

DUBLIN BUSINESS SCHOOL

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**AN EXAMINATION OF THE USE OF PSYCHOANALYTIC APPROACHES IN
TREATING DEMENTIA THERAPEUTICALLY**

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ABSTRACT

In the psychoanalytic tradition Sigmund Freud's work centred around the gaps in memory and the repressed unconscious. Resistance on the part of the patient in Psychoanalysis was, he said, a violent and tenacious resistance, unknown even to the patient, extremely subtle, and hard to detect (Freud, 1963/1991, pp320-328). Freud's efforts were to make conscious what is unconscious, lift repressions and fill gaps in memory (1963/1991, p486). But what about the gaps which come from cognitive impairment and degeneration? If the gaps aren't caused by repression of a memory but instead the cognitive inability to retain the memory, can Psychotherapy have any impact on the patient? The gaps cannot be filled if the memory is truly lost, so this objective becomes instead about helping the client to recall who they are, their essence, and their being in the face of degenerative memory loss.

CHAPTER 1: INTRODUCTION

Dementia is an all-encompassing loss, not just of memory but of self, language, and independence (Nussbaum, 2011, p265). The challenge in addressing the disease therapeutically can be in the belief that if cognitive, communicative, and integrative functions have or are failing, a therapeutic approach is pointless. There is growing evidence to the contrary which demonstrates that a therapeutic approach, and in particular a Psychoanalytic approach, is extremely beneficial for a patient with dementia throughout all stages of the disease, from early to late stage dementia (Cheston, 1998, Husband, 2000, Davenhill, 2007, Ganzer, 2013, Jones, 1995, Evans, 2008, Maslow, 2013, LoboPrabhu et al, 2007, Waddell, 2007, Nussbaum, 2011, Douglas et al, 2004, Polini, 2007). Historically, little interest has been paid to the experiences of people with dementia or to the meaning of their communication and behaviour. The disease has been characterised by cognitive loss. However there is growing interest in the non-cognitive factors relating to this disease and this has been associated with the role that Psychotherapy can play in dementia care (Balfour, 2007, p230). Psychoanalysis in particular has always been concerned with the developmental process, but it is only recently that this interest has extended to the later life cycle. The benefits of this growing research into later life is in the deepening of our understanding of living and ageing (Hess, 2008, p380). Combined research into the importance of later life and into the emotional rather than just the cognitive brain means that the exploration into treating dementia psychotherapeutically can be opened up, and any assumptions that this type of treatment is ineffective because the disease is degenerative can be challenged.

1.2 AIMS & OBJECTIVES

- To demonstrate the all-encompassing loss that a person with dementia faces, not only to their memory, but also to their sense of self, relation to others, independence, previously integrated ways of being, and sense of reality. In-so-doing a fuller picture of the person with dementia is formed, lending weight to the argument that it is not just the cognitive brain that suffers and therefore it is not just the cognitive brain that should be appealed to when treating a person with dementia
- To explore the place that Therapy has in relation to this illness by conducting an examination of current literature, using case examples to demonstrate the impact therapeutic treatment has on patients with dementia
- To examine some of the therapeutic theories which have informed the treatment of dementia, looking in particular at examples of psychoanalytic theory which have informed psychoanalytic approaches to treatment
- To examine a range of psychoanalytic approaches and their effects when treating a person with dementia, using additional case examples to support this research
- To address the question of whether a disease of deterioration can be treated psychotherapeutically
- To address the challenges in this area of research

For the purposes of this thesis the focus is on the patient and their relation to the Therapy and Therapist, and does not explore the effects of dementia and Therapy on the caregiver.

For the purposes of this thesis, the terms Therapy, Psychotherapy and Psychoanalysis will be used interchangeably.

This paper includes statistics from both UK and Ireland and is not geographically focused.

This is a literature review conducted through desk-based research, informed primarily by the Dublin Business School research database ebscohost.com, along with other reference material as cited in the bibliography.

CHAPTER 2: DEMENTIA & LOSS

“Can I tell you about the day my brain left me?” (Anna Darlington, 1994, p92, as cited in Davenhill, 2007, p287).

