

DUBLIN BUSINESS SCHOOL

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**TITLE: A PSYCHOTHERAPEUTIC EXPLORATION OF WORKING WITH
PEOPLE WITH DEMENTIA:
THE THERAPEUTIC ENCOUNTER AND AUXILLARY EGO-AN OBJECT
RELATIONS PERSPECTIVE**

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ABSTRACT

Dementia is increasingly prevalent nationally and globally and is no longer a disease exclusively of old age. In terms of its management medical discourse is preeminent and this dissertation seeks to demonstrate that a psychotherapeutic approach is equally valid within the healthcare paradigm. Understanding early developmental processes from an object relations perspective, in terms of the impact on the prototype of the person, and the well established notion that there are analogies between feelings and experiences from early life with those that reemerge in later life, - and increasingly so in dementia as cognition deteriorates, forms the kernel of this psychotherapeutic exploration of working with people with dementia. Of relevance are the unconscious processes which influence behaviour in this client group which inevitably emerge in the therapeutic encounter where the therapist can act as an auxiliary ego to manage the feeling states of the individual. Therapeutic techniques such as Holding and Containing are integral to the psychotherapeutic management of these unconscious processes.

CHAPTER 1: INTRODUCTION

The World Health Organisation (WHO) defines Dementia as a chronic or progressive illness, typified by deterioration in cognitive function affecting memory, thinking, orientation, understanding, learning capacity, language and judgement, affecting 30 million people, and anticipated to triple by 2050 (“WHO Dementia,” n.d.). Equally, (The Irish National Dementia Strategy [DOH],2014) anticipates an increase in this diagnosis not just in the context of an aging population, but increasingly prevalence in younger age groups. Accordingly, Dementia is an important contemporary issue as evidenced by the (“WHO | Development of the Global Dementia Observatory,” n.d.) and (“HSE & Genio Dementia Programme Overview Genio,” n.d.).

This Dissertation is a Psychotherapeutic exploration of working with people with Dementia, and will consider the dynamics of the therapeutic encounter and psychotherapeutic techniques including Winnicott's concept of Holding, Bion's concept of Containing and the notion that the therapist acts as an auxiliary ego to sustain the client. An Object relations perspective will suffuse the work. The ultimate aim is to justify psychotherapeutic discourse has a valid role together with medical and other relevant discourses in the care of the client with Dementia as recommended by (Brierley et al., 2003a, p. 435). The notion that dementia is dependent on a combination of physiological, neurological and psychological factors is acknowledged, however, it is the psychotherapeutic stance that as a client physically deteriorates unconscious infantile stages of psychological development re-emerge, i.e. “early problematic constellations, if unresolved, are likely to be replayed”, accompanied by infantile needs and defences, as cited by Waddell in (Davenhill, 2007, p. 188), a concept that will operate as the kernel of this Dissertation. Traditional and contemporary perspectives will inform this work to optimise understanding, and specifically to demonstrate how well established psychotherapeutic techniques including ‘holding’, and ‘containing’ the clients

unconscious defences and ‘projective identifications’ can be managed by the creation of an auxiliary ego in therapy.

Chapter 2 will consider the clinical presentation of the dementia client in the psychotherapeutic encounter. Chapter 3 will outline the role of the analyst and consider the relevant psychotherapeutic techniques to sustain the client, manage distress and assist reintegration. Chapter 4 will be a discussion signifying there is robust evidence to demonstrate Psychotherapy has a valid role in caring for the client with dementia, acknowledging there is a requirement for further academic research to verify the therapeutic benefits from its expansion. It is inevitable that personal experience as a primary care giver will influence this work.

GLOSSARY OF TERMS.

