sixteen! It is too late now. Why is it too late?

He gave a hysterical little laugh.

*Yes too late. I can now understand what Dr. A said and what you are trying to convey. But it is too late. I am not the person I used to be. I used to like going off on my bike into the country. I could walk long distances and enjoyed stopping for lunch at some country pub. I can't do any of those things now.*

He looked nostalgic for the strong man he used to be and I could see that his mind was on the outer reality and how he had changed physically. Whilst thus focused he could not consider ways of adapting to meet his present state. I agreed that currently it was not going to be the same as he used to but he could go for shorter walks and eat at pubs and restaurants nearer home. He remained silent. After he left I wondered if he would continue to come. This feeling stayed with me after almost every session until the summer break, which was the first break of the treatment.

#### **Session 4**

As usual he started with how useless this was for him. His favorite phrases were: *all too late, not like I used to be, too late to make changes now*. He continued to be negative and dismissive of any interpretations I made.

Perhaps too late to be how things used to be but maybe your lifestyle can change somewhat for the better.

After a pause he volunteered:

*You see at 16 I had to decide on whether I was going onto higher education. I was never very brilliant at school but always managed to get the grades. My English teacher encouraged me to do so. I told my father what the teacher said.*

He paused, then continued softly and hesitantly:

*I was told I was useless by my father. Yes I do have a narcissistic wound as I was told before. This is all too late. I should have been given this thirty years ago. It is too late to make changes now. I was often unfairly angry towards most people.*

*My father laughed and told me that I was useless and hopeless. He was so vile tempered he would have belted me if I challenged him in any way. He said I*

*would never make anything of my life at college because I was stupid and he had already arranged for me to work at the local corner store. I hated this but did not dare argue with him. I did not say a word. I just walked away.*

He looked emotional and after a longish pause continued to say:

*I was never brilliant at school but managed to cope each year to be promoted to the following year. I so much wanted to go further to qualify at something. I hated the corner store. I had to pack the meat rations that the butcher cut up for the customers. After a year I couldn't take it anymore. I applied for a job as an errand boy in the city. I couldn't believe it when they took me on. My mother was so worried, but I loved going to work in London on the train during the war. Commuting was such fun. This was exciting for someone like me at the age of seventeen to be going into danger. My mother could not relax until I returned but my father never cared a jot He would say, 'Serve you right if you are caught up in a blitz'.*

I said that he had just recalled some very painful experiences. They were hard to dismiss but he had kept this old wound open almost all his lifetime. He replied:

*Yes, I have a 'narcissistic wound'. Nothing is going to change that! I am a victim and a drifter, depending on psychiatric care.*

From an analytical viewpoint I could understand his terminology but was a little surprised to hear it from him. I began to think that it was possible that he had developed an 'ego-destructive superego' (O'Shaughnessy, 1981, 861-875) so that he could protect his vulnerability activated in order to protect his mother as well as take revenge on his father. Perhaps a good ego function was denied and had been replaced by a 'dead object'. There was no one for him to relate to. Whilst he came punctually to every session he often began with:

*I can't see what good this will do me. I should have been given this years ago. I can't do the things you are expecting me to do. I am useless.*

The sessions continued in a somewhat defensive vein until the penultimate session before the first break.

### **Session 11**

He did not smile or look at me. He looked quite angry and sat down as if he was not going to co-operate. He looked a bit dishevelled. Unusually he was carrying a beaker of water from the Reception area. He took a few sips and I waited whilst he remained silent. He has conveyed to me a few times that he does not like silences. If I have nothing to say to him then he thinks he is wasting his time by coming. He looked petulant like a small boy. I broke the silence by saying I was wondering what was on his mind.

*I almost did not come. At the weekend I felt ill and had to go to A&E. I was told that I was dehydrated as I had not been drinking anything in this hot weather. The staff nurse was cross with me when I told her that I had nothing to eat or drink between my lunch and the next morning, when I woke up. Throughout the night I felt restless but did not get myself a drink.*

She made him promise that he will have two glasses of water before bedtime. He hated this because it resulted in getting up during the night to go to the toilet. Then of course he was still terrified of travelling on the bus after the bombing. He was referring to the 7/7 bombings, three weeks later. He had not mentioned this at the time except in connection with being late for his session due to the disruption of the public transport system.

*I have nothing to say. I don't like silences. You won't be around after next week. Dr. R is also going to have two weeks off. I have never felt good enough for anyone to want my company. I have always felt afraid of making a fool of myself and being laughed at because I will say something stupid.*

A brief pause and he continued:

*I cannot see any changes. This is an utter waste of time.*

I could appreciate the effect of the unexpected London bombings, but I also correlated this with the oncoming break which felt like my dropping a bomb, creating havoc and preventing the continuation of our weekly meetings. So after a brief pause I suggested:

Perhaps the bomber within you does not allow for any improvement in yourself. Maybe you have alienated yourself from the world. Perhaps you believe that Dr. R and I are going to have a good time during the two weeks when we are not going to see you. It feels like we have dropped a bomb within you.

He looked astonished. I wondered if I had been a bit too aggressive, considering this was going to be his first break. But when I used the word 'bombing' it seemed to evoke memories of his wartime experiences. After looking on his lap at his entwined hands he looked directly at me and said:

*After the war and all the bombings I moved to several other jobs. Many people left to go abroad. A cousin of mine had left the country and he often wrote, encouraging me to join him in Canada. It was not until I was in my early thirties that I decided to go and join him. I did well because I soon found work in a huge store and quickly moved to a prominent position as a manager. I had many women and men of all ages working under me. Previously I was usually attracted to older women but I could never get intimate with any of them.*

With a smile he said:

*Perhaps you are going to say that I was looking for a mother substitute.*

He paused as if waiting for my response but I remained silent.

*Perhaps that was one of the reasons. I also wanted a change although I was in a good position as manager here.*

He then looked furtively around, cleared his throat and hesitatingly in his longest speech so far he related:

*All was going well when one day a young man came to my notice and I was hopelessly attracted to him. I tried to hide my feelings because I was shocked at what I was feeling. I could not believe that I was so strongly attracted to one of my own sex. Homosexuality was not legal then and I was quite naive. The thoughts kept pounding on my mind. I could not believe my feelings. Eventually I managed to pluck up the courage to tell him. He was flabbergasted and fled. I felt so ashamed and that evening I took an overdose. But it turned out that it was not enough. My housemate found me and I was rushed to hospital. I felt doubly ashamed and guilty. I could not face anyone at work and gave up my job because I could not face him or anyone else I became seriously depressed and a few months later I tried once more to overdose and again failed.*

The important fact here is that the difficult external situation impacted on his already vulnerable mental state. He looked out of the window as if he wanted to avoid my gaze. After a short pause I said that he was reliving some painful experiences. He nodded and softly replied:

*My family was then notified and I was sent home. I was transferred straight to a Psychiatric Hospital on arrival, where I spent six months. My family was too ashamed to take me home. My mother came occasionally to see me but my father never did. I could not face him anyway. My sister came fairly regularly and we have been close until a few years ago.*

Hysterically: *that is another story! Why am I telling you all this?*

His story moved me and I reminded him gently that we had one more session before the break.

*Thank you! I will see you next week! Bye for now!*

## Session 12

He came to his last session before the first break looking a lot better, wearing summery shorts and a matching T Shirt. He explained that as it was fairly warm he was able to wear the clothes he had bought earlier in the year before going to the Caribbean with his ex-partner, Danny. He also related that a friend of Danny's called Gerry had a stall at a market not far from him and he had been there twice during the week. I realized he was telling me he had found a replacement for when I was going to be away and was in denial about the break. When I alluded to this he ignored my comment and said he had a dream in the week. I think by his summery appearance he was telling me that he felt better for having related his terrible story and I had not rejected him because of it. The dream confirms this.

### The Dream

*I was waiting with my mother at the bus stop. When the bus arrived it did not stop. I started running, caught up and quickly moved in front of it. The bus then stopped. I felt very pleased and as I entered the bus I turned around to see if my mother was alright. She was nowhere to be seen. I felt alarmed and disappointed. But I also felt pleased that I had managed to get onto that bus. I found myself thinking she has gone home and I will see her later. I woke up crying.*

I interpreted this as perhaps symbolic of what was happening in the therapy. Just as he was expecting to see me – the mother figure – regularly, I was disappearing during the oncoming break. But within himself he felt he could continue with his therapeutic journey as I was not altogether abandoning him but would be waiting for him after the break.

I wrote a routine letter to his psychiatrist before going on holiday and on my return had the following response.

'His depression is more or less completely lifted with no sustained low mood.

However he is complaining of being irritable and angry with everyone these last few weeks, although he has up to now managed to avoid any significant confrontation. His irritability can be a sign of hypomania, but there are no features to support this diagnosis today. He is aware that he could contact me in the interim should the situation deteriorate.'

### **Session 13**

He arrived twenty minutes late for his session which was most unusual for him. As he walked out of the lift he gave me an uncertain smile and followed me to the room. Once seated he looked out the window ignoring me. I broke the silence by saying,

*Perhaps you are cross with me for not being here for you for a fortnight, so you kept me waiting today*

.

Still keeping his eyes averted he said:

*I was a bit late in going for my lunch to the center and that delayed me. I have been OK! I visited Gerry and Danny came over one evening and managed to fix my washing machine. The fuse had blown at some point and I had not realized that. The three of us went out for a meal at the local. It was not bad but I find it too noisy. Prefer the quiet Italian restaurant around the corner.*

I compared his coming to see me for a quiet uninterrupted session to that of a stall in a rowdy market place, although of course he appreciated being with his friends. He remained silent and then turned to look at me. After a tentative pause:

*I also did other things. I caught a bus from near where I lived right up to the end of the journey. It was very sunny, so I sat in a local park for a while and then caught the bus back home.*

I felt he was telling me that I had let him down and he had to cope on his own.



Obviously he had only started his therapy and had a long way to go to work through some intricate problems but in this instance the break was an incentive to progress. I was pleased that he was able to do something like that and told him so.

## **Session 15**

He turned up twenty minutes early. He smiled as he greeted me. He looked very smart in a matching beige outfit. He commented that the weather was still very pleasant but the experts were forecasting a very cold winter. Smiling, he suggested we are going to pay for it later. I did not comment. Then he added:

*Might as well make the most of it whilst it lasts! I disliked the horrible wet and cold days we had earlier. We waited a long time for this so might as well enjoy it whilst we can.*

I was pleasantly surprised at his light-hearted manner and I agreed but also interpreted that perhaps he was also saying he has waited a long time for therapy and was pleased that he would make the most of it. He immediately looked a bit wary and suspicious, as if he had expressed too much. He went on to make a complaint.

*I took a prescription to the pharmacist to be told that the medication had been taken off the market some months ago and could not be dispensed. I contacted my GP and she was away. The young locum refused to change my medication and told me to go back to the hospital. I did and was told that Dr. R was away for two weeks and I was left without any tablets for nearly a week. It made me feel very angry.*

I was wondering what had brought about the change in his mood, remained silent and pondered.

He looked very annoyed.

*I have nothing more to say. I don't like silences. I have never felt good enough for anyone to want my company. I also feel afraid of making a fool of myself and being laughed at because I will say something stupid.*

I wondered about his dependency on the medication rather than appreciating what was going on in the room. Tentatively I voiced my thoughts but he ignored my comments. After a pause, when I thought what I had said had not registered, he volunteered:

*When Dr. R returned his secretary left a message on my phone to say that I should call and pick up a new prescription. Danny did this for me at the end of the week.*

I suggested that perhaps he felt cross with Dr. R because it reminded him of feelings of being let down by his father who was never there for him when he needed him. He did not respond.

## **Session 20**

The strong transference had become more apparent. I rang reception and asked for KW to be sent up. I was told that about 20 minutes ago he had nodded to the receptionist and walked in the direction of the lifts. She had assumed that I had told him to do so. He had seated himself, not far from the lift, partly hidden. He would have seen me talk to others. He greeted me with a big boyish smile as if we were playing hide and seek.

Once in the room he seated himself with an impish grin and remained silent as if expecting me to reprimand him. Eventually:

*I thought I would make it easier for you so that you would not have to ring downstairs. Anyway, I don't like waiting rooms! They bring back memories. I don't particularly like coming here. I don't know why I am coming! I should just keep to myself like I used to and keep away from everything.*

I was thinking that maybe he felt threatened by a paternalistic and disciplinarian attitude evident in having to do what he was told to. Why could he not come up at the expected time to see me? Unconsciously this could have been an attack on the authoritarian parental figure and in the transference I became that person. He looked cross as he seated himself. Eventually after shifting his position a little, crossing and uncrossing his legs, he volunteered:

*I am fed up with the goings on at my flat. Since the summer I have been a member of the Tenants' Group of my block of flats. A female resident has started to challenge the management over the maintenance of the building. Nothing has been repaired for some time and people are complaining but not taking it up officially. The woman has become a friend of mine and has included me in the small group who are protesting and involving the local council.*

He looked animated. When I said that I was pleased to hear he had found some new friends and was actively involved his expression changed to one of fear. He shuffled around, looked at me and away again. I realized that whenever I made any comments about him feeling more positive he immediately took on a negative stance. If at any time I picked up his negative transference and suggested that if according to him this was a waste of time then maybe we should think of ending the treatment his attitude became condescending and dependent. He could not admit that the treatment was important to him and that some positive changes had taken place. He never wanted to consider the lowering of his intake of medication from five to one and the longer spells between appointments with his psychiatrist. He was actually terrified of feeling well and independent. Whenever his attitude was positive he would quickly oscillate to a more doleful, pessimistic mood.

### **Session 23**

There was a complete mood change and he appeared sullen. I broke the silence by saying that he looked pre-occupied. He looked at me sharply and after a pause said:

*Now Dr. R has kicked me out for two months. He has also cut down my medication to half the dosage. He suggested that I take the same dosage on alternate days or half the quantity every day. I prefer to take half the amount every day.*

I gently reminded him that this confirmed some good news as it meant he was very better. But Dr. R and I had become the caring parents he had so much wanted that the thought of not having us around terrified him.

He looked mentally frozen to take on board what I had conveyed.

Fortunately by the sessions before Christmas he once more had a positive attitude towards his therapy. He was forthcoming and communicative. He dressed very smartly. He had started to be an active member of the Residents Group, but whenever I tentatively suggested that his outer lifestyle had changed he reminded me that:

*This should have been offered to me years ago and it is all too late now. The demons are still around.*

If I suggested that it was up to him to let go of some of these demons I always had the same response:

*All too late now! Should have had this years ago!*

At times I felt exasperated that he was like a spoilt child who threw tantrums and that one could never do enough for him. But I also felt that the statement 'it was all too late now' demonstrated feelings that were linked with internal childhood psychic losses. There was no hope of ever achieving or changing that situation. Furthermore the reality of unspoken thoughts and feelings of a now limited lifetime span were also probably lurking in his mind.

About two weeks before the Christmas break he looked sullen and ill tempered. He sat looking out the window. I could see that the oncoming break was

causing him some distress. His clasped hands lay on his lap and he pouted as if determined to keep his mouth shut. I despaired and gently suggested that he looked as if there was something disturbing on his mind. To this he said crossly:

*I have nothing to talk about. I don't want to come here any longer. This is a waste of time. Nothing has changed. I hate the journey. I hate the place! What is the use of this? Where is it taking me to?*

After this outburst he looked almost tearful. Eventually he broke the silence and almost tearfully said:

*Dr. R is not going to see me again until mid-February. The Day Centre also announced that they would be closed for four days over Christmas. I will have to go elsewhere for my lunch. I don't like the alternate place. It is much larger and I do not know anyone there.*

He had been very close to his sister and her children and divulged some family secrets. Quite abruptly he stopped talking, looked keenly at me and said:

*I don't know why I am telling you this. Never spoken to anyone about all this before! A long time ago I used to drive my sister and her children here for family therapy. It was all so messy. I hated the waiting room. It has been done up since but it still brings up all those memories.*

He looked out the window and blew his nose. Softly he said:

*You know I never really had a proper family. My father was often travelling and when he was around he spent his time in the pub. He usually returned drunk, bad tempered or actually nasty to us. My mother was afraid of him. The only person who showed any feelings toward me was my grandmother. She used to tell my father where to get off. I really liked her. She used to tell my mother to stop being a ninny. I disliked it when she said that but now I do wish my mother stood up to my father. I became caught up in it all and perhaps it is why I took up the invitation from my cousin to join him abroad. It was to get away from it*

*all.*

After a while I broke the silence and suggested:

Perhaps it helped you gain some independence but at the same time you shifted towards becoming dependent on professionals. Unfortunately, they also turn out to be unreliable.

The session continued with him telling me about how difficult a time Christmas had been during his childhood. He could never remember it being a time of celebration.

*I was told I was useless by my father. Yes, I do have a narcissistic wound as I was told before. This is all too late. I should have been given this 30 years ago. It is too late now to make changes. I was often unfairly angry towards most people.*

Once more I noted the cry that 'it is too late' being expressed. This statement was often repeated throughout his treatment.

KW came to the next two sessions before the break. He divulged that he would be pleased when it was all over because Christmas had become a commercialized affair. He seemed less agitated and accepted the change stating that he was:

*I suppose I am much luckier than, those poor bastards in Iraq, who do not know whether they will survive the next day, let alone another Christmas. What must they be feeling being away from their families and loved ones.*

### **Session 30**

After the holiday he looked quite calm and relaxed but remained silent for a while, then volunteered:

*Oh I must confess that I did not feel as stressed as I thought I might be. Altogether things were a lot better. An incident made me think that I was very lucky. There was a gas leak in the block adjacent to mine and the occupants were evacuated. The Gas Board said that there was nothing to worry about. It was just a precaution to move people out. I would not have liked that at all. In fact I would have refused to move out. If it happens, it happens!*

I perfectly understood what he was referring to, i.e. that he was ready to die and in fact hoped this would happen. When I alluded to this he ignored me but he went on to say:

*It is one of those old fashioned laundry rooms! Of course you would not remember that. Not old enough!*

He was making a joke but I wondered whether some envious feelings of me being younger with an opportunity to enjoy a longer life time were unconsciously being conveyed. I also thought of the situation of him being in a position of being dependent on a younger person. I remembered Martindale's (1989, 67-75) paper in which it is stated that 'one of the difficulties for older patients is to become dependent on younger therapists.' After a pause I said that perhaps he was wondering what he was doing with someone younger, who had not lived as long as he had, to be sorting out his problem. Obviously he had many more experiences that were unfamiliar to me. He looked a little annoyed and said:

*You misunderstand me. Dr. R and you are about the same age and I do trust both of you. I do not have your training. But I do feel differently about seeing some young locum when my GP is away. She is retiring soon and I am worried about who will replace her.*

He also related that two French brothers he had become friendly with had invited him to go with them to France at Easter. He looked very pleased to have had such attention and said he would perhaps like to go but was a little fearful of doing so.

*It is all too late! It is all too late!*

This was a poignant moment. He appeared very hopeless and remained silent as he looked down. I gently reminded him that he was mourning the loss of what might have been by recalling some feelings from his past, like at 16 when he felt prevented from doing what he would have liked to do. I said:

Although those experiences have once more been stirred up here and once more feel unbearable it is time to let go of them and move on to do other things that still can be done.

### **Session 35**

By March after having seen Dr. R he announced:

*I told Dr R that I was not going to see him anymore.*

Although I felt pleased that he could show some independence and was fairly confident about this development I was a bit concerned about him opting out of all psychiatric care. Then with a mischievous grin he said:

*Dr. R looked as shocked as you. He did not say anything for a few minutes. Then he said that he would not discharge me just yet. He will see me in six months time when he would review the situation.*

Dr. R wrote informing me: 'I think psychotherapy is having a big impact on KW. Although he persistently voices negative thoughts about psychotherapy he does continue to attend and I have noticed quite a significant change in his thinking processes. He appears to be more psychologically minded and has also become psychologically insightful. He realizes how much he brings upon himself.'

### **Session 36**



KW told me:

*When I was a boy of about eleven or twelve I was given the burden of taking care of my sister. She was six years younger than me. I had to take her to school and bring her home in the afternoons. This I now see was a huge responsibility and a restriction on my time. On one occasion I forgot to fetch her and went on to do something with a friend. When I arrived home I was severely punished for doing so. My mother had gone to look for us and found my sister sitting outside the school, crying.*

He also related that once they were waiting at a bus terminus near the stationary bus that was to take them to school. His sister had accidentally tripped and fell on the wheel. She bruised her forehead and he was once more given a thrashing by his father, who said that he was to take care of her and it was his fault for the accident.

Perhaps in the transference being sent to a young locum GP stirred up some similar reaction. The 'child locum GP' would not be capable of taking care of the 'internal, needy child part' of him. When I conveyed this, I saw his eyes fill with tears and he became fairly emotional. There were now times when he actually cried when relating these memories. He could mourn and justify how cruelly he had been treated by a father who should have loved him. He also could come to terms with a mother who could not nurture him like she should have. He could understand how emotionally deprived he had been during those early years..

#### **5.1.4 End of treatment**

I could not see him the week after session 36 because it was a bank holiday. When he returned the missed session came up and I reminded him that there was going to be another bank holiday in four weeks' time. I saw his face contort and his mouth made movements but no sound came out. He became quiet and was not as verbal as he had been. I attempted to bring up his feelings of rejection about the missed sessions, especially as the treatment was nearing the end. *Well this was going to be only for a year and I have already had that.*

I reminded him of the review meeting when it would be a time to discuss further provision for therapy should he want to continue. He was adamant that he did not want more. He was sorry that Dr. A had referred him here. He should have left him alone, to go on thinking about the end. I understood his anger and tried to discuss this with him but to no avail.

### **Session 37**

Much to my relief he came. As he walked in he announced that he had back problems and needed a higher chair. He looked directly at my desk chair, moved it to the side and sat on it. I was taken aback and for a few minutes felt lost for words. As soon as he had seated himself he launched into how awful he had felt physically and mentally. I realized that the chair was no higher but made no comment. I sat in my usual place and waited. He volunteered:

*I called at Dr. R's clinic during the week for an emergency appointment because I felt stressed. He increased my dosage and gave me an appointment for a fortnight later.*

He paused as if waiting for me to comment, then continued:

*I am finding it difficult to sleep again. I have decided that I will come for the next two weeks and then it will be the bank holiday. I am not coming back. It is not worth coming just for another two weeks.*

Crossly, pouting like a spoilt child:

*As far as I am concerned I have fulfilled the promise I made to come for the year.*

I responded sympathetically saying that I realized he felt let down although he understood the practical arrangement.

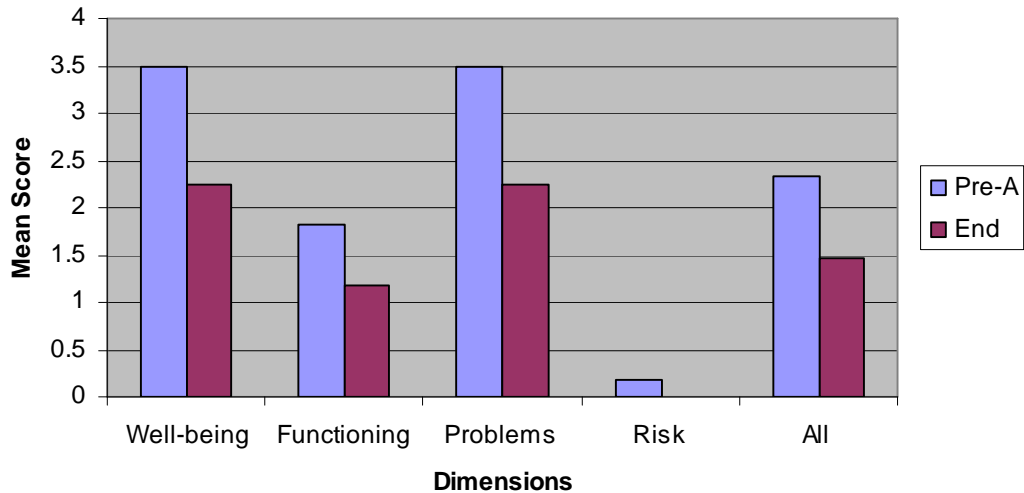
After shifting around and finding that the swivel chair moved as well, he stood up and went back to his usual chair saying:

*Maybe this is better for my back. I would like to say that the therapy has made a big difference to my life, but it still is all too late and now I only wish for the end.*

On the way out he repeated that he would only be coming for the next two weeks. He kept to his word and for the last two sessions chatted but never wanted to go into any in depth about the ending of therapy. I promised to contact him about the review meeting, to which he said: *We will see when the time comes!* He thanked me for my time and patience and left. I felt very sad to see him go.

He did not respond to the first letter offering a review meeting three months after the end of treatment so I sent him a further appointment. I still did not hear from him. He was obviously not going to come. A further three months later I was contacted by his local health authority requesting a report on his treatment as KW was seeking further psychotherapy. He also wanted to see someone nearer his home. I felt pleased that he had found the sessions useful and wished to continue. Some time later I was told by Dr. A that KW was being seen by someone who had done the course on Later Life and an ex-student of mine. She used psychodynamic methods as part of her work as a social worker. KW had settled well with her and was continuing to make good progress emotionally.

### **5.1.5 Core scores and end of treatment graph**



KW's responses to the self-assessment report from CORE are shown in the graph above. He completed the form before his first session and at the end of the treatment. The post-assessment form could not be located by the CORE administrator.

As the graph indicates he started the treatment with higher than normal problems. The scores show that there is some reduction in all the CORE dimensions. The outcome further indicates that he regards himself as having fewer problems and difficulties at the end of the treatment, showing an overall improvement from before to after treatment.

### 5.1.6 Overview and impressions

This CORE study shows how KW made some notable positive changes through his therapeutic relationship with me. He revealed his history in a most moving account of his young childhood and adolescent days. He felt demeaned and denigrated as a child and later at a very impressionable age of 16 was made to feel useless. His father, who had also experienced brutality, perpetuated this by projecting his feelings onto his son and identified his useless, intolerable state of mind as that of his son's. Klein (1946, 68) introduced the psychodynamic concept of projective identification thus:

Envy is deeply implicated in projective identification which then represents the forced entry into another person in order to destroy their best attributes. In various phantasies the ego takes possession by projection of an external object – first of all the mother – and makes it into an extension of the self. The object becomes to some extent a representative of the ego and these processes are in my view the basis for identification by projection or “projective identification”.

Biggs (1997, 563-4) suggested:

*It is proposed within analytic psychology that the persona restricts the process of individuation throughout the first half of life and is then effectively shed as individuation gathers pace ... the conscious ego is increasingly capable of reflexivity and becomes aware of these differing aspects of the self and by degrees can influence their relative dominance at any one time. Secondly an exclusive focus on individuation fails to recognize the protective role of the persona, emphasizing instead its inhibiting function ... In effect the psychodynamic of later life includes two extraordinary processes. On the one hand elders have the capacity to express a broader and more integrated sense of self in more flexible and symbolic ways, but on the other this holistic self must be protected from an inimical social environment.*

Biggs was discussing the above in connection with the subject of masking but it also resonates with KW's reluctance to let go of a persona he had maintained for almost his whole life time and was reluctant to let go of. He had come to recognize this but the fear of the unknown future felt bleak and terrified him. Although a part of him wanted change he dreaded entering a new phase and therefore repeatedly said: *It is all too late!* I do not think KW in his second half of life would have made any appropriate changes without the support of the therapy to help him understand some of his unbearable inner reality. No amount of medication, although this may have been necessary, could change his intrapsychic state. The psychotherapy enabled him to recollect, recognize and

mourn his early losses before he could integrate and relinquish them. Obviously one's past cannot be dispensed with but it can be integrated and accepted as part of the personality by the time of the second half of life. His vulnerable and insatiable need for the love of a father veered him into a mental needy state of looking for that attention via the dependency of the caring psychiatric units.

KW repeatedly said: *It is all too late*. If this was his belief and attitude then how could mourning take place? His mental state remained in stasis until he realized through the therapy that to live in hope that the horrid past experiences could be magically obliterated and desired yearnings could still happen was the kind of thinking that engendered missed opportunities in the present. To some extent many of the desired experiences could never be achieved. By being stuck in the past he was missing out on an improved mental state and the opportunity to enjoy a better quality of lifestyle. Through the therapeutic intervention he developed a frail but nevertheless more positive attitude. Unfortunately when in his thirties and he found for the first time that he could relate to another person he was violently rejected. This only compounded his feelings of never being loved. He once asked:

*Do you think I would I have turned out to be a homosexual if my parents had been different?*

Obviously I did not have an answer to his question.

As Freud (1914, 147-156) indicated, 'at the end of the treatment, some of the original symptoms begin to resurface because of the underlying fear of not being able to depend any longer. But the state of the mind that has now altered continues to go on working through after the ending.' I do hope that some aspects of KW's mental state had altered for the better and he would enjoy a more fruitful future. He had been very secretive and never talked openly about some of the positive changes he had made.

KW's identity was affected by the continual attacks of his self by his father at a very vulnerable age and especially at the impressionable age of sixteen. He had

repressed some or parts of these unbearable experiences of not having a good object, thus preventing a development of normal ego functioning and creating a self-destructive superego.

KW's hostility was repressed and remained split-off. During the therapy his anger was directed towards several people who had helped him, for example the social worker, the locum GP or Dr. A, whom he felt had no right to refer him for psychotherapy. At other times he oscillated towards Dr. R or me. Only one of us could be the good object. There were times when his anger towards me was acted out in several ways. This was most evident towards the end of the therapy. He was going to set the date when the therapy ended by refusing to come to the last three sessions. I had no choice or control over the situation. This attitude as well as the incident of coming up and waiting at the lift instead of waiting to be told was perhaps indicative of him acting out a new emotional experience of defying paternal authority. I could only hope that the positive transference he experienced during his therapy with me will eventually be internalized as a positive part of his personality.

#### **5.1.7 Summary of key facts from the data**

The painful, dysfunctional object-relations experienced by KW during childhood and adolescence led to a protective psychic denial of these experiences. For mental survival he split-off the negativity by acquiring a defensive, ego-destructive superego to maintain some equilibrium. Unfortunately the opportunity to mourn these past negative experiences and relinquish them had never arisen before the psychotherapy sessions. Although he could appreciate the situation there were times during the sessions when he became anxious and fearful of relinquishing his defences and would say: *but this is all too late!* Perhaps simultaneously the prevalent narcissistic personality felt safer and secure, whilst the new personality felt threatened on account of the unknown aspects of the future state of the mind.

Therefore the key facts as findings are:

- 1) Dysfunctional early childhood.
- 2) Developing an ego-destructive superego to avoid the mental distress.
- 3) The incapacity to mourn early object-losses and relinquish the past.
- 4) The constant desire and hope for those losses remaining in the sub-conscious.
- 5) Denial of need by developing a narcissistic personality.

## **5.2 BA (AGE 65)**

### **5.2.1 Reasons for referral**

BA had become mildly depressed soon after taking early retirement. At the time of the referral he had stopped working for approximately three years. He felt depressed and his GP had prescribed anti-depressants. He was not happy about this. He had a psychotic breakdown whilst under anaesthetic during surgery and was referred to the psychologist at a psychiatric centre. She thought he would benefit from psychotherapy because of 'some deep-rooted problems that were now the cause of his depression.' BA had hopes of becoming a novelist and had started writing soon after his retirement. His manuscript had been rejected several times and this did not help his already depressive state.

### **5.2.2 Assessment**

BA had been on Sertraline, an antidepressant, for five years, because of low mood and suicidal phantasies. He had come off them briefly but resumed the medication because he felt depressed and they generally made him feel a little better. He decided that 'due to the nature of the depression, psychoanalytic psychotherapy would be the treatment.' He preferred to be in a position of helping himself rather than depending on medication

He related that he was the youngest of five children, three brothers and a sister. It was discovered that he was dyslexic at about the age of eight when he had been transferred to a boarding school. He was expelled from his local primary school for swearing at the head teacher. Most of his school life had been a



torment. He felt he had never really been understood by teachers or his parents who were very strict and religious. He was very close to a Nanny who left to get married when he was about three or four and he recalled watching her undress. At the age of thirteen he was seduced by a senior girl in exchange for some cigarettes.

Although outwardly he had caring parents who attended to his material needs he never felt like he was offered real love or emotional care. Perhaps he received a little more attention from his mother after being told that he was dyslexic. Stoicism was the order of home life. He was continually told that it was weak to give into physical pain and that it should be borne until it became really unbearable. At the age of sixteen his mother realized that it would be difficult for him to sit for any academic exams and encouraged him to follow an artistic career. From thereon his further education was at an art school.

### **5.2.3 Treatment**

#### **Session 1**

BA greeted me warmly and conveyed how pleased he was to be offered regular appointments. He had an air of being in command and once in the room he started to walk towards the chair near my desk that I usually sit on. I felt I should clarify the situation immediately and said that he could use any other armchair except the one he was heading for. He smiled and said:

*Habit I suppose. I usually go for the most prominent one and in a particular position. But I think a good enough reason to head for that one was that I dislike looking into the light.*

There was another that also faced away from the window but I made no comment. He eventually settled for one opposite me and said:

*Now where should I start! A brief pause.*

*Oh yes 'free associations'! That is what Freud said, did he not? Well I have read quite a bit about Freud, Jung and Lacan. Freud analysed himself but I realize I am not in a position to do that myself. Kierkegaard and Nietzsche are my other favourites. In essence I know what this is about but I do not know where to start from. I know that a lot of repressed childhood experiences are looked at and reassessed.*

He looked at me intensely, which made me feel a bit uncomfortable. I realized that he was going to be quite challenging. He functioned on an unemotional level, centered in cognitive and intellectual activities. I wondered where the artist was, knowing that there was a creative side to him. In the transference he was being very defensive. He gave a little chuckle and added:

*I thought I might be able to analyse myself like Freud did!*

He looked at me piercingly and after a while, whilst I maintained the eye contact, he looked away and then again at me and said:

*I am very willing to try psychotherapy as I have to portray a persona that I have made myself into. For years now I have been unhappy with myself but carried on. This morning my wife asked me if I was ready for all the skeletons to come out and whether I was feeling nervous. If she only knew!*

A pause and then he continued.

*I have written a novel, autobiographical, as the first one often is, and made several attempts to get it published. Some of the publishers are so rude. They do not even write a line but just posted it back. It is so depressing. I haven't spoken about it to anyone. It is such a relief to be able to do so now. I feel a lot better now that I have met you and not as nervous as I did whilst I was waiting to see you.*

Before leaving he took out a slim book and presented it to me saying:

*Perhaps this will help you to understand me better. It is what my life has been about*

I had to explain that I did not take gifts and would rather hear from him about himself than from a book. He determinedly placed it on the little table, as he was leaving.

*Please keep it and read it one day. It has been a relief to talk to someone about my life, who I think is not going to be judgmental. I am looking forward to seeing you again. Goodbye until next week.*

I was taken aback by his directness and his taking control by ignoring what I had said about gifts, assertively leaving the book on the table and walking out. It was obvious that he was in control but I also felt that in the transference that he was leaving something of himself with me.

## **Session 5**

He looked as if he was mentally struggling with something. I waited. Eventually he said:

*I am perturbed with both psychological and physiological problems. I don't know where to start.*

He mumbled something softly to himself and paused.

*I decided that I need to get some exercise and cycled here. When I started I had this feeling of a lump in my chest. This is how the depression gets to me. I don't know how to explain it but it is here. I stopped taking my medication because I have felt a little better lately. I don't usually get physically ill. Until my operation I was very fit. That is why it was such a shock. I thought it was the end. Perhaps I have been depressed all my life.*

He sighed and was silent then continued:

*I was the unwanted fifth child. By then my father was fed up with children. I now realize that there was a cold war between my father and mother. They probably hated each other by the time I was born. We had to be stoical and never complain of physical pain. It was only noticed when we could not bear it any longer and I cried. My dyslexia was not diagnosed until I was nearly eight. My early schooldays were like being in hell.*

He looked emotional and became silent. .

Eventually I broke the silence by saying that he had some very sad memories of his childhood days and they have stayed with him for all these years. He went on to say:

*I know that I do not have a physical lump in my chest. But I feel a tightness. I am sure it is related to my psychological state. I feel hopeful about coming here.*

I remembered him undergoing surgery for a benign lump in his abdomen. I said that perhaps like the surgeon he was hoping I would remove the psychological lump.

*Intellectually I understand what this kind of treatment is all about. It is a time to discuss my feelings. I have kept them so well hidden for so long now that I do not know where to begin. I thought that if you read the book you would understand my feelings because I see myself in him.*

I felt sorry for him and gently said that eventually it would be up to him to as to whether the feeling of the lump in his chest disappeared or not. The treatment depended on his participation. Some of the pain might be difficult to tolerate.

*I understand! You would not want to have preconceived ideas or come to any conclusions about me but try to understand as we go. In essence I realize what this is about but I do not know where to start. I know that a lot of repressed childhood experiences are looked at and reassessed.*

I found myself despairing at his constantly intellectualizing everything. He was very different from all my other patients. But I could appreciate that for a man who functioned almost solely on an academic level he felt de-skilled by my constantly expecting him to express his feelings. I tried to convey that verbal communication can be based entirely on intellect and logic but most people also expressed some emotionality. Intellectually he understood what I was saying but he found it difficult to be in touch with his feelings. He thought for a while and then true to his belief that this activity was 'a lot about repressed childhood experiences' started to talk about something from his childhood.