Dementia is not an inevitable part of later life, but it is a possibility and one that many would prefer not to consider (Balfour, 2007, p223). The most powerful descriptions of dementia are those given by the people who have it.

“My mind’s boggled” (as cited in Balfour, 2007, p222).

“These moments came up on me like the fox, very, very quietly (Anna Darlington, 2007, p287).

“Christ, what’s going on? What’s happening to me? Is this a nightmare? Am I crazy? Is this a joke?” (Jimmie G, as cited in Sachs, 1985/2011, p27).

These extracts capture the feelings of loss, fear, unreality and abandonment that this illness can evoke. Balfour describes a patient who knew he was not the symptom of his illness but in his actions felt like he was, as his illness began to lose meaning (2007, pp230-231). Sachs observes a man who has no day before, and isn’t aware of this deep tragic loss in himself, and of himself (1985/2011, p39). In these ways, dementia is an all-encompassing loss.

Dementia is a syndrome characterised by the gradual loss of a person’s cognitive capacities and is mainly diagnosed in the elderly (Siampani, 2013, p36). It is progressive, meaning cognitive deterioration is ongoing, and the extent and timing of the deterioration cannot be predicted. Symptoms usually include memory loss, change to mood and personality, and

progressive to severe communication problems (Malloy, 2009). It shortens life expectancy and currently an estimated 700,000 people in the UK (Balfour, 2007, p223) and 44,000 people in Ireland (Understanding Alzheimer's, 2015) have dementia. Memory loss is progressive as is loss of functional skills and independence (LoboPrabhu, Molinari & Lomax, 2007).

There are four identified types of dementia. The first is *Alzheimer's Disease*, the most common, beginning with short-term memory loss and becoming progressively severe (Balfour, 2007, p223). It is caused by a build-up of protein on the brain creating tangles which inhibit brain activity (The Alzheimer Society of Ireland, 2014). *Vascular Dementia* is caused by a lessening of the blood supply to the brain, usually brought on by stroke (Balfour, 2007, p223). *Lewy Body Dementia* has the characteristics of both Alzheimer's and Parkinson's Disease, where muscle stiffness can accompany memory loss. *Fronto-Temporal Dementia*, including Picks Disease, is a rare type of dementia. In the early stage it can affect the person's personality and behaviour rather than their memory. Later it takes the form of Alzheimer's Disease. Additional types include *Korsakoff's Syndrome* caused by alcohol abuse and *Creutzfeld-Jacob Dementia* which also arises from a protein defect in the brain. Dementia can become a symptom of other conditions such as Down's Syndrome (The Alzheimer Society of Ireland, 2014).

As dementia progresses it is understood in early, intermediary, and late stages. In early stage dementia, changes happen gradually and those who receive a diagnosis are aware of these changes and what it means (Balfour, 2007, pp225-226). Anxiety is common, and confusion may begin to arise as the person's relation to their internal ways of being and external objects is disturbed. The threat of loss and abandonment is huge (Evans, 2008). This awareness

begins to weaken as the disease progresses (Balfour, 2007, p225). Evans describes a weakening of the ego, and a loss of connection to the self and to reality. Bodily and communicative functions also begin to deteriorate. In late stage dementia, progressive physical deterioration along with loss of higher cognitive function means a return to absolute dependency (Evans 2008).

In a case that will be looked at in more detail later in this paper, Nussbaum felt Eleanor's therapeutic question was how to turn dementia into hope. She was asking how to find a way to live or die through the loss of words, cognitive function, independence, and self, and what Nussbaum interpreted as the hope for company in the face of unimaginable loss (2011, p265). Nepo likens Alzheimer's to a loss of context and of our self-created map (2012, p46). This loss can evoke real anxiety and a return to uncharted beginnings. In a radio interview, Greg describes himself as an observer of his own decline, saying that it is like watching someone holding onto a dock and getting swept slowly away (Greg O'Brien, *The Mind Shaft - Strangers*, 2015).

CHAPTER 3: THERAPY'S PLACE IN THE TREATMENT OF DEMENTIA

“I didn't think I had anything left to lose...I want the loss to stop. I think you should change the name of the illness to hope.” (Eleanor, as cited in Nussbaum, 2001, p263).