(George & Whitehouse, 2007, p. 624) posit that the terms used to describe dementia historically have undergone a “remarkable metamorphosis”, conceding age related cognitive changes have long existed with different meanings attributed by communities. Nonetheless the clinical and pathological perspectives are dominant in contemporary society where dementia is generally understood as a “death sentence for the mind”. In medical discourse Alzheimer’s Disease is the most common form of Dementia, first described by a German Psychiatrist called Alzheimer in 1906 and included by Kraeplin in his Text of Psychiatric illnesses, the precursor of the current ICD- 10 and DSM-V, as described by (Hippius & Neundörfer, 2003, p. 106). The diagnosis was based on clinical observations of paranoia, memory disturbances, sleep disorders, crying, aggressiveness and increased confusion observed in a 50 year old patient over 5 year period 1901-06, coupled with posthumous histopathological analysis describing the presence of “plaques and neurofibrillary tangles” in the brain tissue. The formation of amyloid plaques in brain tissue remains the hallmark of Alzheimers Disease as described by (D’Andrea & Nagele, 2010, p. 133). The (American

Psychiatric Association, 2013, p. 595, 606) describes dementia as evidenced by “behaviour clearly outside the acceptable range” where a changed personality is evident via decreased empathy, inhibition, tendency towards introversion or extroversion, periods of apathy, disinterest, indifference, detachment, restlessness, memory loss, sleep disturbances, and fatigue due to sustained effort to think and remember. (Clare, 2004, p. 968) states reduced awareness in terms of social functioning; emotion recognition and empathy together with a prosocial attitude is evident. (Nelis et al., 2011, p. 968) validated many of these concepts in a study of 97 dementia patients using a Socio- Emotional Questionnaire (SEQ), cross referenced with parallel carer ratings, the presence of neuropsychiatric symptoms and assessment of perceived relationships with partners/significant Others.

(Guntrip, 1992, pp. 42–44) refers to “loss of affect” as a key characteristic of dementia exhibited in behaviour that is insensitive and hurtful to others, whilst from a behavioural perspective (Trahan, Kahng, Fisher, & Hausman, 2011, p. 20) describe presentations of increased aggression, “disruptive vocalisations”, deficient communication and discrimination skills. From the discourse of psychology disturbed perception, thoughts, moods, agitation, wandering, aggression, compounded by depression, anxiety, and delusional ideas in later stages is described by (Osborne, Simpson, & Stokes, 2010, p. 503). Equally, studies conducted in developing countries illustrate behavioural and psychological symptoms of dementia are common, as described by (Kalaria et al., 2008) with depression, anxiety, schizophreniform or paranoid psychosis, apathy, and sleep alterations reported from Brazilian, Indian, Nigerian and African –American Studies, acknowledging regional variants may be influenced by methods of reporting and cultural taboos.

Accordingly a diagnosis of Dementia has cultural and theoretical dimensions, but predominantly in developed countries it is as a medical illness, manifested by symptoms, and with a diagnosis, prognosis and treatment plan, as described by (Verhaeghe & Jottkandt,

2008, pp. 3-12). The paradigm is abnormality, characterised by segregation and difference and compounded by irreversibility. Psychotherapeutically the focus is on psychological constellations and interactions with the therapeutic Other as described by (Verhaeghe & Jottkandt, 2008, p. 12-14).

The concept of object relations derives from psychoanalytic instinct theory, as described by (Ainsworth, Blehar, Waters, & Wall, 1978, p. 1), where the “object is the agent through which the instinctual gain is achieved”. The first Other is the mother, with the infant –mother relationship defining the prototype of object relations from the beginning.

(Davenhill, 2007, p. 209) attributes Hildebrand (1982) with the creation of the term ‘auxiliary-ego’ to describe how the Other assumes the role of translating often “bizarre communications,.. conveyed through projective identification” as cognition and language becomes more challenged. Projective Identification is described as a defence by (Klein, 1997, p. 6-8) and as the archetype for aggressive object –relations, derived from the instinctual desire to harm or control the Other whom he views as a persecutor in early primitive processes.

(Winnicott, Winnicott, Shepherd, & Davis, 1989, p. 32) describe the concept of psychoanalytic “holding” as emanating from the concept of “primary maternal preoccupation”, the process where the mother holds and bonds with her newborn infant. Where maternal failure is experienced the client may have feelings of an “unintegrated self” and “falling forever” with anxiety and psychotic states persisting throughout life.