*About my childhood memories! At the age of about seven or eight someone realized I was dyslexic. I hated school. My headmaster used to make a spectacle of me in front of the whole school. I would have preferred a caning and perhaps forgotten about it. But the awful shame of being disgraced so often for my poor work stays with me up to now. The other recurring memory comes to me for when I was about three or four. My nanny, a lively friendly Yorkshire woman, whom I adored, was leaving to get married. I remember her picking me up, hugging me and handing me over to my mother. Up to this day I distinctly see the utter disgust on my mother's face as she took me, as if I was something horrible, being forced on her. Right now I can see that expression of disgust on her face.*

Exploratively I repeated: 'expression! Of disgust'

*My mother was a middle class woman who married slightly beneath her but remained the dutiful housewife and mother as society expected. I think she probably resented this role and there was often an atmosphere of boredom and anger between my parents but it was never openly expressed. My mother gave me more attention as the youngest child and perhaps because I was the one with the problems. She was also supportive in connection with my later education and career. All my brothers now realize that the relationship between our parents was fraught. They had an unspoken, cold contempt for each other, but their upbringing and religious beliefs prevented them from expressing those*

*feelings.*

For most of the following sessions he oscillated between his intellectual capabilities and that of trying to express his feelings. He often looked contemplative and then divulged many memories from his early childhood as well as current feelings. Some of his past involved guilty feelings which he had incorporated in the novel. But he now dreaded that if it was published he could not imagine what his wife, children or friends would think of some of those scenarios. His work had involved a fair amount of socializing and associating with other women.

*During these social evenings women often made themselves available. I thought this was great and was unfaithful to my wife. Occasionally she brought this up when she suspected something but I usually denied it and she let me be. We have been married now for forty years and at no time did I envisage that I wanted to leave her. She was a good mother to our children. She sacrificed her time to bring them up.*

Since his illness when he felt death closer than he had ever thought about it before it changed his attitude towards his wife and family. He decided to never be unfaithful to his wife ever again.

## **Session 12**

This was his final session before his first break. He came in with a newspaper and a book on Nietzsche and left them on the little table. He informed me that the front page story was about an 85 year old being thrown out at a political party meeting for voicing his opinions against a current political issue. He gave a little laugh and said:

*Nietzsche thought that acquiring knowledge was the most important task in life.*

I questioned whether the oncoming break made him feel that I was deserting him. He had to revert to his old way of functioning, i.e. 'acquiring knowledge'

rather than exploring and thinking about his emotional, experiential self. The book on Nietzsche was readily available for him so he could depend on it. On the other hand as from next week I was not going to be available for a fortnight and he would not have access to me.

Perhaps you are giving me a message. Nietzsche will always be available, I suggested.

*I do feel a bit apprehensive about the two week break. I look forward to our meetings. I had a dream. This might be relevant.*

### **The Dream**

*I had travelled a long way on a train and it felt as if I was almost at the end of the first part of my journey before I had to cross a border. A figure whom I know and whom I trust is waiting at the border in a car to take me across. I get into the car. I turn around to see another figure across the border who is wearing a long black coat and his face is half hidden. It suddenly occurs to me that I made the right choice. I should stay with this person on this side of the border whom I do trust. The car felt safe and I can continue my journey by another route.*

The dream I realized was very much about the break. I said that perhaps the journey in the car was symbolic of the therapeutic journey he was making with me. We have just come to the end of the first part of the journey. The male figure in a black cloak was probably representing the depression that is cloaked with his intellectual activities that had up to now presented a 'false self' (Winnicott, 1964) to the world. Just as in the dream he was now prepared to make the therapeutic journey with me but there are some doubts and perhaps he is reluctant to entirely trust me. Nietzsche was probably a safer and more reliable option. Obviously there were feelings and preconceptions of the risk of undertaking such a journey, which added to the basic problem.

He seemed quite pleased with this interpretation and agreed:

*It all sounds very true. I have friends who have been in analysis and perhaps are still going. I have been curious but also used to think, why bother when you can read all about it yourself? That is when I started to read Freud, Jung and Lacan, but they are difficult to follow, especially Jung. I could never get far with him apart from completing his autobiography. I enjoyed that. He was quite a character! I also went to see a play about them. Did you see it?*

I wondered about this and realized that although he readily agreeing to my interpretation and there was some curiosity about analysis he was terrified of commitment without knowing what it was all about. He had entirely depended on his intellect and tried not to focus on any feelings that might have intermittently been stirred up. But for a long time under this external front there were feelings of discontent and dissatisfaction. Some underlying feelings from his early childhood remained constantly in the background of his mind. The few painful memories he had already related with reference to his school life and the nanny incident had left their scars. Any display of emotion was looked upon as being weak. When in pain s a young boy he had to be stoical until it was unbearable.

Consequently a needy part of him was continuously lurking within him. But he denied these feelings by becoming an academic. He had related in one session that his children had a very warm relationship with their mother. They never expressed any of this with him. They were always polite and asked for help with their homework when they were younger but the 'kisses and cuddles' were always kept for their mother. Bearing in mind what he had just said I suggested that perhaps there was always a nagging feeling to come to terms with some of the needy and unsatisfactory past experiences.

Why undergo analysis when you can do this by reading Freud and Jung? After all they are the authorities on the subject. Perhaps you would rather learn about the self rather than learn about yourself. I doubt that the reading will satisfy or sort out your internal needs.

I could see he was quite startled by my comment and went very quiet.



By the end of the session he confided that he has more often than not tried to impress colleagues and friends with his intellectual knowledge. I have left him with something to think about. As he was leaving he stopped to tell me that he had decided to discontinue the Sertraline, He had thought about other herbal complimentary medicines but had not taken any. I suggested that he discussed this with his GP. He gave me an intense look, smiled and thanked me.

His attitude was very different to that of my other patients.

### **Session 13**

On returning he behaved as if there had not been a break. He gave me an account of his social life with family and friends. The break turned out to be better than he had anticipated. Christmas was always a difficult because his wife often became depressed. But this time they were abroad with their youngest son.

*Everything went so well. It was very pleasant and I felt quite relaxed. My wife said that in future we should go away for Christmas rather than slog in a hot kitchen. It is such a waste of time just for a few hours and I totally agreed with that.*

BA continued to oscillate between being the academic and thinking with me about his feelings. He decided not to read on the way to the clinic so that he could keep his mind free of outer events. To my surprise I discovered that he was a sensitive man as well as being an academic.

*I regularly visit Peter an old colleague of mine who is dying of cancer. Although he is ten years older than me we have always had good times together. I respect him highly and have often sought his advice.*

He paused and looked a little tearful then related:

*I went to see him last night and he unexpectedly asked me if I would give a speech at his funeral. I was not ready for that request. I had to walk out of the room.*

He remained silent for a while and it was a poignant few minutes. Then he said in a matter of fact way:

*I asked him if he would give me an autobiographical account of his working life and if I could tape some of our conversation for posterity. He seemed very pleased. He was an important figure in the art world!*

Unfortunately he could not stay with the pain of realizing that his friend was soon going to die. To avoid showing his feelings he quickly switched to talking in a lively manner about the academic life they had shared together. He rambled on a bit and then paused. I waited.

After a few minutes he moved on to another topic. He talked about his wife and revealed that he thought he had been derogative about her and her lack of achievements. After further exploration I discovered that she was a talented woman in her own right, who had given up her career to bring up the children. When the children decided to go into further education she went back to her career it by working from home whenever she could. He felt that she should have gone back to a full time job. It was the end of the session and I did not pursue this any further.

## **Session 15**

When BA walked in I thought he looked cross. Almost immediately he started saying:

*It is no fun living with someone who is depressed. Definitely no fun in bed! Anyway most of the time we have wine with our meal and I usually stay up to finish the bottle whilst getting on with some work. She is asleep by the time I go*

*to bed.*

He gave a hysterical laugh. I found myself feeling quite annoyed with his pomposity and wondered about his wife being depressed.

*She is the one they seem to turn to.*

His envious outburst was about his children because they seemed to prefer her company whenever they visited. He continued to tell me that although he has a very amicable relationship with all his children and especially his youngest son, he still feels they are more relaxed with their mother. He then told me that he thought his wife had not made the most of her talents.

*She has done about ten illustrations for various books. So I suggested she send some of her latest ones to the US as there is more demand for her kind of work over there. They want her to be there for an exhibition. She has always been reluctant to go. Of course I would have jumped at an opportunity like that. She is hopeless!*

It transpired that although she had worked from home she had been fairly successful, although the work did not bring in much financially. His undermining attitude stemmed from the fact that she had stayed with her original career and furthermore been sought out by publishers. He had been totally unsuccessful with his attempts at getting a book published.

I gently conveyed some of these thoughts to him. He went very quiet. After a longish pause he said:

*All my life I have tried to conform as I was too afraid to be a rebel. All I wanted was to be recognized and to be famous. That has been my goal. I gave up the idea of wanting to get on with my career but managed successfully to work in a connected area. But of course it was not the same. I decided that I had to be the person who provided for my family. It was a cowardly thing to do. So when I retired I thought I could gain success and recognition through writing. I always*

*admired John Burgess and envied his success.*

I was pondering on the contradictory and ambivalent meaning, *wanting to provide for a family and, it was a cowardly thing to do.* It then dawned on me that unconsciously he had probably been afraid of failure if he had followed the desired career. So the demands of a young family made it simpler to settle for the job he had done. At the time he did not have the confidence to try and follow his real ambition. The unrequited desire remained as a gnawing pain. So much so that it became a lump in the upper part of his stomach and eventually had to be removed surgically. I had been told by his referrer that he had undergone exploratory surgery and a benign lump had been removed from his upper abdomen which BA had described to me 'as a lump in my chest'.

I tentatively interpreted this to him and he agreed. I also pointed out to him that it must have been a difficult time when he had to make a choice between providing for his young family and a career that was not easy to live on. I did not think it was a cowardly thing to do. Perhaps circumstances had made the choice easier. In fact he had combined both his interests and a job most successfully.

## **Session 18**

BA smiled as he entered and looked well. His opening remark was:

*I have been thinking quite a lot during the week about what you said. It was quite an eye opener when you pointed out that in the outer reality it was more important for me to provide for a young dependent family rather than follow a precarious career, which obviously would not have brought in the immediate, necessary money. It was a sacrifice but unconsciously as you pointed out maybe I was being cowardly because I was afraid of being a failure. Whether it was conscious or unconscious I will never know. I chose the necessary option.*

He related that his father had very different aspirations for him. He wanted him to go into the family business or become a probation officer. He burst out

laughing.

*Can you imagine me as a probation officer? Neither of these occupations appealed to me. I went on to use my creative training as an artist to lecture on the subject. Often dream-like imagery comes to my mind. I painted a long time ago. I had forgotten about it until now.*

### **Dream/Vision**

*I am standing in a room facing a window. My son who is about five is at the window looking down a long street. I do not know why but the image often comes to my mind.*

### **Session 23**

As BA entered I could see he was excited.

*I was offered the opportunity to give a couple of lectures abroad just before Easter. We thought about it but my wife cannot come because we cannot afford two fares. Her agent suggested that she should go to the U.S. to the launch of the book with her illustrations. That would be great because we could both have working holidays.*

He could not refrain from criticizing her by telling me that she finds it difficult to motivate herself.

*She is wasting her talent. She could be earning a lot more money than she is currently.*

Although the remaining sessions were about the trip abroad BA was able to be in touch with his feelings rather than totally concentrate on the outer activities. He brought a dream to the next session.

### **The Dream**

*I was cycling on an unknown path that was wet and often muddy and bumpy. I did not recognize the place but was cycling on and on to get somewhere. It was going to be a difficult, long ride. I could not see the end of the journey nor tell where I was going. Suddenly I saw a fence and knew that once I had reached a gate or an opening I would be able to go through and that would be the place. But as I approached a break in the fence I noticed a girl standing at the entrance. I was shocked to see that she was holding something that looked like a snake and she had it very close to her mouth. I was wondering how I was going to get past her. At that point I awoke.*

The dream left him puzzled and bewildered. He could not make any associations. At first I was also puzzled although it was once more about a journey. I connected the muddy path with the therapeutic journey and the fence as symbolic of the oncoming break. I said that apart from this we might leave the dream for now and something might come up to clarify any further meaning

## **Session 25**

This was to be BA's last session before his second break as well as the one before he left on his lecture tour. He was really excited and felt motivated. He went on to discuss that he had tried all week to correlate some psychoanalysis with his lectures on art. After all he won't be the first and in fact Freud did that with his paper on Leonardo da Vinci. But his paper did not read well and he told me he will probably not present it. Intermittently he tried to draw me into a discussion on my thoughts on the subject. Recognizing my evasiveness he eventually gave up and spoke about his sick friend.

*The opportunity to go to America to give these lectures really came through my friend Peter. He set them up with an old friend of his who used to be in London some years ago and worked under him for the same company. I am also looking forward to visiting the ex-wife of another friend whom I have a lot of respect for. It was sad when they split up.*

Excitedly he went on to tell me about the approaching trip. For the first time I saw such enthusiasm in him that I let him go on until it was time to end the session. He thanked me and said that he would send me a postcard, smiled and left.

### **Session 30**

BA was two weeks late, having gone abroad on his lecture tour. The break turned out to be better than he had anticipated. His wife after all was not depressed although she did not go abroad. He apologized for not having sent me a card. The fortnight was very intense involving a fair amount of travelling. He looked directly at me and appreciatively said:

*I would never have been able to do what I have just done. Coming here has done me a world of good. Peter would not have asked me a few months ago. In fact he told me so. He had thought several times of offering me the chance but felt I looked too depressed to take on such a task. He has noticed the change in me. I was surprised that my depression had been so noticeable. I never discussed my low feelings with any of my friends or colleagues. I was relieved to find that Peter looked a lot better but as his wife pointed out he has some very good days but then there are the other awful ones.*

His strong positive transference towards the therapy was evident.

*Perhaps as you can see all the hard work you have put in has helped me get out of the rut. I am moving into interesting fields connected with what was my mainstream work before I took early retirement. I thought you would be pleased to see that I am becoming alive again and achieving what you have been expecting of me.*

I had to agree with him but as the sessions progressed I noticed that there were times when he reverted to becoming challenging. He oscillated between becoming angry and pompous to sheepishly apologizing for being rude to me.

## Session 36

As soon as BA made himself comfortable on the couch, which he had asked to use from the second week of his therapy, he crossed his arms on his chest. I observed that he was quiet, as if in deep contemplation. Eventually he said:

*It is the anniversary of the death of a very close friend of mine. We had a strange relationship. We often argued and disagreed mostly about his women. George was very successful and famous. I had a love/hate relationship with him because he did all the things that I would like to have done. George had a mistress. He used to say that he needed both women, because the one gave him stability and respectability whilst the other inspired his creativity. He did not care a jot about what other people thought of him. Sadly George died tragically in a car accident, whilst sober. No one knew how the accident had happened because no one else was involved. It was on of those freak accidents.*

He became quiet once more as if in deep thought. I waited and hesitantly he said:

*Sometimes I wonder if that was his punishment. His wife was devastated when she found out and divorced him. Retribution! I used to envy him his lifestyle. It was not worth it.*

His last sentence made me wonder if he was talking about himself. So I picked this up questioningly.

*Not worth it for whom!*

After a longish pause:

*When I was away I was introduced to many really nice, attractive women involved in the art world and the lecture tour. I did have some fantasies about some of them. You see it took me back to my work days. Incidentally I have not been unfaithful to my wife in a long time. Not since we promised each other*



*when she had a relationship with someone out of revenge.*

### **Session 38**

BA seemed to be a lot more in touch with his feelings. He had a positive transference in the sessions and said that he appreciated my support. He spoke more lovingly about his family and especially his wife. He realized she had given his children the love and emotional connection he had failed to give them. He provided for them, but had never been emotionally available for them. He repeatedly said:

*I can now appreciate that it was not cowardly to go to work instead of persevering with what I had trained to do. Instinctively I knew I had to provide for the children. My wife also made a huge sacrifice. For the first time I can see this and it makes me feel sad. I am almost certain that she does not really regret what she did. The boys really love her and my daughter adores her.*

Nevertheless he expressed his sadness about them both having to make the choices they made between creativity and raising a family. He wondered what it would have been like if they had both decided to follow the careers they had trained for.

*But, I know given the chance again we would make the same decision. We have lovely children. The alternative career was very unpredictable and an insecure path. Very few artists managed to be successful during their life time. I could count them on one hand.*

BA had come to terms with some of the repressed, split-off parts of his psyche. He realized that for a long time he had continually longed and hoped for some early insatiable desires to be realised. But he now understood the hopelessness of these desires, because they could never take place. He was an adult in later life and a grandfather. He had to adjust and find fulfillment differently. I shared these thoughts with him.

He reflected and added:

*Perhaps correlating my knowledge on art, writing and lecturing on the subject has given me more satisfaction than I have experienced before. The feeling of a lump on my chest has disappeared.*

#### **5.2.4 End of treatment**

By the end of his treatment BA continued to be in touch with his internal states of mind rather than striving for recognition in the outer world. Paradoxically, some interesting offers came his way which recognized his creative talent. He looked much happier, smiled more often and was according to him definitely not depressed. Towards almost the end of his therapy when I contacted the receptionist she remarked, 'What have you done with him? He actually smiles now!' This unlooked for feedback obviously pleased me very much.

The end of the treatment had been difficult for BA. He became anxious and continued to ask for how he could continue with therapy even if he had to find it elsewhere and pay for it. The financial situation was not going to be easy. Fortunately as the ending approached he related something that had transpired when visiting his old friend. He revealed:

*Believe me I had not thought about what he almost yelled to me ... stupid man! Why don't you find a job? At least part-time! You can do that with your experience.*

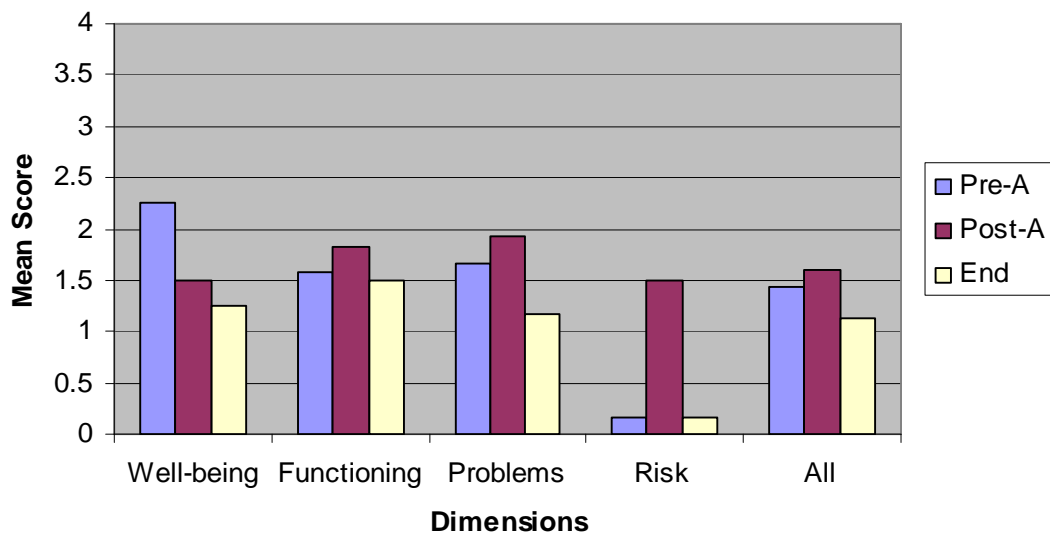
*That has given me an idea. I have been looking up various places that advertise to see what I might come up with. A review journal has agreed for me to make a monthly critical contribution.*

*I don't want to think of this as my last session here. This has been a very important part of my week. I have never before spoken to anyone so intimately about my feelings. At times I was surprised at some of the things I recalled. I had not even thought openly to myself about some of them. You are right in*

saying that I covered up my real feelings with an academic and intellectual front. I am feeling very anxious about all this ending.

I reminded him that the therapeutic situation is an odd one because it is one sided and yet so many of his innermost feelings and thoughts had been re-experienced. What he had gained would now be a part of him, I explained. His personality had made some positive changes that would remain with him and psychic growth could continue.

### 5.2.5 Core scores and end of treatment graph



BA's graph indicates that although at pre-assessment stage he had fewer problems they increased during the post-assessment stage and the risk increased during treatment. Perhaps this was due to him becoming less defensive and resistant, more vulnerable and in touch with his most painful feelings and not in denial. A more detailed account will be given when discussing the CORE results in Chapter 4.

### 5.2.6 Overview and impressions

As BA's therapy progressed he was able to come to terms with the fact that he never had the confidence to take risks. He thought about the past opportunities

he had missed and although he had moved onto a prominent position in his career he realized he had never really felt content. As previously related his weak dysfunctional ego had been reconstructed and was dominated by an ego-destructive superego that made him desperate for recognition and popularity. Although he was surrounded by family and friends he was internally a very lonely man. Neither did the veneer of success help him to improve or dispose of his very low self-esteem. He reported little incidents, perhaps unimportant in themselves, but relevant to his cry for recognition.

BA was to some extent obsessed with the idea that he had been a failure. He could not hold onto an identity for the lack of really having one. Although he had given up smoking he accepted a cigarette against his better judgment just to join an impressive social group. He had often been in a state of inner loneliness even amongst his family and socially. This perhaps originated from his younger days when he was not achieving at school. The tactless headmaster was intolerant of the young boy's difficulty. As BA had expressed he would rather have had a caning than be 'picked on, in front of my peers'. These incidents took place before he was diagnosed dyslexic.

He also often commented that he felt he was the fifth and unwanted child, especially for his father, who by then was tired of babies. BA had strong feelings of being a weapon between his parents' 'cold war'. Of course he had no proof of this but found himself in the midst of arguments about him. His father thought his mother was pandering to his whims and ought to have been stricter. He felt he had to prove himself and his escape in adulthood was towards academia. His choice of a more stable career rather than an uncertain and unpredictable artistic one perhaps indicates the beginning of his depression. He defended his real feelings by escaping into an intellectual sphere as a defence against stifled passion. He became so unemotional that he became depressed. Unlike Jacques' (1965, 502-514) writing on the mid-life crisis when BA became aware of his depression during his mid-life his creativity did not come as a 'manic defence to rescue or ward off the oncoming ageing process'.

His obsession with seeking recognition continued but became less frequent. BA

is a man of significant importance in himself as he held a fairly prominent position during his working lifetime but did not have the inner capacity to recognize his own worth. The early depression probably set in when he could not get a smile from his mother. He never felt loveable and perhaps his several affairs had been a means of looking for that smile. He continued to hope that the impossible would happen, that is that that early desired experience would happen. The non-recognition of his dyslexia before his traumatic experiences at school only exacerbated his depressive state. He made his intellect his 'second skin' (Bick, 1964) to protect the feelings of vulnerability experienced as an unwanted child. His self idealization led to a state of feeling omniscient and omnipotent. The year's treatment provided a space to change in some way with the hope of the development of stronger ego functioning.

### **5.2.7 Summary of key facts from the data**

The vivid screen memory of the disgust on his mother's face when the nanny handed him over as a young child remained with him well into older adulthood. Added to this experience he considered that he had a cold, unemotional father who was fed up with children by the time he had arrived. Consequently as a protection he denied the need to be loved. Unconsciously he maintained a strong ego-destructive superego and a self-sufficient narcissistic personality. Although in denial of the painful feelings of not being loved by his parents in his memory there was the continual hope that the pleasanter desires would still be achieved and these remained in the psyche. Retirement, an end in itself, evoked the suspicion that his early desires was hopeless. The unbearable mental state led to his depressive state. Perhaps the 'lump in his chest' was symbolic of the unbearable mental state. Only when BA became aware of his negative mental processing of the past was he able to relinquish his hope for the fruition of his desires. Then his lifestyle started to change positively.

The key facts as findings for his depression are :

- 1) Dysfunctional early childhood object-relations.
- 2) Development of an ego-destructive superego.

- 3) Internal loneliness during most of his life.
- 4) Inability to mourn desired lost experiences.
- 5) Retaining hope that the unfulfilled desires would be realised.

### **5.3 SP (AGE 67)**

#### **5.3.1 Reasons for referral**

SP was referred to the Consultant Clinical Psychologist of the primary care trust by her GP. After a few sessions of assessments the Psychologist decided that SP had previously suffered from bouts of depression. The last episode was about four years ago and she was treated with ECT. I thought that this kind of treatment was surprising and maybe drastic for someone who had not been admitted for intensive care. She has been feeling very low but the current episode of depression she felt was triggered off by worries about the future and her nearing retirement. She held a post of responsibility in a large publishing company and was now constantly comparing herself with younger members who had been under her supervision. She saw them as successful and a threat to her own position. Everything was now felt to be burdensome. She found it difficult to function like she used to. The pressure of meeting deadlines made her feel ill. This consequently led to her being regularly absent from her work and eventually she decided to take retirement a year sooner than she had intended.

#### **5.3.2 Assessment**

Unlike the previous two patients I assessed SP and am therefore giving the account of our first meeting in detail. Perhaps this had some advantages in that I could see her without pre-conceived ideas about her state of mind. Initially she had been offered an appointment by a colleague who was unexpectedly unavailable to see her. The delayed first meeting had added to SP's low self esteem and I think had a devastating impact on her of feeling unwanted. The appointment was arranged for mid-morning. When I contacted the receptionist to send SP up I was told that she had not arrived. After intermittent requests I suggested that the receptionist look into the waiting room to see if she was

sitting there. I was surprised to be told that she had arrived forty five minutes early and been unfortunately forgotten. Fortunately I realized that I could give her a full assessment and make up for the lost time. I was a bit surprised because the receptionist was normally very efficient.

As SP walked in I noticed that she looked forlorn. She was dressed in black trousers and a black top. My immediate thoughts were, 'mousy, withdrawn, lost,' and I felt sorry for her. It did not surprise me that she had been forgotten. After the initial introductions and my apology for the delay I thanked her for the self-assessment form which she had returned within two weeks. It was filled in densely and extremely comprehensively. She said it had been an effort to fill in the form. She related in a hardly audible voice that her current depression had started in 2002 when she had suddenly felt that retirement looming.

*The ECT did not prove very effective although it enabled me to go back to work for a while but eventually I decided I would give up before I was due to retire. I had enjoyed many things up to then and I had several younger employees who worked under my wing. I felt I could not cope with their excitement.*

After further exploration she informed me:

*I have been married for twenty years and have four grown up children, two of each gender. They are all leading fairly successful lives except for my youngest daughter who is having difficulty in finding a permanent job. My oldest son, Graham, is married now but I did feel a little guilty when he needed therapeutic treatment. I keep wondering where I had gone wrong.*

She went on to tell me that they had led a fairly bohemian existence. She never believed in letting her life revolve around the children when they were young. She and her husband fed and loved them but they were encouraged to be independent individuals. She met her husband whilst at college. He was a popular musician. Her parents did not approve of their relationship because he was not an academic so she deliberately got pregnant and as that would be a disgrace to the family name they allowed her to marry him.

She became depressed after the birth of her youngest child and could not throw off her depressive state, although she carried on working. She thought that her husband had been very supportive but eventually discovered that he'd had numerous affairs and their marriage ended about fifteen years ago. They divorced three years later and since then he has re-married and separated once more. They try to maintain an amicable relationship for the sake of the children but recently she found his company unbearable and has refused to go to any of her children's houses when he is there.

She paused and I suggested that perhaps she was finding it difficult to let him see how she is now.

*I do not want to give him the satisfaction of seeing me in this state. I am not anything like I used to be. Work enabled me to survive my depression to some degree but I started to feel exposed and humiliated. I lacked the efficiency and confidence I used to have and did not know how to construe myself or my life.*

I realized that she was an extremely intelligent woman and perhaps her intelligence from early childhood had served her as a defence against feelings brought up by the lack of attention she missed from her parents. When I tentatively brought up her 'early lack of a good object' (Klein 1946), she said:

*I used to feel I was getting in the way whenever my brother or sister became ill. I did not wait to be told to go and occupy myself by reading or doing my homework. My parents usually wanted me out of the way.*

Paradoxically she gained the attention she needed at school and later as a scholar and through being a performing, popular partner. SP told me that her ex-husband had charisma and all the women fell for him. Men also seemed to enjoy his company. He was very popular. She was happy to follow him around and watch him being admired. When I said it sounded as if she was happy to be his shadow and live through his popularity and glamour rather than seek an identity for herself she nodded. As she became more and more depressed her



children took over.

*I always enjoyed cooking and entertaining the family and they conveyed how much they enjoyed this. But then it all seemed to be reversed and I suddenly saw them taking over, organizing family functions. I also found that my children, especially the older son and his partner, had more sophisticated tastes and ways of entertaining. This made me feel not good enough.*

SP was the middle child of three with an older brother four years her senior and a sister two years younger. Both siblings had been asthmatic and needed constant parental attention. She obviously did not get the same nurturing as she was the healthy one. She instead did exceedingly well at school, outshone her siblings and was the only one who managed to achieve an Oxbridge place.

Before the depression set in she had a fairly manic lifestyle full of social activities. The depression took hold soon after the breakdown of her marriage, coinciding with a mid-life crisis. The approaching retirement exacerbated her inner loneliness. The first bout of ECT had helped but the last treatment given about three years ago did not alleviate her depression. She was eager to try psychotherapy and agreed to come once weekly for a year.

### **5.3.3 Treatment**

#### **Session 2**

Once more SP arrived early but this time the receptionist noted her arrival. She seated herself and took some time looking into her bag. Eventually she took out a tissue. She related:

*I was thinking of my friend Paula. I often do. We were very close when I lived in the same town after my divorce. She has had major surgery for cancer. I know I should go and see her but I can't!*

Silence and an expression of utter dejection, until I softly prompted her saying:

'Can't?'

After some hesitation:

*We were very close for many years from the time my husband and I lived in the same town. The four of us often met socially and had great times together. Paula was very supportive after my marriage broke down. They have always remained my best friends, visited me regularly and we phoned each other frequently even after I had moved to London. For a while now I have not been able to contact Paula. More often than not she phones me. I can't bear for her to see me in this state.*

To my responding that perhaps Paula's illness is just as devastating to her as her own feelings of anxiety she then said:

*Perhaps it is worse having cancer and undergoing chemotherapy. So many of my friends have been seriously ill and two have died. I could not even go to their funerals. My daughter offered to drive me but I could not bear to have people see me as I now am. The last funeral I attended was my mother's. Two years before then it was my father's. He died of cancer. My friends used to know me as a very different person.*

I was a little surprised at her vanity, worrying about her appearance at a funeral. She broke the silence and volunteered:

*I dislike being dependent on my children and could not take up their offer of driving me to see people. I am unable to go on trains, the underground and even dread the buses. I just about managed to come here and had to change at Oxford Street. I know it is a long way round but it is the only way I am able to do it.*

While I was wondering what to make of this she said:

*I know that I have to make the effort as my children keep reminding me. My psychiatrist also says the same thing. I am not allowed to drive. My younger daughter uses my car but even if I still had it I would be terrified to drive now. I used to drive a huge car because we needed a large one to take the whole family. I am not like I used to be!*

Another pause and she divulged:

*I was thinking of Paula. She is so brave. Her husband died a few years ago and she decided to remain in this remote village instead of moving into the city. Years ago my husband and I loved to go there at weekends to flop and re-charge the batteries after the week's work. The four of us used to sit around a fire in the fields and talk. Sometimes my husband used to play the guitar. We used to have such fun!*

She looked nostalgic and I wondered aloud as to what prevented her from having fun. She huddled up as much as she could into a foetal position and looked away. It was nearing the end of the session so I broke the silence that followed and said that it seemed as if she wanted things to be as they used to.. After a pause she nodded and said:

*I will try and phone Paula this evening.*

She looked quite puzzled and fraught when I said that we had to finish for now.

As the sessions progressed SP was very much the same mentally except for a few changes in her appearance. She now wore different, more colourful tops. At one session she related that she had a wardrobe full of clothes that she hardly wore. Her younger daughter sometimes borrowed them but never returned them. Everything just hangs on her as if still on a coat hanger. She used to have really nice breasts, she told me, ending with her usual statement:

*This is not how I used to be!*

## Session 8

She had gone back to yoga classes at her local community centre and not at her usual club. She cheered up just a little and whispered that she was going to try again. Her children were being very encouraging. She wanted to give this a try instead of having more ECT. The mention of ECT brought on a distorted expression. She continued to relate how sick she used to feel after each treatment.

*I definitely don't want to undergo that experience again!*

She was taking a little more care about her appearance and looked slightly better. She oscillated from being manic to depressed, constantly alluding to the past.

*There were so many things I used to do but now they are not the same. I did go to the yoga class on Tuesday to discover another tutor and then was told that she is the usual person for that time. She was really nice and tolerant. I sat at the back of the class and she came up to me and helped me with the postures but I remained at the back of the class. I also did the other usual things. I went to the library and for walks in the park. I did not see any of my children at the weekend. They were all busy, although my older son and his wife asked me to join them for supper on Sunday. I decided not to go. I read four novels. They were all full of pain and violence. I was determined to finish each one although I did not enjoy them. In the early evening I watched some TV but it was the usual boring stuff.*

I did not know what to make of this and waited. She continued after a brief pause:

*I did something I had not done in a long time. I went to an exhibition at the Barbican. It was so grim and disappointing. I walked out as I could not bear to see it all.*

In my countertransference I wondered about her frantic reading, asking myself whether she was phantasizing being an editor again.

Tentatively I said:

*Perhaps the exhibition like the novels was grim and caused pain instead of pleasure. Maybe it was too much a reflection of the way you feel currently. Perhaps for a long time now nothing has given you any pleasure.*

She did not respond to this but looked down at her hands resting on her lap. When it was time to end the session I said so. She whispered, 'bye,' and left.

## **Session 12**

As SP sat down she took out a few tissues from her handbag and tucked them into her sleeve. She remained silent as she looked past me out of the window. After a short pause I reminded her that this was going to be our last meeting before the oncoming fortnight break. She nodded but remained silent. I felt that it was going to be almost impossible to engage with her. I made an effort and suggested that not only would a fortnight's break from here feel difficult but she was cross with me for leaving her at Easter when some of her children were also going away. She had spoken about this briefly at the previous session.

Just before the oncoming break I wrote to her psychiatrist who replied promptly and notified me that he was moving to another department and someone else would be seeing SP. He also stated that:

Mrs P is suffering from 'treatment resistant depression' but seems to show some slight positive mood change. She takes a little more interest in her general appearance and actually smiled for the first time as she left. She asked if she could change to taking her medication in the evenings. I agreed but will be looking at the effect when I see her for the last time in two weeks. I have taken her off the Mirtazapine and Cipralext as she is adamantly refusing to take them. She has agreed to stay on the Sertraline after some persuasion until our

next appointment.

## **Session 15**

Although still fairly depressed and melancholic at this point in the treatment SP divulged that she had been thinking of various ways of doing something different. With very little enthusiasm she said:

*I was thinking about writing but that feels impossible right now. Perhaps I could do some voluntary work for charity. But I cannot stand the charity shops any longer. As soon as I enter one it makes me feel sick. Yet I used to go to them frequently because you can get some really nice things cheaply.*

She repeated how her daughters love her clothes and often borrow them. Then she regressed as some memories had been stirred up and related the following:

*Sometimes I wonder if I was a good mother. We led a very bohemian life style. We never had a kind of together family way of life and yet we were very close. My husband often stayed in his studio to compose or finish some music he had to play at a function. This often meant going away. I would get the children's meal ready and leave it to them to help themselves as they came in. Both my husband and I thought that was encouraging them to be independent. But now I wonder! He was anti-bourgeois although he got on well with my parents. He was very charismatic.*

This led to her telling me about how conservative her parents were in comparison and regressed to her childhood.

*I remember having to occupy myself, all on my own, whilst my parents were with my brother and sister because they were sick. I used to write stories about a princess who was very poor and a prince who would come to rescue her. I liked being at school*

I associated this with later meeting her charismatic prince who rescued her from her conservative parents. She made no response.

I felt that she conveyed a very low self esteem She could no longer hide behind her peripheral 'false self' through the charismatic husband. Although she was a very busy editor and socialized frequently she felt totally incompetent and a 'nobody.' This was confirmed during the penultimate session before the Christmas break.

## **Session 24**

SP looked distraught. Her face was contorted and she slumped in the chair. She kept trying to curl up into a foetal position but this was not possible in the confined space. After a pause that I felt was becoming uncomfortable I said that she looked very distraught and upset. In almost a whisper and after much hesitation she related:

*They are planning a big Christmas Dinner. I don't want to go. I do not want to meet Chris (ex-husband). I don't want him to see me like this. Janet's parents will also come with their current partners and they will all be very sociable to each other. Chris will insist on bringing his current woman. In the past I always did the cooking. I feel completely left out and useless.*

Frantically she searched in her bag and then said pleadingly:

*I can't find any! I can't find any!*

I thought that this was an unconscious cry for more than whatever she was looking for concretely but did not say so and waited. She looked helpless and mumbled what I thought to be 'tissue'. I handed her one from the nearby box. She dabbed at her eyes but there were no visible tears. After a longish pause she volunteered that her youngest son was also hesitant about going to the Christmas dinner. His girlfriend, whom she had not yet met, was non-Christian and not keen on celebrating. There would be no problem if her daughters were

going to be around but both were going abroad with their partners. I alluded to my absence and the feelings that I was also leaving her for my family and friends. She remained silent for a long while but it did not feel uncomfortable. She broke the silence by saying:

*I feel so stupid and worthless.*

I suggested that perhaps at a time like this when I am also deserting her I come over as worthless and useless. After all, what do I care? I choose to leave her when she needs me. Perhaps it once more felt like I was the parent who had no time for her. She ignored this and went on to tell me of the big Christmas dinners she used to make. She thought that now Graham and his partner would not approve of her style.

*Too unsophisticated! Not posh enough for them. Everything has to be perfect. They make me feel useless.*

When it was time to leave I thought she looked slightly better.

## **Session 28**

SP returned looking a lot better than I was expecting. I felt relieved and her opening remark was:

*It is lovely and warm here. It is so cold outside. The underground wasn't too bad. It is only when you come up the escalators that you feel the cold.*

This surprised me even more because she had not mentioned she had been regularly travelling on the underground, something she had been terrified of doing for a long time. I made no comment. As the sessions progressed I thought a positive transference was developing. She looked a lot better and was trying to occupy herself more productively. It transpired that Graham, her eldest son, had understood how she felt and invited her for lunch on Christmas Day. He had also invited the younger son and his girlfriend. The plan was for them to



go back to her place for the evening meal.