Freud's work centred on unconscious developmental processes which were disturbed or repressed (1963/1991, p320). Using himself in the transference and allowing patients to direct behaviours or emotional impulses at him to create a new experience for the patient, formed the basis for a stronger ego. Freud's efforts were to make conscious what is unconscious, lift repressions and fill gaps in memory (1963/1991, pp486-490).

Melanie Klein based her work on Freud's ideas about the unconscious. She was interested in the inner life (Segal, 1992/2004, p28). In Klein's work, the object of love or hate, namely the mother, was implicit in the experience for the child of loving and hating, and from this she developed the theory of the paranoid-schizoid position. The paranoid state is experienced as persecutory and the schizoid formed as the child splits off the bad instead of integrating it (Stevens, 2013, pp49-50).

Psychoanalysis does not reduce older adults to babies but it provides an understanding of the adverse reactions to loss and change, which will partly be determined by the individual's developmental experiences (Balfour, 2007, p232). Balfour draws on these perspectives of primary modes of relating, observing that they are states of mind, developing in constant oscillation throughout life. The leading anxiety is about the survival of the self, and the goal is to move towards an integrated state. From the perspective of later life, there can often be a return to these earlier conflicted states and the way they were experienced before will often

be how they are experienced again. Death, for example, can be viewed through the persecutory lens of the paranoid-schizoid position. If this natural return in later life is accompanied by a diagnosis of dementia, the return can be far more traumatic, combined with a fear of loss, loneliness and dependency (Balfour, 2007, p223).

Donald Winnicott furthered these theories about external and internal realities. The infant struggles with the notion of a shared reality, compounded by the mother's ability to contain and hold the child. If the mother can do this, the subject can relate in a healthy way to her and others (Rodman, 2003, pp326-328). The transitional object is important in Winnicott's work. It is the first symbol of the union between mother and baby. It represents the confidence that when the baby reaches out it will find what it is looking for, based on the mother's reliability and ability to predict and meet the baby's needs (Rodman, 2003, p50).

Having explored these psychoanalytic ideas, a basis from where to meet dementia in a therapeutic setting is formed and an opportunity arises to explore where Therapy is placed in the treatment of dementia, and how Psychoanalysis specifically can play a part. Clinical interest in the provision of Therapy to people with dementia has grown and continues to grow, however this interest has not yet been matched by evidence of the most successful way to do this (Cheston & Jones, 2009, pp421-423). The degenerative nature of this disease, with a gradual loss of self-objects and the self (LoboPrabhu, et al, 2007, p147), adds additional complications. There is growing evidence to suggest that early psychotherapeutic intervention is very useful for those with dementia (Cheston, 1998, Husband, 2000, as cited in Davenhill, 2007, p209), but there are limitations to how useful this approach can be, as dementia begins to take over and takes with it the patient's ability to communicate and

interject. It is here where it is thought that the Psychoanalytic approach can continue to support the patient (Davenhill, 2007, p209).

With this in mind, looking at Waddell's observation about the chronological loss of time for those who have dementia strengthens this argument in favour of psychoanalytical intervention. She states that it is not the loss, but what is done with the time that matters. Psychological development can either be prolonged or limited and foreclosed (2007, p188). Her reference here to the danger of foreclosing psychological development can be linked to Davenhill's observation about recent studies which indicate the need to be careful about making assumptions about the lack of awareness on the part of the person with dementia (2007, p227). It is not simply a case of linear progression from awareness to no awareness, but fluid states of moving from one to the other (Phineas, 2002, as cited in Davenhill, 2007, p227). In addition to this, old age is now viewed as just as important a stage in human development as infancy, childhood, adolescence and adulthood, and as worthy of psychoanalytic treatment (Ness, 2008, p382).

Evidence that personality traits of the person with dementia can impact how they cope and adapt to the illness suggests that the person is still present in the disease. Although this particular body of research is more relevant to examining patients with pre-existing personality disorders and neurobiological vulnerabilities which are linked to subsequent development of a neurodegenerative disorder like dementia, it still stands that if this is the case then there is something to appeal to behind the veil (Poletti et al, 2011, 173). If these personality traits are impacting the process, then perhaps Therapy can ease something for the patient with an individualised approach. An example of this is seen in Shatsky's observation that Ann, who was diagnosed with Lewy Body Dementia, never lost her personality and

never became a ghost of her who she used to be (as cited in Gazner, 2013, p57). Ann's dementia forced Shatsky to work outside the psychotherapeutic box; the work sometimes bypassing words altogether. Shatsky placed herself in the transference so Ann could work through feelings of previously experienced feelings of loss previously experienced through and positive identity. Needless to say, this was linked to current identity issues arising from the diagnosis. Shatsky worked outside of the frame so she could reach Ann on a deeper and more effective level (Ganzer, 2013, p-51-60).