Containment, is used by (B. W. R. Bion, n.d., p. 68) to describe the analysts role as a container to hold the split of parts of the self projected by the client in the therapeutic encounter, parts that have to be contained until the client is ready to “reingest them as part of the cure”.

In summary, Wood and Hess cited in (Davenhill, 2007, p. 280; and p.271) welcome the recent inclusion of the older client in psychotherapy, commending Davenhills furtherance of same at the Tavistock Clinic following its initiation there by Hildebrand. (Hildebrand, 1987, p.113) contended object-relations should be viewed from the perspective of processes that underlie thinking, feeling and perception as they apply in later life. In respect of dementia, (LoboPrabhu, Molinari, & Lomax, 2007a, p. 147-157) state psychotherapeutic exploration of working with dementia distinguishes development and degeneration as opposite life processes, the former being progressive maturation, the latter a reversal of development resulting in a gradual loss of self and self-objects. Losses include memory, incremental incapability undertaking activities of daily living, gradual loss of sensory motor skills, and eventually loss of basic bodily functions in a state analogous with an infant, with the client “constantly exposed to an ever-changing universe of objects accompanying the neurologically driven memory deficit, and loss of internal and external objects which accompanies this illness”. (Ng, 2009, p. 83) concurs the trajectory of life reverses in dementia, adding that regression also occurs and suggesting understanding infant behaviour will provide insight into the internal worlds of the client. Equally, (Waddell, 2000, p. 55) refers to the “inextricable relationship between beginnings and endings”, establishing an intrinsic link between psychoanalytic theories, clinical experience and client observation, ultimately contending behaviours of “childishness” have immediate and direct parallels with the state of “second childishness”. In this milieu (Evans, 2008a, p. 155-176) postulates the psychoanalytic theories of Klein, Bion, Bowlby and Winnicott are relevant, accrediting same to their studies of the psychotic and fragmenting states of mind observed in psychoanalytic study of babies and small children, and the correlation from understanding the infant’s emotional and psychological needs and developmental processes with states that emerge in later life.

CHAPTER 2: THE DYNAMICS OF THE PSYCHOTHEURAPEUTIC ENCOUNTER

(Bowlby, 1998, p. 25) states “troubled states of early childhood can be discerned as the prototype of many pathological conditions of later life”. Thus, external affect states must be linked to internal states where concealed emotional responses can be expressed in an environment that is safe and contained in therapy, as described by (Fonagy, 2004, p. 439). In this chapter it is proposed to discuss some of the characteristic feeling states including anxiety, fear, loneliness and annihilation that may emerge in the therapeutic encounter.

(Winnicott, 1989, pp. 5–7) in his paper ‘Anxiety Associated with Insecurity (1952)’ describes three types of anxiety, all attributed to failures in early infant care with commensurate failure in primitive developmental processes resulting in a state of “unintegration”, this subsequently translates into feelings of disintegration and depersonalisation as a consequence of lack of relationship between the “psyche and the soma”. Disintegration is defined by (Winnicott, 1990a, p. 61) as “the unthinkable or archaic anxiety that results from failure of holding in the stage of absolute dependence” and a state that is used as a “sophisticated defence” in response to the unintegration and chaos due to the absence of maternal ego-support. (Ainsworth et al., 1978, p. 3), concur attributing the security-anxiety dimension of infant attachment to maternal behaviour in early childhood, describing where the infant was insecurely attached internalised/introjected feelings of rejection and/or submerged anger due to the mother’s lack of awareness of the infant’s signals persist. Ultimately feelings of disintegration transcend into fear experienced “as a terror” as described by Winnicott cited in (A. Phillips, 2007, pp. 80–83). Extant meanings, such as those provided by Balfour cited in (Davenhill, 2007, p. 225) continue to describe the affective state of the person diagnosed with dementia as a “world of tremendous helplessness and terror”. (Evans, 2008b) associates the anxiety in early dementia with the ‘nameless dread’ described by (B. W. R. Bion, n.d., p. 116), whom equally applied this term to absence

of maternal reverie with the mother failing to accept and contain the infants projections and consequently failing to translate fragmented experience and dread into more tolerable thinking and ways of being in the world. (Longhin, 2012, p. 20) agrees the extent to which maternal reverie existed is critical as when the maternal object fails in her task of auxiliary-ego the result is the mother simply returns “returning the raw materials that the child sends her”. (Fonagy, 2004, p. 439) uses an alternative term in reference to the role of psychotherapy in regulating these affects, stating the therapist operates in “pretend mode” to allow the patient act out his fantasies and imagination.