SP's current psychiatrist, a young woman registrar, informed me in the termly correspondence that SP had refused the new medication she had been prescribed and preferred to continue taking the Sertraline. The psychiatrist thought a change might speed up her recovery. She had also suggested ECT. I could not help feeling angry with this young woman who unlike the previous psychiatrist was not open to other forms of treatment like therapeutic intervention. She came over as authoritarian and was not prepared to discuss any further that she might allow SP to continue for a few months with the current treatment.

### **Session 30**

I was shocked when SP walked in as I had never seen her look so ill. I felt something awful had happened. She hardly looked at me. She slumped into the armchair, huddled up once more like a baby. Her face was distorted and she tried to tell me something. She mouthed something but no sounds came out. I could see that she was extremely distressed. When I gently said this to her she looked even more distressed. She started to gasp and pant as if she could not breathe. I did something I have never done before. I poured out some water and offered this to her. She shook her head. Perhaps this changed her attitude a little and she looked at me with a mixture of expressions of pain, agitation, despair and pleading. Almost half hour into the session she rocked herself and then shook her head several times. I took this action to mean that she found something totally unacceptable and was trying to shake it off but it would not go away.

Another pause, then softly:

*Graham and Janet invited me for Sunday lunch. As I entered he gave me a big hug. I was surprised. He led me into the lounge and made me sit down saying he would be back soon and that I should not move. He came back with an arm around Janet, carrying a tray a tray with glasses and a bottle of champagne. He*

*announced that I was going to become a grandmother.*

This was told in a soft, hardly audible voice with intermittent body jerks and distorted, excruciating facial movements. I find it difficult to express the actual despair of this scenario. My feelings of sympathy and tolerance changed almost to anger. I could not negotiate my feelings to understand her total narcissism and self pity. I contained myself and tried to think with her about her feelings. Her response was

*I am in no fit state to have a grandchild. I dread being anywhere near in case I do some harm.*

To further exploration she said that she was in no position to take care of herself properly but her son would expect her to baby sit and she might drop the infant. I could not comprehend her line of thinking but could understand her distress. Her baby self needed her children to take care of her. Her place was being usurped. From thereon she regressed to being like she was when she first came in to see me.

She continued to come regularly to her sessions but I could not shift her from the theme of dropping the baby. I tried to point out that her inner state was the negative side of an outer state that should be celebrating. During supervision we discussed the possibility that there might be a feeling of deadness in her whilst there was going to be a birth. But when I tentatively repeated this to her it had no effect. She sat in the confined space of the armchair in a foetal position and remained mostly silent. I found myself dreading her sessions because she incapacitated me mentally. I felt that she wanted to curl up inside me like a baby. In hindsight I realized that in the transference it was the way she felt but at the time I wished she would stop coming. I did not want the responsibility of this demanding baby. The sessions probably offered her something because she attended punctually and regularly without fail. But nothing I offered alleviated her insatiable baby state of frustration and despair. She was experiencing a nameless dread (Bion 1962) that could not be worked with.

When she did speak it was to tell me some details about her hospital appointments that had become more frequent. I discovered that Graham had by now become impatient with her and had accompanied her to see the psychiatrist. She was adamant that she would not go through the nightmarish experience of ECT again especially as she did not know whether it would be successful as it was not two years ago. Every session from then on was about the pressure of her having to make a decision about ECT. She informed me that the psychiatrist had given her some forms to fill in which she did reluctantly. I sensed there was some pressure from her son as well.

*I don't have to go. It is just in case I decide to go through with the ECT. Dr. K just wanted to make sure. I have to have a few tests before the treatment. This would not mean that I have to undergo ECT. She was making sure I had them. She will be leaving soon. She is heavily pregnant. I have just one more appointment with her.*

The last bit of information was hardly audible but I was dumbfounded. The irony of the whole situation! She must have known for a while now that her psychiatrist was pregnant and she had never mentioned it. There was once again new life and growth in front of her but this depressed her even more. I felt that something malignant and detrimental was being enacted and my creativity was also being threatened. I soon realized that her needy part in the transference conveyed something in my countertransference, causing me to feel pretty useless. I made the effort to understand her feelings and felt sorry for her but nevertheless continued to feel helpless with an ever demanding baby that could not take any comfort I offered.

### **Session 36**

She agreed to ECT. It was going to start from the next day. She felt ambivalent about going through with it but Graham was going to take her for her first treatment and then Janet would go with her and later in the day would pick her up to take her home. Her youngest daughter would be there to stay with her for the duration of the treatment. In all it was going to last for three weeks. I

realized that to some extent the decision had been taken out of her control and she could not put up any more resistance. She agreed when I said this to her and replied:

*I have no fight left in me. It is all too much to make decisions. I can only hope it is the right one!*

SP spent the rest of the session quietly answering my questions about the treatment and what was involved. Surprisingly she attended every therapy session during the ECT and for most of the time we talked about her physical problems. I gathered that the anaesthetic left her feeling quite ill afterwards. She told me of the most horrendous headaches she experienced soon after the treatment. I was obviously not working psychoanalytically but it was a space for her to talk about her treatment, which she felt she could not do with any of her children. I had the impression that once they had persuaded her to start the treatment they were worried about the risk they had put her through against her wishes. There was no certainty that the ECT was going to work and what if it once more failed like it did over two years ago?

She felt petrified that at the end of all this pain and suffering she might still be the same. There was no guarantee that if she did feel better the effects would be lasting. I had no answers to her dilemmas but could only listen to her. Obviously she could not discuss these feelings with her family. They were optimistic about the ECT as a quick fix for her depression.

### **Session 38**

In the last few minutes of the session SP announced:

*The baby arrived last Friday a few weeks early but all is well!*

She said no more and left. She never brought up the baby again except to say that Graham had asked her if she could cook them an evening meal. She made a casserole which they could eat over a few days. She said nonchalantly:

*The baby must be nearly a month old now! I have not been since they came home. Better leave them to it. They need the space!*

I realized that she had annihilated herself from her grandchild. The whole experience had become unbearable to her instead of it being a joyful time.

#### **5.3.4 End of treatment**

In her penultimate session I waited as usual for SP to come up. I noticed someone coming along waving and shouting, 'Hello, Hello!' I realized it was SP. She was dressed in summery clothes and excitedly told me of what a beautiful day it was. She arranged a few carrier bags around her and immediately told me that she had gone shopping before coming and this had been exciting. I could not believe that I was seeing this lively woman for the first time. She was full of news.

It did not take me long to understand that she had moved from her depressed, melancholic state to being quite manic. She went on about her weekend and without stopping to take a breath I was being told about one activity after another. It was a deluge and I felt swamped. When it was time to finish I told her so but this did not register. I intervened several times but she carried on talking. Eventually I stood up and walked towards the door. She then stopped and said:

*Oh is it already time to finish! Already! It has flown by so quickly!*

I smiled and nodded. She gathered her things together, gave me a big smile, thanked me and left.

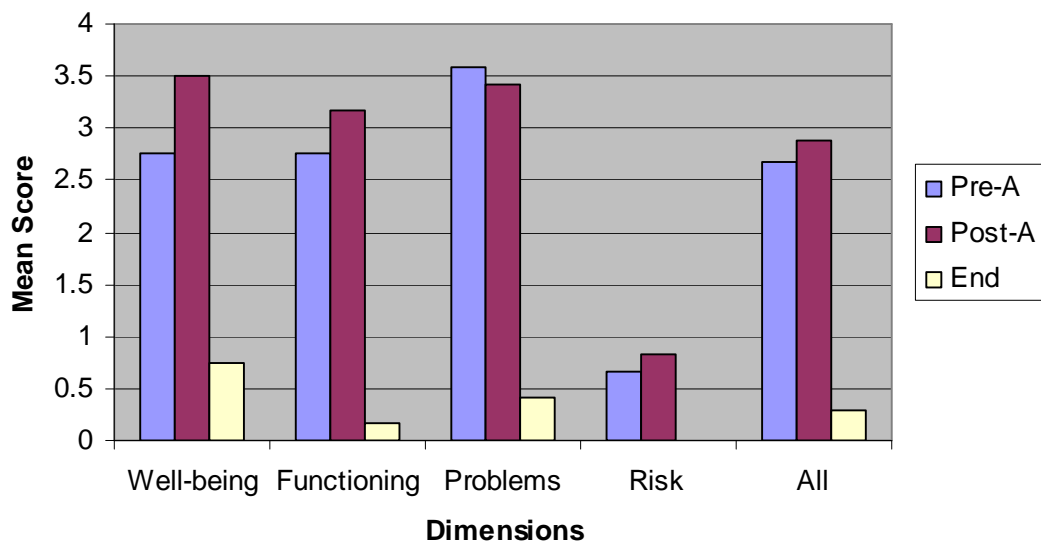
In her last session she said:

*I will look through my address book and make contact with all my friends I have not seen for a long time. I will arrange to visit them at the weekend and ask to stay until the Monday. For a start I could visit my brother and my sister whom I*

*have not visited for a long time. They have often wanted me to come. It would be nice to be able to do that. I do miss them.*

It took me a while to register that she was going to miss coming on the Monday and this was how she was going to fill in the missed sessions. I said I would contact her for a review meeting in about three months time when could further assess if she could perhaps use more psychotherapy. She had shown some response to the treatment at the beginning. She seemed pleased with this arrangement and thanked me before leaving.

### 5.3.5 Core scores and end of treatment graph



SP's CORE results indicative of pre and post-assessment of treatment routinely done as with all the research patients showed some improvement. It would be difficult to make any conclusive opinion about the scoring results at the end of the treatment because she had ECT whilst also coming to her weekly sessions for therapy.

### 5.3.6 Overview and impressions

SP was with no doubt a very difficult patient. With hindsight perhaps she required more than once weekly psychotherapy sessions for a longer period to work through her melancholia. She attended regularly – even whilst she had

ECT – and at the beginning had responded in little ways to psychotherapy. Perhaps with more frequent sessions and over a longer period her ‘non-medically treatable depression’ might have responded to psychotherapy. The question on my mind was whether ‘non-treatable depression’ was comparable to the lump in BA’s chest which I will discuss later in Chapter 6. It felt like trying to penetrate a brick wall. The early, minor positive changes unfortunately were not given a chance to progress once the pressure and effects of ECT took over. As a therapist I felt I was dysfunctional but I was able to offer her a space to talk about the ECT and paradoxically this was a time when she shared some real anxieties about having decided to follow the alternate treatment. It took her nearly three months to agree to the ECT. Sadly so much of our time swiveled around her ambivalence regarding this decision because of the pressure from her family. In this regard the psychotherapy was not given a chance to indicate whether it was productive.

In my countertransference I could not help my rivalrous feelings between the therapy I was offering and the ECT being offered by the psychiatrist. I felt impatient and cross with the young psychiatrist who had insisted on it. In contradiction to those feelings I also realized that the ECT was a manifestation of SP acting out. She was obtaining attention from her children that she so much desired whilst also taking away from them the joy and excitement of the arrival of a baby. One would have expected that the news of the arrival of a first grandchild would act as a stimulant for life and encourage self-progress but instead it became a millstone that had to be endured by a harsh invasion of her brain. Some repressed childhood feelings were evoked inside SP. Perhaps her ‘super ego defense mechanism’ (Roth, 2001) developed in order to deny the feelings of neediness she felt were of no importance to her parents whilst they attended to her sick siblings and prevented her achieving a normal state of ego functioning.

As Hinshelwood (1994 58-77) has claimed:

*The super-ego is manifested as a self-directed aggressive force, or to put it the other way the origins of the super-ego are*

*in the first projection of the self-directed aggression into an object which then becomes the danger to the self.*

Hinshelwood further explained Klein's (1957) concept of 'envy as a manifestation of innate aggressiveness, to hate the life of the subject; one manoeuvre is a hatred of an external object which gives or supports the object's life.' He went on to say that 'envious object-relations form on the basis of hating objects, which support or represent life. There is thus a spoiling of good things apparently for the sake of it.' (Hinshelwood 1994).

For SP being the star pupil at school and successfully gaining an Oxbridge scholarship served to give her the attention she was deprived of at home. But she could not hold onto this successful false self, once her husband left her. He had provided the excitement through which most of her previous existence had depended. She admitted this in a session when she said, 'I found excitement by living as a shadow of his charisma and popularity. The students used to love his music and he made people laugh'. As soon as the marriage started to crumble her inner state suffered likewise. The long repressed demons came to the fore causing her depression.

Hunt et al (1997) elaborated on Klein's (1959) theory:

*Clinical experience shows us that a patient's shift towards integration of early childhood anxieties with which the conflicts and concerns of later life are intimately related are re-activated.*

However, SP could not stay with the process when the arrival of a new baby was announced. The information reactivated her feelings surrounding early losses whilst her siblings took over the object (her parents). I wonder if there was an unconscious mechanism being activated to get all her children's attention to focus on her as the needy baby. She deprived the family of the excitement involved with the expectation of a new baby as she had been deprived when her siblings had all the attention. Unconsciously she was becoming the sick baby and projecting her need to the extent of demanding



their attention. So they were forced to make the decision of whether she should undergo ECT. Perhaps with perseverance the therapy might have worked if the disruption of a new arrival had not taken place.

### **5.3.7 Summary of key facts from the data**

Compared to all the research study patients I think SP was the most defended and sad person. As a very sensitive child her parents' arguably protective behaviour had been totally misinterpreted by her. Her experience of being isolated from her sick siblings she understood as a punishment. She could not explain why she was so often on her own whilst her parents seemed to be always nursing them and denying her the love she craved for. Her prince charming, a phantasy figure she literally became involved with, was her defensive ego-destructive superego, which protected her very vulnerable mental state. Later as an adult she found her superego in a charismatic partner. But when he betrayed her and left she had a mental breakdown. At the time the ECT perhaps replaced him as a manic defence. It also provided the craved for attention from her children, for her needy child part of the self. Unfortunately for her the arrival of the son's baby was an intolerable threat to her needy child part. Unable to contain these feelings she found the therapy threatening and escaped from working through this by opting for the ECT. At her review meeting she was hyper as the ECT was once more the superego that had helped her vulnerable psychic state. The youngest son and his partner seemed to have taken on caring for her, for she mentioned that she saw them very often. It seemed that she still hoped that her early desires would continue to be provided for by her children.

Therefore the key facts as findings are:

- 1) Dysfunctional early childhood.
- 2) The phantasised Prince Charming during childhood replaced her needy mental state leading to an ego-destructive superego.
- 3) Internal loneliness lived through her studies and later her charismatic husband.
- 4) Inability to mourn early object-related losses; the breakdown of marriage.

- 5) Throughout her early and adult life she desperately sought love she felt she never had as a child.

#### **5.4 CF (AGE 72)**

##### **5.4.1 Reasons for referral**

CF came to me via her local Older Adults Psychiatric Services. She had been referred there by her GP and her Consultant appointed a psychologist to assess her mental state. The tests concluded that she was 'not clinically depressed but remains quite fretful and anxious. She is a lady who remains incredibly active despite her complaints. She has mobility problems, has fallen over a few times and had to be hospitalized once for severe bruises.' Once more in my thoughts, I was connecting this with BA's 'lump in the chest' and SP's 'non-medically treatable depression'. She needed a prop and perhaps the walking stick represented this, although she hated using it.

At the time of the referral CF had continuously complained of poor mobility and lack of sleep. She had several falls ending in her being taken by ambulance to the local hospital. This was followed by her attending the 'falls clinic' for several weeks. CF was then prescribed Paroxetine 20mgs daily but complained of side effects and asked to come off them. Before this she had been treated with a number of different anti-depressants, including Prozac, Lofepamine, Dothiepin and Venlafaxine. CF had told the psychologist she had a fear of becoming dependent on drugs. She said that they made her lose her self confidence. Physically CF was a healthy person although she felt that the lymphadema was related to her state of mind, often becoming worse when she felt depressed.

##### **5.4.2 Assessment**

CF arrived on time. I noticed a fairly tall, big woman who was very smartly dressed in beige and white. Her hair looked as if she had just come out of a salon and there was a certain air of dignity about her. She had a very attractive

face and I thought that she must have been a beauty during her younger days. Her gait was slightly unsteady and she explained that she had left her walking stick in the car as she knew she could manage the short distance without it.

Once she had seated herself she immediately launched into telling me how much she disliked using the walking stick. The 'falls clinic' insisted she used it because she usually falls on her face and during the last incident she broke her glasses. Fortunately she was not seriously hurt. She ended up with a few scratches. Without pausing to take a breath she went on to divulge her hatred of hospitals and her mistrust of medical and care staff. Her husband had a very good opinion of them but she disagreed with him. He trusted his doctors implicitly. Her sentences were beginning to run into each other. It was a tirade of information and I was struggling to keep pace with it all. It was also difficult to interrupt the flow. I made a few unsuccessful attempts and then thought it would be best to let her get all she had to say off her chest.

Eventually she paused to get a tissue out of her bag and I took the opportunity to say that it sounded as if she had little faith in the provisions that hospitals made for her. This was an NHS Clinic and I wondered about her trusting me to be able to support her.

After a pause she said:

*This is different. I have every confidence in Dr. K. He would not send me here if he thought I would not want to come. He knows my feelings about hospitals. Anyway this is not a hospital.*

Without a pause she went on to say that a brother ten years younger than her died of cancer. Before he became ill he left his wife and came to be with her. She now realized that he must have known he had cancer but did not tell her. She saw him slowly deteriorate and die. They were always very close. She had mothered him after her father's death when her mother remarried.

I felt bombarded with her 'verbal diarrhea' and almost mentally dysfunctional. I

had to make a conscious effort to stop her deluge and interrupted her by saying that maybe she could tell me a little more about her father's death and her mother re-marrying.

She took a sip of water from the plastic beaker she had brought in with her. Then in a little more contained manner she related the following:

*My father died in a plane accident when I was nearly fourteen and my brother was four. I adored my father. He was an academic and encouraged me with my studies. He said I could do what he did or take up my music seriously. I was devastated by his death.*

She paused and wiped her eyes, although I could not see any tears. She then continued:

*My mother who was always frivolous and supercilious married two years later. I did not get on with my stepfather. There is a half-sister from that relationship who lived abroad. After the death of my brother she got in touch with and we have met a few times. My brother and I had always been very close. I was like a mother to him. At twenty I was sent to London to do a teacher training course specializing in music.*

CF had no problem relating her life story. Soon after I had to conclude the session as we had already run over time, which I very rarely do. She thanked me profusely and said that she would like to continue coming on a weekly basis. She also imparted that she was willing to participate as a research patient. I wondered about how these sessions would progress because I felt exhausted by the end of it and found it even more difficult to write up.

### **5.4.3 Treatment**

#### **Session 4**

As usual CF was elegantly dressed and polite and placed her beaker of water

on the little table. Immediately she started talking. She conveyed how amazed she is at having told me so much about herself. She is not usually so open about her personal life, then she quickly added:

*Please don't get me wrong. My GP is an excellent man. He is always concerned about how I am. I don't talk to my friends about my personal life. My Rabbi is very understanding but you see I am not an Orthodox. Yet surprisingly he does include me at some of his family functions.*

She gave a little uncomfortable giggle.

*He has seven children, who are all musical and play a variety of instruments. I think of them as the Von Trapp family. He knows I am very fond of music and really enjoy listening to them perform at their functions and parties.*

She was ready to go on but I cut in to ask her about her interest in music. She went on to relate that she always had been very academic and had hoped to follow her father's footsteps.

*I used to spend hours with him in his study. But I was also musical and was encouraged to have private lessons. After my father's death my mother took the advice of the music teacher who suggested that I further my education at a music college. When I turned twenty I applied for a scholarship to come to London. My mother gave a very large party and one of her friends was invited. I was introduced to many people and amongst them was this man, whom my mother had already arranged to be my future husband, who was twenty-two years my senior.*

She paused, took a sip of water and continued:

*Of course at the time I did not know about the plotting that was going on between my mother and him. He kindly offered to meet me when I arrived at Victoria station. He did and took me to my hostel accommodation. He then used to arrange for me to meet his young daughter at the weekends and to show us*

*around London.*

It transpired that she hated this hostel and had very little in common with her frivolous peer group, and when the man suggested she sometimes came to stay at his place on weekends to be with his daughter, who usually lived with her mother, she agreed. Of course she thereafter realized that it had all been planned by her mother and a family friend. She went on to say that her husband was a kind, generous man and she had agreed to marry him when he proposed. She finished her studies before they married but gave up her career when she started a family. She gave private lessons after her four children went to school. Her youngest son who lived with her hoarded every magazine and book he bought. He collects all kinds of unwanted stuff and has filled almost every space in her flat. She is ashamed to invite her friends.

Once more I found myself struggling to find a space to be, so I grasped the opportunity to associate this with her taking up my mental space.

*I am sorry I am unable to stop myself from telling you everything. I find it so easy to talk to you because you are so understanding. I have never spoken to anyone else like this. I am talking about things I had forgotten.*

I felt trapped. There seemed to me to be a discrepancy between her internal need and state of her mind and what was happening externally.

## **Session 8**

*I still keep up my lifestyle as much as possible. I still go to concerts, lectures and go to the theatre. I don't like going out for meals to restaurants or to coffee mornings like most of my friends. They can sit for hours and gossip about stupid things. I don't enjoy that sort of thing. Often I seem to be the one who is driving them around. I also end up doing the booking for tickets. They depend on me.*

Once more another tirade of facts and I could hardly get a word in. I wondered about how her active, manic lifestyle was in such a contrast to her depressive

behaviour, as she was so full of anxiety and professionally diagnosed as depressed. Perhaps she was avoiding some very deep repressed feelings. Her external behaviour presented a pseudo or 'false self' (Winnicott, 1958) or 'a second skin'.(Bick, 1964).

Eventually I managed to say it sounded as if she led a very busy and active social life so I was wondering about her feelings of being depressed. She responded with:

*I know I talk too much! My children often say this to me. They say I don't listen. I do don't I?*

I was not sure whether she was referring to 'talking too much' or the 'not listening part'. Mentally I was agreeing with her children. She went on:

*But things are not the same! I am not like I used to be. I used to do so much. I am so pleased that I can still drive although my optician says that I will not be able to do that for much longer.*

She hesitated whilst she became emotional and then continued:

*One very nice man from our synagogue used to help me with all my papers. He took a particular interest in me and asked me to marry him. I hesitated because I did not want to leave my children and go abroad, which was what he wanted. I also was left fairly well off and became suspicious. This is when my brother used to remind me that I had to make my own decisions. But I foolishly trusted a friend of my husband who was a divorcee. I thought he was a nice man.*

Another pause and quite unexpectedly she gave a little hysterical chuckle. She further volunteered:

*The nice man ended up marrying one of my friends, who hardly had any money and they now live happily abroad. He was a good man. I still see them when they come to London. We are kind of friends. I now think I made a big mistake.*

She gave another hysterical laugh and repeatedly said:

*But, I made the mistake of trusting one of my husband's best friends!*

*He was so kind. He continued to visit me after my husband died. He used to come to see me often as a friend and helped with various things. My eldest son warned me saying that I trusted him too much but I did not listen to him. I really thought he wanted to marry me. Eventually I trusted him with some valuable jewelry that he was going to sell for me at a good price. He went off with them and kept saying that he was negotiating with the buyer. After several months he denied that I had ever given them to him. I had no proof. You see! I am not good at making decisions! My children tried to confront him but I had no proof. I recently heard that he was very ill with cancer. Perhaps he ...*

She did not complete her sentence and I could guess her thoughts but said nothing. After a while I interrupted the silence by saying that she seemed to be in deep thought. She did not respond immediately but then with some hesitation she said:

*I know it sounds dreadful! But I can't help thinking that he is paying for what he did! I know I should feel pleased that he is suffering but who are we to be judgmental?*

I sensed a feeling of triumph in her but remained silent

## **Session 12**

In this session before her first break she seemed to be less talkative and allowed some room to reflect and for me to respond to her. But I wondered if this was her way of showing me that there were going to be long silences, or perhaps for the first time that she was appreciating the space I provided for her to be listened to. She reflectively said that she could now see that although she had always put the needs of others and especially that of her family before her



own it was never reciprocated. They were not really concerned with her. The children did the expected things like inviting her over regularly on a Friday for dinner and to family gatherings or celebrations but it did not feel that it was because she was loved.

I felt she was telling me defensively that she did not need me. She was unusually quiet and I associated her behaviour with the coming silence during the break. She then divulged emotionally:

*I don't know what came over me. Last Thursday I had a row with my second daughter-in-law. She left a message on my answer machine the evening before to say that I should pick up Susannah and Nick from school and take them to their music lessons. The au pair will be giving them a snack to take for after school so she will not have to worry about that. Just pick them up. I heard this message at eleven o'clock when I came back from a lecture. I immediately felt angry and did something I would never do before. I phoned straightaway and my son picked up the phone. I told him to tell Gina that I am not going to be able to do what she wants and put the receiver back.*

She paused and went on:

*Of course he phoned back immediately not knowing what it was about. I said I was not going to be free which was not true. He of course was not really interested and said he would pass on the message. We talked about other things. I expected Gina to phone me the next morning but she did not. I knew she would be angry with me. I felt I was tired of people taking advantage of me. But I did write a letter that morning saying that I did not feel as strong as I used to be doing all that rushing around with the children and I sent it off. Two days later she phoned to say that she would expect to see me at the usual Friday meal with the family at my eldest son's place.*

She said all this with great difficulty and was not her usual articulate positive self.

## Session 13

After the break she looked well and gave me a big smile. No sooner had she seated herself than she started in an excited manner to tell me about her latest grandchild who was born just before Christmas. The daughter-in law was in Europe in her hometown and although she was fairly young she was a very stable, sensible person. CF had a good relationship with her and conveyed that she was an ideal partner for her son. His previous partner, a brilliant career woman, was never emotionally available for him. The new woman was very bright but she was also caring. After a little pause she gave another smile and said:

*You are not going to believe this! You know how I was worrying about the travelling and all the walking I would have to do at the airport. Well, I said at the check-in desk that it will take me a long time to get to the departure gate. The young man smiled and told me not to worry as he would organize all that. I did not take him seriously or I didn't quite understand, but as soon as I went through security a porter was waiting for me with a wheelchair. I felt a bit embarrassed but he was so nice and made everything so easy for me. Of course Mike could not believe what he was seeing when he came to meet me at the airport.*

She paused, looked directly at me and gave me another huge smile.

*You see I have been taking what you say seriously. Once I was at the airport I did not hesitate to ask for a wheelchair. I did not feel awkward. Mind you I would hate it if I always had to depend on a wheelchair! I accept that I can only do so much now!*

In my countertransference I was a little uncomfortable. I was questioning myself as to whether I was advancing her dependency rather than stimulating her independence.

The rest of the session was about the christening and her attending the

Christian ceremony. The parents had given her a name that was neither Christian nor Jewish and she felt relieved.

At about this stage in her therapy she had to see her psychiatrist who soon afterwards sent me a letter:

'She clearly is gaining greatly from her weekly psychotherapy sessions with you and she was noticeably much calmer and less agitated. In contrast to previous encounters with her she was much more in the present and appeared easier to engage with. However as the interview went on the themes that you have outlined in your letter clearly resurfaced, including worries about ageing, the possibility of physical frailty, and following a recent lecture she attended the possibility of developing Alzheimer's disease ... Overall however I thought she was much better than when I had seen her last year'.

He also informed me that apart from some very light medication to help her sleep patterns – which she told me she was not taking – she was not on any of her other medication. I felt pleased.

The letter was encouraging and I felt that CF had improved in her outer state but that she had a long way to go 'to reorganize her fragmented inner state or psychic self' (Steiner 1993). But as expected one can only move from the known to the unknown through exploration. The visit to her psychiatrist and his encouragement helped her to become more positive in her transference. Previously she had been resistant and pessimistic about the treatment. She had become more open to my interpretations of her resistances. I realized that she was in some ways quite young for someone in her seventies. She was still a very smart, good looking woman and something to do with her personality was preventing from her leading a more active lifestyle.

## **Session 18**

Once she sat down she said:

*At the weekend I visited an old friend who is ninety. We had lunch together before going on to a lecture. Her son came in the afternoon and drove us to the lecture. She is amazingly independent and it is remarkable how she copes with everything. She has a daily helper, who cleans, shops and cooks her meals.*

She took a sip from her beaker of water and I thought by shifting herself around she indicated that she was feeling a little uncomfortable. She looked at me and smiled. From my observation I felt that she was a little envious of her friend. So I gently said:

*Perhaps you would like to be like her not only at ninety but even now.*

She gave me a furtive smile, shifted her position in the chair and then said:

*You know I would like to be like her. She is quite casual about everything and I hardly know her to be worried about anything. She always says that 'what will happen will happen! So why worry!' I suppose there is some truth in that. Maybe I will also be like that if I get to ninety.*

She gave a little laugh. I sensed the uncomfortable thoughts that might be linked with her future life but did not take this up.

She seemed calmer as the session progressed and she related the difficulties for her of using the electronic system that now goes with most telephone calls to theatres and other business companies. She had tried to purchase some tickets for a performance to which she was taking some of her grandchildren. She just about managed to do it but now she has to remember to take her credit card out which she does not like to carry around.

The sessions seemed to progress in a calmer and non-hysterical mode. Communication improved, allowing for dialogue. She became more thoughtful and reflective. She often paused and also was able to think about my interpretations. She was able to acknowledge what I felt had been her denial of mourning her much loved father and the anger she experienced over his death.

She was able to look at her mother in a more kindly way and not think of her as 'a frivolous floozy'. She recognised that she had found a replacement father in her husband. Whenever this came up she always added that her husband was a good man and really adored her although he could never support her in any practical way.

### **Session 25**

More and more CF became open to discussing her past life openly and was insightful to how it had been. At one point in this session she talked about her family and some memories of the children during their younger days. This led to her saying the following about her late husband.

*I wish he had supported me at least emotionally even if he could not help with the children. He was a jovial man and no doubt loved us all very much. We were never short of anything or deprived of anything we wanted. But I now see we were part of his business programme. What was necessary had to be done.*

I thought she looked sad when she related this.

### **Session 30**

CF informed me:

*I made the final payment for the holiday. Sometimes I worry, wondering if I made a good decision, but the best news is that a very good friend of mine is also going to be on it. I was at some good friends' golden wedding anniversary. They are in their eighties but look so fit. It was a long way for me to go but I pushed myself to do so. It was there that I was told that my friend was also going on the trip. I phoned her immediately when I returned. She is also excited now.*

I repeated 'long way to go' and she then went on to relate that the couple lived nearly seventy miles from London. She went on a train from Waterloo. She

giggled as she informed me:

*You see I did not know that there were compartments that only went a certain distance! It became too complicated for me. I hadn't travelled on a train for years. Not since my husband became ill. We used to go to Paris by boat and train. It is all different now. I have not been on the Eurostar to Paris and I would like to do that.*

I noticed that she had become nostalgic and she looked sad. She divulged how different it is to have someone in your life who takes responsibility for you compared to being on one's own.

*My husband was a very organized person. I used to tease him that it was easy for him because it was his secretary who did it all. On the other hand it was true. He did have people doing things for him. He had me at home and his secretary at work. Don't get me wrong. I liked her very much. She really helped him very much with running his business.*

I realized that she now talked frequently about her relationship and of her experiences with her husband other than her having nursed him for almost twelve years. She had shifted to a depressive state (Klein, 1935) and had begun the intrapsychic mourning process of losing her father, mother, brother and her husband. The sessions were now full of anecdotes about life with her husband before his illness. She was able to speak of her teenage desire to go into her father's profession. She knew it was going to be a struggle because of her cultural background but was sure that her father would have supported her.

### **Session 33**

At the beginning of the session, as often, CF filled me in with some of her activities with family and friends. She had managed to persuade her younger son to move out all his books and papers from near the piano and the spare room. Throughout her therapy the son's obsession with hoarding everything intermittently came into the sessions. Although he had a small room of his own

he often stayed with her and used her flat as a dumping ground. Her second son was coming for a week with his wife and toddler. She wanted the flat cleaned out properly especially as there was going to be a young child crawling around. She said:

*I threatened to have everything taken away and burned. This brought him to his senses. I haven't a clue what he has done with them and I don't care.*

Unexpectedly she looked as if she was in deep thought. After a longish pause I said that I wondered what was on her mind. She looked nostalgic as she revealed:

*I used to spend many, many hours in my father's study. He used to have lots of books and papers about but they were orderly. I used to do my own work but at times helped him to sort out his books and do some filing. He would say to me, 'One day you will appreciate and understand what I am trying to explain to you.'*

She couldn't go on and for the first time I saw tears whilst she became overcome with emotion. I was thinking of the prolonged Oedipal phantasy (Freud, 1924; Britton, 1998) that existed and continued to be evident. She herself had admitted that she had married a man who was a substitute father.

### **Session 36**

For the first time I realized that she was now coming without her walking stick. I could not recall the first time she did this but I remembered that for a few weeks now I had not been assisting her to pick it up at the end of the session. She excitedly related that she had met an old acquaintance at the wedding anniversary luncheon who was also going on the trip abroad. She had not seen this friend since she moved out of London. This made her feel good about going. For the first time she looked a little animated as she spoke about the places she was going to visit.

*I would have to adapt and only do the tours and walks that I can manage. I am*

*always happy to sit somewhere comfortable and read a book whilst the others are out sightseeing.*

This gave me the opportunity to bring up the walking stick. She quickly explained that she always had one in the car in case she needed it. It was straightforward and a short distance from the car to the building. I did not want to push the point that previously she used it regardless of the distance.

She also became a lot more assertive and less inclined to let her friends take advantage of her. She could say 'no' as she described.

*I had arranged to go with a friend, recently widowed, to a concert. I agreed to pick her up and once we set off she asked me if we could deliver a parcel to a friend on the way. She could not remember the door number but said she would recognize the house. I refused to do that. Once before when I did something similar we were late for the concert.*

When I suggested that she was now able to think of herself and her needs more than she used to, she quickly said:

*I do not want to become heartless and selfish. Oh don't misunderstand me. I know what you mean. I realize I used to be a willing slave to but I now think differently.*

#### **5.4.4 End of treatment**

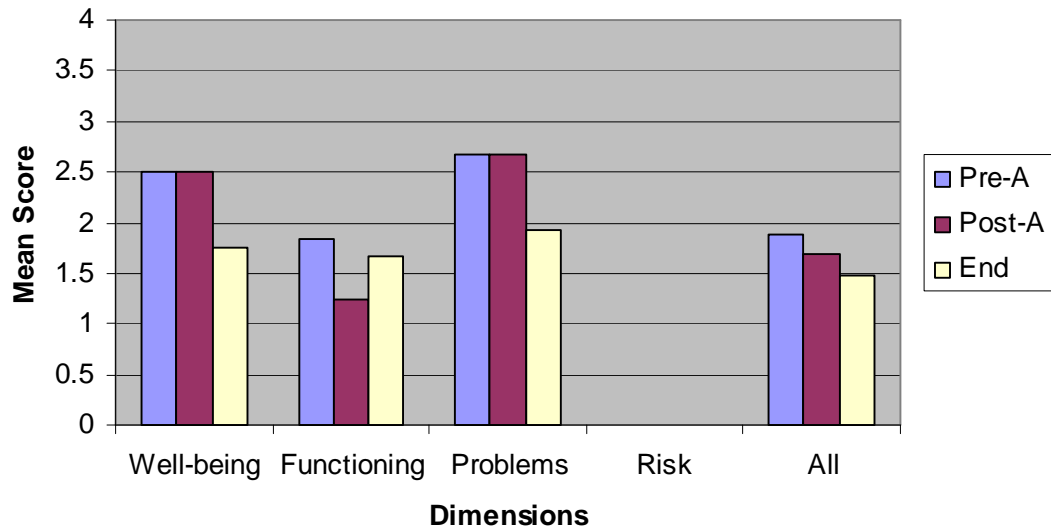
She continued to come regularly saying that she looked forward to coming and continued to openly discuss personal feelings. I noticed that she hardly ever brought her stick and at one session when this came up she explained that she always had one in the car for an emergency. She also carried a folded stick if going anywhere uneven or at night but she hardly used it these days. At times she regressed and was terrified that she might lose her friends if she stopped being a chauffeur at their request. She decided that if they did not want her company other than to exploit her then they were not her friends.



By the end of the arranged therapeutic time limit she was able to look at her mental state in a more positive way. She was able to assess and accept her physical limitations. The more she allowed herself to think about her vulnerabilities the stronger she became mentally. Paradoxically she was doing more than she used to. Meanwhile she had plans for local outings and concerts. The latter had been her favorite pastime since her days with her father and continued throughout out her life. I was a bit concerned that this might be a manic way of not wanting to mourn the end of the therapy.

At about this stage in her therapy a major event took place. She was able to get her son to remove all of his junk and long hoarded, useless gadgets and computers out of the flat. He actually started dating a woman, whom she liked and much to her relief he spent time away from the flat. Consequently she went back to playing the piano. At first she grumbled about her fingers not being as flexible as they used to be but fortunately persevered. I was delighted when she explained that her son persuaded her to encourage his younger daughter to practice with her, to help the girl with her lessons. She started to do this regularly and this enabled her to become a lot more enthusiastic. I thought she enjoyed being a piano teacher once more. In some ways she had already changed but there was a lot more to think about. I also felt sad when it was time to say 'goodbye'. At the beginning I used to dread her never-ending verbal flow but as she settled in more it was satisfying to see the changes she had accomplished.

#### **5.4.5 Core scores and end of treatment graph**



CF's reported scores at the beginning are not as high as some of the other case studies and there is no indication of risk. The scores indicate a slight rise in all the areas during the psychotherapy. Perhaps this was due to her becoming emotionally aware but by the end of treatment there is some notable reduction in all the dimensions.

#### 5.4.6 Overview and impressions

CF had developed a 'second skin' (Bick, 1964) to protect her vulnerable psychic equilibrium that repressed and redirected her basic needs by splitting them off as the needy parts of others. Instead she exerted her mental energy by providing for her ever-demanding family. Her defence mechanism was to split-off and project her needy part. This became a defensive shield apparent in her insatiable need to talk (verbal diarrhea). The defensive mechanism of hoping to find a father through her husband could be seen as 'defensive hope' (Potamianos, 1997). She hoped that by doing for others she would fulfill her own needy little girl part, thereby denying her own needy child part.