In examining the interpersonal approach to Therapy with older people with dementia, Jones observes the journey from the pointless application of standard techniques without considering the individual, to consideration of the person behind the disease, and the effectiveness of a Therapy that considers aspects such as personality, the links this has to infantile experiences, how ways of experiencing the illness are linked to ways of experiencing reality, and ultimately believing in a person's innate tendency towards better functioning. For example, Therapy can assist by providing coping mechanisms and an environment to discharge the inevitable anxiety created by this illness, as well as decrease feelings of isolation and loneliness. The Therapist can help the client to self-reflect by reflecting back to them, helping in this way to maintain some perception of self, loss of which can seem like the ultimate loss (Jones, 1995, pp602-605). From the point of view of examining non-pharmaceutical approaches to treating dementia, Douglas, James & Ballard outline recent research which has shown the usefulness of Therapy in managing the non-cognitive symptoms of dementia such as agitation, aggression, mood disorders, sexual disinhibition, eating problems, and abnormal vocalisations (2004). These are what the International Psychogeriatric Association calls 'behavioural and psychological symptoms of dementia' (BPSD) (Finkel et al, 1996, as cited in Douglas et al, 2004). Evidence that there

can be some form of development in the face of a degenerative disease, and that there is benefit to psychotherapeutic intervention, is, from these examples, clear.

It is important to note however that although these studies have positively impacted this area of investigation, there are studies that negate it, casting doubt over this type of research. For example, a study by Bird, Llewellyn & Korten which examines the effectiveness of a case-specific approach to treating challenging behaviour associated with dementia, acknowledges that non-pharmaceutical and psychosocial approaches to treating behaviour like this is recommended as the first approach, but states that the evidence to support this approach is modest. It refers to these studies as discrete approaches that show promise but lack methodological rigour (2009, p73). This is a common theme through literature arguing against a psychotherapeutic approach to dementia. Another example is seen in a 2008 study which observes that therapeutic failure or poor therapeutic outcome for people with dementia is a direct consequence of non-adherence to correct drug-taking, despite the study's recognition that therapeutic treatment is a dynamic process (Arlt, Lindner, Rösler, & Von Renteln-Kruse). This is of course a pharmaceutical argument against non-pharmaceutical approaches, but the presence of studies like these creates a challenge for research into the therapeutic treatment of dementia. However, with both strengths and weaknesses of this literature in mind, examining the responses that can be generated by dementia provides the opportunity to examine Therapy's place in its treatment.

CHAPTER 4: PSYCHOANALYTIC APPROACHES

“...It was as if mental pathways that had seemed to be totally overgrown...has for a moment cleared or miraculously re-joined” (Waddell, 2007, p200).

Exploring psychoanalytic theory and its use in the therapeutic setting when treating dementia invites consideration into stepping outside the boundaries of language, finding a way to accompany a person through a journey of gradual and all-encompassing loss, and in-so-doing providing an outlet for them to communicate, gain control, and manage their own loss in some way.

Jacques Lacan refuted the idea of a whole self. For him symptoms spoke loud and clear through the life of language. He saw the Therapist less as a fixed point, but as a human being in as much flux as the patient; someone who sits with the patient who is asking, who am I? What should I do? (Ragland-Sullivan, 1987, pp119-125). People who have dementia differ in their cognitive and communicative abilities, at different stages of their own dementia, and in comparison to other patients. Language is of course one of the main barriers. As language begins to deteriorate, this is not the point of giving up but the point where the focus shifts to really seeing and knowing the individual (Maslow, 2013, pp11-12).