Loneliness is ascribed to the return to dependency and fear of “being left alone with what are felt to be bad and unintegrated parts of the self”, as described by (Davenhill, 2007, p. 232-233). (Kitwood, 1997, p. 21) agrees, stating “somewhere, deep inside, there are dim memories of times of crushing loneliness and ice-cold fear”, whilst (Klein, 1997, p. 13; Klein, Riviere, Heimann, & Isaacs, 1989b, p. 306-7) state loneliness is a fear of “destruction of the object by the aggressive impulses directed against it”, and to “excessive weakening of the ego” where the client has a “feeling there is nothing to sustain it”. (Mahler, Pine, & Bergman, 1975, p. 8) suggest loneliness arises from an intrapsychic sense of separateness, with clinging behaviour aligned with “primitive cognitive- affective life wherein the differentiation between self and mother has not taken place”. The latter is consistent with (Winnicott, 1992, p. 99) contention “there is no such thing as a baby” i.e. that the mother and child are a unit, and the “good –enough” mother neutralises the external persecutions and anxiety for the infant, a position from which the ego develops and the child becomes a person as described by (Winnicott, 1990a, pp. 59–62). This developmental process facilitating the union between the ego and the body results in ‘personalisation’, and commencement of “object –relating” as a consequence of maternal “holding, handling and object –presenting”, with the infant recognising the ‘I am’ and ‘I exist’ sense of being in the world. (Kahn, 1997,

p. 91) refers to Kohut's concept of mirroring that also emerges from this developmental stage where the child, and by extrapolation the adult "transmuting internalisation" "adds structure, building a strong cohesive self with self esteem firmly rooted. Conversely if needs are "traumatically frustrated and then repressed because it is too painful for the child to be in touch with them" psychoanalytically the implication is that the need does not become integrated into the personality as it is walled off by the ego, remaining in its primitive form with feelings of insecurity and worthlessness persisting, and resultant need for the therapist to act as an auxiliary ego in therapy.

Irrespective of the developmental process (Winnicott, 1992, p. 149 -55) states a specific anxiety affect termed "an expectation of persecution" co-exists. However, where failures of integration occur, it is not the unintegration that is frightening, but the disintegration of the personality, where the person feels depersonalised perceiving the world as "unreal", a primitive state where the ultimate fear is "true annihilation" and "abandonment to impulses" as presented in a case study by (Ng, 2009, p. 96). (Klein, 1997, p. 1-2) states this may be observed as the defence of denial which is unconsciously associated with annihilation. (Cheston, 1998, p. 214) concurs that as the illness progresses primitive defence mechanisms emerge, signifying the dementia client may progress from denial to the unconscious processes of projection and displacement before splitting. (Klein, Riviere, Heimann, & Isaacs, 1989b, p. 306) describe the return to splitting as a primitive mode of relating, and vacillating between paranoid schizoid and depressive positions as typifying dementia, further ascribing schizoid object-relations to "infantile introjective and projective" processes. (Klein, 1997, p. 300) posits paranoid -schizoid and depressive anxieties exist in every individual but become "excessively strong in illness". Furthermore, (Klein, 1997, p. 1-2) describes the emotion of aggression as consequent to the infant experiencing excessive

exposure to frustration and pain, identifying with it, and expelling these via projection in the therapeutic encounter.