The little girl part of CF was unable to mourn the traumatic experience of her father's death and unconsciously forced her into a mental state of denial of the loss. By becoming controlling she was in charge and nothing could be taken away from her. She had everything the way she wanted it to be and made

others dependent on her because she was never going to depend on anyone. She could not allow any room for anyone to let her down like her father did. At first this interpretation made her feel uncomfortable but as the sessions progressed she was able to think more productively and openly.

Firstly, perhaps dissatisfied with having to give up a career following in her father's footsteps she repressed these feelings and redirected her energy into becoming a good wife and mother. She believed that her mother had never been a good object for her and perhaps in an act of reparation her children's needs became her priority. Secondly, she deprived herself of the opportunity to pursue a career in music and become a concert pianist as she had wished to be. Instead she married an affluent man who provide willingly and unstintingly. She could have pursued a career with home help if she wished to but she sacrificed her ambitions to marry a replacement father figure. She would have entered a competitive world and might not have been successful but she never gave it a chance.

She could never think of her mother as a good object. All love was directed towards her father. The Oedipal love could never be relinquished, especially after her father's death, nor transferred in any meaningful way towards her husband. She once said that she had always been fond of her husband who was very considerate towards her but 'but the word love was never mentioned'. He was a kind man but not a passionate person. On the contrary her caring self could not extend towards her mother when she became needy, who according to her had never been a 'containing object'.(Bion, 1964; Williams, 1997). She often referred to her as 'my floozy mum' who in her consciousness had never been a holding mother. But perhaps she hid her own guilt feelings in connection with denying her support towards her mother when she became dependent and needy. Her pseudo caring personality could not expand to incorporate the mother she did not like. She at times during the course of the therapy conveyed how much she missed her father when he was away lecturing abroad. She could never depend on her mother to give her any support.

With hindsight, as she pointed out to me during supervision, she was in denial

about her mother's death and the inability to mourn her loss. There evidently was also the unspoken repressed and passive anger that became the cause of her depression. As CF's therapy progressed it was evident that her depression originated from the time when she lost her father so tragically. Consequently his death became unbearable, she was unable to mourn and could not mentally cope with the reality of the situation (Jacques, 1965; Murray-Parkes, 1972; Hildebrand, 1982).

Waddell (1998, 195-211) has said:

*If a person lacks an internal container of feeling, one that is sturdy enough to withstand new or renewed challenges to his peace of mind and sense of self, he may have recourse to earlier patterns of functioning, ones mobilized in the service of avoiding pain. The pain may now be of actual bereavement and loneliness, or it may be associated with the many losses that will, at this later stage, shadow normal life ... the presence and support of children.*

After listing the many concrete losses one can experience she goes on to say:

*In the face of these difficulties it is to be expected that people will seek ways of protecting themselves from the immediacy of the impact. They will take defensive measures in order to lessen their psychic and physical discomfort.*

When this vein of thought connected to the unbearable nature of her losses filtered through she was able to speak about her relationship and the impact of her father's death. No one could ever replace him in her mind. She had idealized him and even her agreeing to marry an older man did not alleviate the need for this unmourned father. Her anger was projected towards her mother. Slowly as she came to terms with this and her mother's death she was able to connect her grief to her depression. The process of growing old did not become such an ordeal, as CF had made out. She was able to accept that she was

physically a bit more needy than she used to be but that her mental functioning was almost intact and therefore there was much for her to enjoy and live for.

She was not only capable of thinking about her unfulfilled dream but she constructively expressed that she might not have been successful in achieving this.

*But I will never know. If it was meant to be it would have happened!*

This was quite a poignant moment. Although the very complicated 'unconscious phantasy' (Klein, 1948; Isaacs, 1983) of the Oedipal development between CF and her father had never been explored during the treatment I sometimes wondered about the idealized relationship she frequently spoke of.

However CF had made some very recognizable changes for the better. She had stopped taking any kind of medication. She was continuing to be active but in a less manic way and seemed to enjoy what she was doing. The most noticeable and important change in her personality was for her to be able to say 'no' when family and friends made unnecessary demands. She looked physically much better and walked reasonably well without her stick, which was not only a physical support but also a mental prop for a fragmented state of mind.

#### **5.4.7 Summary of key facts from the data**

For some unknown reason CF felt and referred to her mother as a 'useless floozy' and an incompetent object, which was the counterpoint an idealised, oedipal relationship with the father. His sudden death left her devastated and traumatised. She gave the impression of being a kind and generous person but she seemed to lack real internal warmth and was deprived of emotionality. Everything she did because she thought it was the right thing to do. Replacing her father by marrying an older man did not seem to change this situation. She was at times over indulgent towards her family and friends but I thought that this was due to indulging a needy part of herself that she could never accept. She had split-off some very painful experiences, such as the many losses of people

whom she had close relationships with – father, brother, husband – and she could not accept this and mourn their loss. This was only achievable during the later part of the psychotherapeutic intervention. There had been a constant desire that her many desired childhood needs would still come to fruition until she realised that this was not going to happen. The mourning process could only take place after this realisation. The physical losses that came with the ageing process as well as the family being less involved with her exacerbated the early losses.

Therefore the key facts as findings are:

- 1) The traumatic experience of the tragic death of her father during childhood.
- 2) Replacement of father by marrying a much older man and thereby creating a state of denial, not mourning the loss of her father.
- 3) Holding on to hope as a defence instead of mourning losses and refusing to relinquish what could now not be achieved. Internal state of loneliness made her become a constant carer of others; thus she kept herself busy whilst denying the reality.
- 4) Falling over for no identifiable reason was perhaps a cry for help which she could not express directly.

## **5.5 DL (71)**

### **5.5.1 Reasons for referral**

DL was referred by her GP who stated that he had been seeing her for the past year with arthritis and other chronic joint problems. She seemed to be depressed and was taking Prozac. She refused to take any other form of medication for her depression and conveyed that a friend had suggested she saw a counselor. He went on to inform me that she had twelve sessions of counselling about two years ago. 'At my last meeting with her she started

saying she was very lonely and admitted to having been physically abused by her daughter. She broke down crying and could not go into details about what was happening at home. I do know that she shares her home with her unmarried daughter and her child.'

He further conveyed that she made frequent appointments to see him but her need to do so was obviously for more than her physical joint problems. He ended his letter by stating: 'She is always very well presented and has family, friends and interests. She is, however, very troubled by what has happened in her family and I wonder if she would be helped by psychoanalysis'.

### **5.5.2 Assessment**

The original assessment given by a colleague never took place due to some transport delay on the part of the therapist and a misunderstanding in communication. DL was irate, walked out of the clinic and wrote to the director of the department. A letter of apology with a date for another appointment was sent. She accepted the appointment but did not want to be seen by the previous psychotherapist. Understandably I was a little anxious and expected to perhaps meet some indomitable tartar. Her complaint letter was very well structured and self righteous. On meeting her I discovered that my image of her had been totally wrong.

She arrived on time and I found a short, white haired, slightly plump woman who looked ten years younger than her age. She was very smartly dressed in a two piece lilac summery suit and was quite mobile. Her hair had been recently coiffured. Altogether I had the impression of a smart, pleasant, smiling woman. I immediately noticed she had rather an unlined face for her age. She carried a beaker of water and took a sip from it before settling into a chair. To my surprise I felt I liked this woman.

Once seated, she took a sip of water, looked at me and then hesitatingly explained:

*Recently I have been feeling low and depressed. I find myself withdrawing more and more from doing the things I used to do and prefer to stay indoors in my room, watching television. Nothing really interests me, except when I am with my grandson. He is my only delight in life. I thought that his arrival would bring me the peace I wished for in old age but this is not happening!*

She quickly added:

*Not him. He is wonderful and I could not wish for a better little boy. He is just wonderful and a delight to have around.*

Another pause and she became tearful. She mopped her eyes and fidgeted with a carrier bag she had left on the floor beside her. I softly prompted her. More tears and then she said:

*It is my daughter.*

She started sobbing and then continued hesitantly and in a fragmented way:

*Fran separated from her partner two years ago after a very destructive relationship. Her partner as well as the daughter had on and off abused drugs. I am so pleased that my grandson, Alex, is normal. He is so caring and loving. I think Fran only smoked cannabis after he was born. She was under a lot of stress. When they broke up Fran had nowhere to go and although she had a better relationship with her father he had no room at his house. So I had to take them in because I still have the family house all to myself.*

She gave another sob. She took a few more sips from her beaker and then went on:

*Fortunately Fran found a part time job, working from one to six everyday. I was delighted to be able to take care of Alex.*

She gave a little smile and said:



*He is my greatest joy. The other pleasurable beings in my life are my two cats. I love them very much.*

I was still at a loss as to what caused her to feel so unhappy, depressed and tearful. Eventually she divulged that she never had a good relationship with her daughter. They quarreled almost everyday over several things. She tried to avoid her when she came home by going into her room and leaving the communal living space for Fran. Sometimes Alex stayed with her until it was his bedtime. I still found that I was ignorant of the root of her mental distress and as it was an assessment I questioned her about this. She related the following details:

*Fran has a nasty temper. She has always been like that since a teenager. She seemed to have a better relationship with her father. He is a passive man and she used to twist him around her finger. Since moving in she has roughly pushed me aside on occasions. Once she punched me on the shoulder as she turned and walked away.*

She became really emotional and sobbed. I waited until she had become calmer. With some encouragement she continued.

*Twice now she has really hurt me. A few months ago she came right up to me and slapped me really hard. I was so shocked I ran up to my room and shut myself in. I cried myself to sleep. A few weeks ago she punched me on this shoulder.*

She pointed to her left shoulder as she spoke.

I felt quite shocked and incapacitated and tried to gather myself. The quarrels had been over some trivial incidents. For example: the daughter also had two cats and she felt it was impossible to only feed her two and not the daughter's, especially as Alex wanted to do so. On the first occasion Fran stayed on at her office to finish some of her work and was late getting back. She said that her

mother should not interfere and take over. On the second occasion it was due to her not keeping a promise she had made to Alex. An argument arose because she had once more helped herself to twenty pounds from Alex's moneybox. Fran was furious and told her mother to mind her own business. Whenever Alex visited his father, now a changed man, he usually returned with money from his father as well as his other grandparents. At the end of the month DL usually took her grandson to the post office to bank his money.

I gently conveyed that it seemed as if no one was going to do anything about her situation if she allowed it to continue. She looked puzzled. I said that she had time to think things over until we met in a fortnight's time and ended the interview. She thanked me profusely, smiled and left.

### **5.5.3 Treatment**

#### **Session 1**

On the morning before the session DL phoned to confirm that she was coming. She arrived 15 minutes before her time. As she removed her outer jacket she volunteered:

*I know I talk too much but I couldn't wait to get here today. I have so much to tell you. It is unbelievable. I kept thinking about what you said last time I saw you. I know I should tell Fran to go but how will she manage. She has no money and what about Alex?*

She was obviously looking at the concrete 'outer reality' and I could appreciate her difficulty. She went on to tell me that Fran's current boyfriend, Colin, had just gone through a divorce and had two children to maintain. He had moved into a one room flat. She then went on to say:

*Fran stays over some Saturday evenings but as there is no room for Alex he stays with me. We have had rows about her cats. When she goes off to Colin on the Friday she usually comes in the next morning to feed her cats. By then I*

*am up and have already fed mine. Hers come to me miaowing for food. I give in and feed them too. We have had awful arguments about that. She calls me an interfering old fool. I am always intruding on her life.*

She took a few sips of water and dabbed at her eyes:

After a pause she looked directly at me, shrugging her shoulders, and pleadingly asked:

*What can I do?*

My thoughts linked with the concept of Klein's projective identification; with this in mind I wondered if she had ever thought that Fran might be the intruder who was interfering in her space. After all she was a divorced mother with a child who had lived previously with Alex's father, whilst she (DL) had her home to herself. She was doing her daughter a favour by giving her a home.

At first she looked taken aback but what I said eventually dawned on her. She nodded and volunteered:

*I did it for Alex. I could not bear to see him drifting around from one place to another. But I see what you mean!*

Another pause and then she mentioned her son Andy, ten years older than Fran, who lives 50 miles away. She did not tell him about the physical abuse, although she felt very close to him. He was very sympathetic about Fran being awkward and said that they would discuss this in a few weeks time when he was in London.

The next few sessions were mostly anecdotes of her experiences with her grandson. She spoke of her routine of taking him to school daily, the meals she made for him and how she loved having him around. Her whole life seemed to be centered around him and her cat. Fran left early and came back in the evening. By then she was usually out of the kitchen, in her room watching the

television. Alex spent his time between being with his mother and running upstairs to watch TV with her until he went to bed. I felt sorry for this lonely woman who seemed to lead a monotonous lifestyle and at times felt quite bored. I felt that in the countertransference I was being influenced by her state of mind and lacked the initiative to encourage any movement in the therapy. I made comments about her sharing her lonely feelings and how dependent her life was on Alex. She smiled but never commented, as if agreeing with what I said.

### **Session 8**

Two days after our previous meeting a quarrel arose between DL and Fran who kept insulting her and called her an interfering old fool. Fran had gone to stay with Colin on the Saturday evening and her cats were getting really hungry. They kept coming towards her. She was now in the habit of feeding her cat in the kitchen. Not being able to bear it any longer she fed Fran's cats. Not long afterwards Fran arrived and she tried to explain. Fran came threateningly towards her and she quickly thought she had to do something. She was near the phone.

*I screamed. Stop right there or I will phone the police!*

Fran taunted her.

*Go on then! Go on then!*

*I don't know where the courage came from but I calmly picked up the phone and dialed 999. Before I realized what was happening I was talking to a woman. Straight away a police woman asked me a lot of questions. I found myself telling her what was happening. I vaguely heard a door slam. I put the receiver down and started to tremble all over. Alex ran up to me and we huddled together on the sofa. Suddenly the doorbell rang very loudly. It was the police. I was confused and I started to cry. The police woman sat me down and calmed me. Eventually I told them what had happened but I refused to press charges.*

A couple of hours later Colin phoned and spoke to her. He said that Fran wanted to speak to her but she refused. He said they were coming around but she told him that she did not want to see either of them. Early the next morning at about seven o' clock she heard the front door open and Fran came in. She looked sheepish and said that she had come to take Alex out for the day. Whilst she was busy making Alex's breakfast Fran came into the kitchen and stood around. She ignored her and then Fran volunteered that she would be moving out as soon as she found a place. Angrily she said:

*I felt furious. Not an apology from her. She went out and waited for Alex in the car. He looked very confused. I could see he did not want to go I felt sorry for him and I told him to go and said that I would see him later. He hugged me before going out. I felt like picking up her things and throwing them out after her and screaming: get out now! It was only the thought of Alex that prevented me from doing this*

The long repressed, passive anger had now surfaced and perhaps my reference that it was her space that was being invaded upon made her react in this manner.

Two weeks later Fran moved out with Colin into a small flat. Her comments were:

*God knows how that is going to work out. He is a nice guy. Don't get me wrong but he has now been unemployed for nearly two years. He does some part time work at a shop, helping with sales. He is a very clever man who had a job in the city. About two years ago he was made redundant without compensation. I don't know how they are going to manage.*

Colin came in one morning and asked if she would pick up Alex from school in the afternoons and give him his supper. They will pick him up later. She felt very pleased. Fran started to come in the evenings with Colin to pick Alex up. Then one morning before school she turned up with Alex and they had breakfast with

her. This started to become almost a regular event.

By the end of the first term I realized that nothing of her past life had been revealed. The current traumatic experiences had taken up all the sessions. The only information I had was from the initial assessment form. She never spoke in any detail about her son or any of her relations or current friends. Alex wanted to stay for the weekend as it was half term and surprisingly Fran had agreed. When Fran came to pick him up she was very pleasant and said, 'Hello mum. Hope Alex has been a good boy!' The second she responded that, 'Alex was always a good boy' he immediately ran over and hugged her. Almost without stopping she went on:

*I miss him so much! The house feels so empty without him. He was my only joy.*

The tears started to appear and she wept softly. I waited feeling really sad for this lonely woman. After nearly ten minutes of sobbing she dried her eyes, looked at me and said that after what I had said about Fran being the intruder she realized that it was up to her to seriously think about what was going on. She had not expected Fran to move out but to change her behaviour. Colin had suggested that it would be better for everyone.

I said that perhaps she feels angry with me for making her aware of the situation and perhaps with Colin for suggesting the move. She immediately refuted this, adding that on the whole it was for the best.

## **Session 10**

DL revealed:

*Fran comes in every morning with Alex, early enough for us all to have breakfast together before going on to work. I realized that Fran actually misses me. The other morning before leaving she actually hugged and kissed me and said 'I love you Mummy!' I was too shocked to respond to her behaviour.*

Perhaps this made a difference to her reaction to the coming break. She seemed calm and a lot more relaxed, relating her week's events with the family. She came in, having done a huge amount of shopping at a local supermarket and said that it was her favourite place to shop. She did not have a branch near her. She talked all about the cooking she was going to do for Easter Sunday. Colin, Fran and Alex were going to be around but Andy (DL's ex-husband) had not as yet confirmed. I did not go into the reunion dinner because for the first time she looked happy and it was the session before the break. Just as she was leaving she mentioned that her ex-husband and his partner were also joining them later that afternoon. I was surprised but just smiled. She said: *'Goodbye! See you in three weeks time.'*

After she left I realized it had been the first time that her ex-husband had come up in a session since the assessment. From what she said I assumed they had an amicable relationship but it left me feeling quite curious.

I sent the usual letter to her GP to inform him of her progress but did not receive a reply.

### **Session 13**

DL was as always smartly dressed and gave me a big smile. As she sat down she said that she was pleased to be back and chattily asked about my holiday. I responded as politely as possible without making it a point of conversation. I could see that she looked excited and could not wait to give me some news. She gave me another big smile and looking almost manic she said:

*Remember I mentioned that I wanted to change my bathroom. Well, I had some estimates and chose a very nice person, recommended by a neighbour, to do the work. I decided that it was time to do the things I wanted. For a long time now I have wanted to modernize it as well as my dining room. After a lot of hesitation I arranged for an equity plan. It is only a seven year one.*

The rest of the session was full of her plans about the house. I also gathered

that her ex-husband had agreed to the house being transferred to her many years ago. This had created problems with her son who thought it should be both on his and Fran's name.

*He was being stupid. Who else would I leave it to?*

I was thinking how controlling and powerful she could be when she wanted something and yet there was a very vulnerable split-off needy part of her. I also wondered when I was going to see this side of her again that she had brought to her early sessions in connection with Fran's behaviour and her feelings towards Alex. But I was also pleased that she looked happier than I had ever seen her.

## **Session 18**

DL looked quite excited and not long into the session she said:

*Remember I told you about an equity scheme to find the money to modernize my bathroom and decorate the place, especially my old dining room. When my mother came to stay with us we converted it into a bedroom for her so that she would not have to go upstairs. My son was horrified. He complained that I was doing a SKI (Spending the Kid's Inheritance). He stormed out and I have not heard from him since.*

She further explained that she thought her ex-husband whom she was still in contact with on family social occasions would demand his share but he had not said anything when she told him about it. That was a big relief. This led to her relating details about the house being theirs and she had remained there with the children when they divorced. She continued to keep up the mortgage payments by working as an administrator of a large company. He could actually demand half but up to now had never done so. He now lives at his partner's place and seems very content with the way things are.

At some stage during this session in connection with refurbishing the old dining



room she spoke of her mother for the first time.

*My mother lived well into her nineties. A year before she died we moved her into a nursing home because she needed twenty four hours of care. Neither she nor my husband could afford this. But he was a good man and made sacrifices. He treated her very kindly. He loved her like she was his own mother. I will always respect him for this.*

She gave a big sigh and I gently questioned this. After a little hesitation she smiled uncomfortably and shifted her position. There was a pause and once more she took the inevitable sip of water whenever she felt slightly flustered and I waited. She then started hesitantly:

*I would hate to think that I am complaining. I have always tried to do my best with both my children but somehow it never seems to be right. Ever since the argument over the equity plan my son has not spoken to me. Once before he stopped speaking for nearly a year because he found a letter I had written saying how my children do not care about me. Oh! I did not post the letter. You see I often write my thoughts down as I feel and then I lock the sheets of paper in my wardrobe. One day when I am dead and gone they will find them. I would like them to know how badly they have treated me after all I have done for them. The letter was lying on my bed.*

Immediately I could not make sense of her paranoia. She had a large folder full of these letters addressed to both Andy and Fran. I thought of this as persecutory and obsessional. She wanted to make both her children feel guilty after she was dead. Although I tried to tentatively explore this strange notion, she did not respond. Instead she started to tell me about the good relationship she had with Fran while Andy was now not speaking to her. As it later transpired she was unable to have a close ongoing relationship with both her children simultaneously. I also recognized a very self righteous aspect to her personality. She was never in the wrong.

*I have so many letters written and addressed to my solicitor about both Andy*

*and especially Fran. They really express my feelings. When I am dead my solicitor will read them to them.*

She paused and shifted uncomfortably as if acting her feelings of discomfort in a bodily manner. I waited and she gave a little hysterical laugh and repeated:

*I don't know what you are going to think of me. I keep those letters in a locked cabinet in my dressing table. I, I, I, Oh! I hope they will read them when I am dead and gone. I want them to feel guilty about the way they have treated me. They never listen or consider how I feel. I want them to know!*

I was confused. I thought the letters were with her solicitor. She burst out crying. Eventually she dried her eyes, sipped her water and said:

*Thank you! Thank you! I have never spoken of this to any one. Now you know my secret. I feel better for talking about it with you.*

It was time to finish and she took a long time to gather up her things before leaving.

I felt quite drained and confused.

### **Session 23**

By this session I had learnt about more of DL's secrets. She divulged that when she became nervous or anxious she started to harm herself. She scratched the upper part of her arms, thighs and calves until she drew blood. Nobody ever got to know about this because they were parts of her body that were always covered. This usually happened after arguments with either Andy or Fran and occasionally with her ex-husband. Once Alex had noticed the scratch marks on her calf and commented on them. She told him that the cat had clawed her when he accidentally caught his claws in her stockings. He believed her and suggested she rub some cream on the scratches. She looked a little uncomfortable.

I realized that in her assessment form DL described herself as a happy person and did not have any regrets about her life. In reality as her therapy progressed I realized that she appeared to look smart and cheerful but on scrutiny she was chronically unhappy, felt unloved, aggravated and awfully disappointed with her life. She was depressed and had been so since she stopped working. On further reflection I think the depression had been there for most of her life and she had learned to present a false self. We were approaching the end of the second term of our treatment plan and I despaired of how very little I really knew about her. My perception was that there was a whole lot more than her repression and split-off part of her personality to explore. I was never going to be able to do justice in the limited time and began to feel guilty. I also had to acknowledge that in the transference I was being left with much of her unprocessed guilty feelings. As it transpired this became true during the following term.

By the end of her second term into the treatment I felt that her outer lifestyle had changed. She had become animated about the concrete changes she was making in her home. But I could not see any internal growth. Her life seemed involved with her outer activities. The fact that her son was very upset and had made no contact did not seem to worry her at all. She was now having a reasonably good relationship with Fran. I wondered about her relationship with her children. The mental picture I had was that it was good with only one or the other at any one time.

### **Session 28**

DL informed me that she had started writing down as much of her therapy sessions as she could remember. This had started during the break when she missed coming. She had so much to tell me. To my amazement and despair she produced a thick exercise book. I did not think that the psychotherapy should become an autobiographical exercise and suggested that she kept what she had written down for her own reading but maybe used it to free associate. She was quiet and in order to explore her psychic state I wondered if she had

any dreams. Her response to this was:

*I never dream. People say everyone dreams every night but we don't remember most of them. I don't remember any.*

Fortunately, the writing had brought back several childhood memories. To my encouragement she went on to relate the following:

*My mother was a very hard working and house proud woman. She was like this all her life until she died at the age of 97. We were very poor but my mother could produce wonderful meals from the few things she had. We never starved and my brother nearly ten years older than me went to work at sixteen, when things became a lot better.*

She told me that both her parents came from immigrant families and were refugees. Her mother came before the war and her father soon after. Her mother never learnt to read or write but knew enough English to be understood. Her father came via France as a wounded war veteran. Jobs were scarce and a friend of her paternal grandfather suggested he visited him in England and gave him an introductory letter. DL's father visited her grandfather's family as suggested. He became a frequent visitor and before long the relationship between her parents developed. Looking very sad she said:

*It was definitely a love match and they were very happy together but sadly it did not last for very long. My father developed an abdominal illness and died at the age of thirty-eight. I was just over a year old.*

After a pause she continued to tell me that she has no memories of her father but just a small snapshot which she keeps with her mother's photo on her dressing table. She was very attached to her mother. Eventually when she went into a nursing home she saw her almost every day.

During this stage of the psychotherapy I discovered that she slept with her mother in the marital bed until she left home to marry at the age of twenty-six.

She went on to divulge:

*When I was nineteen and started working my brother had left to go into the navy and I asked my mother if I could move into his room. My mother would not hear of it and insisted that she was going to make it into a dining room. What for? We always ate in the kitchen even when the family came.*

After a brief pause:

*After I turned twenty one I was allowed to go out on Saturday evenings. I loved dancing. I married the first man who asked me. It was too late when I realized that I did not really love him. It was to escape from feeling claustrophobic at home. My husband was a very passive man. I never felt sexually happy with him. He was very kind. After the birth of our son I felt I owed it to him to remain in the marriage.*

Her mother was probably depressed after becoming a widow when very young and left with two children to care for. She depended on hand outs from the family and did some sewing to keep her young family. Mother and daughter became an enmeshed. DL escaped into a loveless marriage. She did everything she could do for her two children, expecting them to provide the love she had hardly experienced in her lifetime. Unfortunately her insatiable need for love made it oppressive and demanding and the more she tried, the more she alienated them.

*I have never been really happy throughout my life. When the children were young I did all I could for them but I never ever felt loved for myself. I now realize that my mother was like an automatic machine. She did all the right things but she herself was depressed. Of course it is not surprising as she had to feed and take care of us without my father to support her. There was no income support in those days and she really must have struggled to keep us. It was after the war and not easy as refugees. My mother also had a very independent streak in her.*

She gave a little smile and said:

*Perhaps I take after her. Keep the chin up, no matter how difficult things are.*

There was still a very strong omnipotent side to her and although she seemed so dissatisfied and unhappy she gave the impression that there was as she said:

*No room for regrets in my life although it has been a struggle for a lot of the time.*

I realized how defensive she had been for most of her life. Before leaving she thanked me profusely and said that it 'felt so good for being able to speak so openly and regularly to someone'.

### **Session 30**

As she walked in I noticed that she looked thoughtful and wasn't smiling in a set fashion as she usually did. She had come in with a few carrier bags as always and rummaged around in one of them. Then she pushed the bag to the side and looked at me. I could see she was struggling to voice her thoughts. Eventually I said:

*It seems as if there is something on your mind that you are finding difficult to talk about.*

She gave a brief little smile but still said nothing. I waited and thought this was unusual for her. Then softly and hesitantly she divulged the following:

*Fran encouraged me to visit my friend up north who I have not seen for a while. You know the one I mentioned to you that I can take in small doses. She can be very difficult and does not like to be contradicted. The Friday went well but by Monday I could not wait to leave. She does not think like me. We are both determined people and often want our own way. We could not agree about*

*anything. By Sunday I gave into her plans to visit some gardens. I can't even remember the name, although it was raining. I would have preferred the Laurie Museum, although I have been there before. It is very good. Have you been there?*

I did not respond but smiled whilst she took a sip of water. She seemed less fraught and I thought looked a little animated. Meanwhile I was thinking about several things. Firstly she was beginning to socialize again. She and her friend were both 'determined people' and there seemed to be more to her like her interest in art. So I made the link that she seemed more open to getting away from the house and doing interesting things. She quickly interrupted me and said:

*Oh I have always done a lot with my friends. It is only recently that I stopped. It was after my best friend Lena left for the States.*

She became emotional, looked down and rubbed her hands, looked at me and explained:

*Lena and I have been friends for many years since she became a widow. We used to do a lot together until seven months ago when she left to visit her daughter in the States for six weeks. Just as she was about to return she became ill and they discovered that she had cancer.*

She became emotional and said very softly:

*I don't think she is going to get better. Her daughter phoned me recently to say she is having chemotherapy. I do miss her very much. We always got on so well together.*

She became emotional and I quietly waited. I felt it was not the appropriate time to interpret my other thoughts about 'determined people' in connection with her trip up north. By the end of the session she calmed down, gave me a little smile, thanked me and left. I wondered if her friend's illness had exacerbated her

depressive feelings that resulted in her going to see her GP and also about her getting in touch with her ageing. What lies ahead for her? Will she suddenly discover she has cancer?

### **Session 37**

DL complained about Andy's stubbornness.

*I am feeling fed up with Andy's stubbornness. He did not phone me or send a card for Mother's Day. It makes me feel sick! Fran and Colin took me out for a meal to a restaurant in the country. It was so good of them.*

I tentatively brought up the sad situation that it seemed she could never have a good relationship with both her children at the same time. Also thinking about her statement a few weeks back about 'we are both determined people' I suggested that perhaps this is how it is between Andy and her. But I could see it was something she did not want to explore. She said defensively:

*It is his problem if he does not want to know his own mother!*

After a pause I used the tack of agreeing with her and added:

You find this more comforting than the 'false hope' that he will come to his senses and acknowledge her for who she is.

As I was saying this I could see her face twitch and contort and then the tears came. I let her sob as she fumbled in her bag for some tissues. I did not hand her the box. I felt she needed the space to become emotional. Eventually, still very tearful, she whispered:

*I have never been loved. In all my life I have never felt I have been loved for myself.*

More tears. I waited and slowly she gathered herself together and looked at me



sorrowfully. I felt sorry for her. She remained quiet and looked pensive. I waited and eventually she smiled and said,

*I have not spoken like this to anyone before. You must have a special knack to get people talking. I must say I do feel relieved saying all this to you. Perhaps I do need to come regularly! Can I continue to see you?'*

After a pause she volunteered that she agreed with everything I said but she also realised that she still needs to work through some of these unhelpful ways of behaving. She said:

*Actually by thinking about what goes on here I have changed tremendously. My attitude towards Fran is so different. She really is so good to me and we get on very well. She often phones and asks me to accompany her when she goes out shopping or for lunch.*

I gently reminded her of the situation of not being able to have a good relationship with both her children at the same time. It had to be one or the other. At this point she made a very insightful comment that impressed me. She said:

*I have wondered about this since you have brought it up! Could it be because I never had to share my feelings with both my parents? I only knew how to relate to one of them because it was the way it was!*

I acknowledged that she was being quite perceptive and this opened up a new area about the absent father. She went on to reveal:

*I have a photo of him from before the war when he was in his early twenties. It was a tiny one probably taken by a grateful diner who had eaten at the restaurant my father worked in. He was wearing a small white apron and looked very happy. I remember my mother giving it to me when I married and I placed it in the same frame that had my mother's photo. It has been standing on my dressing table ever since.*

Her eyes filled with tears and after a while she went on to relate that she used to ask her mother about her father, but her mother would not go into any details. She tried to evade any questioning and she realized that her mother found it too painful to talk about him so she stopped asking her. She was once told by an uncle that he was an excellent chef and that he worked at a prestigious hotel restaurant. She went on to relate what little information she had about her Dad from hearsay whenever he was mentioned at family gatherings.

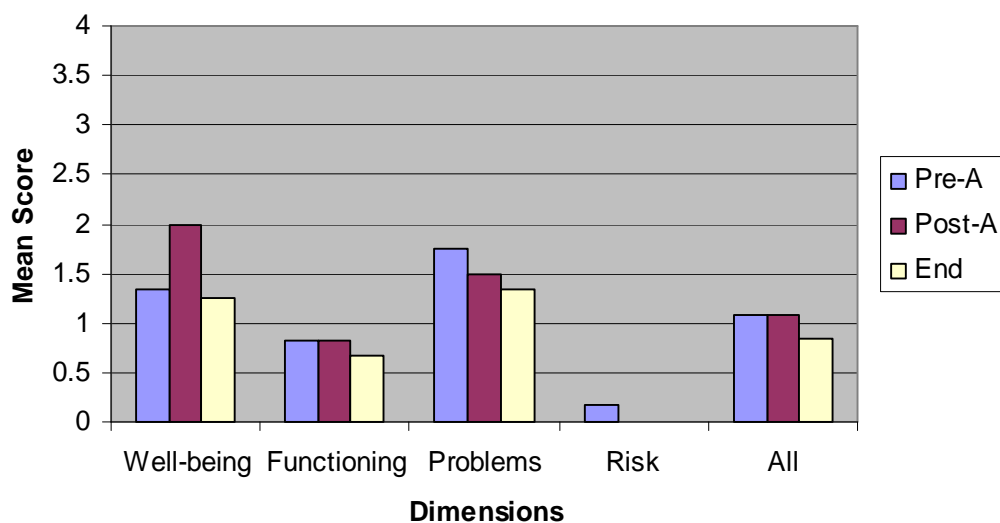
As the therapy progressed she divulged without reservation her innermost feelings about her difficulties with relationships. She often went into lengthy discussion about difficult encounters, especially with family relationships and the decision she made to separate from her husband. The consequence of sharing long-repressed feelings during the therapy alleviated some of her depression. She started to have a more active social life and joined a club for older people. They met once a month and either went out for dinner or contributed towards a meal at a member's house and played card games. She very much enjoyed going to the club and this led to her meeting with an old acquaintance. They became close friends and arranged to go on a cruise. They also went out fairly regularly and planned another cruise in the autumn.

#### **5.5.4 End of treatment**

During the last few sessions she surprised me more by divulging something she was going to do almost immediately after her therapy ended. Compared to the many activities she was getting involved in this particular one took me by surprise. She had looked through the local prospectus for further education and joined what was called a 'Life Writing Class'. This provided a space on a weekly basis to write one's autobiography from memory starting with the earliest one could recall or remember. At the end of the workshop the group read out what they had written if they wished to do so. The course lasted a year and by the end of it they would have reached their present life stage. She seemed delighted with having discovered this.

I was aware that she was finding an alternate space for the therapy she was going to miss. Writing about herself was going to be like talking to me about her life both past and present. I felt pleased for her ambitious future but was also wondering about the preparation she was making, perhaps confronting the end of her therapy. As expected she found it difficult that the therapy had come to the end and I also found it sad to say 'goodbye' although we had arranged for a review meeting.

### 5.5.5 Core scores and end of treatment graph



DL came into treatment with the belief that she did not have any serious problems, functioned very well, was self-sufficient and there were no anxieties or risk factors. But as the treatment progressed became more aware of her problems. Her defences started to crumble and she admitted to her neediness, felt less secure and saw the usefulness of some ongoing psychotherapy to improve her lifestyle. The changes in the CORE chart do not indicate any vast improvement.

### 5.5.6 Overview and impressions

DL came into psychotherapy with very vague notions as to what it was about, which did not surprise me because it is not easily understood as an experiential activity until one is in the therapy. She had been a well-defended person that staved off all show of weakness and neediness by controlling others and she

was a little self-righteous, claiming to be able to cope without others and do everything on her own. In traditional terminology she had acquired a narcissistic personality. Although she described herself as being happy and not having any regrets in her life she paradoxically was full of 'what might have been' ideologies. In the concrete outer reality she presented as being stoical, independent and competent. But as the therapy progressed she showed her vulnerability and her worrying feelings about being stuck, unhappy and her troubling relationships with her children and friends. Perhaps the illness of her best friend reminded her of the possibility of her own death and instigated thoughts about her own ageing process.

Internally DL was a very lonely person who felt that she had never been loved. Her mother was depressed throughout her younger life and she had never mourned the loss of a father she had never known. Both her brothers had died and I realised that she had hardly spoken about them. She had split-off some of the painful childhood memories in order to survive, as Klein (1946, 6-12) comments:

*Splitting is one of the earliest defensive operations that comes into play by the immature ego in an attempt to cope with intense anxieties to which it was at times subjected ... The denial of psychic reality becomes possible only through strong feelings of omnipotence – an essential characteristic of early mentality. Omnipotent denial of the existence of the bad object and of the painful situation is in the unconscious equal to annihilation by the destructive impulse.*

In the transference there was evidence of the little girl who wanted a strong 'daddy person' in whose arms she could collapse and who would hold her firmly so that she could forget the woes of the world. For most of her life she functioned on a level of not thinking about the absent father or the depressed mother. She came into the therapy with feelings about a special, idealised mother. By the end of the therapy, she could appreciate that she had inherited her oppressive sense of duty and stoicism towards her children from her

mother. She was able to recognize her difficulties with separating, thereby acquiring a false sense of the idealised object. Her only means of flight from mother's clutches had been to rush off and marry the first person who asked her. The experience of being in the same bed for nearly twenty six years with her mother was the direct opposite of hers with her daughter. As Quinidoz, D. (2010, 19) pointed out:

*Memories that are in the background are not lost, they are part of a personal history, they are still alive and linked unconsciously to all our other memories, they can be revealed. Unconsciously we do not want to acknowledge that these items belong to us. These memories are simply not forgotten, we have split them off, so that they appear to have been lost. Although splitting protects us from pain or shame, it does to some extent make us poorer.*

As the therapy progressed she was able to relinquish the idealization of her parents and mourn their loss without attaching blame and integrating these losses. Her defensive hope led to a position of splitting-off the unbearable losses. The time-limited therapy prevented further exploration but perhaps hopefully she indicated she would be interested in further psychotherapy.

A few months after the review appointment she wrote to me asking whether she could come back to see me or if I could refer her to someone else. Due to our research arrangement I decided it might be better for her to go to someone else and gave her the appropriate phone number of the private service amenity. I never heard from her again.