In conjunction with descriptions of organic and cognitive deterioration, dementia is described as a break in cohesive awareness, so that the person loses his or her bearings in the world and is invaded by the feelings within (Kitwood, 1990, as cited in Davenhill, 2007, p208). It is an interesting description to think of internal feelings invading us, but it is this idea which further opens up the investigation of the use of psychoanalytic approaches in the treatment of dementia. When the Freudian strong ego is no longer available to the patient, the Therapist

can act as an auxiliary ego, attempting to make sense of and navigate the anxieties and feelings that the patient cannot. This is the replacement of language that Waddell describes (2007, p195). As the mental capillaries dissolve, the ego empties out, weakening the patient's sense of being (Davenhill, 2007, p210). The Therapist can act as a foothold, and provide some sense in a place that seems to be becoming senseless. The anxiety arising from the diagnosis is felt by the threatened ego. The Therapist as container can hold the projections of distress and transform it; to be given back to the patient in neutralized form. Late stage dementia is a return to the earliest ways of relating. At this stage, the ego is in turmoil, breaking down and forcing the patient to split off the bad, and projecting often as a means to expel it. The mind is a persecutory object and there is a return to absolute dependency and uncontainable anxiety (Evans, 2008).

In this way it is not just the continuation of support and human contact which can support a person through these stages of dementia, but the replacement of object constancy. It is the loss of this that the patient with dementia experiences. The goal therefore is to maintain object relatedness for the patient who is experiencing progressive loss of self and others, to enable them to feel secure (LoboPrabhu et al, 2007, pp145-158).

It is not just the loss of external awareness that creates anxiety, but the breakdown of connection to internalised objects (Davenhill, 2007, p209), in other words an undoing of the development which has created a sense of self. Waddell likens this to a second childishness, and a return to complete dependency. With that arises an unresolved psychic response. Infantile anxieties rise up and infantile defences are reignited to meet those anxieties, as coping deteriorates. Growing research is supporting the theory that it is not just the cognitive deterioration of dementia that causes these anxieties but the intricate link between the

functioning of the brain and the mind (Waddell, 2007, pp188-189). To draw on Kalinin theory (Stevens, 2013, p50), Waddell describes the case of Mrs Brown. As she drifts deeper into Alzheimer's, she develops a terrible jealousy toward her husband. She feels persecuted and abandoned. She is losing the internalised model that can recognise that the other, in infancy the mother and in adulthood the husband, can have interactions with other people and still love her. She experiences instead a polarised and persecuting version of her husband, and takes up a paranoid-schizoid position. In this infantile position she cannot tolerate loss, or lack of control, and splits everything into bad and good. These tasks of early childhood become the tasks of dementia sufferers. It is the task of the Therapist to contain these anxieties, so they can then be internalised differently by the patient. The Therapist can make sense of this raw data that is being presented (Waddell, 2007, pp190-193).

As lifelong defences break down like this and anxiety begins to take hold, patients require more than they can get, and in fact than is often available, in larger care settings. Primitive processes of projection and projective identification can take place, for example, in a care setting where a patient is competing with many others for care. This cannot be managed as it could be in a therapeutic setting. Projection occurs when unwanted feelings are externalised, because they are too much to manage. Carers who are not receiving support themselves can become unconsciously involved in a projective identification exchange, where these unwanted feelings of anxiety and aggression from patients become their feelings too, and can be given back to the patient in unhealthy ways. This primitive means of communication can be a valuable avenue into helping the patient, but needs a receptive container to take it in (Ravenhall, 2007, pp216-217). The therapeutic setting in this way is more able and supported.

Eleanor was diagnosed with dementia at age eighty-three. Nussbaum observes that to be Eleanor's doctor was to be a witness to her decline but also to the changing affect Therapy can have on the individual. She retreated from Therapy numerous times before committing to it, finding that she could not even say the word dementia when first diagnosed. She was angry. Through the process of Therapy, Eleanor saw that the rejection of the word was linked to feelings of shame. These feelings could be connected to the diagnosis by sharing with her Therapist her experience of being speechless when she learned of her husband's infidelity, and the wordless shame she felt after experiencing sexual abuse as a child. These experiences impacted her ability to cope with her diagnosis. She connected these experiences with dementia and the process of losing her words. Through working with the transference, Eleanor was able to resolve feelings connected to past relationships. This process was not in parallel to her illness but part of the working through of it. Although losing her words, she was creating associations and healing parts of herself (Nussbaum, 2011, pp255-260). With Winnicott's work on the good enough mother in mind (Rodman, 2003, p50), Eleanor said towards the end of her life, "I just want to be suckled down to the grave." (Nussbaum, 2011, p260). The Therapist essentially does this for her until her passing.