(Kitwood, 1997, p. 18) agrees the Kleinian concepts of splitting good and bad objects is relevant in working with people with dementia. His theory the Zone of Negative Experience incorporates three primary domains - Anger, Frustration, and a Sense of Uselessness, followed by global states of “raw emotion” when the Autonomic Nervous System (ANS) is activated with feelings of terror, rage, misery and chaos. Ultimately, “burnt out” states of despair, depression, exhaustion, apathy and vegetation are described as emerging when the intensity of discharges from ANS activation can no longer be sustained. Allegedly, these states can be traversed many times in the disease trajectory. (LoboPrabhu et al., 2007, p. 159) in working with dementia clients contend repetition of unconscious processes throughout life may be attempts to gain mastery over feelings of being out of control and in mortal danger. Thus, in therapy the return of the unconscious and re-emergence of themes from early development is fundamental to understanding this progressive illness and managing its symptoms as described by (Davenhill, 2007, p. 231; Malloy, 2009, p. 83), in respect of which (Ng, 2009 p. 83) emphasises the psychological versus biological model of care offers the greatest therapeutic benefit.

CHAPTER 3: THE ROLE OF THE ANALYST

(Balfour, 2006, pp. 342–343) concurs an understanding of unconscious processes is integral to understanding the experience of the person with dementia whom becomes less able to verbalise their experiences and feelings as the disease progresses thus becoming increasingly reliant on communication by projective processes. (Waska, 2017, p.26) states our task is to help the patient understand, face, and resolve anxieties regarding self and Other within their internal world, and where projective identification brings the clients phantasies alive in the external world facilitating working through the “powerfully rigid projective identification path” and achievement of “solace, control, and a pathological yet known psychic shelter”. This is reliant on the therapist being the subjective object for the client as described by (Winnicott, 1990a, pp. 166–167) in order to develop “unconscious cooperation”, allowing “universal” primitive mechanisms of splitting, introjection, projection, object retaliation and disintegration to emerge as defences. (W. R. Bion, 1994, pp. 31–32) describes the clients ability to “gear” his phantasy to reality as directly related to his capacity to tolerate frustration further stating “there must be some sort of omnipotent phantasy that it is possible to split off temporarily undesired, through sometimes valued, parts of the personality and put them into an object”. (Klein, 1997, pp. 5–9) describes Projection as the mechanism for overcoming anxiety from danger, badness and experience of the oral-sadistic cannibalistic feelings towards the bad breast. Conversely, its opposite Introjection is described as intake of the good object, i.e. feeding from the comforting, nourishing breast, in a manner analogous with Bions aforementioned idiom of container. In addition, the splitting defence refers to splitting of the ego where good and bad objects alternate as idealisation and persecution, ultimately weakening the ego and affecting the client’s ability to relate to the inner and outer worlds. By contrast, Winnicott cited in (Winnicott & Rodman, 1999, p. 92) disliked the term projective identification stating it was not a distinct entity *per se* but

“contained in the ordinary analytic theory of paranoid anxiety”. Winnicott did however concede that aggression develops out of the impulsive need of the new-born infant for an external object, - “and not merely as satisfying one”, contending that as a consequence of the baby being “fobbed off” by feeding alone, other psychical satisfactions deprived in failures of maternal ‘handling’ result in undischarged tensions remaining in the body which remerge in later life as an unconscious processes, as cited in (Abram & Karnac, 1997, p. 198). (Evans, 2008b, p155) suggests that in dementia the unconscious process of projective identification is maximised at the last of a three stages, the former being anxiety and depression, and latter repression and denial. The notion that the therapist has to link with an infant’s early state of mind, with capacity to register, contain and reflect the anxieties by means of projective identification is described by Waddell (2002) in (Abram & Karnac, 1997, p. 198)

THEURAPEUTIC TECHNIQUES

The beginnings of the cohesive self in infancy where mothering was not "good enough" results in “the traumatic state of psychic helplessness—the precursor of the massive automatic anxiety experience”, is restated, as described by (Tolpin, 1971), whom contends inadequate emphasis on "what every mother knows" needs to be rectified via the therapeutic encounter. (Mahler et al., 1975) suggests that if the Other is "quietly available” and has capacity to support processing of “imitation, externalization, and internalisation”, both verbally and nonverbally, this assists the client work through thought processes, reality testing, and to identify coping strategies. (Davidson, 2009, p. 62-82) describes the role of the therapist as an auxiliary-ego, to support patients with this reality testing, judgment, and self-object differentiation. The therapist as a reliable presence creates a secure base to facilitate