### **5.5.7 Summary of key facts from the data**

DL was one of my most difficult cases to penetrate psychically. She had maintained an extraordinarily resilient mental defensive structure for almost all her life. The experience of losing a father she had never known and being cared for by a depressed mother who had not been able to mourn the loss of her

husband had created a defensive structure of independence in DL which helped her survive the lack of emotional support. She learned to depend on an ego-destructive superego as a defence. She was never going to trust anyone to take care of her and it was very difficult to find a crack in her armour to work with the residue that was stored internally. In order to relieve herself of the pain she scratched herself until she bled. The vulnerable, needy child part of her still hoped that she would be loved without restrictions.

Therefore the key facts as findings are:

- 1) Dysfunctional early childhood: father died while she was an infant, mother depressed and replaced husband with infant in her bed until DL was 26.
- 2) Split-off feelings of need for herself. She became a doer.
- 3) A sense of never being loved for herself, creating difficulty with relationships in adult life.
- 4) She could never become really attached for fear of being used, like she thought her mother had done to her.
- 5) She cultivated a defensive hope that she would be loved by at least by her children.

## **5.6 GS (AGE 68)**

### **5.6.1 Reasons for referral**

GS was referred by his GP. He had previously attended the clinic in the seventies for about six years for individual psychoanalytic psychotherapy. The GP informed us that 'over the past year he has been experiencing disturbing thoughts, particularly at bedtime. Suicidal thoughts float into his mind.' His past medical history indicated that he suffered from depression and in 1999 had been admitted to hospital. Then he was prescribed a course of Prozac. He had also been treated with Citirizine Hydrochloride tablets. GS had over the years complained of erectile dysfunction. He especially requested to be referred to the clinic in particular on account of his previous attendance and furthermore because 'there was no similar suitable NHS service in his locality.' The given information was minimal but fairly clear.

### 5.6.2 Assessments

The psychiatrist to whom he had been originally referred saw him for three assessments before referring him to me for psychotherapy. It transpired that he reported a long-standing history dating back to his childhood years of feeling isolated and lonely. It was also reported that 'this state of mind continues to the present date and he finds himself perplexed, wanting help to overcome his experience of feeling continuously impinged upon, which results in difficulties in living his life in a fuller way.' His brief family history revealed that he came from a colonial, rural background abroad. They were a very ordinary family. Father was a manual factory worker who eventually bought the factory. His mother remained a housewife throughout her life. His father died when the patient was in his late forties and his mother in his early fifties. He had two younger siblings, a sister and the youngest was a brother.

His mother came from a middle class European background and was familiar with classical music. As a child she had wanted to play the piano but this remained a dream. When he was three he was introduced to having piano lessons whilst she tried to learn with him. His father did not take much interest in this activity but at the age of eleven he was encouraged by his piano teacher at school to take up practicing seriously. Father bought him a piano to do so. As a teenager he was chosen to enter a local musical contest. His father promised that if he won he would take him to the production of *Oliver Twist* that was on in the local town playhouse. He very much desired this but when he won his father did not keep his promise. He did not even go to hear his son play. When told about his success he just nodded and remained silent. He so much wanted his father to give him a hug. Furthermore his father did not want to keep his promise and it was his mother's intervention and persuasion that resulted in the promise ultimately being kept. By now all excitement about the theatre trip had vanished and he indicated that his father's behaviour remained somewhat like that throughout his experience.

Although his mother had originally encouraged his musical ability, which led to a close relationship between them, she grew more distant as his talent developed

and he showed greater promise. He grew up in the countryside where boys rarely played the piano, let alone any musical instruments. He became more and more isolated and 'spent a lot of time practicing with few memories of being with the lads'. He eventually won a scholarship at the age of eighteen to a prestigious university in a big town many miles from home and recalled that none of his immediate family went with him to the big city to hear him play at the competition. A distant aunt from his mother's family whom he hardly knew had turned up at the event and discovered who he was. He felt pleased to think that there was someone who knew him in that strange environment. As he entered university she was there to meet him and he kept in contact with her whenever he could.

He spoke of a romance during high school which led to disappointment when the girl ended the relationship although he was not too perturbed. A relationship with an older young man at the university left more of an impression, although it was never intimate. Not long after the end of that relationship the first suicidal thoughts started to occur. During the relationship with this more sophisticated man he felt socially inadequate but simultaneously learnt to exchange and enjoy social events. He had never been to a restaurant before and was enjoying similar new experiences. With retrospect he now realizes that the other boy was more interested in his musical ability than any intrinsic quality. He liked showing him off to his more mature friends. He was devastated when the friend started a relationship with a woman whom he eventually married.

Soon after qualifying he decided to come to Britain after having successfully acquired a place as a lecturer in music at a university. He prefers to think of himself as a concert pianist and accompanist which he had continued with whilst being a lecturer and also moving on to hold senior positions at various universities. He made a few recordings and his main reason for wanting to come into therapy at the time was because he was 'suffering from a performance block'. During the previous year he failed to be able to record and his agent suggested he took six months off and returned in the summer.



### 5.6.3 Treatment

#### Session 1

Throughout the day before my meeting with GS I looked for his file without any success. No one in the admin department could trace it and assumed that the psychiatrist who had assessed him probably had it with her and could not be contacted. Therefore on our first meeting I had no details of the assessments apart from the verbal exchange the assessor and I had when we agreed that he was a suitable patient for my research study. Initially I also had to temporarily postpone the commencement of his psychotherapy until the funding from his trust had been sorted out. I had been forewarned that he was angry about the delay as he was anxious to start treatment.

With hindsight I realized that our first meeting was a surprise to both of us. Although he had been briefly described by the psychiatrist I was taken aback when we met. He was about 6' 3" tall, immaculately dressed like a city gent and he was carrying a briefcase. My immediate thought was, 'Where is the unfolded umbrella and the bowler hat? He looked about ten years younger than his age. I noticed his evidently surprised expression on meeting me. As I discovered soon after he was expecting a man and not a petite Asian woman. Once in the room he hesitated between two armchairs then chose the one opposite to the one I was standing against. He opened his mouth as if to start speaking, looked agitated and remained silent.

As it was our preliminary meeting I broke the silence, referred to the psychiatrist who had assessed him and the funding eventually having been sorted out. His immediate response was fairly angry:

*Yes, the funding has come through and as expected I am here to start my therapy. I have waited long enough. I do not understand all this about a preliminary meeting.*

I explained that a preliminary meeting is the usual procedure and that it helps us

assess the suitability of the patient/therapist relationship. Careful consideration is usually given to suitability and the experience of the chosen therapist. He remained silent and I alluded to this in an explorative way by verbalizing my counter transference:

*Perhaps you have some doubts about seeing me now that we have met.*

A bit hesitantly he said:

*I am glad you brought this up! I do not know if a woman would be able to understand me. Furthermore I'm a classical musician! European, Western classical music! I find it difficult to envisage you understanding all this part of me!*

He looked at me piercingly and challengingly then focused on something outside the window in an arrogant manner. I could not help feeling undermined and insulted without any consideration on his part to explore rather than assume. In my countertransference I felt angry and demeaned at his assumptions as though he knew me and my musical interests, especially as I enjoy listening to Western classical music and going to the opera. But as my training has counseled me I kept my feelings to myself and said:

*You obviously have doubts about my capability. Firstly you have assumed that as an Asian woman I am ignorant of Western classical music and secondly as a woman I am not going to understand your world as a man.*

Looking a little uncomfortable:

*I am glad you are being so direct because I am homosexual. My previous therapist was a man but he did not want to know about this.*

Still feeling undermined, insulted and irritated by his arrogance and assumption, I tentatively ventured:

Perhaps you do not understand how therapy works. As a psychoanalytic psychotherapist I will be exploring your intrapsychic structure, your unconscious inner state and how it resonates in your outer functioning world. I will not be discussing the finer points of Western classical music or your homosexuality, except perhaps in the context of the session. Whether I am knowledgeable on these subjects or not would not make much of a difference to the sessions. I will be exploring your inner state in connection with your relationships whilst you free associate so that we can think together about your emotional difficulties.

I was a little surprised at this speech. This was not my usual way of responding, especially at an initial meeting with a patient. There was something about his overbearing, belittling attitude that I had reacted to intuitively. Surprisingly the challenge had a positive response.

He looked a bit abashed, gave me a cynical smile and said:

*That's put me in my place! Thinking about it the English male therapist I saw for seven years did not know anything about classical music and never referred to my homosexuality. He remained silent whenever it came up. Perhaps he was embarrassed. Perhaps coming to you is my 'karma' as you probably know, my fate, in Indian philosophy.*

He gave what sounded like a hysterical laugh and then became silent, but I sensed that he felt relieved. I broke the silence by saying that perhaps he might want to reconsider whether he would like to continue seeing me. I found myself feeling that I did not like this arrogant, supercilious man who undermined my professionalism. I thought that I would not be disappointed if he decided not to continue as I already had my quota of research cases. (We were not sure that his funding would come through so I had gone ahead and assessed another patient). I suggested that he did not have to make a decision immediately but could phone the contact staff in the department and notify them. He immediately responded with:

*No! No! I would like to come and see you! I need to sort myself out. The sooner*

*the better! I am sorry if I came over being rude. Besides, I like your style.*

My immediate feeling was of disappointment. I had hoped he would storm out and I would never see him again but I also felt as if I was in a room with a stropky teenager who was full of himself and uncomfortable but nevertheless asking for help. His unconscious narcissistic attitude perhaps made him feel suspicious of any support from anyone and he could not really accept any good offers made to him. He could not experience me as a good object. I agreed to see him for six weeks during which time we could understand whether we could work together. He looked relieved and thanked me, adding:

*Who knows, you might know more about classical music than I myself do.*

I thought that he was trying to pacify me. He seemed to bring out some very powerful feelings in me. It was unusual for me to be so robust and challenging at an initial meeting. I had expected him to phone and say that he had decided not to continue. Perhaps it was my own wishful thinking due to my strong, adverse feelings towards him.

## **Session 2**

There had been no phone message to say GS had decided against coming as I had expected. I kept reminding myself that his behaviour was due to the nature of his problem and that I should keep an open mind and practice Bion's (1962) advice of having 'no memory or desire'. He arrived on time and initially appeared relaxed as he walked in and sat down. He quite quickly tried to take charge of what was probably an anxiety-provoking situation by asking several questions about my experience and training to which I gave truthful but minimal responses. He said that he knew that I would not divulge anything much about myself.

*This is how it was with my previous analyst. I do not see the point of a further six weeks assessment, or going into my past history once more. That was all done with Dr. N. We can now get on with it!*

A little puzzled I clarified that:

*The six week trial period came up as an issue only because you had doubts about my suitability as a therapist for you.*

He looked out the window and ignored this. He remained silent briefly and went on to say:

*About 30 years ago I was assessed here by a senior person and then ended up having once weekly sessions with a junior.*

Sneeringly, he said:

*Perhaps he was a trainee! Musicians have a certain temperament and character and very few people can understand them.*

Almost every time he opened his mouth I felt insulted and undermined. The psychiatrist who assessed him was not only younger than me but she also came from another ethnicity. I found myself responding with:

*Perhaps like you are doing now thirty years ago you had not taken your therapy seriously. It maybe feels easier to attach and blame others for your inadequacies, rather than allowing the therapist to explore your real feelings and what is going on in you that perhaps is preventing you from functioning like you would like to.*

He looked shocked and I saw the expression of despair on his face. Perhaps I was being too direct too soon. He shifted in the chair and then shaking his head from side to side said almost pleadingly like a naughty child who was worried of the consequences of his misbehaviour:

*Oh no, no! I really want to seriously come and sort myself out with you. I would like to come for the year as originally was offered. I just felt afraid you would say to me that you would not be seeing me after six weeks.*

I felt I had an adolescent in the room. I repeated why the six week assessment had come up. He gave a sigh and I could tell by his expression that he felt relieved. He went on to say:

*I waited so long for the funding and now it would be unbearable to think that I might have to wait once more through my own stupidity. I am sorry if I sounded insulting. I would like to take this up seriously.*

I wondered if in the transference I had become the internal father whom he had un-challengingly accepted through compulsion. He went on to divulge:

*I have not been in a good state of mind for some time now. I have no one to talk to about my horrible feelings. The thought of growing old and thoughts of death make me feel that I would like to end it all because of the loneliness.*

After a brief pause I responded:

*Contradictorily you want to isolate yourself and not want to let anyone in like a psychotherapist. Maybe this process of making some sense of your life also terrifies you. The psychotherapy might be destabilizing but on the whole this would be a more appropriate course of action to eventually bring about an understanding of the inner turbulence.*

He nodded.

*I understand that it is not going to be easy but I will come regularly as arranged.*

We discussed appointment times and he thanked me before leaving.

## **Session 6**

GS took out a red book before he seated himself and smilingly said:

*I know you are going to love this! I have a dream for you!*

I made no comment and he looked at me for encouragement, hesitating as if expecting me to jump for joy at his announcement. Then hesitantly he started to read it:

### **The Dream**

*I was about three or four and I was on the floor near the piano. My mother was seated and playing her favourite tune. She was wearing a long skirt like she always did. I made a game of creeping in and out. She did not stop me and so I thought I would creep into the piano and started doing so. Just as I entered and thought it was great fun a large serpent appeared. I was terrified and rushed out. I woke up in a sweat, feeling terrified.*

He could not associate any thoughts and instead smiled, saying that it was a stupid dream because there is no space at the bottom of the piano even for a one year old to creep in. But perhaps the serpent was a symbol of wisdom as one of his associates had told him a long time ago at university. He looked a bit skeptical as he waited for my response.

I ventured that the dream perhaps was connected with some Oedipal phantasies, as he was getting under mother's skirt and entered a forbidden space. The serpent perhaps represented father who was telling him that he had no business there. That was his space and he was more powerful. The serpent could be a phallic symbol and the dream associated with masturbatory feelings.

He looked momentarily stunned and then slowly nodded his head as if acknowledging my interpretation. After a pause he volunteered:

*My mother was unbearably close and suffocating during my early years. I liked that but now I can see that she wanted me to fulfill her unresolved desires of being a pianist. I felt abandoned when she lost interest in my playing. I now*

*realize that I outgrew her skills and she became incompetent to support me. She only liked me for what I could give her.*

He recalled her pushing him away drastically during his adolescence. He used to love curling up near his mother and speaking to her but also remembered her becoming cold and aloof.

## **Session 9**

By this session of the treatment GS volunteered that he had been storing up a lot of anti-depressants for several years now. His GP had given him regular prescriptions for Sertraline. He did not take them as instructed but stored them. He collected a new prescription regularly. One day, if need be, he hoped to make his own 'champagne cocktail'.

*These thoughts often float on my mind just before bed time. I could have a nice long sleep!*

*A permanent sleep!* I said.

*Something like that! But as you can see I am a coward. I am unable to do it. For over a year now the jar has been in a safe place. Who knows when it will become handy?*

For the first time I found myself actually feeling sorry for this man and wondered about his arrogance as a defence against his vulnerability. He could not even be decisive about committing suicide. I felt his lack of a self and said:

Perhaps the tablets by now have lost their potency to be active, somewhat like yourself!

He looked astonished and stared at me with his mouth half open. I picked up this cue and after some silence suggested that I had perhaps struck at a delicate point that had shocked him. Eventually he spoke and related that he



has not been in any kind of close relationship for sometime now. His last relationship was with a young East European who had openly flirted with him at a gay sauna. They saw each other for a few weeks and he brought the relationship to an end. He did not have much in common with the young man who was here on holiday and was hoping the relationship would develop into providing him with a place to hang about in. But he knows that he has lost all incentive to want to be in any kind of relationship.

This led him to tell me about one of his oldest friends in Britain whom he had met when he first came as a lecturer in music at a university on the west coast of England. Jeremy, the senior lecturer, twenty-two years older, had befriended him. Although there was never anything sexual in the relationship they remained very close. So much so that when he moved to London Jeremy bought a flat for him to move into and he came regularly to visit. He described him as an unemotional man who spent all his life in academia. Everything he said was on an intellectual level:

*Of course I enjoy a good conversation but he is a bore. I have never known him to be emotional about anything and all he does is to go on an intellectual tirade, oblivious to anyone listening to him.*

At one point I alluded to his attraction to an older, unemotional man who lived on a different plane to him as someone perhaps replacing his own father who had similar features. His father also provided him with the material comforts like Jeremy did. This did surprise him and he volunteered that he had never equated the relationship in that manner but he could understand the connection I was making. He went on to divulge other similar relationships with older men he met through his musical career. He had become amenable and involved in his therapy and I wondered about how he was going to take the oncoming first break. He related an important dream in his penultimate session.

### **The Dream**

*I walked into what seemed like a large hotel/factory and found myself going to a*

*room that had been transformed into an extraordinary and beautiful living quarters. As I entered the lovely Diana Washington, the black American singer, whom I admired very much during my younger days, was waiting for me. She warmly greeted me and made me feel welcome.*

His associations: He always loved listening to her but now regrets that he never bought one of her records. After his last session he walked into a music shop as he often does before catching his train. He was surprised to see a CD of her songs marked down to £2.99. For some stupid reason he did not buy it. When he got home he regretted it. So he made a point of going in the next day to purchase but found that the CD was sold out. The salesman had told him that they had been in stock for over a month now and had gone pretty fast. He couldn't believe that he had missed noticing this before and when he did see it he did not immediately buy a copy. He was very disappointed and was near to tears.

He could not interpret what I thought was a fairly clear message in the dream. When I suggested that the hotel/factory was perhaps the clinic and the beautiful apartment as symbolic of my consulting room where I was waiting to see him he started smiling and said:

*Of course and you are Diane Washington!*

I nodded and went on to suggest that perhaps as the dream suggested he had ambivalent feelings about the therapy and now that he has some feelings of trust in me he should 'buy what I have to offer'. But perhaps also he has some doubts about doing so. If he does not take up the 'cheap offer at a reduced price' (in reality he was not paying for it) he might be left with nothing.

He looked slightly unsettled and volunteered:

*I was afraid that you might end the treatment on account of my rude behaviour just when I was beginning to appreciate your support. I realized I would be*

*missing out through my stupidity that it can't be good enough.*

He then recalled the dream he had brought a fortnight before about going into his barbershop to find that his usual hairdresser had been replaced by an Indian. He was a bit uncertain of whether to remain or go. But decided to stay and came out very satisfied with the way his hair had been done. Laughingly, he said:

*It is time for me to see the message for what it is as there is strong evidence that I should take my therapy with you seriously. In fact I have felt a lot better in some ways. All those horrid suicidal thoughts seemed to have gone and I have stopped calling for a repeat prescription.*

During his last session there were several long silences between anecdotes about Jeremy not keeping regular contact. He did not know what was going to happen over Easter. They usually met at some point over the long weekend. I interpreted Jeremy's silence as connected with the break and the silence that was going to be the case with us. He did not respond to this.

There was obviously a positive transference at this stage of the treatment although the beginning of the first term proved to be a very difficult period as I had expected. GS oscillated from telling me about his relationship with Jeremy to being obnoxious and arrogant. I often felt as if I was with a spoilt demanding baby and that nothing I say would satisfy his insatiable neediness for a good object. He feared becoming in any way dependent on his therapy because that would make him feel vulnerable and open up feelings of emptiness inside. How could he trust that anyone really could care about him. His 'destructive narcissism' (Rosenfeld 1987) continually got in the way of him tolerating any feelings of trust and or dependency on another. Consequently his attitude was conveyed as contempt of the other. He chose to ignore that I was somewhat like him in being middle-class and professional. He would rather have kept the session sterile. A white male therapist, regardless of his capacity to understand Western classical music, would have been the 'Daddy' he never had. As the sessions progressed I was able to verbalize some of these thoughts and

feelings.

I returned from my holiday after the break at Easter to find he had written a letter of complaint to the director of the department stating that he did not think he was benefiting from the treatment and asking to be referred to a male therapist. I was taken aback and as the director suggested he was probably very angry about the break. He wrote to him suggesting that he should meet me once more to discuss why he felt he wanted to stop coming to see me and that we would re-assess thereafter. I felt cross and fed up with his unreasonable behaviour but also apprehensive about how he would take the director's letter. In my countertransference I both wanted him to come back and hoped he would not. I patiently waited for a response to the director's letter or a phone call from him cancelling his appointment. I was left feeling frustrated.

### **Session 13**

I did not expect GS to turn up but he arrived as arranged and one look at his expression made me once more feel warm towards him. He looked sheepish, gave me a genuine smile and immediately started by saying:

*I have been dreading you saying that you did not want to see me any more. I kept expecting a letter from you cancelling the appointment. The moment I posted that letter I regretted it. As soon as I heard it drop I wished I could have withdrawn it. But it was too late. It made me feel more miserable than I had felt and I knew you were not going to be at the clinic to phone. If the director had not suggested I meet with you then I would have written to you. I wrote the letter when I felt exceedingly angry probably with Jeremy more than you. Nothing I said to him made any impact!*

My countertransference indicated that I had a helpless child/adolescent once more who felt rejected by my leaving him over the break to have a good time with someone else like Jeremy had. His feelings were hurt and he wanted to split me off and reject me. But added to these unconscious feelings he was acting in the session because he could not in reality reject Jeremy as he was

dependent on him for several things. He now felt secure enough with me as a good object to do so.

Whilst my thoughts were occupied thus he continued without a pause, as if afraid of what I might say. He went on talking about the books he had read in the holidays in great detail. He went on to relate that he'd had a very lonely holiday, although he did go for lunch at Debbie's on Easter Sunday. Her grown-up children, whom he knew fairly well, were also there, but he could not wait to go home. He felt terribly sad and tearful. He often thought about going to social gatherings at his local music society but could not gather himself enough to do this.

He became very quiet and eventually I said:

All the questioning at the beginning was about your ambivalent feelings towards me. As your dream conveyed you found me professionally as attractive as Diana Washington but this was confusing to you as I am a woman and you are usually attracted to men. In the transference situation it is part of the normal therapeutic process to feel attracted to the therapist in various ways. You felt confused as to whether I would be able to understand your infantile needs that had never been resolved. It probably was very confusing for you as a grown-up, intelligent and talented man to envisage that a younger, ethnic woman could understand or support your emotional state

With hindsight I realized I had shocked him with this interpretation but I felt I had hit on the truth.

He looked down, wriggled his position, crossed and uncrossed his legs and then almost like a little boy said:

*You are right to feel impatient with me. I missed not coming to the sessions and on the spur of the moment I wrote that letter. It was an ill-judged one! As I said I regretted what I had done soon after I posted it. It was not easy for me to come and face you today but now that I have done it I want to say that I would like you*

*to forget that I wrote that letter. You are right about a lot of what you are saying.*

I responded:

*You became exceedingly angry with both Jeremy and me, emotionally your surrogate parents, and could not actually come to terms with your immediate feelings of anger which you acted out.*

I could sense the emotional struggle he was undergoing whilst he remained silent. He looked relieved that I was prepared to go on seeing him. He thanked me before leaving.

Having given this session some thought I realized that with my holiday coming so soon after his positive transference, coinciding with the problems with Jeremy's behaviour, he felt doubly rejected. He regressed to a time when he felt bereft of parental love. Childhood feelings of emotional deprivation took over. Jeremy and I symbolized the disinterested parental couple totally unaware of his insatiable need to feel loved and recognized. Our non-communication left him feeling unwanted and rejected.. His false hopes had been shattered.

### **Session 15**

He started the session by saying that Jeremy had unexpectedly decided to come down for the weekend and he had found him intolerable.

*He is so pedantic and goes on about his interests which are so boring. He hardly ever listens or wants to know about me, nor is he interested in my music. He is a very intelligent man and was highly respected at the university. Of course he retired some years ago. I find him overbearing. I switch off and go and play the piano, hoping he will shut up and listen. He goes for a walk instead, slamming the door. It makes me want to weep.*

The constant desire to obtain Jeremy's interest in his music is repeated in the following sessions. I tried to think of what the attraction and relationship was

between these two very different personalities, bearing in mind the huge age gap. I repeated exploratively that maybe he was looking for a father figure in Jeremy who was so similar in personality to his father but who would provide the emotional connection his father had not offered. Unfortunately Jeremy could not do this either but only perpetuated the relationship he had with his father.

He paused and said:

*Maybe! But who would want such a bore for a father?*

From then on he oscillated between being critical and appreciative, from a positive to a negative transference, perhaps for the fear of being too dependent on me. Whenever I touched on the subject of his insatiable need from very young to be appreciated for his talent by his parents, he would regress and at times recalled his past experiences of the pain of rejection.

*At least you seem to understand when I talk about my music. You linked my incapacity to perform with my dream. I keep thinking of the pain of being rejected. You are right I have exposed myself once more to rejection by depending for attention from him. How stupid can I get?*

Mostly during the positive transference after the anti-feelings towards me when he constantly denigrated and undermined my abilities I felt that I was more and more being accepted as the interested substitute mother/father who cared, listened and appreciated his musical talents. But simultaneously these feelings frightened him.

## **Session 24**

GS was wearing a cream summer suit and a blue shirt. He looked very elegant and gave me a big smile as he walked in. After a brief silence he related that he felt very pleased as he had gone to the Music Society's AGM and was now on the organizing committee. I acknowledged this by giving a brief nod and waited. Once more he broke the silence by saying that he'd had a dream the night

before and thought it was very meaningful but he was unable to make much of it. He took out his red note book in which he writes down all his dreams and sometimes his thoughts.

### **The Dream**

*I am travelling on a train which seems like a long endless journey. I know that there is a town some way off where I will disembark but it seems miles away. The train is travelling cross country from east to west and at times goes over huge spans of water. There must be bridges but I cannot see them. I feel frightened but there are times when I feel assured that I am making the right journey and will reach my destination. During some of the journey there is the feeling that I am travelling back to my hometown and arriving home.*

The dream left him with mixed feeling of fear and insecurity.

He was surprised when I interpreted the dream by saying that the long train journey was perhaps symbolic of his therapeutic journey. Obviously he was afraid of what might arise from the therapy and the unknown path he was taking made him feel insecure. He now had qualms and was fearful of where all this was going to lead. But a part of him wanted to continue with his therapeutic journey and reach a positive destination, psychically a more 'secure self'. It was also interesting that he was travelling from east to west geographically as well as in the therapeutic alliance. He had originally travelled in the same direction and perhaps the east –west journey was symbolic of me as the eastern figure imparting something to him the westerner. There were many psychic oceans to cross since he had left home.

He looked stunned and said:

*It still amazes me as to how accurate your interpretations are. I had sleepless nights after posting that letter, terrified that you would refuse to see me and I felt strongly that you are my only hope! My karma! As you say this is going to be a long and difficult journey.*



I agreed that the therapy was not going to flow easily on account of his strong defences and there would be many oceans to cross. As he left he added:

*I will try my best not to be such a pain and respect your knowledge on the subject. I don't know what more to say.*

He thanked me, smiled and left.

Outside the session I realized that there were times like this when his dreams vividly expressed his internal state. It was fortunately that I could be in touch with them. He appreciated my knowledge and became the submissive little boy who responded to my understanding of his feelings. He gave the impression that he never had this from either parent and perhaps for the first time he was experiencing a genuinely good object- relationship.

Throughout this part of his therapy he oscillated from being grandiose to using the time productively and consequently regressing but also exploring huge areas of his early childhood and adult life. His angry feelings about his unemotional father who took no interest in him came up fairly regularly:

*He provided materially but retained 'a macho front'. How I used to long just to be able to sit alone and talk to him. I can never recall a time when my father even placed a hand on my shoulder in a friendly fatherly way. I feel my mother betrayed me. As a child she encouraged my piano playing and then deserted me. I often wonder about that!. Could it be because I moved on whilst she became stuck and could not keep up?*

He became emotional and remained quiet. After a pause he softly volunteered:

*When my father sold the business he bought me a Steinway grand piano. He arranged for me to go to a huge piano centre in London and choose the piano I wanted. He sent a direct debit payment for it. I could not believe his generous gift. Although I appreciated this I would have loved for him to come to London*

*so we could have bought the piano together. It is the only good memory I have of my father.*

I found myself connecting the piano with his father's unspoken feelings about the recognition of his talent. He was able to integrate some of these adverse experiences that his parents were not deliberately uncaring of him.

At about this time the narcissistic, destructive side of his character became less evident and he could tolerate some of the negative aspects of himself and explore them. The date of the 'dreaded recording' was getting closer. Fortunately he was able to go back to practicing on a regular basis. He had to miss two sessions because they coincided with the recording but on the session before this he arrived in a panic and could not wait to relate some dreams he'd had. The first was in particular most disturbing. In a rush he snapped open the briefcase and out came the red book. Before he could even open it to the correct page he was relating the dreams.

### **Dream 1**

*I was in a car driving along a winding path. Suddenly I realized that the brakes were not working and I was losing control. I was desperately looking around to find the right pedal to push. I panicked and woke up in a sweat. I had difficulty going back to sleep but when I did I had another dream.*

### **Dream 2**

*In this dream I was in the company of RM, a distinguished professional accompanist, whose presence I was aware of but strangely he was not really next to me. Before the performance he gave me a trinket box and when I opened it I found a collection of pretty trinkets. My immediate thought was, 'What use is all this to me?' I could not identify what they were but, although they were 'just trinkets' they were beautiful and I liked them.*

As usual he had no associations to these dreams but conveyed that he had

known RM during his younger days and was besotted with him. RM did not ever respond to his infatuation but always gave him encouragement about his ability to perform.

I interpreted the first dream as him the driver/pianist, symbolic of what his role had to be and that was to be in control of, his talent and his driving/playing ability. Due to (faulty brakes) his mental dysfunctional state he had lost control of the keyboard (pedals) and had temporarily lost the ability to function and to perform.

In the second dream suggested that the trinkets perhaps represented how little RM was really giving him by being encouraging. The dream perhaps was also indicating that feelings of my presence, like RM's, would be with him to support him at the time of the recording. Like RM I was helping his talent rather than responding to any other feelings he might be experiencing. At first he nodded as if he had become aware of what I had said, then he was bemused, then he laughed out loudly. I was puzzled and waited.

*I am not totally a homosexual you know. I have had relationships with woman. The last was when I was in a sauna in Brighton, lying contentedly on the marble slab, eyes shut and totally relaxed. Suddenly I found hands exploring me. I opened my eyes to see a beautiful woman. Neither of us said a word and before I knew what was happening it happened. I enjoyed that experience very much but that was the last time I have been with a woman.*

He also volunteered that although he had been a homosexual for most of his life he had also had heterosexual relationships. In an almost manic non-stop manner he went on to relate the history of those times when he had relationships with women. It transpired that they were mostly the partners of friends who had found him attractive and encouraged the relationship. The one woman, a widow with whom he had shared a house with for six years, he refused to have a sexual relationship with. Eventually she decided to sell the place. It was her way of ending the relationship in despair. He related that he became impotent in her company. He still sometimes visits her as a friend but

feels angry with her for letting him down. I tried to think with him about her feelings of being let down to which he remained silent.

I thought about his reference to sleeping with his best friend's partners and the love/ hate relationship he had with his mother, and I wondered if his behaviour had been the result of an 'illusional Oedipal configuration' Britton (1989, 83-101), of wanting to get between the couple. But as it was towards the end of the session I decided not to bring it up. He seemed a lot calmer compared to his manner when he came in. Before leaving he said he hoped to remember and think about some of the things we had discussed. He smiled, as he usually did now, and left.

## **Session 26**

He looked really happy as he walked in. As he was sitting down he said:

*Well I have done it. The recording went extremely well. The CD should be out in time for Christmas. Both the baritones and sopranos congratulated me on my playing. The company director was also highly enthusiastic of the success. I cannot express how I feel and my thanks to you.*

He went on to tell me some personal things about the people involved and how much he was looking forward to further recordings and concerts when he would be accompanying the soloists.

Consequently GS was much changed from the sullen, rude, grandiose man who originally came for assessments. The only fly in the ointment was his friend Jeremy.

*I phoned Jeremy to give him the good news. He barely congratulated me, was being elusive and more than ever cool towards me. He took no interest in the successful recordings nor did he come to visit. He seemed to be getting involved with a younger relative and his wife. I am worried that he might ask me to move out of the house.*

But this never transpired. I thought with him about his need for a father figure when he first met Jeremy. Obviously this need had changed somewhat since he had become more independent and was looking at the relationship as that of friendship. I suggested that he had moved on but that Jeremy was still fixed at the original point of the relationship whatever that meant to him. GS acknowledged that his needs had changed. I tentatively approached the subject that perhaps Jeremy found it difficult to accept his new found independence and achievement. It surprised him but he could perceive the point I was making.

As I was leaving the clinic that afternoon the receptionist commented about the change in him personally and his manner towards her because he now tended to stop to chat with her briefly. He actually joked about the weather saying that it was like an 'Indian summer'. I smiled and thought that perhaps he was referring to more than the outer reality.

There was a long summer break but he returned looking reasonably well. He had once more attended the meetings at The Musical Society he was a member of and although they were boring he told me it felt good to be with people with similar interests who recognized his recent achievement. They made jokes about his 'second chance'. All were now retired from whatever they had been doing. He had also accepted an invitation from a friend in Europe and enjoyed travelling around with him. Another acquaintance from his university days had found him through the internet and contacted him because he was coming to London. It was really good to see him and catch up with news. He had also become interested in some of the local amateur musical activities and could share some of his experiences with the younger members of the community. Although his attitude was appreciative I noticed that he would suddenly become a little elusive and even arrogant. This puzzled me but after a while I realized that he was becoming conscious that at the end of this term his treatment was going to end.

## **Session 29**

I sensed an undercurrent of something troubling him as GS sat down. Reluctantly, he volunteered:

*I have always been a loner from a long time back. These feelings of aloneness were from my early schooldays and as an adolescent when I felt I was different but could never understand why. It was a lot better during university when I socialized more, although this was a new experience for me. I have never been to a restaurant or bar before. I used to go with people but never felt I was a real part of the group. These feelings have come back strongly, not only at the club but at any time of the day. I find myself wishing I could be with people although I am now more with people. I feel so lonely. I am good at occupying myself and love my privacy but it is not enough anymore. I feel the need to be with other people like myself. Maybe I am not explaining myself very well. You know the feeling of loneliness hangs over me even when I am busy.*

He gave an uncomfortable, nervous chuckle and then looked reflective.

After a brief silence I interrupted by saying:

Perhaps your feelings of aloneness come from letting go of your 'false self', the belief that you could cope on your own and did not need anyone. Now that you have let go of that feeling you are ready for relationships and need other people. But until you meet the right people you psychically feel alone.

He responded to this by saying:

*I can now see what an arrogant and stupid ass I have been. You put me in my place and thanks to you I can now see some acceptable results. As you say there has to be development now in the right direction.*

From about his thirtieth session onwards he divulged various positive events taking place in his career. His social life had also slightly expanded and become a little more active. His big news was about contacting an old friend he had in France whom he invited to stay with him. They really got on well and the week

went by amicably. He had just one complaint which was that the friend was a smoker. Although he was very discreet and always went out of the house to smoke he smelt of it. It was arranged that he would go over to France nearer Christmas. He looked forward to it but there was the issue of the smoking. Obviously the friend smoked inside at his home and the place would stink heavily. Then he gave a hearty laugh and related:

*The best news of all is that I now have some money in my account. Payments have been made from the recording sessions and from the sale of my CDs other than my pension. Unfortunately it is just one payment and does not depend on sales. It is not a vast amount but I have never had so much money in a long time. I had been toying with bringing you a copy of the CD but perhaps not a good idea for now! Psychotherapists don't like accepting gifts. Maybe more appropriate for sometime later!*

I made no response and then he went on to say that the old friend from home had listened to his CD and phoned to compliment him. I acknowledged that perhaps he was also telling me his inner feelings of aloneness were not as acute because his whole outlook had changed and unexpected activities were taking place. He smiled and said:

*But I am now becoming greedy and want a lot more.*

He remembered a dream.

### **The Dream**

*I was once more making a long train journey which felt endless and lonely. I was not going anywhere in particular and yet there was a feeling of a destination. At the end of the journey I could see there was someone waiting for me. He was standing next to a huge parcel and as I walked towards it I recognized it to be a grand piano, a bit like in the film when the piano was standing on the beach.*

He had no associations except that he woke up with mixed feelings of sadness and discomfort was also a little pleased.

I once more felt that the dream was about an internal journey. The therapy, felt endless and lonely but he could now see an end. The figure, disciplined and stern but also kind and giving, perhaps was his father who gave him a piano and deep within acknowledged his son's talent.

He looked down and remained quiet for some time and when he looked at me his eyes were moist. He couldn't speak but nodded as if agreeing with all that I had said. We remained in silence for a good ten minutes. I could feel the poignancy of his deep sadness. It felt as if a huge insightful experience was going on and for the first time he could cry about his father and mourn his loss. After some time he whispered that he wished he had gone to his father's funeral.

*About six months earlier, before the death of my father, my brother phoned to say that he'd had a stroke. To visit seemed not to have any particular significance because at the time I felt no love for him and as my father was ignorant of anyone's presence it would make no difference as to whether I was there or not. I hated the environment and especially my self-righteous mother, and vile-mouthed sister.*

The only person he felt any kinship with was his brother, who he felt was being 'hen-pecked' by his wife. When the message came through he could not see the point of spending all that money to go to the funeral of a man he hardly related to.

I suggested that the issue of his immense anger prevented him mourning the death of his father. But now for the first time he was ready to acknowledge this. He also perhaps now realized the dream was addressing the fact that his father had appreciated his musical talent, although he never made any open overtures about this. Perhaps it was not in his nature to do so or he did not know what to make of a creative, sensitive son when he had wanted a macho son like himself



to run the factory. GS was able to think about this as well as his relationship with his mother and siblings. He could not come to terms with his sister's devious behaviour regarding the family's estate after the death of their mother. Somehow she and her children had inherited all of it.

From there on GS's sessions developed in terms of his ability to self-analyse his role in relation to his siblings and other family members. He became perceptive and insightful as to what part he had played in his relationships on account of his own needy and destructive behaviour. He brought his dreams fairly regularly and they were mostly about his transitional stage from being a narcissistic and arrogant person to seeing the part he had played in this construction and thinking about how he could make positive changes to his personality. Obviously his loneliness remained but he was making efforts to find new interests. His internal journey had come a long way and there seemed no stopping him now.