Akin to Winnicott's work on the transitional object (Rodman, 2003, p50), the Therapist can act as a transitional object, supporting and containing the transition from independent to dependent. It is the good enough model of care during the transition from self to loss of self (LoboPrabhu et al, 2007, pp145-148), and it is linked to ideas about early development and Winnicott's 'good enough' mothering (Rodman, 2003, pp63, 119, 137). The transitional object serves to bridge the gap between pure subjectivity and shared objective reality and in this way is symbolic (LoboPrabhu et al, 2007, pp146). If it was used, for example in the case

of Mrs Brown (Waddell, 2007, pp190-191), it might have been able to create a new reality that was not so persecutory.

The question of development versus degeneration is unavoidably embedded in discussion about dementia. As Lobo observes, it is a degenerative disease with gradual loss of self, object relatedness, memory and physical functions which naturally casts doubt on the effectiveness of Therapy. However, the crux of the argument lies in the evidence that patients can be met on a psychoanalytic level to help them to better manage at all stages of dementia. In the early stage of the diagnosis, for example, the Therapist can give the patient support as the information is digested and all manner of emotions accompany it (LoboPrabhu et al, 2007, p152). As the disease progresses, the treatment can provide the patient with a new stability, and creation of a new sense of self (LoboPrabhu et al, 2007, p15). In the late stages, psychoanalytically informed thinking can create an appropriate and supportive environment. Aids like photographs and other psychical stimulants will also support the individual (Evans, 2008). The frightening aloneness and disintegration can be met by the constant presence of the Therapist or simply used to sooth the patient (LoboPrabhu et al, 2007, pp158, 167), which in light of the terrible journey the patient is on, is not simple but extraordinary.

The Creative Therapies seem to be psychoanalytically-informed treatments that have containing and transforming abilities (Evans 2008). William Utermohlen's experience of Alzheimer's conveyed through art is a powerful example of why they are this way informed. His paintings were a means to convey his subjective experience, showing the radical, gradual change in his perspective and how he related to both the external and internal world. One of the most powerful results of his communication through art is that there is evidence of an

awareness of his illness long after there should have been, by neurological standards. It also assisted him to maintain his existential bearings and sense of identity. His paintings from his early stage of Alzheimer's allowed him to categorise the things and people around him reflecting something of the desperation to remember; to beat the impending cognitive deterioration. He began to paint himself out of his paintings as time went on reflecting his disappearance into dementia. The psychoanalytic processes of object relating and projection are clear, seen particularly in his own image projected in the mirror – as he detaches from his body it is his last effort to preserve his image and sense of self. The fragmented self-image in his later paintings represents his fragmented ego and broken identity. The paintings act as a transitional object, from being to not being, accompanying him along the journey and facilitating communication when language is lost (Polini, 2007, pp299-318).

Further Challenges

Dementia is the reversal of a developmental process. That is the ultimate challenge when treating dementia psychotherapeutically. It can seem hopeless and pointless and it is difficult to apply these concepts directly. The central premise is that the patient's task is to cope successfully with the loss of self and object relationships, by using the treatment relationship as a transitional phenomenon in the provision of, if nothing else, comfort. This ultimately helps the patient to retain a sense of relatedness even in the presence of forgetting and deterioration of relationships. It is ultimately adversarial (LoboPrabhu et al, 2007, p150).

In studies such as Linden's which examine the side effects of Therapy, illness by deterioration is not counted as observable (2013, p287). This is an example of the dangers of side-lining a patient with a deteriorating cognition. Despite the relevance of this area and the

evidence that psychotherapeutic techniques can work, the number of high quality studies into it are small (Douglas et al, 2004, p177). Even with work such as Davenhill has produced (2007), the number of clinical studies and examples in this work is small compared to other studies (Hess, 2008, p282).