emotional re-experiencing, and acts as a container for the projections and “unconscious experience of the patient's unconscious feelings, which the patient himself could not for many years bring into consciousness”, an approach that enables re-experiencing of often very painful early developmental stages which is described as not “about infantilising the person”. Consequently, the aim of therapy is to support and sustain the client via techniques of holding, containing and the creation of an auxiliary-ego as described by (Evans, 2008d). As previously stated (Winnicott, 1990a, p. 60) contends ego growth is reliant on processes of therapeutic ‘holding’, and ‘handling’ to support integration enhancing the capacity for object relating with the Therapist. In this context Primary Maternal Preoccupation, described as a state of disassociation and where “there is no such thing as a baby” is attributed to the early bonding process when the “ordinary devoted mother” lends her ego to the baby, which then acts as a “protective shield” to allow the infant's ego to develop, as described by (Winnicott, 1992, p. 300). If the therapeutic environment is right the omnipotent infant (client) re-creates the Object (mother) as therapy progresses. The role of the therapist as “protective shield” for the true self is also described by (Ogden, 1977, p.78) to enable the client progress from “extreme emotional dependence” and a defensive false self to a new phase of psychological development if the environment is facilitating enough. (DeLia, 2004, pp.179-99; Sirois, 2011, p.57-73) similarly describe the auxiliary-ego as a protective shield conferred by the analyst, whilst (Abraham, 2005, p. 196) refers to the therapeutic relationship as the holding environment, both in terms of attention and physicality, and in a manner that “mirrors the mother's primary maternal preoccupation”. Commensurately, handling i.e. the care and enjoyment of her baby if ‘good-enough’ results in the aforementioned concept of personalisation where “the psyche can indwell in the soma”, enabling the person to feel his sense of self centred in his body.

(M. Phillips, 2013, p. 20) aligns these concepts with Mahlers theory of Separation-Individuation, where the role of the mother is to serve as an auxiliary- ego, assisting with regulation of feelings of frustration and gratification and to protect the child from becoming overwhelmed, ultimately allowing the child to emerge from “inside the symbiotic unit with mother” to the outside world with of sense of identity as "I." in a manner previously described by Winnicott. Equally, (Ogden, 2014a, p. 210-14) describes absolute dependence on the Other to supply “an auxiliary-ego function”, recognising where there is a “breakdown” in the “mother-infant tie”, the “ original experience of primitive agony cannot get into the past unless the ego can first gather it into its own present time, experience it, and take into omnipotent control now (assuming the auxiliary ego-supporting function of the mother (analyst)”. Thus, the therapist must become the “symbolic “mother” so that what “cannot be remembered can be re experienced and repaired”, facilitated by the “ordinary devoted mother” as described by (Slochower, 2013, p. 16-20), whom also states the therapist must be capable of functioning within the “maternal metaphor because she is implicated” in the therapy, and because ‘there’s “neither a baby or a mother in the consulting room. Just two grownups”’.

In this context (Fonagy, 2004, p. 145) refers to the technique of mentalization as the “social bioemotional feedback theory integral to emotional development” requiring linking of early experience to later vulnerability and psychosocial distress. Akhtar, 2007, p. 690-704) in endorsing this technique states it is reliant on the auxiliary- ego created by the Other, and grounded in addressing deficits in developmental attachment in infancy, understanding these mental and emotional states, whilst simultaneously facilitating re experiencing the feelings and emotions thereby assisting with their regulation as described by (P. D. Hoffman & Steiner-Grossman, 2008, pp. 187–191).