#### **5.6.4 End of treatment**

GS started to demonstrate some end of treatment anxieties. He wanted the sessions to go on regardless of the fact that we had a time limit and especially as he had been funded by another Trust who would not continue claiming that he ought to see someone within the area. He was keen for me to see him privately but I felt this would be overstepping our arrangement. I agreed that at least a further year of therapy might help him continue to explore areas we had not been able to. Consequently he would come in feeling cross with me but recognized his own animosity and accepted my point of view.

I also discussed the counter productiveness of the idealization that he had for me and his dependence. He needed a space to assimilate the work we had done and the progress he had made but we did not want to set up a new problem about dependency with a substitute parent. All the exploration in connection with ending made it easier for him to accept that a successful psychic journey had been taken and now he had reached a destination. It did not mean that he was not to take further journeys and reach other destinations.

We ended by arranging a further review meeting four months later. He seemed by now more comfortable with the arrangement but also showed some conflict about ending. He did not want to 'start all over again with someone new' but came to terms with the realization that it would not really be like starting all over again. Sometimes he might regress but a new course of therapy might more explore his present difficulties.

### **Session 36**

I noticed something very different about him. It then dawned on me that he had dyed his hair so that there was hardly any grey and had changed his hairstyle altogether. It suited him but also made him look much younger than he was. Very early in the session made a joke about being a new man with a new self presentation. I smiled and said if this was his way of showing me an inner new being then that was a positive point. But it could also be dangerous and counterproductive if it became another front. He smiled and said:

*Gone too far now to go back there! Would rather be where I am right now, as it feels good!*

In his last session and when it was almost time to end he opened his briefcase and took out a little package. Handing it over to me, he said:

*You can guess what this is! Without you it would never have materialized!*

I felt very touched as I accepted this gift which I knew was his CD. He thanked me several times and it was difficult for me to keep calm in such a moving last session. I said:

*This is the result of our work together and I feel very moved by your gift. I hope you continue to produce more of these.*

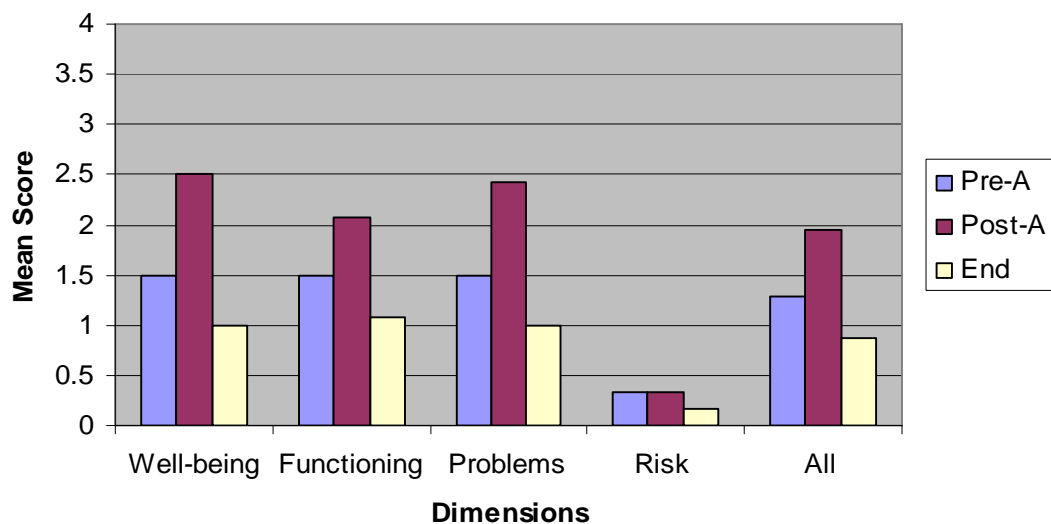
This led to him telling me about how RM had always been encouraging and given him excellent advice. He was too stupid not to take him seriously but all

he longed for was for RM to have an intimate relationship with him. This made me feel slightly uncomfortable because by now he had a strong positive transference towards me. He went on relating memories of the times he saw RM. At one point when I was able to gather my thoughts and countertransference feelings together I mentioned the corresponding phantasies that he possibly had about me. He smiled and said:

*Can you blame me after what you have done for me?*

I had to smile and he shook my hand warmly before leaving.

### 5.6.5 Core scores and end of treatment graph



GS's CORE scores reduced in all dimensions of the scale from first assessment to the end of treatment indicating an overall improvement.

### 5.6.6 Overview and impressions

From the time that he was a very young child GS was made to feel he was someone special by his mother. It might be an assumption to state that her motivation derived from some personal desire to achieve in an area she felt deprived, that was the opportunity to play the piano. Initially she lived through her son who did have some talent. But when she felt she was unable to keep up at his pace she emotionally abandoned him and thereby detached herself from

the previously enmeshed relationship they'd had. In his Oedipal phantasies GS imagined his mother to be his partner, made more powerful by the fact that she had an unemotional, uninvolved partner and father. As a young boy he needed encouragement from his parents but his father seemed to resent having a sensitive son who was more interested in playing the piano. He would have preferred a 'macho son' who would take over from him in the business. He also considered piano playing to be a feminine pastime. GS felt isolated and unloved, especially as his mother stopped showing him her loving feelings. Consequently GS became lonely and developed an ego-destructive superego. Bion (1959, 1993-109), (O'Shaughnessy 1999,861-870). He was not altogether accepted by his peer group and grew up as an odd, solitary but sensitive child. He tried hard to make friends during his adolescence but his passion for the piano excluded him. He became a solitary figure who could not talk about his feelings either to his parents or his peer group.

The splitting –off (Klein, 1935; Steiner,(1993), Britton,( 2003). Was the only way he was able to make bearable his unbearable inner state. Thus he was able to protect his fragmented state of mind .or develop a 'second skin' (Bick (1964) which protected him from the criticisms and the taunting. This mental state progressed to feelings of grandiosity and the acquiring of 'a narcissistic personality' (Rosenfeld, 1964) which informed him that he did not need anyone else and psychically an ego-destructive superego superficially made him feel he could take care of himself. He could cope up to a point but this was at the expense of developing emotionally. He isolated himself from the 'rough and tumble world' of his siblings and classmates. He had one relationship with a girl when he was sixteen who admired him for his difference but when she teased about him being posh she ended the relationship. Although he was not unduly disturbed by this, as he pointed out to me, he did feel rejected. This resulted in him becoming all the more isolated and played a major role in deciding that he did not need anyone.

During late adolescence and young adulthood at university he found the city life more in tune with his talents. He was highly respected and applauded. This unfortunately added to his superego and feelings of importance. The admiration

he received from a slightly older young man boosted his state of mind but he also felt unbalanced and felt he had a slightly deranged mentality. The rejection was unbearable and he experienced what he refers to as a breakdown although he had never been hospitalized. He saw a psychiatrist who kept him on medication. As soon as he acquired his degree he fled from the country of his birthplace, dissociating himself from all the mental pain he had experienced from very young. There was no place for him anywhere and he felt he had to escape to somewhere far and unconnected to those painful experiences. In the therapeutic sessions provided for him we explored his 'superego, narcissistic, false front personality'. As Roth (2001) has explained:

*Interestingly by far the biggest part of our superego is unconscious. What that means is that we are motivated by feelings – of which we are unaware – about the things we do and the things we think and sometimes about things that we are not even aware that we think! In other words while your superego can attack you by making you feel guilty it can also attack in much more surreptitious ways, making you feel depressed or just 'under par'. It can sap the pleasure from your life and leave you feeling that life is meaningless.*

Although most reluctant at first through fear of losing himself into a world that was a void GS managed to contain the 'destructive narcissism' (Rosenfeld, 1987) and developed a truer self. His anxieties and suicidal thoughts disappeared as he learned to trust the more positive aspects of his personality leading to a more secure 'inner state' that provided a space for the continuing development of his creative ability.

At our review meeting I met a more confident, happy person who had widened his professional contacts. Of course all his problems had not just disappeared. He was still lonely and desired companionship, but the possibilities of this seemed much brighter. He was negotiating within his Trust with the support of his GP and myself to explore further funding to continue with psychotherapy more locally.

### **5.6.7 Summary of key facts from the data**

During his early childhood and adolescence GS was emotionally lonely. He felt neither loved nor understood by both his parents and especially his father who had very different plans for his son's future. He was sensitive and felt ostracized by his peers because he could not fit into their ways of being. As a loner he developed an ego-destructive superego to protect himself from psychic pain and concentrated on playing the piano in which he was fairly talented. Sadly, the better he became at this the more rejected he felt by both family and friends. Young adulthood brought new hope when he won a talent competition and was accepted at a prestigious university to follow a career in music.

A further failed attempt at making a close relationship with an older male student brought on suicidal thoughts. He saw a psychiatrist who suggested that a change of environment might help. Although GS left the country to come to Britain his inner state remained that of a loner. To counteract this feeling he became arrogant and developed a narcissistic personality, pretending that he did not need anyone. But in the vast unconscious there remained the yearning to be loved and for his musical ability recognized. Psychically the search for this continued and unfortunately he became attracted to Jeremy, a man old enough to be his father with a similar personality who could not express any emotion. The desire and memories remained intensely alive in his unconscious and he could not mourn or relinquish these feelings. He continued to hope that what he so much wanted will happen. The therapy helped him to see the futility of his hopes and desires, integrate the losses and move on.

Therefore the key facts as findings are:

- 1) Dysfunctional early childhood with poor object relations.
- 2) Feelings of loneliness which led to developing an ego-destructive superego.
- 3) Inability to mourn early losses and relinquish the past.
- 4) The hope that early desires would still be fulfilled.
- 5) Retirement exacerbated feeling of early losses and led to temporary mental impotence and suicidal thoughts.

## 6 FINDINGS AND DISCUSSION

### Chapter Summary

- A summary of the research aims.
- The context of the research study.
- The research findings by the qualitative research method of Grounded Theory as applied to the clinical data of psychoanalytic psychotherapy sessions.
- Patterns of consistent findings in the clinical data across the domain categorized as themes and tabulated as 'key facts'.
- Key facts grounded as hypotheses for depression in later life.
- Further findings and thoughts on the research study as applicable to later life.

#### 6.1 SUMMARY OF THE RESEARCH AIMS

As previously iterated in the Introduction of my thesis the focal aim was to investigate whether psychoanalytic psychotherapy as a research methodology would identify some hypotheses for depression in older adults who were diagnosed as depressed by clinical professionals. Firstly, although there are several clinical papers as discussed in the chapter, 'A Review of Psychoanalysis and old Age', none of them specifically arose out of a qualitative research method with several case studies involving the application of the 'Grounded Theory' method. The findings in these papers evolved during clinical sessions with the respective therapists' patients. The qualitative research method with adults in psychotherapy is at a minimal stage and almost non-existent for people in later life. Therefore my thesis presents an original undertaking which I think is much needed, considering the expansion of the number of people living into old age. Some psychological therapists, as also discussed, confirm the usefulness of this kind of therapy and the lack of treatment facilities for older people.

In my thesis I have questioned whether my study would show any further reasons for depression at this stage of life other than the already acknowledged failure to mourn early losses as indicated in most of the clinical papers. Evidence of other very interesting dysfunctional mental states of significant importance noted as common features across the domain are shown in tabulated form in Tables 2-6 below. The most significant and recognizable theme was that the lost object remained an intensely desired feature in the background of the patients' mind and was not repressed. A yearning in the sub-conscious/conscious mind as 'defensive hope' that 'it will still happen' was the basis of the depression. All the patients at some stage in their therapy, without exception, were able to speak about what they desired during their younger days, and gave the impression during the transference that they still wanted to be satisfied internally by acquiring these lost experiences. Perhaps retirement instigated a state of despair that the desired lost object would now never be gratified. This I think is an added important feature to that of the failure to mourn early repressed losses.

## **6.2 THE CONTEXT OF THE RESEARCH STUDY**

Ageism cannot be seen in isolation from the perspective of psychoanalytic psychotherapy alone but necessitates the understanding of contributions from other approaches related to the ageing process, such as psychology, sociology, gerontology and pharmacology. Physical impairment is sadly part of the ageing process and has to be taken into account although it was not a significant feature in the cases of this study. For the external comfort of people in later life many forms of provision have been made available by appropriate authorities, but there seems to be a noticeable lack of concern for emotional well-being as discussed in Chapter 4.

In Chapter 2 I summarized a review of psychoanalysis and old age incorporating the psychology of ageing. The purpose of this was mainly to set out the context in which the clinical findings could be understood. A literature review represented the psychoanalytic work carried out by past and present clinicians in the field of work with older adults suffering from depression. The



common understanding through their work has been concluded to be the failure to mourn early losses. Such losses obviously vary, personally from one patient to the other.

In Chapter 3 a description of the qualitative research method of the applied form of 'Grounded Theory' on which this study is based was discussed in order to substantiate the findings from the clinical work with one of the research patients, GS. Similarly the clinical data of all the other case studies was scrutinized for patterns of 'unconscious processes' to identify 'clinical facts'. Every patient was seen as an individual with problems stemming from his or her life experiences. Although globally very different from each other there were some well-defined common features for their depressive states. A comparison across the domain resulted in some significant similarities that have been tabulated (Tables 2-6) and grounded as hypotheses for depression in later life.

In Chapter 4 I argued that some well-intended government policies have failed to come up to expectations. Policy makers such as Byrne, Crisp & Philp (2006 DOH) have not been able to meet the overwhelming demands of the ever-growing older population satisfactorily. This was followed by a discussion that although the provision for the external need of older adults was available to some extent there seemed a lack of consideration for their emotional well-being. The thinking in a similar vein from the disciplines of psychology, sociology and gerontology was presented. Institutions and medical professionals continually meet with complaints of inadequate hospital provision, and about the poor care of some old people. The lack of understanding of the individual's emotional need is almost a daily subject in the media.

Chapter 5 gives a more detailed account of the verbatim material written up soon after the session, which is the basis of the study.

### **6.3 THE RESEARCH FINDINGS**

Tables 2 - 6 give a tabulated conclusion as my findings for the reasons for the depression of my six case studies. There seemed to be some strands of

common features as discussed below. The research patients stayed for the duration of the therapy and all seemed to benefit by more than one measure, which I believe is a substantial finding. The transferable value of my thesis lies not only in demonstrating that a qualitative research method with a sample of six subjects utilizing the mode of psychotherapeutic intervention can be done with good effect, but also in identifying the principal clinical issues needed to be addressed to help these older adults with their depression when other treatments had failed. Perhaps the general attitude has been to expect old people to be doleful, unadventurous mentally and moribund. My research findings proved otherwise. The failure to mourn early losses as a cause for depression in later was repeatedly identified. My thesis adds further subtleties, which I think are relevant contributions to bear in mind when working with people in later life.

#### **6.4 A COMPARATIVE STUDY OF 'KEY FACTS' ACROSS THE SAMPLE**

The scrutiny of the process notes of the clinical material from the case studies produced some identifiable similarities or 'key facts' in connection with their pathological states. In order to identify the source of my key facts I have given further samples each from four other patients in the appendix. These examples were chosen to indicate noticeable repetition in the psychic patterns of behaviour as well as my observations as a psychoanalytic psychotherapist. Below is a representation in tabulated form in Tables 2 to 6 of the treatment and my thematic analyses of identifiable themes grounded as hypotheses.

These tables are by no means stating that the findings are identical in manner or form.— every human being is an individual with individual characteristics – but some noticeable similarities in connection with emotionality could be recognized and pin-pointed as common features. One factor featuring in the cases of all the research patients was that they had led satisfactory lifestyles until they were diagnosed as depressed in later life by professional clinicians. As discussed previously I consider the patients to have been depressed for most of their lifetime but their depression became overtly activated and significantly apparent after or about retirement.

**Table 2: Noted facts and processes during the early stage of therapy**

	<b>KW</b>	<b>BA</b>	<b>SP</b>	<b>CF</b>	<b>DL</b>	<b>GS</b>
<b>Noted Features</b>	Unhappy childhood.	Fifth child.	Parents	Pre-occupied	Death of father	Non-caring father.
	Violent father, passive mother.	Uninvolved father, cold mother.	unintentionally more involved with two older sick children.	mother. Traumatic death of much-loved father. Cut-off from grief.	when one. Mother depressed. Enmeshed with mother.	Over involved mother. Unhappy, solitary.
	Solitary state of aloneness.	Dyslexic. Unhappy at school. State of aloneness.	Unhappy. Cut-off from self.		Cut-off from self.	State of aloneness.
<b>Functioning</b>	Emotionally cut-off.	Escape into intellectual activities.	Low self esteem.	Assumed a caring role of partner	Desperate for love but wary.	Emotionally needy.
	Dependent on authority.	Emotionally cut-off. State of depression.	Cut-off emotionally. Pseudo lifestyle. Insecure.	children and friends. Depressed but manic behaviour.	Underlying depression. Emotionally cut-off.	Desperate for love of father and recognition.
<b>Clinical facts</b>	State of insecurity.					
	Ego-destructive superego.	Unhappy.	Emotionally cut-off.	Emotionally cut off.	No secure attachment in early childhood.	Arrogant, emotionally shallow.
	Insecure.	Discontented, lonely. No early containment.	No early containment.	Shallow personality.		Insecure.
	No early containment.	Narcissistic.	Dependent on charismatic partner.	Underlying depression.	Underlying depression.	Ego- destructive superego.
	Narcissistic. Depressed.	Depressed	Depressed.			Narcissistic. Depressed.

**Table 3: Noted facts and processes during the middle stage of therapy**

	<b>KW</b>	<b>BA</b>	<b>SP</b>	<b>CF</b>	<b>DL</b>	<b>GS</b>
<b><i>Noted Features</i></b>	Regression, awareness of needy self. Solitary.	Regression, awareness of dysfunctional self.	Defensive, fear of looking at self emptiness.	Oscillates between being defensive and needy.	Highly defensive, can cope independently. Solitary.	Recognition of neediness less defended self awareness
<b><i>Functioning</i></b>	Aware of depression. Slight inner motivation. Associating with others.	Aware of depression. More aware of self and tolerant of partner.	Still depressed and narcissistic. Full of self pity and lonely.	Becoming aware of how she behaves.	A little more acceptance of early losses. More aware of self.	In touch with painful events of early life experiences. Open to interpretation.
<b><i>Clinical facts</i></b>	Unable to mourn early losses. Slight awareness of feelings.	Never mourned early losses. Aware of reasons for depression.	Unable to be in touch with inner state. Early losses never mourned.	Never mourned loss of father or mother.	Never mourned loss of father she never knew.	Aware of reasons for depression. Beginning to mourn the loss.

**Table 4: Noted facts and processes during the later stage of therapy**

	<b>KW</b>	<b>BA</b>	<b>SP</b>	<b>CF</b>	<b>DL</b>	<b>GS</b>
<b><i>Noted Features</i></b>	Perceptive and insightful. Open to exploring past painful experiences.	Attempting to understand the past adverse experiences.	Very defended. Arrival of grandchild unacceptable. Regressed. Melancholic.	Started the mourning process by talking about father and mother.	Beginning to understand her insatiable need for love and mourned loss of father.	Started mourning early losses. Acknowledged father's gift as recognition of his talent.
<b><i>Functioning</i></b>	Coming to terms with early losses. Able to mourn. Not as dependent on psychiatric care.	Depression lifted. Personal achievements. More emotional involvement at home and with friends.	Acting out for attention. Settled for ECT. Manic reaction. Still narcissistic.	Moved on a little. Able to say 'No'. More assertive with son and family. Beginning to mourn early losses.	More self aware. Able to understand her behaviour towards her children.	Dramatic movement. Able to perform successfully. Excited with achievement.
<b><i>Clinical facts</i></b>	Relinquished early losses and false hope. Depression lifted. More active and improved lifestyle.	Relinquished early losses and false hope. Achieving and much improved lifestyle.	Difficult to ascertain after ECT. Looked manic at review meeting.	Accepting death of father. Relinquishing false hope. More open to accepting help from others. Less of a doer. In touch with self.	More aware of her behaviour. General improvement. Mourned the loss of a father.	Relinquished all false hope. Definitive movement from depressive state. Making friends and hopeful of the future.

**Table 5: Noted changes and observations at the end of therapy**

	<b>KW</b>	<b>BA</b>	<b>SP</b>	<b>CF</b>	<b>DL</b>	<b>GS</b>
<b><i>End of treatment Observations and facts</i></b>	Dramatic change of lifestyle. Less psychiatric input. Angry that treatment ended but moved on and sought continuation of treatment.	Depression lifted. Very grateful for support and decided to have further therapy.	Slightly manic. Went on to have Cognitive-analytic Treatment.	More in touch with her emotions and less of a doer. Seeing her psychiatrist.	More lively but still defensive. More aware of her state. Asked to be referred on for further therapy.	Went on to ongoing therapy to work through more entrenched anxieties of his sexuality.

Tables 2- 5 summarise the clinical findings as noted with each research patient. The tabulated format is indicative of some of the factors and observations noted during the clinical session of the individual case study's progress during the year's treatment. A comparative study across the domain was made to deduce the key facts grounded as hypotheses for depression in later life.

Table 6 below shows a summary of some of the more noticeable mental processes connected with psychoanalytic theory found to be common features with the research patients. The last two columns especially generated some further findings such as feelings of aloneness and hope which I think of as 'defensive hope'. Perhaps the workplace in the outer reality consciously helped alleviate the inner reality but as soon as this was lost the patients despaired that all was lost. The feeling that all hope was gone was perhaps a common reason for depression in each case to become overtly apparent.

<i>Dysfunctional early containment</i>	<i>Ego- destructive superego</i>	<i>Un-mourned early losses</i>	<i>Narcissistic personality</i>	<i>Inner state of loneliness</i>	<i>Hope as a defence. It will happen</i>
KW	KW	KW		KW	KW
BA	BA	BA	BA	BA	BA
SP	SP	SP		SP	SP
CF	CF	CF		CF	CF
DL	DL	DL	DL	DL	DL
GS	GS	GS	GS	GS	GS

**Table 6: Findings linked with psychoanalytic theory**

## 6.5 FURTHER FINDINGS

I will continue by discussing some themes as noted in psychoanalytic theory that were identified during the course of the treatment. These concepts were distinguishable features observed during the transference situation other than those discussed in Chapter 2. I think they are added, important features that contributed to the depression and were noted as 'key facts'. The research study identified these further findings, discussed below, and also grounded them as

hypotheses for depression in later life.

### **6.5.1 Memory, Desire and Hope as a Defence**

Pertinent to the point I am making is Bion's (1993 143-157) writing on the subject. Without exception all my case studies recalled and referred to events or described them as 'remembered' and still desired their resolution, following Bion's thinking that memory could be represented by desire. My patients were able to speak about their desires and eventually at different stages of their therapy recollect some memories connected with these desires.

Hope, as generally understood, is a word connected with our daily lives and often used to gratify some wish or other. The intensity varies according to what we desire but on the whole we are prepared to forego this feeling if our wish/desire is not granted. It was very different with my patients. They persistently throughout their lifetime hoped their desires would come to fruition and never gave up on them. This state of mind was a defence against confronting the lost desire or object that was not 'remembered'. I therefore see the hope my patients had as 'defensive hope'. Potamianiou (1997, 57-69) pointed out:

*Hope can be seen as a characteristic instance of the human tendency to oscillate between the 'reality principle' which demands renunciation of the hope that certain things might change and the 'pleasure principle' that cancels out renunciation.*

She was discussing her work with borderline patients. She obviously connected her conclusions with Freud's thinking on the reality and pleasure principles that when reality is too painful the tendency is to deny the experience.

Similarly I consider that my patients continued to desire their lost objects and continued to seek union with them. This hope acted as a defence, seeking not to acknowledge the original painful experience but restrict psychic development,



and became the foundation of stasis in their life. During my discussion on this theme with Gianna Williams she pointed out: 'the unconscious wish or expectation was that it will come tomorrow'.

### **6.5.2 Inner State of Aloneness**

A state of loneliness differs to a state of aloneness. The processed recordings indicated that the research patients were not lonely people. Most of them had close family and friends or in the case of KW and GS friends as well as a reasonable community lifestyle. But without exception all expressed feelings of 'lack or loss of companionship'. Townsend (1974) stated: 'the one is objective and the other subjective, and as we can see the two do not coincide'. The development of a narcissistic personality unfortunately leads to a state of inner aloneness. As BA pointed out to me often in a social gathering with his work colleagues he felt like an outsider. He had to accept the cigarettes offered against his wishes to smoke just to be part of the group. But it made no difference as he still felt lonely. Freud (1917) explained the intrapsychic state as 'an ego ideal of the lost narcissism of his childhood of which he was his own ideal' Therefore it was not surprising that BA with a narcissistic personality felt this way. The other patients also experienced a state of what they thought of as feelings of loneliness regardless of having family and friends, They were not aware of their state of inner aloneness until these feelings were explored, interpreted and understood during the psychotherapy.

## **6.6 THE OUTCOME RESULTS FROM THE CORE GRAPHS**

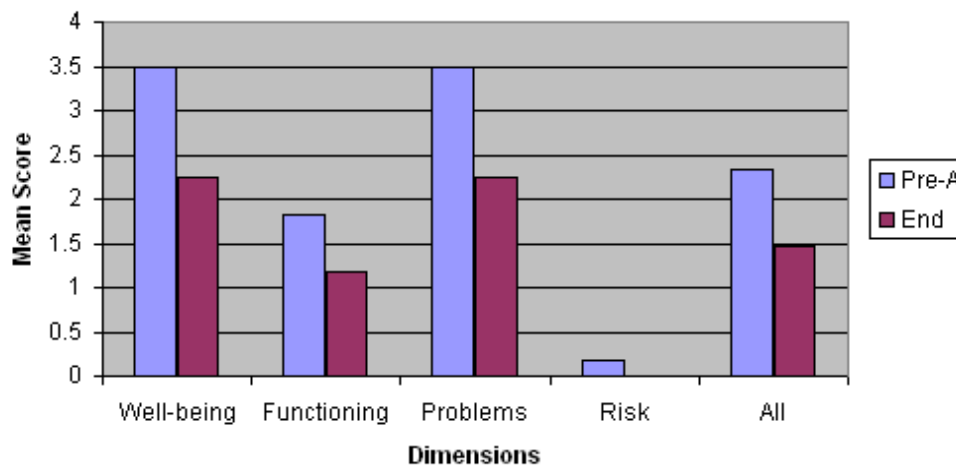
The CORE outcome (discussed in Chapter 1) generated independently to that of my findings suggested that the mental functioning of all the patients had improved to varying degrees by the end of the years' treatment. Although the CORE results cannot be established as a determinant they give some indication of evidence in support of the proposition of the patients' reaction to the treatment. The outcomes shown below give some indication that the patients responded positively to psychotherapeutic intervention. The following graphs and charts indicate the progress made by each of the individual case studies as

well as a group. As the cut-off line for treatment for the different genders differs I will group them accordingly – 3 males and 3 females – for the individual results. The cut-off clinical point for males is 1.7 and 2.5 for females. Overall there was some change in all the cases as the Mean Score indicates.

### 6.6.1 Male Sample

**CCO (Clinical Cut Off) W-1.37, F -1.29, P-1.44, R-0.43, All-1.19.**

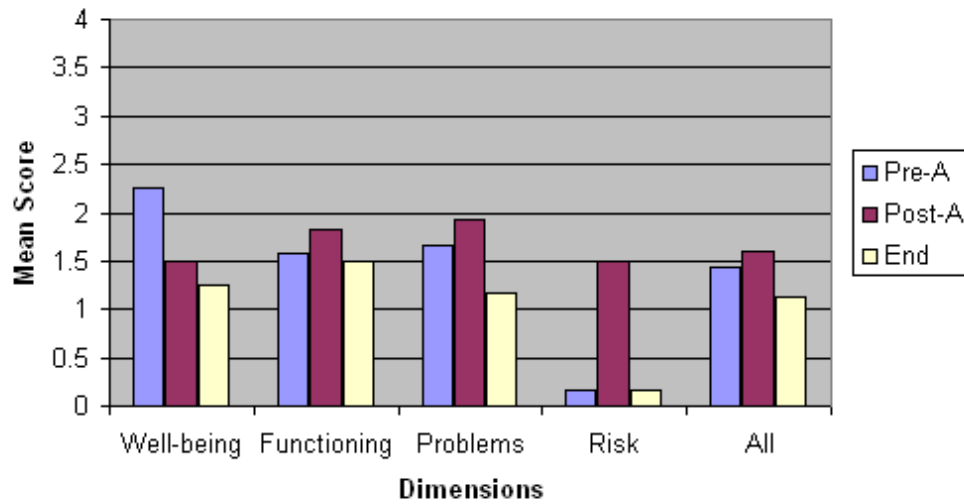
#### KW



KW's responses to the self-report from CORE are shown in the graph above. He completed the form before his first session and at the end of the treatment. The post-assessment form could not be located by the CORE administrator. Perhaps he had not returned it.

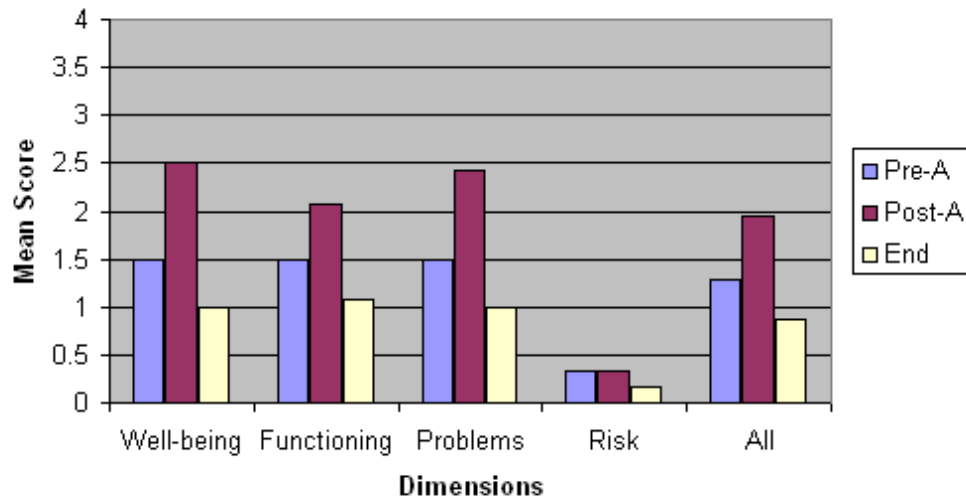
As the graph indicates he started treatment with higher than normal problems. He regarded himself as having fewer problems and difficulties at the end of treatment. In terms of function or risk he was within the normal range at the end of treatment. The graph further indicates that he is still in the clinical range in terms of well-being and problems but overall there were fewer problems by the end of the psychotherapy treatment.

## BA



The graph for this case study indicates that although at pre-assessment stage BA had fewer problems they increased during the post-assessment stage and the risk increased at treatment. Perhaps the reason for this was that he had become less resistant to his emotionality and more vulnerable as he got in touch with his adverse feelings. Perhaps for the first time he was able to emotionally address his early life experiences and not remain in denial. Overall at the end of treatment there was little change perhaps exacerbated by the anxiety about the treatment coming to an end. He needed a longer, more intensive form of treatment which was being arranged. The positive outcome was that he became aware of the origin of his depression and altogether was functioning better.

## GS



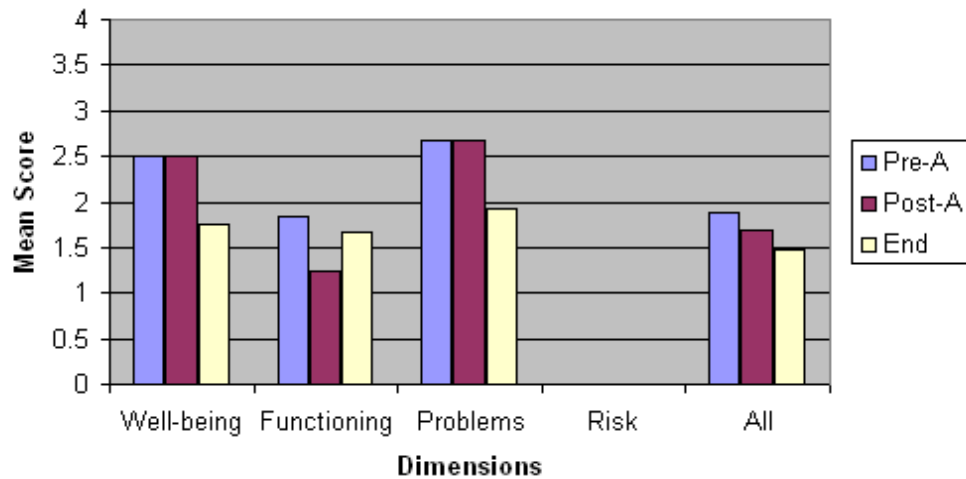
The CORE results of GS's chart shows that he started the treatment with average problems and scored higher than other case studies. During treatment his problems were alleviated to some extent and then became as intense as when he started. The clinical recording perhaps explains the reasons for this. After the initial period of the treatment he became resistant when he felt vulnerable. But when he once more became amenable and positive to the therapy the graph indicates the change. Towards the end of treatment he panicked but he had made some improvement in all the dimensions.

## 6.6.2 Female Sample

The CCO (Clinical Cut Off) for females is scored on a slightly higher level.

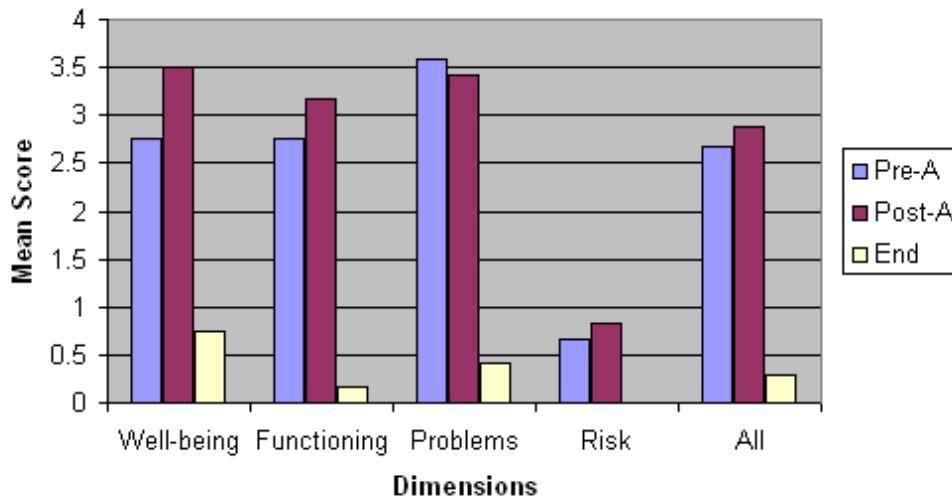
W – 1.77, F- 1.3, P – 1.62, R – 0.31, A – 1.29

### CF



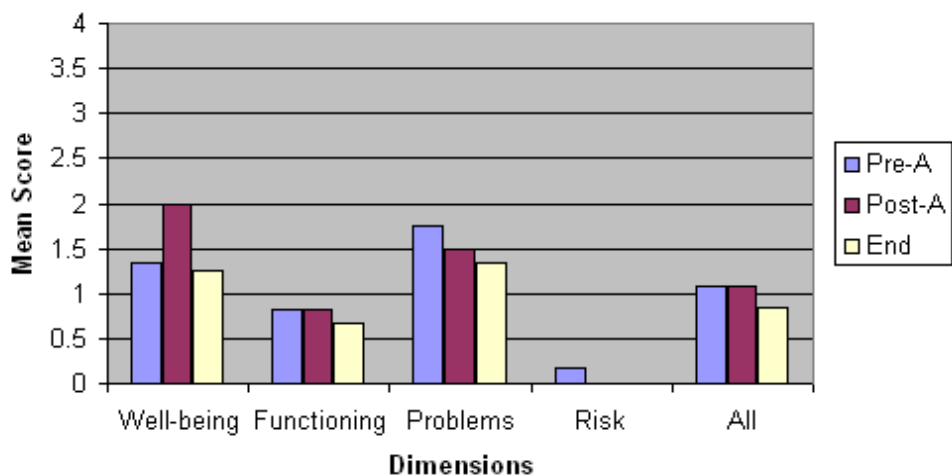
By the end of the treatment CF thought that she felt a lot better and there was improvement in her functioning capacity, but by the time of her post-assessment her problems seemed to have increased. This was probably due to the fact that she became more aware and in touch with her problems. Overall there was some improvement in her general state of mental well-being by the end of the treatment. CF's chart shows no risk factors. This might be due to her strong denial that she was the needy person and not the people she projected this onto.

## SP



SP was the most disturbed of all the participants of the research study. She was highly defended and previously had undergone ECT. The continual conflict of deciding whether to once more undergo ECT made it difficult for her to stay within the boundaries of the treatment and give this a chance. But her graph indicates a greater improvement than had been expected. The outcome cannot be ascertained as the direct result of the treatment

## DL



At the beginning of treatment DL came with the belief that she did not have any serious problems, functioned very well and that there were no anxieties or risk factors. By the end of treatment although there seemed to be a general state of

well-being she had also become more aware of her problems. Her defences had crumbled and she had become more needy. This left her feeling insecure but she admitted to the need for support to improve her lifestyle. The graph indicates some improvement in all areas.

## **Conclusion**

In Tables 2 - 6 I have given an overall synopsis of the progress of each patient indicating the important reasons for their depression as discovered during the treatment through the methodology of psychoanalytic psychotherapy. Table 7 represents an account of what I consider as relevant interpretations linked with psychoanalytic theory. The findings are tabulated and highlighted as 'key facts' in preference to 'clinical facts'.

Both the findings from my psychotherapy treatment and the outcome from the CORE graphs indicate that to some extent the patients were able to use the treatment of psychotherapy beneficially and made mental efforts to change their lifestyle productively. The holistic and reflective nature of the method, whereby their unconscious processes were made a little more available to them, arguably allowed them to understand their internal dysfunctional states as never before. Even SP who was fairly ill mentally, confused and the most emotionally defended, can be shown to have responded to the treatment to some extent. Perhaps if she had not experienced the pressure from her anxious family she might have used the treatment more effectively. Medication did not have the same effect as the psychotherapy.