Jones asks the important question when investigating the treatment of dementia - what constitutes benefit and is limiting anxiety and enhancing the quality of life somehow enough? Examining the effects of areas like patient fit environments could address this question (1995, p606). Studies like those conducted by Apóstolo, Cardoso, Rosa & Paúl into the benefits of cognitive stimulation on the elderly in nursing homes (2014) support the argument about the importance of individualised treatment in later life and may serve to stimulate the examination into the treatment of dementia. Shatsky's study highlights the importance of thinking outside the therapeutic frame rather than abandoning attempts if the case is outside the usual frame (2013). However, Jones's presentation of this question of what constitutes benefit as one still unanswered is evidence of the fact that the biggest challenge is still the lack of evidence and exploration into this area of research.

Embarking on a psychoanalytically informed dementia service could have many educational and resource implications, in particular for health and social services. If in the services that treat dementia the language of a psychoanalytically-informed practice can become a common or at least a more accessible language, it stands a chance of filtering through all layers of service, encouraging a more thoughtful and compassionate practice (Evans, 2008).

CHAPTER 5: CONCLUSION

Therapy is understood to be a forward moving process, involving a patient with the cognitive and emotional ability to change, improve, interject and develop (Rogers, 1951/2003, pp132-133). The very fact that dementia is a disease which is degenerative, encompassing gradual loss of cognitive and communicative abilities, and the ability to relate in a continuous way might seem cause to disregard the treatment of the person with dementia psychotherapeutically. The growing body of research into this area however demonstrates that it is an illness that can be treated therapeutically (Cheston, 1998, Husband, 2000, Davenhill, 2007, Ganzer, 2013, Jones, 1995, Evans, 2008, Maslow, 2013, LoboPrabhu et al, 2007, Waddell, 2007, Nussbaum, 2011, Douglas, 2004, Polini, 2007). This research is uncovering the layers within dementia which can be appealed to using psychoanalytic techniques and the benefits to those who receive it. Further to this it demonstrates that this treatment can be effective at all stages of dementia and not just at the early diagnosis stage where the patient has not yet lost communicative ability and memory (LoboPrabhu et al, 2007). Old age is gaining acknowledgment as a stage of the developmental life-cycle as important as infancy, and perhaps more importantly, as responsive to psychoanalytic treatment as any other stage of life (Hess, 2008, p380). That being said, although the body of research is growing it is still small and there are still studies which will discount deteriorative diseases like dementia (Linden, 2013, p287). There is enough evidence to suggest that this is a vital body of work which needs to be continued but there is a requirement for more research studies to be conducted, to challenge the current issue that although there is some evidence in favour of treating dementia therapeutically, there is not enough. This need is even more critical now that the later life cycle is being considered as important an area of research as

any other, given that dementia is a disease which mainly affects the elderly (Siampani, 2013, p36).

Siampani, in her study on dementia, observes that often right before the end of life, people, perhaps intuitively, begin to live (2013, p56). Perhaps this is reason alone to consider the therapeutic treatment of those with dementia.

“It’s a death in slow motion; a race I can’t win. But I refuse to stop running. Because I don’t know what else to do” (Greg O’Brien, *The Mind Shaft - Strangers*, 2015).

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APPENDIX

DSM-IV: DEMENTIA

“The disorders in the “Dementia” section are characterised by the development of multiple cognitive deficits (including memory impairment) that are due to the direct psychological effects of a general medical condition , to the persisting effects of a substance, or to multiple etiologies (eg the combined effects of cerebrovascular disease or Alzheimer’s disease). The disorders listed in this section share a common symptom presentation but are differentiated based on etiology. The diagnostic features listed in this section pertain to Dementia of the Alzheimer’s Type, Vascular Dementia, Dementia due to HIV Disease, Dementia due to head trauma, Dementia due to Parkinson’s Disease, Dementia due to Huntington’s Disease, Dementia due to Pick’s Disease, Dementia due to Creutzfeldt-Jakob Disease, Dementia due to Other General Medical Conditions, Substance-Induced Persisting Dementia and Dementia Due to Multiple Etiologies. In addition, Dementia Not Otherwise Specified is included in the section” (American Psychiatric Association, 2000/2008, pp147-148).