(Malloy, 2009) provides a number of vignettes to demonstrate these therapeutic approaches, recommending “deeper understanding of the unconscious communications and anxieties in this area (dementia) and the containment provided by this understanding” of “an intimate and complex interaction between the internal world and the changing relationship with the world at large” is essential. (Guntrip, 1975, p. 361) states when in therapy with Winnicott he felt that he was in the presence of an analyst who was remarkably attuned and caring, allowing him “to reach right back to an ultimate good mother, and to find her recreated in him in the transference”, validating the views of (Winnicott, 1990b, p. 185) Correspondingly, (Friedemann, Tolmacz, & Doron, 2016, pp. 71–84) refers to "The Development of the Capacity for Concern," by Winnicott (1963) which attributes this capacity as emerging from ‘good- enough’ care, an indication that the infant has begun to be independent of the ‘auxiliary –ego’ provided by the mother, and credited as one of the major developmental achievements.

In terms of lifecycle (Erikson, 1980, p. Worksheet) describes the requirement for an auxiliary ego as “the client experiences the final stage of development ‘Integrity vs despair’ and of “not being”. Equally, (Rosnick, 2017, p.747) review of Stracheys 1934 paper ‘Nature of Therapeutic Action in Psychoanalysis’ describes how the “analyst is set up as an auxiliary super-ego” so that unconscious processes including Introjection and Projection can be worked through, the role of the analyst being to strengthen the ego by observing “the archaic phantasies in the contemporary relationship”. (Ogden, 1977, p. 40) too describes the therapeutic benefit of the therapist in containing the projective identifications of the client’s phantasies so that ultimately they can be taken back by the client in a modified form to assist with integration and psychological growth. Conversely, (Malcolm, 1988, p. 149) disagrees with Strachey positing that the analyst becomes much more than an auxiliary –ego and is experienced by the client as many different objects, based on the events that emerge in the

analysis, but conceding that when the therapist is introjected by the client, and separated from the clients super-ego, an auxiliary superego which is less sadistic is formed allowing for further development. (Strachey, 1999, p.69) applies a Kleinian interpretation to introjected objects, stating some function as a “good” i.e. mild super-ego and some as “bad” i.e. harsh super-ego, the extent to which the ego maintains contact with reality in therapy relying on the ‘good’ introjects being projected on to a compassionate real objects as well as the ‘bad’ on to perceived malevolent real outside objects. Equally, (Akhtar, 2010, pp. 219–244) contends that the analyst cannot but provide auxiliary –ego support for the patient needs and in doing so offers the client the opportunity to create new integrations. The "integrative processes that result from acceptance of destructive impulses" are described by (P. H. M. King, 1974a, p. 29) whom states objects that are consciously loved and valued enable the client to see whole objects as incorporating the good and bad parts. Likewise, (Kohut, 1984, pp. 6–9) states the lethargies and rages of early infancy, are “analogous with the needs and frustration- responses of later developmental stages” associating it with the need for “cohesion-firming responses of a self object” especially empathy and closeness, resulting in feelings of disappointment if unattained. (Rowe, 2000, p.61-62) refers to Kohuts aforementioned concept of Transmuting Internalisation as a three stage process where the persons mental development has matured adequately to allow introjects to take place, optimal frustration with the object (often as the idealized parent) to be experienced, and depersonalisation of the internalised aspect of the internal parent to form, and in doing so adjust their own selfobject perception. In acknowledging the Kleinian psychotherapeutic perspective Kohut equally cautions a better therapeutic outcome may emerge from “let sleeping dogs lie” as deconstructing defences that have afforded a lifetime of protection may expose the client to the aforementioned “unspeakable anxieties” and chaotic pre-psychological states where emphatic responses were

lacking. Hence, the goal of therapy may be “to assist with fortressing the defences to sustain the client in his distresses”, as described by (Kohut, 1984, p. 18-21).