My qualitative research study in this field was set up with a definitive purpose and was an innovative undertaking. Previous wider studies by psychological therapists from different perspectives, for example Murphy (2000), Ardern (2002), Evans (2004) and Garner (2008) were discussed in earlier chapters. But none of these were set up with psychoanalytic psychotherapy as a research methodology in association with a qualitative Grounded Theory method. Therefore the contribution of my thesis specifically lies in the structured, qualitative, research framework of once-weekly sessions over a period of a year

using 'Grounded Theory' methods applied to clinical data to generate themes. To my knowledge this has not been done before with this age group. The study was deliberately set up as a clinical undertaking to work with a selected sample so that some grounded hypotheses might come to light to work with older people who were depressed.

A further subtle point, not identified previously in the literature, is that it was necessary for my patients to renounce hopes and desires connected to the lost object ever present in the subconscious/conscious dimensions of their daily lives. My research patients had been depressed for most of their lifetime and had successfully masked their feelings until reaching old age. By this latter stage of their lifespan, not having obtained the long yearned for fulfillment of the desire they despaired of their phantasies ever being satisfied. The consequences of this dissatisfied inner state became overt as their depressed state.

The findings listed in the thesis I claim to be original and important factors in relation to psychotherapeutic treatment for depression in later life. The hypotheses grounded from my research study should lead to a broader understanding of old people's mental needs.

## **6.7 MEDICATION**

Unexpectedly, the research study provided a further important finding. It became evident that the patients' intake of medication dramatically either stopped completely or the quantity and frequency was lessened by their GP or consultant during the therapy. Table 7 below is indicative of the overall progress made in connection with reducing the medication coinciding with stages of the psychotherapy sessions. It seems that although the medication alleviated their mental pathology it did not get to the root of their problems. As the psychotherapy treatment progressed the anti-depressants became unnecessary for a healthy mental state. The intake of other prescribed medication for physical well-being, for example for GS's back problems and CF's insomnia,



were completely stopped. Perhaps a healthy body results from a healthy mind! A more profound and intensive longitudinal study on a larger scale is obviously needed in order to establish whether psychological therapies are perhaps more productive than medicinal treatment for people in later life suffering from depression. Perhaps research into cost effectiveness could be undertaken arising from this thesis. The cost of continual dispensation of medication for older adults, perhaps for the rest of their lifetime, might not be beneficial because of side-effects as pointed out by The World Health Organization (2008) noted in Chapter 3. That more people live well into later life in the UK is now a fact. It is important that forms of treatment other than medication should be considered to enhance the lifestyle of depressed older adults.

Table 7 is a summary of the diagnoses and medication prescribed by the patient's GPs and psychiatrists. Included are details of the research case study's frequency of attendance to see either the consultant at the Old Age Psychiatric Unit (OAPU) or the GP before the beginning of the psychotherapy sessions. Detailed descriptions of the medication each patient was taking at the different stages of the therapy, i.e. the beginning, during and at the end of the therapy, have been shown. The table also indicates the positive changes in connection with visits to their doctors and psychiatrists and ends with an indication of what they decided to do after the year's treatment.

<b>Patients</b>	<b>KW Male (77)</b>	<b>BA Male (65)</b>	<b>SP Female (67)</b>	<b>CF Female (72)</b>	<b>DL Female (71)</b>	<b>GS Male (68)</b>
<b>Referrer</b>	Psychiatrist, OAPU	Psychologist, GP	Psychologist, GP	Psychiatrist, OAPU	GP Service	GP Service
<b>Reasons for referral</b>	Long term depression, care since in 30's	Long term mild depression, psychotic features	Terminally depressed, ECT 3x, last dose in 2003 unsuccessful	Depression, insomnia, falling over frequently	Depression, recently physically abused by daughter	Long term mild depression, psycho-somatic back problem
<b>Frequency of visits to GP before treatment</b>	1x3 weekly to OAPU	Frequently saw GP 1x monthly	1x3 weekly to GP, psychiatric unit	1x3 monthly to OAPU. Frequent visits to GP	Frequently to see GP, 12 weeks counselling.	At least 1 x monthly visits to GP
<b>Visits to GP during treatment</b>	Once every 3 months	None	1x every 6 weeks to OAPU	1x 6 monthly to OAPU. Rarely to GP	None	Twice for other physical reasons
<b>Attendance</b>	37/40. Missed 3 sessions	40/40. None missed	38/40. Missed 2 during ECT	40/40 (none missed)	40/40. None missed.	40/40. None missed.
<b>Medication at beginning of treatment</b>	Sodium valproate, Venlafaxine, Moclobelide, Moxazosin	Sertraline	Cipralelex, zispin, sertraline, mirtazapine	Prozac, zopiclone, venlafaxine, sleeping tablets	Fluoxetine (Prozac),	None
<b>Medication during treatment</b>	Veulafaxine 50mg	None	Discontinued taking any. Her choice.	Discontinued all	Discontinued all	None
<b>Medication at end of treatment</b>	Venlafaxine every alternate day	None	None. Had ECT	None	None	None
<b>Future treatment</b>	Further Therapy	Further therapy	Further CAT	Knee operation, no plans for further therapy	Seeking further therapy	Further therapy within Trust

**Table 7: Survey of medication taken during the treatment**

## 6.8 DISCUSSION OF THE METHODOLOGY

Finally the research was set up to explore through the means of psychoanalytic psychotherapy the cause(s) of depressive states in later life. A qualitative research method, namely Grounded Theory, was chosen because it enabled me as a researcher to understand the meaning and nature of the internal experiences of the sample. From my previous observational research I discovered that people in later life often become more distressed than younger people over simple matters. They sometimes misunderstand what a younger adult accepts more readily the reason perhaps being a fear of another loss when old age is a time of experiencing many losses. I have discovered that older adults often feel they are a burden to others through their dependency, regardless of how trivial their needs may be. Many are afraid that they will not be listened to or feel undermined and are not confident enough to demand their rights. Currently, some more forceful baby boomers who know their rights are becoming assertive and demanding what they feel is due to them.

The application of the qualitative Grounded Theory method was an effective means of justifying the observations and actions during the transference. The consensus amongst authors quoted in connection with 'clinical facts' (3.3.1) is that there is a common understanding of what a 'clinical fact' is to that of a 'scientific fact'. This has enabled a further developmental process in understanding psychoanalytic psychotherapy as a methodology. The compatibility of Grounded Theory to assess psychotherapeutic treatment engenders the thinking that psychotherapy as a methodology is less unique than anticipated. The study has conveyed the practicality of the applied Grounded Theory method as useful to generate hypotheses from therapy sessions similar to that of data from the social sciences.

Listening is part of the psychotherapy technique and gave my case studies an opportunity they rarely experienced. The transference, countertransference and free associations, all powerful tools of the treatment, can encourage people in later life to share their difficulties. The danger of course is that they

unconsciously link mental health with being alive and avoiding ageing and death, inducing unrealistic hopes and expectations. This requires subtle negotiation on the part of the therapist in order that such feelings might be addressed and recognized rather than be allowed to delude a patient. King (1980, 153-160) referred to this topic by stating: 'The reaction from the middle-aged patient can be difficult for the analyst to deal with emotionally, because these patients also manage to convey the impression that analysis is keeping them alive.' She adds that it is possible the patient might leave the analyst with some guilt. King was discussing these thoughts in connection with a middle-aged patient and in my experience these transference feelings are more powerful with older people.

Psychotherapy with elders requires some minor adjustments (see below), but I would like to add that none of my patients left me feeling that they believed therapy was keeping them physically alive. Instead they showed me in various ways that I had given them the impetus to enjoy their daily lives a lot more than they previously had done. My research case studies clearly indicated that they do not feel they have this kind of opportunity with many other professionals, friends or family, who are not usually able to understand their emotional states in an in-depth manner, as can happen within the psychotherapy setting. No doubt the ethos of psychotherapy is to incorporate and understand feelings, so it is not surprising they felt that this was a different experience from that of other professional encounters.

This research study enabled the processing of particular clinical facts within and outside the session to be linked with psychoanalytic theory in order to understand what I considered 'key facts' about the patients' depression. Particular facts, first mentally noted, were interpreted to patients by making appropriate links to how they were reacting. This humane, holistic approach of the method was a framework that was suitable and encouraging for vulnerable, depressed older people who often find it difficult to communicate their inner states. As the analytic session allows for confidentiality and trust they were able to relate their long unspoken feelings for the first time. As one past event evoked other memories they could within the session indulge or confront

experiences. Although other clinicians, care workers and auxiliary staff may listen to old people, it requires specialist training, such as psychotherapy, to gain the expertise necessary to understand psychic activity, for example through the transference and projective identification.

At the beginning most of the research patients often felt confused by some of the interpretations I made. To BA, SP and GS, who were very intelligent people functioning within a mostly intellectual parameter psychic activity felt foreign and difficult to understand. The turning point of their therapy was when they eventually recognized and understood some of their dysfunctional feelings and how counter-productive these were for their mental well-being. In other cases like CF and DL in particular, an air of misunderstanding or neglect prevailed in their lives. The psychotherapy provided a space for them to be understood. As Fonagy and Moran (1993, 62) have suggested:

*The psychoanalytic method provides access to unique data that may not be accessible outside of this long-term, intimate and confidential relationship. The method provides a relatively standardized observational framework with a observer trained to minimally disrupt the flow of emerging material while remaining attuned to his or her own, as well as the patient's, emotional reactions.*

Quantitative methods are useful in many fields and have produced informative results but I do feel that the qualitative research method of the application of Grounded Theory which I chose for this study was well suited to work with older adults because it provided insight into behaviour and nuances which might have gone unnoticed with other modes of study. The non-judgemental approach of psychotherapy also encouraged spontaneity and trust. Valuable, rich material could be noted during the sessions. As Strauss and Corbin (1990) have said, 'Qualitative data it is affirmed is useful for uncovering endemic views; theories, to be valid, should be qualitatively grounded'. They are specifying that such grounding of inside data is crucial in order to provide factual accounts of an interview. Similarly psychoanalysts as previously discussed have argued that

the context of a clinical session provides clinical facts. Following this thinking the important and consistent information gathered from my patients' sessions are clinical facts that I have termed key facts.

Occasionally the clinician might come to incorrect conclusions for a variety of reasons, as when one is working with unfamiliar material on any other subject. The vast expanse of unconscious processes differs with each patient but common features do exist and are recognizable. The lengthy training as well as the clinician having undergone a long period of intensive, personal analysis helps in discerning repetitive mental behaviour. In my thesis I have demonstrated by the use of a qualitative method how a researcher can have sufficient control to understand and determine certain repeated, factual phenomena to be recognizable as clinical facts. Sometimes they were also the patients' historical facts as they unfolded or recalled as their experiences during the session. Glaser et al (1986) confirm this when they say:

*Episodes identified as containing previously warded-off mental content were not characterized by anxiety, as might have been predicted by classical psychoanalytic theory. Rather, these episodes tended to follow periods during which the patient was insightful, free associating, able to articulate and explore his experience.*

In this thesis conclusions were drawn from this method by observing, listening and trying to understand the free associations of patients insightfully as they articulated their experiences. The final task was to filter patterns of associated findings from the accumulated, recorded data that linked with established psychoanalytic concepts.

## **6.9 OTHER SUGGESTIONS IN CONNECTION WITH MY FINDINGS**

In the Introduction I made reference to my previous study, McKenzie-Smith (1992, 356-390) on the use of approaches stemming from the procedure of

psychoanalytic infant observation and how these approaches might be transferred to observing the elderly. I claimed that this was an original contribution which was subsequently taken up by other clinicians and professionals. Similarly the findings in this thesis demonstrate how beneficial the psychotherapy treatment was for my research patients. It encourages me to make the suggestion that this kind of work in both public and private sectors should be undertaken on a larger scale. I am convinced that psychotherapeutic services should be more readily and widely available for the older population. Doing so would not only improve the quality of some lives but would also reduce the burden they place on medical and other services as a consequence of depression.

A notable finding resulting from the research study is the efficacy of the treatment as the patients continued to make progress even after the therapy had terminated. The review meeting, three months later, confirmed that this state of mind had become very much a part of their improved lifestyle. None of them had gone back to taking medication. The study cannot confirm whether SP's sense of well-being was the result of the ECT or whether the therapy had anything to do with it.

From the outcomes of my small study one might expect that similar studies on a wider scale might reveal other notable reasons for depression in older adults and the real benefits that psychoanalytic psychotherapy can bring to such patients. Such a study might also widen understanding of the therapeutic issues arising in this kind of work with a broader range of patients than my small sample could include.

As a follow up to the findings from my research I would like to suggest:

Firstly, that there is potential for work both in the public and private sectors to support the emotional well-being of many of the elderly. The NHS as the main provider for good health should include psychotherapeutic treatment for older adults as part of the service. Obviously mental problems of a more severe nature than mild depression are already being catered for but similarly to my

patients many people suffering from mild depression are neglected (Age UK, 2008). It would be desirable to compare psychotherapy treatment with other more standardized treatment modalities. By providing facilities for psychotherapy treatment the quality of their lives may be improved.

Secondly, as other authors quoted in the study, pointed out that there is a lack of training to understand the emotional needs of the elderly by professionals and care workers. It would be useful for some form of psychological awareness training to be given to staff working with the elderly.

Thirdly, the given statistics confirmed that people are living well into their eighties and nineties. A longitudinal study could be undertaken to assess if the efficacy of a years' psychotherapy treatment, is beneficial and can continue to enhance older people well into later life. The treated patients would have to be monitored for significant changes in their mental well-being.

Fourthly, it would be useful for a comparative survey on a wider scale to be undertaken to compare the cost effectiveness of a year's psychotherapy treatment to that of the intake of medication for depression over the same period of time.

#### **6.10 MY ROLE AS A PSYCHOTHERAPIST WITH OLDER ADULTS**

My operational role as an adult psychoanalytic psychotherapist encouraged free associations whilst listening to the patient during the stipulated fifty minute session time. Whilst an interpersonal relationship was cultivated the usual professional boundaries were maintained with a few adjustments. For example CF often brought a walking stick to her sessions although she did not use it along the corridor. She generally dropped it with her handbag on the floor beside her. Being a large person and mildly disabled she struggled to reach them at the end of the first session. I picked them up for her at this initial meeting and suggested that she placed them on the couch as she came in. Although she acknowledged this at the time she continued to repeat the pattern.



On my tentatively reminding her of my suggestion she replied that she did not like 'placing things on other people's beds'. Unfortunately the alternate place in the therapy room would have been the desk, which I felt would be an inappropriate place and an intrusion into my space. I had to adapt my role to often help her with her things and hold the door open for her. This might be thought of as unprofessional by some analysts but further thinking is necessary on how one might deviate from the conventional without blurring the boundaries for this age group. Perhaps a special therapy room would need to be set up for example where patients are disabled, as one does with children.

Another example of deviating from the rule occurred with KW. Towards the latter part of his therapy he complained of suffering with a stiff back and painful lumbago. Physically he was obviously in pain and insisted that the only chair that would suit him was my upright, high computer chair in the room. I realized that the ending of the treatment was painful and that there was more intrapsychic activity going on. I intuitively felt that he would have walked out if I refused which I might have done with a younger patient even if he were insistent. But I agreed to KW's request and he used the chair for the following session as well.

Other minor practical management issues of this kind arose with my other case studies. I found myself allowing for this, with careful thought which I might not have done with younger adults. KW and CF had had physical degenerative impediments that had to be taken into account. Nevertheless except for some of these minor adaptations the practice and principles of psychoanalytic psychotherapy were on the whole strictly adhered to with my older adults as practiced with any other adult.

## 6.11 THE RESEARCH PATIENTS

The research patients were very appreciative by the end of the treatment to be given the unique opportunity of an experience that was unusual for most of them, which they found helpful in overcoming their depression. After the initial assessment they were all willing to try the 'talking cure' treatment but with some

scepticism. Even GS who had undergone psychotherapeutic treatment as a younger man had not envisaged that his mental state might improve. This reaction was not surprising as in my experience many very intelligent people cannot conceive of how psychoanalysis works. Internal psychic activity can only be understood when one is a participant in the intricate treatment of psychoanalysis. At the beginning KW, CF and especially GS, who was arrogant and undermining, were the most resistant and defensive. But as they recollected and learned to trust me with their innermost feelings, hopes and desires they came to see the benefit of sharing them. CF and KW required some minor adjustments to meet their physical disabilities.

An intellectual with expansive knowledge on several subjects, BA found it difficult to express any emotionality at the beginning of the therapy. He tried to discuss and understand what was going on in his session through what he had read by Freud, Jung and Lacan. He further tried to make comparative links with philosophers such as Nietzsche and Kierkegaard and was dismayed at not being able to find logical reasons for his depressive state. But to his credit he quickly adjusted to the fact that sharing his emotionality with me, although he was initially well-defended and difficult, would be more beneficial. Once he was able to do this he brought several dreams that were most informative of his inner state.

Developmentally each patient reached a state of psychic awareness at a different stage of the treatment. The transference with some of the patients developed sooner and more strongly than with others depending on their resistance and defences. The end of the treatment also affected them differently. Some acknowledged that coming to me was only for a limited period of a year and accepted this although they wished otherwise and that they could look into finding future support. KW despaired and could not envisage that there were other possibilities until well after the therapy ended with me.

Without exception all the patients were willing to participate in my research project. The trust they had in me and appreciation of my support humbled me. Any early reservations that KW and CF had about sharing their experiences

with a younger therapist soon disappeared. All the patients soon trusted my judgement and knowledge on the subject and on the whole willingly cooperated. Obviously as part of the process some negative transference feelings came into play, especially before breaks and at the end of the treatment. KW's reaction was to stop coming before it was time to end, SP who was most depressed and confused made the effort to keep her appointments even during her ECT sessions. I felt very touched by her dedication, although whether it was through personal need or faith in me I could not ascertain.

## 7 CONCLUSION

### DISCUSSION

My thesis is about an innovative and exploratory attempt with a small sample to discuss whether the treatment of psychoanalytic psychotherapy as a methodology would not only alleviate depression in later life but produce some further findings that might give reasons other than the already known ones for depressive states in older people. By an applied form similar to the qualitative Grounded Theory method it was possible to assess and conclude some very important factors for depression in later life. Corresponding with established psychoanalytic theory several themes arose that have been noted during the clinical sessions and have been termed as 'key facts'. In a summarized form Tables 2-5 indicate these key facts as hypotheses for depression in older patients. Table 6 gives a tabulated form of the main psychoanalytic theoretical terms that were recognized as: early dysfunctional childhood followed by the reluctance to give up the lost, desired object; formation of an ego-destructive superego; the development of a narcissistic personality in some of the case studies and a state of inner aloneness.

Detection of such dysfunctional mental activities would not have been possible without the use of the humane, holistic method of psychoanalytic psychotherapy. Years of medication, as indicated in Table 7, did not alleviate the depression. The concepts of transference, countertransference and projective identification gave access and scope for assessing the patients' emotionality. Repressed and split-off parts of the self became evident during the treatment and were addressed, explored and interpreted. The patients gradually became aware of some of their dysfunctional mental behaviour. They realized that they would need to give up the yearning for the lost desired object from the past and think of what might be possible during their present lifetime. Obviously this was not by any means easy or immediate but it started a process that at least alleviated their depression. Fortunately without exception they accepted

this as a new beginning and could envisage a more pleasant future.

Although retirement in itself may be considered as an end to a lifestyle, resonant of other endings, it was not the main cause of the depression in my case studies. KW, CF and DL had retired some time before they came to see me. BA and SP had deliberately taken retirement before they were due to do so. There was more to their depression than feelings surrounding their retirements. As it transpired there was not only the failure to mourn the loss of the early object in their histories but a continual desire for the early lost object. Some contribution of psychoanalytic theory in particular associated with early attachment, separation and loss, container and contained, ego function, memory, desire and hope and the mourning process were found to be useful tools to explore mental states in later life.

Further to the above concepts some other theoretical recognized aspects such as the ego-destructive superego, narcissism, false hope and inner aloneness (as discussed in Chapter 2) were also recognizable features that contributed as findings. Psychic growth and development were achieved by exploring some of the split-off parts of the self and dispensing with long standing, false internal mental structures. A constructive mental state of what might be achievable instead of maintaining false hope lessened the depressive states of my research cases. The technique of psychotherapy involving the understanding of the intrapsychic structure via the humane, interpersonal relationship is vital to understand psychic states. Therefore I conclude by my findings in this thesis that the methodology of psychoanalytic psychotherapy was especially invaluable in helping older people overcome depression. I conclude that the research aims have been fruitful in generating some grounded hypotheses concerning depression for people in later life. Briefly, I repeat that the generated hypothesis other than the broader definition of the failure to mourn early losses for depression in later life is:

- The research patients believed that gratification and fulfillment of an inner yearning would still take place

- The patients had developed an ego-destructive superego that coincided with a narcissistic personality
- The patients experienced a state of psychic aloneness rather than being lonely.

Life expectancy in the 21st century has increased and the availability of technology in various areas has made the task of living much easier for most people, especially the elderly. As in Rider Haggard's 'Ayesha' immortality does not exist and there is an inevitable and ultimate end. Indeed the only certainty of one's lifetime is that there will be an end to it. Nevertheless this does not mean that the quality of the lifestyle of older adults cannot be improved. Obviously there are manifold problems encountered during the ageing process. Some people look forward to retirement as a time to travel, create new relationships or build stronger bonds and spend more time with children and grandchildren, without the responsibilities that come with the usual commitments of nurturing the family.

The qualitative method from a social science perspective made it possible to understand and assess the nuances and behaviour patterns of my patients as they unfolded, which perhaps would have gone undetected in a quantitative study. For example notably at the beginning of the treatment there were some long silences with KW in particular. He would sigh and look thoughtful. At first I thought it might have something to do with the experience of being in an unusual setting, in which someone was listening intently and encouraging him to speak about his feelings. But after the recurrence of this behaviour I wondered about what the silences meant and thought that perhaps he was referring to something on a deeper level. It could have been connected to the inevitable silence of death. Often he would break these silences by saying: '*This is all too late*', '*Things are not like they used to be*', '*Where is the point now?*' There was the sense that these utterances were uncontrollable and rooted in unconscious thoughts. It took some persuasion that all was not necessarily lost or in vain and that there were possibilities of KW enjoying an enhanced quality of life during what remained.

Idiosyncratically, some of the sessions were like being in the theatre, watching a play. Shakespeare implied that although humans consciously communicate verbally they also express their unspoken feelings through emotional and behavioural mannerisms. It is universally acknowledged that language is not the only form of communication. 'Inference from the unspoken but observable actions and nuances whilst in communication with the other is incorporated as part of the experience of the other' (McKenzie-Smith, 2009). Sometimes the meaning of, or the reason for a given mental state, is not easily recognizable, especially if in conflict with the conscious state. Erikson (1966) added an eighth stage to his earlier seven stages of our life experiences: 'Wisdom vs Integration.' Perhaps it takes the eighth stage for some people to gain the wisdom as typified by my research case studies to discover that past dysfunctional memories have to be dispensed with or re-negotiated and not held onto.

The parameters of the qualitative method allowed for access to the processes of transference and countertransference, projections and projective identifications as operational theories, which gave scope for accessing the patients' emotionality. It would be dangerous to assume that psychotherapy is the answer for all depressive states in later life, or for depression diagnosed at retirement. This study implies that there are avenues for future research in connection with developing strategies to make later life as comfortable as possible. In particular provision by the NHS for counselling older people should be made more readily available. This may prevent the anxieties and stress experienced by so many institutionalized and other older people who need to be listened to.

The focal aim of my thesis was to constructively ascertain by the means of psychoanalytic psychotherapy as a research methodology whether depression could be alleviated and thereby enhance the lifestyle of people in later life. I hope that in this thesis I have illustrated that it is possible to do so by recognition of some of the negative psychic activity that was at the root of my patients' depression. My exploratory attempt I hope will invigorate further research and give scope for a better understanding of people in later life.

## BIBLIOGRAPHY

- Abraham, K. (1919)** On the prognosis of psychoanalytic treatments in advanced age. *Int. Z Psychoanal* 6& 113-117
- Ainsworth, M.D. & Bell, S.** Attachment, exploration and separation: Illustrated by the behavior of one-year olds in a strange situation. *Child Development*, 41 49-67
- Aldwin et al 2004** Health, Behaviour, and Optimal Ageing: A Life Span Developmental Perspective. In *Handbook of Psychology of Ageing*. Eds: Birren & Warner Schaie (2006). 6<sup>th</sup> Ed. 91-95. Elsevier Academic Press.
- Alexander, C. & Morgan, M.D. 2003** Practical Geriatrics: *Psychodynamic Psychotherapy with Older Adults Psychiatric Services* 54: 1592-1594. Harvard Medical School, Massachusetts. USA.
- Ardern, M. 2000** Dynamic Psychotherapy with Older People. *Chapter 16 in Psychiatry in the Elderly*. Ed. Jaldry and Oppenheimer, Third Ed. Oxford Union.
- Ardern, M. 2002** Psychodynamic Psychotherapy. *Chapter 2, Psychological Therapies with Older people: Developing Treatment for Effective Practice*. London: Routledge.
- Anderson, J. 2001** Risk-Taking, Dangerous Behaviour in Childhood. *Doctorate Thesis, University of East London*.
- Anderson, J. 2006** Well-suited partners: psychoanalytic research and Grounded Theory. *Journal of Child Psychotherapy*. Vol 32 3 329-348 Routledge
- Anderson, R. & Dartington, A. 1998 Ed:** Facing it Out. *Tavistock Clinic Series*. London: Duckworth & Co Ltd.
- Bick, E. 1964** Notes on Infant Observation in Psychoanalytic Training. *International Journal of Psychoanalysis*. 45: 484-488.
- Bick, E. 1968** The experience of the Skin in Early Object Relations. *Int. Journal of Psychoanalysis*. Vol. 49.
- Biggs, S. 1997** Choosing Not To Be Old? Masks, Bodies and Identity. Management in Later Life. *Ageing and Society* (1997), 17: 553-570
- Biggs, S. et al 2006** The Age Shift: Observations on Social Policy, Ageism and the Dynamics of the Adult Lifecourse. *Journal of Social Work Practice* 20:3; 239-250
- Bion, W.R. 1991** Learning from Experience London :Karnac .(First published 1962 by London: Heinemann.
- Bion, W.R. 1993** Opacity of Memory and Desire 41-54 in Attention and Interpretation London: Karnac. (First published in 1970 by Heinemann.
- Bion, W.R. 1993** Second Thoughts. Commentary 120-166 London:Karnac. (First Published 1967, London: Heinemann.
- Blaikie, A. 1999** Ageing and Popular Culture: Views of Later Life. Cambridge, University Press.
- Blaikie, A. 2006** The Features of Old Age. London, Sage.
- Blos, P. 1962** On Adolescence. A Psychoanalytic Interpretation. *The Free Press. A Division of*



Macmillan, Inc. New York.

**Bowlby, J. 1969** Attachment. London, Harmondsworth

**Bowlby, J. 1973** Separation. London, Harmondsworth.

**Bowlby, J. 1980** Loss. London, Harmondsworth.

**Bowlby, J. 1980** Psychoanalysis as a Natural Science. *Freud Memorial Inaugural Lectures*. University College London.

**Briggs, S. 1997** Growth and Risk In Infancy *Jessica Kingsley Publishers*.

**Britton, R. 2003** Sex, Death and the Superego. Experiences in Psychoanalysis. London: Karnac Books.

**Butler, R. 1963** The Life Review: an interpretation of reminiscence in old age. *Psychiatry Journal of the Study of Interpersonal Processes*. Vole 26 1 65-76

**Cartwright, D. 2002** The Psychoanalytic Research Interview: *Preliminary Suggestions*. University of Durban, SA.

**Chadwick, M. 1929** Notes on the fear of death. *International Journal of Psychoanalysis* 10: 321-334

**Charmaz, C. 1995** Grounded Theory in Rethinking Methods in Psychology, Ed J. A. Smith, R. Harré and L.V. Langenhove.

**Clarke, A. & Warren, L. 2007** ' Hopes, fears and expectations about the future, what do older people's stories tell us about active ageing?' *Ageing and Society*, Vol 27 4 465-488 .

**Coltart, N. 1991** The analysis of an elderly patient: *International Journal of Psychoanalysis* 72: 209 -219

**Daatland, S.O. & Biggs, S. 2006 Ed.** Ageing and Diversity Multiple Pathways and Cultural Migrations. The Policy Press, Bristol

**Dartington, T. 2010** Managing Vulnerability. *The Tavistock Clinic Series London Karnac Books*.

**Datler, W. et al 2009** An exploration of the quality of life in nursing homes: the use of single case and organizational observation as a research project. *Infant Observation. The Int. Journal of Infant Observations and Application*. Volume 12 No 1 Routledge.

**Davenhill, R. Balfour, A. Rustin, M E. 2007** Psychoanalytic observation and old age: *In Davenhill, R Ed. Looking into later life: a psychoanalytic approach to depression and dementia in old age. Tavistock Publications*. London Karnac.

**Davenhill, R. 2007 Ed** Looking into Later Life: a psychoanalytic approach to depression and dementia in old age. *Tavistock Publications*. London: Karnac.

**Denzin, N. K. & Lincoln Y.S. 1994** Introduction: Entering the field of qualitative research. In *Handbook of Qualitative Research*.

**Edmondson, R. & Kondratowitz, H-J. 2009** Valuing Older People. A humanist approach to ageing. *The Policy Press, Univ. of Bristol*

**Erikson, E. 1966** The Eight Ages of Man. *International Journal of Psychiatry* Vol.2. Issue 3. 281-38.7

**Erikson et al 1986** The Experience of Old Age: *In Vital Involvement in Old Age* London & New

York.

**Evandrou, M. 1997 Ed.** Baby Boomers. Ageing in the 21 Century: *Social care today and beyond 2020*. 119-141 *Age Concern: Norton .Publications, London.*

**Evans, S. 2004** A Survey of the Provision of Psychological Treatments for Older Adults in the NHS. *Psychiatric Bulletin, November 1, 28(11).* 411-414.

**Evans, S. & Garner, J. ED. 2004** Talking Over the Years: *A handbook of Dynamic Psychotherapy with Older Adults*. London: Routledge.

**Fonagy, P. & Moran, G. 1993** 'Selecting single case research designs for clinicians' *In Miller et al (Eds) Psychodynamic Treatment Research*. New York Basic Books.

**Fonagy, P & Moran, G. 2003** Psychodynamic Treatment Research. *A Handbook for Clinical Practice*. Basic Books. New York.

**Fraser, D. 2009** The Evaluation of the British Welfare State 1- 7. Palgrave, Macmillan UK.

**Freud, S. 1905a** On Psychotherapy. *Standard Edition 7: 257-268*. London: Hogarth Press.

**Freud, S. 1911** Formulations on the Two Principles of Mental Functioning. *Standard Edition 12 11 - 35* London: Hogarth Press.

**Freud, S. 1914** On Transference. Remembering, Repeating and Working Through. *Standard Edition. 12: 147-156*. London: Hogarth Press.

**Freud, S. 1915** On Metapsychology: The Unconscious. *Standard Edition. 11: 167-173* London Hogarth Press..

**Freud, S. 1917** Mourning and Melancholia. *Standard Edition 14:237-259* London: Hogarth Press,

**Freud, S. 1920** Beyond the Pleasure Principle. *Standard Edition 18: 1-64*. London: Hogarth Press.

**Freud, S. 1923** The Ego and the Super-ego (Ego Ideal) *Standard Edition. 19: 28-39*. London: Hogarth Press.

**Freud, S. 1940** Splitting of the Ego in the Process of Defence. *Standard Edition 23. 275-278* London Hogarth Press.

**Garner, J. 1999** Psychotherapy and Old Age Psychiatry. *Psychiatric Bulletin, 33: 149-153*.

**Garner, J. 2008** Psychological treatments: psychodynamic psychotherapy. *Oxford Textbook of Old Age Psychiatry*. Ed. Jacoby, Oppenheimer, Denning & Thomas. Oxford Union Press.

**Glaser, & Strauss 1967** The Discovery of Grounded Theory. Chicago, Aldine.

**Glaser et al 1986** in Emotional Abuse: briefing NSPCC by Helen Evans *NSPCC Research Statistics, Feb. 2002*

**Glennerster, H. 1995** British Social Policy since 1945 193-208. Blackwell Publishers Ltd Oxford.

**Heimann, P. 1950** On Counter-transference *Int. Journal of Psychoanalysis, 30: 81-84*.

**Hepple, J. 2004** Psychotherapies with Older People: *An Overview. Advances in Psychiatric Treatment. Vol. 10: 371-377*.

**Hildebrand, P. 1982** Psychotherapy with older patients. *British Journal of Medical Psychology, 55:19-28*.

- Hildebrand, P. 1986** Dynamic psychotherapy with the elderly. In *Hanley & Gilhooly (Eds) Psychological Therapies for the Elderly*. London, Croom Helm.
- Hildebrand, P. 1988** The Other Side of the Wall: A Psychoanalytic Study of Creativity in Later Life. *International Review of Psychoanalysis*: 5. 353-363
- Hildebrand, P. 1995** Beyond Mid – Life Crisis, A psychodynamic approach to ageing. *Sheldon Press SPCK, London*
- Hill, A & Brettle, A 2006** Counselling Older People. What can we Learn from Research Evidence? . Vol 3 *Journal of Social Work Practice* 20:
- Hinshelwood, R. 1994** Clinical Klein Free Association Press.
- Hinshelwood, R. & Skogstad, W. 2002** Irradiated by Distress: Observing Psychic Pain in Health-Care organizations. *Psychoanalytic Psychotherapy Vol. : 16. No 2 110-114*. London: Routledge.
- Hunt, L. et al 1997** Past trauma in later Life. Ed by Hunt, L. Jessica Kingsley Pub.
- Hunt, S.J. 2005** The Life Course: A Sociological Introduction. London: Palgrave.
- Joseph, B. 1985** Transference – the total situation, *Int. Journal of Psychoanalysis* 66: 147-154.
- Junkers, G 2006** Is It Too Late? *Key Papers in psychoanalysis. Introd. xii* London Karnac Books.
- Kaufman, M.R. 1937** Psychoanalysis in later-life depressions. *Psychoanalytic Quarterly*, 6: 308-335.
- Klein, M. 1935** A Contribution to the Psychogenesis of Manic-Depressive States. In *Love, Guilt and Reparation and Other Works 1921-1945 Vol. 1: 262- 289*.London: Karnac Books.
- Klein, M. 1940** Mourning and its Relation to Manic-Depressive States. In *Love, Guilt and Reparation and Other Works 1921-1945 Vol. 1: 344-369*.London: Karnac Books.
- Klein, M. 1946** Notes on some Interior Mechanisms. *Envy and Gratitude and Other Works 1946-1963 Vol.1:1-24*. London: Karnac Books.
- Klein, M. 1952** The Origins of Transference. *Envy and Gratitude and Other Works. 1946-1963 Vol. 1 48-56* London: Karnac Books.
- Klein, M. 1959** Our Adult World and its Roots in Infancy. *Envy and Gratitude and Other Works 1946- 1963 Vol.111 : 247-263* London: Karnac Books.
- King, P. 1974** Notes on the Psychoanalysis of Older Patients. *Journal of Analytic Psychology*, 19: 22-37.
- King, P. 1980** The Life Cycle as Indicated by the Nature of the Transference in the Psychoanalysis of the Middle Aged and the Elderly. *International Journal of Psychoanalysis*, 61: 153-160.
- Kvale, S. 1985** The Qualitative Research Interview: A Phenomenological and Hermeneutical Mode of Understanding. *Journal of Phenomenological Psychology Vol.14. No 2: 171-196*.
- Levenson M.R. et al 2001** Transcending the Self: Towards a liberative model of adult development. *Quoted in: Handbook of the Psychology of Ageing. Ed. Birren & Schaie (2006) Ed. 98*. Elsevier Academic Press.
- Maris, P. 1074** Loss and change. London, Rutledge and Keegan Paul.