Finally, the capacity of the therapist to recreate maternal reverie relies on the ability to contain their own fears of annihilation, as stated by (Sandler, 2010, p. 27) whom contends and where this exists fragmentation and anxiety can be prevented. (Ogden, 1977, p.32) states failures to contain the projective identifications results in the client reinternalising both his own projected feelings and the therapists fears and inadequate handling of the those fears thereby reinforcing and expanding the patients defences. Thus, as described by (Lipgar, 2003, p. 20) the analyst must serve as a container for the infants “proto-mental” experiences and just like the mother must use the concepts of reverie and containment to sense the profound pain of her infant, (the client), in a process analogous with Winnicotts aforementioned concept of Primary Maternal Preoccupation. (Slochower, 1996, p.323-353) describes the challenges of holding and containing using the process of attunement, detailing the therapeutic benefits for the client but concurrently recognising the demand on the analyst receiving the intense projections and difficult emotional states whilst simultaneously fulfilling the role of a caring and nurturing parent, stating “When I feel required to contain these experiences fully, an added dimension of tension enters and remains in the psychoanalytic setting”. Similarly, (Lotterman, 2016, p. 63-78) states the ability of the therapist to accept, tolerate, live with, and, ultimately, be conscious of the client’s emotions requires that the therapist must become an auxiliary- ego to “affect tolerance, affect awareness, and affect translation into verbal concepts”.

(Ramsay-Jones, 2015, p. 249) describes the use of many of these techniques in clinical practice with Dementia clients, referring to the therapist’s capacity to use reverie as responsiveness when we come into intimate contact with a client’s state of mind, the observed implications in its absence being feelings of being unlovable, abandoned and hated,

surely a reminder, as described by (Hildebrand, 1988, p. 353) of the aging person “at the other side of the wall” with “a basic unconscious human need to maintain meaningful contact with others”. Accordingly, (Ng, 2009, p. 104) states “we cannot rely on our traditional approaches in dementia with its distinct hegemony of biological reductionism that neglects the person behind the disease”, proffering a psychodynamic approach offers a much more comprehensive approach to treating the patient as a whole person.

CHAPTER 4: DISCUSSION

(George & Whitehouse, 2007, p. 624) describe dementia as a progressive and irreversible illness and consistent with the aim of this dissertation concur that, “To describe an elderly person as experiencing “second childishness” produces a very different relationship and treatment regimen from asserting that the person’s brain is being attacked by a ravaging neurobiological disease called dementia”. The fact that the underlying biology is the same is irrelevant as it is the social construction that invariably influences how cognitive decline is viewed, a process which often places “individuals in the cage of their dementia”. Whilst acknowledging advances in the pharmacological treatment delay cognitive decline, (Brierley et al., 2003b, p. 20) equally posit patients may have insight into their illness for longer which may be equally emotionally distressing, hence expansion of access to psychodynamic-interpersonal and humanistic therapies such as , “staying with feelings; working in the ‘here and now’, picking up cues and linking these with the past” to develop “a mutual feeling language” and a relationship of “aleness-togetherness” is advocated. (Rowe, 2010, p. 304) in reference to Kohut’s process of empathetic attunement refers to the requirement that the treatment process is one where the needs of the patient are understood, not just in dynamic, genetic and economic terms but where “mirroring and idealising needs” are both understood and explained to the patient. Thus the techniques of holding and containing the projective identifications in the psychotherapeutic exploration of the feeling states of the client with dementia, and in particular the therapeutic benefit of the creation of an auxiliary ego is evident. This is endorsed by (Ardern, Garner, & Porter, 1998, p. 47) who demonstrated that psychoanalytic theory and practice has a place within the psychiatric service for the elderly, contending a culture that “synthesises psychodynamic thinking alongside biological, social and other psychological approaches” in a psychoanalytically informed department, where staff have the space and time to reflect on their work, enables the patient make some sense of his life. Similarly, (Ramsay-Jones, 2015, p. 251) concludes that without the containing

presence of healthcare workers, the dementia client will be further disabled by the lack of validation of their existence of “going on being in the world”. This view is consistent with (Winnicott, 1992, p. 153) analysis of the most primitive state, “often retained in illness” which results in the “object behaving accordingly to magical laws, i.e. it exists when desired, approaches when approached, hurts when hurt. Lastly it vanishes when not wanted”. Whilst, the (“Future-of-Mental-Health-Care---Final-Report-(amended).pdf,” n.d., p. 7) recommends a reduction in over-reliance on the prescribing of medication by increasing investment in counselling and talk therapies it remains the case that further academic research to validate the benefits of psychotherapy in the clinical management of dementia is warranted.

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