- Maslow, A.H. 1999** Toward a Psychology of Being (Third Edition). *John Wiley & Sons, INC:* New York, Chichester, UK.
- Martindale B. 1989** Becoming Dependent Again. The fears of some Elderly Persons and their Younger Therapists. *Psychoanalytic Psychotherapy*. 4 (1) 67-75.
- Martindale B. 1998** On dying, death and eternal life. *Psychoanalytic Psychotherapy*.12 (3) 259-270.
- McKenzie-Smith S. 1992** A Psychoanalytic Observation Study of the Elderly. *Free Associations Journal*. Vol. 3: 27: 355-390.
- McKenzie-Smith S. 2009** Observation Study of the Elderly: An applied observation of older adults utilizing Esther Bick's Infant Observation Technique. *Infant Observation: the International Journal of Infant Observation and its Applications*. Vol.12:1. London: Routledge.
- Meltzer, D. 1968** The Psychoanalytic Process. Clunie Press, Perthshire, UK.
- Meltzer, D. 1973** Sexual States of Mind: Identification and Socialization in Adolescence Ch 7: 51-57. Clunie Press, Perthshire, UK.
- Menzies Lyth, I. 1975** 'Nurses under stress'. *International Nursing Review* 7(6)
- Menzies Lyth, I. 1988** Containing Anxieties in Institutions. *London Free Association Books*.
- Midgley, N. 2006** 'The inseparable bond between cure and research: clinical case study as a method of psychoanalytic inquiry'. *Journal of Child Psychotherapy* 32 (2) August 122-147  
Routledge
- Midgley, N. et al 2009** Child Psychotherapy and Research: New Approaches, Emerging Findings.. *London. Routledge*
- Murphy S. 2000** Provision of Psychotherapy Services for Older People. *Psychiatric Bulletin*., 2000. 24: 181-184
- Nichol, J. 2009** Does eldership mean anything in the contemporary West? 249-260. In *Valuing Older People, A humanist approach to ageing*. Ed: Edmondson & Kondratowitz, The Policy Press University of Bristol UK.
- Ng, A.V. 2009** Making sense of dementia using infant observation technique: a psychoanalytic perspective on a neuropathological disease. *Infant Observation. The Int. Journal of Infant Observation and Applications*. Vol12 No 1. Routledge.
- Obholzer, A. 1989** Psychoanalysis and the political process. *Psychoanalytic Psychotherapy* 4 (1); 55-66.
- Obholzer, A. & Roberts V.Z. 1994** Ed. The Unconscious at Work. London: Routledge.
- O'Shaughnessy E. 1994** What is a Clinical Fact? *International Journal of Psychoanalysis*. 75: 939-947
- O'Shaughnessy E. 1999** Relating to the Superego. *Int. Journal of Psychoanalysis* 80: 861-875.
- Philps, J.F. (2003)** Applications of Child Psychotherapy to work with children in temporary foster care. *Doctoral Thesis University of East London/Tavistock Clinic*.
- Phillipson, C. 1998** Reconstructing old age: new agendas for social theory and social practice. 13-14 London: Sage.
- Pidgeon, N. 1997** Grounded Theory: theoretical background in *Handbook of Qualitative*

- Research Methods, *Ch 6 & 7 75-101 Ed Richardson J.T.E.* Biddles Ltd. UK.
- Pincus L. 1981** *The Challenge of a Long Life.* London: Faber.
- Pollock, A. 2004** *NHS plc: The Privatization of Our Health Care.* 157-199. London: Verso.
- Pollock, G. 1982** On ageing and psychopathology. *Discussion on N. A. Cohen's paper 'On loneliness and the ageing process'.* *International Journal of Psychoanalysis.* 63: 275-281.
- Potamianou A. 1997** *Hope: A Shield in the Economy of Borderline States. Chapter 3: 57-69.* London: Routledge.
- Porter, R. 1991** *Psychotherapy with the Elderly. Ed by Holmes, J. in Textbook of Psychotherapy and Psychiatric Practice.* Churchill, Livingstone.
- Quagliata, E. 2008** *A Psychoanalytic Study of Recurrent Miscarriage: Brief Psychotherapeutic Work with Pregnant Women.* D. Psych, Psych Thesis University of East London/ Tavistock Clinic.
- Quinodoz, D. 2010** *Growing Old. A Journey of Self-Discovery. Translated by Alcon, D.* London: Routledge.
- Quinodoz, J.M. 1994** *What is a Clinical Fact? Int. Journal of Psychoanalysis 75*
- Reid, M. 2003** *The mother' state of mind following the loss of a baby and the birth of the next infant.* D Psych Psych Thesis University of East London/Tavistock Clinic
- Roth, P. 2001** *The Superego. Ideas in Psychoanalysis.* Icon Books, UK
- Rustin M. J. 1991** *The Good Society and the Inner World. Psychoanalysis, Politics and Culture.* London: Verso.
- Rustin, M.J. 1997** *Give me a consulting room: psychoanalysis and science studies. Part 1The generation of psychoanalytic knowledge,, sociological and clinical perspectives. British Journal of Psychotherapy. 13 (4) 527-541..*
- Rustin, M.J. 2009** *Grounded Theory in Clinical Practice: A Clinical Example.* Presentation Aalborg Seminar. October 30-31.
- Segal H. 1958** *Fear of Death: Notes on the Analysis of an old man. Int. Journal of Psychoanalysis, 39:178-181.*
- Schaffer, H.R. & Emerson, P.E. 1964** *'The Development of Social Attachments in Infancy. Monographs of the Society for Research in Child Development, 29 (3) serial no. 94*
- Segal H. 1983** *Some clinical implications of Melanie Klein's work. Int. Journal of Psychoanalysis. 64: 269-276*
- Sharkey P. 2000** *The Essentials of Community Care. A guide for practitioners.* Palgrave Macmillan.
- Spitz, R.A. 1965** *The first year of Life. New York International University Press.*
- Steiner J. 1993** *Psychic Retreats.* London; Routledge.
- Strauss, A.L. & Corbin, J. 1990** *Basics of qualitative research. Grounded Theory procedures and techniques.* Newbury Park CA Sage.
- Terry P. 1997** *Counselling Older People and their Carers.* London: Macmillan.
- Terry, P. 2006** *Terrors of Growing Old. Therapy Today, April 2006*
- Townsend, P. 1963** *The Family Life of Old People. Isolation and Loneliness in the Aged.*

188-205. London: Penguin Books.

**Tuckett, D. 1994** Developing a Grounded Hypothesis to Understand Clinical Process :the Role of Conceptualization in Validation. *International Journal of Psychoanalysis Vol. 75: 1160-1180*

**Waddell M. 1998** Inside Lives. Psychoanalysis and the Growth of the Personality. *Tavistock Clinic Series Redwood Books Ltd. Trowbridge.*

**Williams, G. 1991** Reflections on the Process of Internalization. *Journal of Child Psychotherapy, 17: (2) :3-14*

**Williams G. 1997** Self Esteem and Object Esteem. *In Internal Landscapes and Foreign Bodies.* London: Duckworth.

**Winnicott, D.W. 1958** Clinical Varieties of the Transference. *Through Paediatrics To Psychoanalysis, Collected Papers. 295-299* London; Karnac.

**Woods, R.T. 1998** Psychological Problems of Ageing: Assessment, Treatment and Care. John, Wiley & Sons Ltd. Chichester & New York.

**Wylie, H & Wylie, M. 1987** The older analysand: countertransference issues in psychoanalysis. *In Junkers, G Ed., Is it too late? Key papers on psychoanalysis and ageing. 111- 129.* Karnac..

## REPORTS

**Age Concern/Age UK 2008** : Undiagnosed, untreated, at risk. The anxieties of older people with depression

**DOH 2005a** Organizing and Delivering Psychological Therapies. *London Department of Health.*

**DOH 2005b** Securing Better Mental Health for Older Adults. *London, Department of Mental Health.*

**DOH 2006**, A New Ambition for Old Age. Next Steps in Implementing the National Service Framework for Older People. *A report from Prof Ian Philp. . National Director for Older People, Dept of Health.*

**Government White Paper 1997** A New Partnership for Care in Old Age. *Government Actuary's Department.*

**IAPT: Improving Access to Psychological Therapies 2009.** Older People, Positive Practice Guide. Relieving distress, transforming lives.

**World Health Organization (WHO) 2004** What is the effectiveness of old age mental health services? P7

## FOOTNOTES

<sup>1</sup> **Berg, Maelstrom, Persson, Svanborg (1990)**. The Prevention of Disability in the Aged. In *Journal of Scientific Exploration* Vol 2

<sup>2</sup> **Hamilton M (1960)**, The Hamilton Depression Rating Scale: Has the Gold Standard Become a Lead Weight? *The American Journal of Psychiatry*. Revision and Overview: 161 2163 -2177

<sup>3</sup> **Smith, Ahmed, Mehta, Hamilton (1971)** The Benefits of Psychotherapy with Couples. *British Journal of Psychiatry* 115 947-958

<sup>4</sup> **Templar, Ruff and Frank (1971)** Death Anxiety as Related to Depression and Health of Retired Persons. *Journal of Gerontology* 26 (4) 521-523

<sup>5</sup> **Vaillant (2002) in Birren & Warner Schaie (2005)** *Handbook of Psychology of Ageing*. 6<sup>th</sup> Ed. 91-95. Elsevier Academic Press

<sup>6</sup> **Byrne, Liam MP (2006)** (Minister for Care Services) In DOH Report: *Anew Ambition for Old Age* 'Next Steps in Implementing the National Service Framework for Older People' by Prof. Ian Philp.

<sup>7</sup> **Goodman, A. Myck, M. & Shepherd, A (2003)** *Sharing in the Nation's Prosperity? Pensioner Poverty in Britain*. Institute for Fiscal Studies, London 2003.

<sup>8</sup> **Turner, R. H. (1969)** *The Theme of Contemporary Social Movements* *British Journal of Sociology* XX 390-405.

<sup>9</sup> **Moody, H (1989)** *Gerontology with a Human Face* in L. E. Thomas (Ed) *Research on Adulthood and Ageing: The Human Science Approach*. New York State, University of New York Press 227-239.

<sup>10</sup> **Manheimer, R (2007)** *Becoming Historical to oneself*. *Journal of Ageing Studies* Vol. 22 No. 2 177-183

<sup>11</sup> **Manheimer, R (2009)** *Gateways to humanistic gerontology*. In *Valuing Older people, A humanistic approach to ageing*. Ed. Edmondson, R. & Kondrawitz, H. J. 2009 283-287

<sup>12</sup> **Rustin (1991)** has noted that a 'difficulty in implementing such a diffuse conception of social justice is that the nurturing of development through relationships and understanding ... requires above all sensitivity to the individual case.' To actualize individual needs becomes more complicated and requires 'discretion, autonomy and variation in each instance'.

**CONSENT FORM**

**TITLE OF PROJECT**

***THE ROLE OF PSYCHOTHERAPY WITH OLDER ADULTS***  
***Mental Adjustments in Older Life)***

**CONTACT PHONE NUMBER:**

**Work:**

**Other: 020 7794 9026**

1. I the undersigned have read and understand the information sheet and have had the opportunity to ask questions.
2. My participation in this project is voluntary and confidential and I am free to withdraw at any time, without giving any reason and without my treatment or legal rights being affected..
3. I understand that any publication resulting from this research will not identify me and all confidentiality will be maintained..
3. I have read the above and agree to take part in the above study.

SIGNATURE.....DATE.....

NAME IN FULL.....

ADDRESS OF PARTICIPANT.....

.....

.....

RESEARCHER: Savi Mckenzie-Smith

SIGNATURE.....DATE.....



**The Joint UCL/UCLH Committees on the Ethics of Human Research (Committee A)**

Research & Development Directorate  
 1st Floor Maple House, 149 Tottenham Court Road  
 London W1P 9LL  
**POSTAL ADDRESS**  
 Ground Floor, Rosenheim Wing Postroom  
 25 Grafton Way, London  
 WC1E 5DB

Telephone: 020 7380 6977  
 Facsimile: 020 7380 9937

GS/cw/06A305

11<sup>th</sup> August 2006

**Mrs Savi McKenzie-Smith**  
 Psychoanalytical psychotherapist visiting lecturer  
 Adult Department  
 Tavistock and Portman NHS Trust  
 120 Belsize Lane  
 London NW3 5BA

Dear Mrs McKenzie-Smith

**Full title of study:**           **The role of psychotherapy with older adults: mental adjustments in later life**  
**REC reference number:**       **06/Q0505/53**

Thank you for your letter of 1<sup>st</sup> August 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation [as revised].

**Ethical review of research sites**

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

**Conditions of approval**

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

**Approved documents**

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application	5.1	24 May 2006
Investigator CV	Stephen Briggs	
Investigator CV	Savi McKenzie-Smith	
Protocol	1	
Covering Letter		

An advisory committee to London Strategic Health Authority

Peer Review	Dr. Stephen Briggs	09 May 2006
Questionnaire: Clinical Outcomes in Routine Evaluation (CORE)		
Questionnaire: Review at end of psychotherapy treatment questionnaire		
Participant Information Sheet:	3 (revised)	07 March 2006
Participant Consent Form:	3 (revised)	07 March 2006
Response to Request for Further Information		01 August 2006
Declaration of Supervisor, Q A71		24 July 2006
CORE information sheet		

#### Research governance approval

You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

#### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/Q0505/53	Please quote this number on all correspondence
-------------	--

With the Committee's best wishes for the success of this project

Yours sincerely



**Dr. Geoff Scott**  
Chair

Email: caroline.williams@uclh.nhs.uk

*Enclosures:* Standard approval conditions

Copy to: Prof. Andrew Cooper  
The Tavistock and Portman NHS Trust  
120 Belsize Lane  
London NW3 5BA

APPENDIX 3

**C**LINICAL  
**O**UTCOMES in  
**R**OUTINE  
**E**VALUATION  
  
**OUTCOME  
MEASURE**

Site ID	<input type="text"/>	<input type="text"/>	Male	<input type="checkbox"/>
letters only	<input type="text"/>	numbers only	Age	Female
Client ID	<input type="text"/>	<input type="text"/>		<input type="checkbox"/>
Therapist ID	<input type="text"/>	numbers only (1)	numbers only (2)	Stage Completed
Sub codes	<input type="text"/>	<input type="text"/>	<input type="text"/>	S Screening
Date form given	<input type="text"/>	<input type="text"/>	<input type="text"/>	R Referral
				A Assessment
				F First Therapy Session
				P Pre-therapy (unspecified)
				D During Therapy
				L Last therapy session
				X Follow up 1
				Y Follow up 2
				Stage
				<input type="text"/>
				Episode
				<input type="text"/>

**IMPORTANT - PLEASE READ THIS FIRST**

This form has 34 statements about how you have been OVER THE LAST WEEK. Please read each statement and think how often you felt that way last week. Then tick the box which is closest to this.

*Please use a dark pen (not pencil) and tick clearly within the boxes.*

Over the last week	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
1 I have felt terribly alone and isolated	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
2 I have felt tense, anxious or nervous	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
3 I have felt I have someone to turn to for support when needed	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
4 I have felt O.K. about myself	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> W
5 I have felt totally lacking in energy and enthusiasm	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
6 I have been physically violent to others	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
7 I have felt able to cope when things go wrong	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
8 I have been troubled by aches, pains or other physical problems	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
9 I have thought of hurting myself	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
10 Talking to people has felt too much for me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
11 Tension and anxiety have prevented me doing important things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
12 I have been happy with the things I have done.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
13 I have been disturbed by unwanted thoughts and feelings	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
14 I have felt like crying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> W

**Please turn over**





Over the last week

Not at all    Only Occasionally    Sometimes    Often    Most or all the time    OFFICE USE ONLY

15	I have felt panic or terror	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	P
16	I made plans to end my life	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	R
17	I have felt overwhelmed by my problems	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	W
18	I have had difficulty getting to sleep or staying asleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	P
19	I have felt warmth or affection for someone	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/>	F
20	My problems have been impossible to put to one side	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	P
21	I have been able to do most things I needed to	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/>	F
22	I have threatened or intimidated another person	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	R
23	I have felt despairing or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	P
24	I have thought it would be better if I were dead	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	R
25	I have felt criticised by other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	F
26	I have thought I have no friends	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	F
27	I have felt unhappy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	P
28	Unwanted images or memories have been distressing me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	P
29	I have been irritable when with other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	F
30	I have thought I am to blame for my problems and difficulties	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	P
31	I have felt optimistic about my future	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/>	W
32	I have achieved the things I wanted to	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/>	F
33	I have felt humiliated or shamed by other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	F
34	I have hurt myself physically or taken dangerous risks with my health	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	R

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

**Total Scores**

               →        →   

**Mean Scores**  
(Total score for each dimension divided by number of items completed in that dimension)

(W)    (P)    (F)    (R)    All items    All minus R



**APPENDIX 4  
REVIEW AT THE END OF PSYCHOTHERAPY TREATMENT QUESTIONNAIRE**

**REVIEW AT THE END OF PSYCHOTHERAPY TREATMENT  
QUESTIONNAIRE**

**This form is to assess and reflect on once weekly psychoanalytic psychotherapy sessions over a period of one year from the participant's point of view. The form will be completed by the research participant and looked at during a review meeting arranged approximately six months after treatment has ended. All information will be confidential and pseudonyms will be used throughout the research.**

1. Looking back how would you now describe your predominant emotional state just before you came into therapy?
  
2. Looking back how would you describe the range of feelings whilst in therapy?
  
3. Describe how you would identify any changes during and since therapy.
  
4. Can you describe how you feel since your therapy has ended.
  
5. Do you have any further comments you wish to make?

Signature.....

Date.....

## APPENDIX 5

**The following are examples of the process notes of four sessions, each from a different patient and how the method of 'grounded theory' was applied to the sessions.**

Psychotherapy sessions over a period of time, whether of a short duration or for a longer time like a year with my patients, cannot be isolated as separate interventions. Continual and sequential flow of conscious and unconscious thought processes both from the present and past experiences are often related or repeated. Sometimes these feelings are presented through the transference process. Repetitiveness is a common factor in psychotherapeutic intervention. The sessions below have been isolated to present some significant findings in connection with the application of the qualitative 'grounded theory' method to present how some 'clinical facts' or 'key facts' were categorised as themes that generated hypotheses.

### 1. RW Session 4

As usual he started with how useless this was for him. His favourite phrases were, *all too late, not like I used to be, too late to make changes now*. He continued to be negative and dismissal of any interpretations I made.

Perhaps too late to be how things used to be but maybe your lifestyle can change somewhat for the better.

After a pause he volunteered,

*You see at 16 I had to decide on whether I was going onto higher education. I was never very brilliant at school but always managed to get the grades. My English teacher encouraged me to do so. I told my father what the teacher said.*

He paused, then continued softly and hesitantly,

*I was told I was useless by my father. Yes I do have a 'narcissistic wound' as I was told before. This is all too late. I should have been given this, thirty years ago. It is too late to make changes now. I was often unfairly angry towards most people.*

*My father laughed and told me that I was useless and hopeless. He was so vile tempered he would have belted me if I challenged him in any way. He said I would never make anything of my life at college because I was stupid and had already arranged for me to work at the local corner store. I hated this but did not dare argue with him. I did not say a word. I just walked away.*

He looked emotional and after a longish pause continued to say,

*I was never brilliant at school but managed to cope each year to be promoted to the following year. I so much wanted to go further to qualify at something. I hated the corner store. I had to pack the meat rations that the butcher cut up for the customers. After a year I couldn't take it anymore. I applied for a job as an errand boy in the city. I couldn't believe it when they took me on. My mother was so worried, but I loved to go to work in London on the train during the war. Commuting was such fun. This was exciting for someone like me at the age of seventeen to be going into danger. My mother could not relax until I returned but my father never cared a jot He would say, 'Serve you right if you are caught up in a blitz'.*

I said that he had just recalled some very painful experiences. They were hard to dismiss but he

had kept this old wound open almost all his lifetime. He replied,  
*Yes, I have a 'narcissistic wound'. Nothing is going to change that! I am a victim and a drifter, depending on psychiatric care.*

From an analytical viewpoint I could understand his terminology but was a little surprised to hear it from him. I began to think that it was possible that he had developed an “ego-destructive superego” (O’Shaughnessy, 1981 861-875), so that he could protect his vulnerability that had been activated in order to protect mother as well as take revenge on father. Perhaps, a good ego function was denied and was replaced by a “dead object”, there was no one to relate to.

Whilst he came punctually to every session he often began with,

*I can't see what good this will do me. I should have been given this, years ago. I can't do the things you are expecting me to do. I am useless.*

**Case Study RW: Session 4**

Noted from patient's written-out data	Recognition of themes sorted and coded	Thematic analysis and categorizing for 'key facts'
<p>At sixteen I had to decide on whether I was going on to higher education. My English teacher encouraged me. My father laughed and told me that I was useless. He was so vile tempered he would have belted me if I challenged him in any way. He said I would never make anything of my life at college because I was stupid. He had already arranged for me to work at the local corner store. (His mother never contradicted his father. She was terrified of him)</p>	<p>Inconsiderate, intolerant and cruel paternal figure. Abusive both emotionally and physically.            Weak mother who herself needed protection.</p>	<p>Dysfunctional object relations. No containing, good parenting. Perhaps the beginnings of experiencing a harsh superego.</p>
<p>I hated the corner store. I had to pack the meat rations the butcher cut up for customers. After a year I couldn't take it anymore. I applied for a job as an errand boy in the city. Commuting was such fun...going into danger</p>	<p>Showing some initiative. Pleased to have achieved but also signs of non-caring of self.</p>	<p>Perhaps being a typical adolescent. Challenging and daring. Enjoyed the danger of travelling into the city where bombing was experienced regularly.</p>
<p>My mother was so worried. She could not relax            But I discovered as the therapy session continued, mother was a weak figure, who felt threatened by father's drunken violence. She was unable to do anything when father was physically violent towards RW. She looked on in fear and dare not intervene. RW became quite protective towards her.</p>	<p>Understandable concern by mother but too passive to challenge her husband. Later sessions conveyed that there was an enmeshed relationship between mother and son. He took on the role as protector.</p>	<p>Cruel, un-protective violent father and weak and needy mother. Painful experiences repressed. The beginnings of the dysfunctional psychic activity of needing anyone. Development of an ego-destructive superego. No containing 'good object' during early childhood and adolescence.</p>
<p>I have a 'narcissistic wound'. It is all too late, too late to make</p>	<p>Clinical terminology- 'narcissistic wound' used by a</p>	<p>Emotionally stuck. Constantly angry with parents and</p>

changes.	previous clinician. Despair and disillusionment.	especially father. Sees himself as useless. Un-mourned early losses but not narcissistic. In fact very needy. Still yearning for the love he never experienced.
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## 2. BA Session 5

He looked as if he was mentally struggling with something. I waited. Eventually he said,

*I am perturbed with both psychological and physiological problems. I don't know where to start.*

He mumbled something softly to himself and paused.

*I decided that I need to get some exercise and decided to cycle here. When I started I had this feeling of a lump in my chest. This is how the depression gets to me. I don't know how to explain it but it is here. I stopped taking my medication because I have felt a little better lately. I don't usually get physically ill. Until my operation I was very fit. That is why it was such a shock. I thought it was the end. Perhaps I have been depressed all my life.*

He sighed and was silent then continued,

*I was the unwanted fifth child. By then my father was fed up with children. I now realize that there was a cold war between my father and mother. They probably hated each other by the time I was born. We had to be stoical and never complain of physical pain. It was only noticed when we could not bear it any longer and cried. My dyslexia was not diagnosed until I was nearly eight. My early schooldays was like being in hell.*

He looked emotional and became silent. .

Eventually, I broke the silence by saying that he had some very sad memories of his childhood days and they have stayed with him for all these years. He went on to say,

*I know that I do not have a physical lump in my chest. But I feel 'a tightness'. I am sure it is related to my psychological state. I feel hopeful about coming here.*

I remembered him undergoing surgery for a benign lump in his abdomen. I said that perhaps like the surgeon, he was hoping I will remove the psychological lump.

*Intellectually I understand what this kind of treatment is all about. It is a time to discuss my feelings. I have kept them so well hidden for so long now, that I do not know where to begin. I thought that if you read the book you will understand my feelings, because I see myself in him.*

I felt sorry for him and gently said that eventually it would be up to him to as to whether the feeling of the lump in his chest disappears or not. The treatment depended on his participation. Some of the pain might be difficult to tolerate.

*I understand! You would not want to have preconceived ideas or come to any conclusions about me, but try to understand as we go. In essence I realize what this is about but I do not know where to start. I know that a lot of repressed childhood experiences are looked at and reassessed.*

I found myself despairing at his constantly intellectualizing everything. He was very different from all my other patients. But I could appreciate that for a man who functioned almost solely on an academic level, he felt de-skilled by my constantly expecting him to express his feelings. I



tried to convey that verbal communication can be based entirely on intellect and logic but most people also expressed some emotionality. Intellectually he understood what I was saying but he found it difficult to be in touch with his feelings. He thought for a while and then true to his belief that this activity was ‘a lot about repressed childhood experiences’ started to talk about something from his childhood.

*About my childhood memories! At the age of about seven or eight, someone realized I was dyslexic. I hated school. My headmaster used to make a spectacle of me in front of the whole school. I would have preferred a caning and perhaps forgotten about it. But the awful shame of being disgraced so often for my poor work stays with me up to now. The other recurring memory comes to me for when I was about three or four. My nanny, a lively friendly Yorkshire woman, whom I adored, was leaving to get married. I remember her picking me up, hugging me and handing me over to my mother. Up to this day I distinctly see the utter disgust on my mother’s face as she took me, as if I was something horrible, being forced on her. Right now I can see that expression of disgust on her face.*

Exploratively I repeated, ‘expression! Of disgust’

*My mother was a middle class woman who married slightly beneath her, but remained the dutiful housewife and mother, as society expected. I think she probably resented this role and there was often an atmosphere of boredom and anger between my parents but it was never openly expressed. My mother gave me more attention as the youngest child and perhaps because I was the one with the problems. She was also supportive in connection with my later education and career. All my brothers now realize that the relationship between our parents was fraught. ‘They had an unspoken, cold contempt for each other, but their upbringing and religious beliefs prevented them from expressing those feelings.*

For most of the following sessions he oscillated between his intellectual capabilities and that of trying to express his feelings. He often looked contemplative and then divulged many memories from his early childhood as well as current feelings.

<b>Noted from Patient’s written-out data</b>	<b>Recognition of themes sorted and coded</b>	<b>Thematic analysis and categorising for ‘key facts’</b>
<p>I am perturbed with both psychological and physiological problems. I don’t know where to start. I have this feeling of a lump in my chest. This is how the depression gets me. I stopped taking my medication because I feel a little better lately. Perhaps I have been depressed all my life.</p>	<p>Aware of his physical state of feeling depressed and frustrated but intellectually unable to understand his state. Trying to analyse his condition. A mixed bag of thoughts being presented.</p>	<p>Dependency on his intellect to logically understand his emotional problems. Feelings well repressed under an intellectual front. Emotionally cut-off.</p>

I was the fifth child. By then my father was fed up with children. We had to be stoical and never complain of physical pain. It was only noticed when we could not bear it any longer and cried.	Feelings of not being wanted. Unloved. Any show of feelings were looked upon as weak and denied.	Puritanical early childhood. No signs of love or any emotional expression from parents. Perhaps mother was a depressed woman caught up in a cold relationship.
The headmaster used to make a spectacle of me in front of the whole school because of my poor work. I would have preferred a caning. When I was about eight it was discovered that I was dyslexic.	Experience of cruelty and unfair treatment by authoritarian figures firstly parents and then the headmaster.	Non-verbal acquiescence of an unfair situation but internally felt angry and lonely. Misunderstood and non sympathetic adults. No good object relations.
The other recurring memory comes to me for when I was about three or four. My nanny whom I adored was leaving to get married. I remember her picking me up, hugging me and handing me to my mother. Up to this day, I distinctly see the utter disgust on my mother's face. She took me, as if I was something horrible, forced on her.	Young childhood memory remained constantly in his conscious world and very much alive. Unable to come to term with this experience of disdain shown by his mother who could not show any loving feelings.	Emotionally stuck with this image. Unable to let go and move on. Still yearning for it to have been different – like mother embracing him warmly. The painful experiences meted out by the cruel headmaster, unemotional father and mother led the development of an ego-destructive superego to deny the pain and protect his vulnerable psyche. Strong feelings of, 'I don't need anyone'. This also led to cultivating a narcissistic personality.
Mother was supportive in connection with my later education and career. They (parents) had an unspoken,	A childhood where emotional feelings were not expressed. It was a weakness to do so.	No loving role model. An emotionally, cold, bleak and severe childhood. Physically catered for but no

<p>cold contempt for each other, but their upbringing and religious beliefs also prevented them from expressing those feelings.</p>		<p>emotionality was expressed from either parent during early childhood. Internally alone but denied any neediness. Used the intellect as a front to protect inner state of vulnerability.</p>
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### 3. CF Session 13

After the break, she looked well and gave me a big smile. No sooner she seated herself she started in an excited manner to tell me about her latest grandchild who was born just before Christmas. The daughter-in law was in Europe in her home town and although she was fairly young she was a very stable, sensible person. She had a good relationship with her and CF conveyed that she was an ideal partner for her son. His previous partner, a brilliant career woman was never emotionally available for him. This woman was also very bright but she also was caring. After a little pause she gave another smile and said,

*You are not going to believe this! You know how I was worrying about the travelling and all the walking I would have to do at the airport. Well, I said at the check in desk that it will take me a long time to get to the "Departure Gate". The young man, smiled and told me not to worry he will organize all that. I did not take him seriously or I didn't quite understand. But as soon as I went through security, a porter was waiting for me with a wheelchair. I felt a bit embarrassed but he was so nice and made everything so easy for me. Of course Mike could not believe what he was seeing when he came to meet me at the airport,*

She paused, looked directly at me and gave me another huge smile.

*You see I have been taking what you say seriously. Once I was at the airport I did not hesitate to ask for a wheelchair. I did not feel awkward. Mind you I would hate it if I had to always depend on a wheelchair! I accept that I can only do so much now!*

In my countertransference, I was a little uncomfortable. I was questioning myself as to whether I was advancing her dependency rather than stimulating her independence.

The rest of the session was about the christening and her attending the Christian ceremony. They gave her a name that is neither Christian nor Jewish and she felt relieved.

At about this stage in her therapy she had to see her psychiatrist who soon after sent me a letter from which I am quoting.

'She clearly is gaining greatly from her weekly psychotherapy sessions with you, and she was noticeably much calmer and less agitated. In contrast to previous encounters with her she was much more in the present and appeared easier to engage with. However, as the interview went on the themes that you have outlined in your letter, clearly resurfaced, including worries about ageing, the possibility of physical frailty and following a recent lecture she attended, the possibility of developing Alzheimer's disease.....Overall however I thought she was much

better than when I had seen her last year’.

He also informed me that apart from some very light medication to help her sleep patterns - which she informed me that she was not taking- she was not on any of her other medication. I felt pleased.

Although the letter was encouraging I felt that CF had improved in her “outer state” but she had a long way to go, ‘to reorganize her fragmented inner state or psychic self’ (Steiner 1993). But as expected one can only move from the known to the unknown through exploration. The visit to her psychiatrist and his encouragement helped her to become more positive in her transference. Previously she had been resistant and pessimistic about the treatment. She had become more open to my interpretations of her resistances. I realized that she was in some ways quite young for someone in her seventies.. She was still a very smart, good looking woman and that it was something to do with her personality that prevented her leading a more active lifestyle.

Noted from patient’s written-out data	Recognition of themes sorted and coded	Thematic analysis and categorizing for ‘key facts’
<p>From CF’s previous sessions I had noted that she was most reluctant to be dependent on anyone since her father’s death during her early teens. Instead she was the one to make others become dependent on her or thought they were. Reference to this state of her personality had come up during the sessions either openly or during the transference. She had up to now denied this.</p>		
<p>You are not going to believe this! You know how I was worrying about the travelling and all the walking. The young man at the desk smiled and told me not to worry he will organize all that. As soon as I went through security a porter was waiting for me with a wheelchair. I felt embarrassed but he was so nice and made everything so easy for me. Mike (son) could not believe what he was seeing.</p>	<p>Unusual for her - admitting to one of her physical difficulties. Giving in and accepting support. Aware of son noting this state of how needy she really was.</p>	<p>Awareness of her dependency and neediness, albeit just physically at present.</p>
<p>You see I have been taking what you say seriously. I did not hesitate to ask for a wheelchair. I did not feel awkward. Mind you I would hate it if I had to always</p>	<p>Emotionally, something regarding her physical state had changed. She can accept the deterioration of her physical state. She inadvertently lied when she</p>	<p>Psychic change in not remaining in denial. Not being defended but admitting to neediness. Not as defensive as she used to be. A huge change in her personality to</p>

depend on a wheelchair. I accept that I can only do so much.	said she had asked for a wheelchair. For her to admit dependency on any level was a huge change.	confront the truth.
Her psychiatrist's letter confirmed the changes she had begun to make as he said, 'In contrast to previous encounters with her she was much more in the present and appeared easier to engage with. Overall, however she was much better than when I had seen her last year'. He also confirmed her dependency on medication had dramatically changed as she was only on some light sleeping tablets.	Although still early in the treatment stage she had made some progress emotionally but quite a change in physical well-being that all her relevant medication was stopped.	Symptoms of the depression definitely alleviated. Intake of all previous necessary medication terminated. Internally a lot more able to accept her limited physical state and loss. More contained and able to let others know of her state of dependency. Not in denial as much as she used to be.

#### 4. DL Session 37

She complained about Andy's stubbornness.

*I am fed up with Andy's stubbornness. He did not phone or send me a card for Mother's day! It makes me feel sick! Fran and Colin took me out for a meal to a restaurant in the country. It was so good of them. They had invited Andy but he did not turn up.*

I tentatively brought up the sad situation that it seemed she could never have a good relationship with both her children at the same time. Also thinking about her statement a few weeks back about, 'we are both determined people', I suggested that perhaps this is how it was between Andy and her. But I could see that it was something she did not want to explore. She said defensively,

*It is his problem if he does not want to know his own mother!*

After a pause I used the tack of agreeing with her and added,

I said that she found this more comforting with the 'false hope' that he will come to his senses and acknowledge her for who she is.

As I was saying this I could see her face twitch and contort and then the tears came flooding. I let her sob as she fumbled in her bag for some tissues. I did not hand her the box. I felt she needed the space to become emotional. Eventually, still very tearful she whispered,

*I have never been loved. In all my life I have never felt I have been loved for myself.*

More tears. I waited and slowly she gathered herself together and looked at me sorrowfully. I felt sorry for her. She remained quiet and looked pensive. I waited and eventually she smiled and said,

*I have not spoken like this to anyone before. You must have a special knack to get people talking. I must say, I do feel relieved saying all this to you. Perhaps I do need to come regularly! Can I continue to see you?'*

After a pause she volunteered that she agreed with everything I have said but she also realised that she still needs to work through some of these unhelpful ways of behaving stating,

*Actually by thinking about what goes on here, I have changed tremendously. My attitude towards Fran is so different. She really is so good to me and we get on very well. She often phones and asks me to accompany her when she goes out shopping or for lunch.*

I gently reminded her of the situation of not being able to have a good relationship with both her children at the same time. It has to be one or the other. At this point she made a very insightful comment that impressed me. She said,

*I have wondered about this since you have brought it up! Could it be because I never had to share my feelings with both my parents? I only knew how to relate to one of them because it was the way it was!*

I acknowledged that she was being quite perceptive and this opened up a new area about the ‘absent father.’ She went on to reveal,

*I have a photo of him from before the war when he was in his early twenties. It was a tiny one probably taken by a grateful diner who had eaten at the restaurant my father worked in. He was wearing a small white apron and looked very happy. I remember my mother giving it to me when I married and I placed it in the same frame that had my mother’s photo. It has been standing on my dressing table ever since.*

Her eyes filled with tears and after a while she went on to relate that she used to ask her mother about her father, but her mother would not go into any details. She tried to evade any questioning and she realized that her mother found it too painful to talk about him, so she stopped asking her. She was once told by an uncle that he was an excellent chef and that he worked at a prestigious hotel restaurant. She went on to relate what little information she had about her Dad from hearsay whenever he was mentioned at family gatherings.

As the therapy progressed she divulged without reservation her innermost feelings about her difficulties with relationships. She often went into lengthy discussion about difficult encounters and especially with family relationships. She chose to separate from her husband. The consequence of sharing long repressed feelings during the therapy alleviated some of her depression. She started to have a more active social life and joined a club for older people. They met once a month and either went out for dinner or contributed towards a meal at a member’s house and played card games. She very much enjoyed going to the club and this led to her meeting with an old acquaintance. They became close friends and arranged to go on a cruise. They also went out fairly regularly and planned going on a cruise in the Autumn.

<b>Noted from patient’s written-out data</b>	Recognition of themes sorted and coded	Thematic analysis and categorizing for ‘key facts’
By this stage of the therapy DL was still having difficulties with having a good relationship with both her children simultaneously. The relationship with the daughter was now going very well but she had fallen out with her son. She had not met him for months and hoped that Mother’s Day would once	Anger with one or the other of her children had been a regular feature in the sessions. Difficulty of relating with two people of the opposite sex had been a difficulty throughout her life. Since infancy she was closely attached to her mother. Later as a young child and an	Absent father, dysfunctional attachment to mother. Attachment to son whilst he was a similar age to her brothers but started growing apart from him at about the same age as when brothers left home to join as soldiers. Missed out on the triad of the ‘mother-father and child relationship’. No early

<p>more unite them as a family. The daughter had arranged a lunch party at a country hotel and specifically invited her brother to come so that he would make it up with their mother. When she was with her husband she could relate with her son but had a turbulent relationship with her daughter.</p>	<p>adolescent she could had a good relationship with one of her two older brothers whom she distanced from after marriage. When she came into therapy one was already dead and the other lived a long distance away in a nursing home.</p>	<p>experience of the normal, triangular relationship and particularly with two people of the opposite gender.</p>
<p>I have never been loved. All my life I have never felt I have been loved for myself... I have not spoken like this to anyone before... I must say I do feel relieved saying all this to you.</p>	<p>Perhaps for the first time verbalizing her feelings of not being loved. A painful and excruciating discovery. Seeing herself for how she had been defensive in the past and pretending not to be in a state of need in the external world. Internally she was crying out to be loved</p>	<p>Mother's sad plight had led her to comfort her child physically but was unable to extend the love so required during early infancy due to her husband's death. There was a strong bond between mother and child but unfortunately not an emotionally containing one. Mother was probably depressed under the circumstances but kept physically alive for her children. DL developed an ego-destructive superego for self psychic preservation. She was not going to need or depend on anyone in her internal state of mind.</p>
<p>When she continued to speak about her good relationship with Fran saying, 'My attitude towards Fran is different', I reminded her of not being able to relate to both her children at the same time. Her response: 'I have wondered about this since you have brought it up! Could it be because I never had to share my feelings with both my parents? I only knew how to relate to one of them because it was the way it was'.</p>	<p>Awareness of long-standing problem with relationships. Regression and really mourning her parents and especially the father, perhaps for the first time.</p>	<p>Mourning her loss of not having the couple as a pair. Mourning inner losses for the first time. Yearning for the mother and father as a couple in her internal world.</p>
<p>I have a photo of my father from before the war when he was in his early twenties. It was a tiny one probably taken by a grateful diner who had eaten at the restaurant my father worked in. I placed it in the same frame that had my mother's photo.</p>	<p>Placing the photos in the same frame in the external state perhaps was trying to come to terms with seeing them as a united couple. A small photo, perhaps suggests that there was only a small place in her psyche to envisage the father she never knew. Mother was too depressed to speak of him.</p>	<p>An acceptance of her internal state of the needy part of herself of the desire for the couple as she would have liked but never experienced. Sadly, it had affected all her relationships in her adult life, such as, with her children, her partner and perhaps the brothers in her external life.</p>

