"Who am I" Using Fairbairn's object relational theory to reconceptualise experiences of dementia.

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Prefatory Note

The candidate for this PhD, Mike Larkins, died suddenly before having fully completed his work on the thesis. Mike was studying part-time while working as a nurse on a dementia ward. He had taken time out from his studies during the Covid pandemic to support the NHS and was due to return to enter a period of Completion in October 2021. Sadly he suffered a stroke and died in September 2021.

As the majority of his thesis had been completed, it was felt that it would be possible for the thesis to be submitted for examination for a PhD. During this process, both the external and internal examiner made it clear that they felt that not only did the thesis meet the required standard but that its findings are important and should be made available to a wider audience. As a result, it had been decided to upload this thesis even though it has not been fully revised and copy-edited.

ABSTRACT

The purpose of my PhD is to try to answer the question, 'Who am I?' from the perspective of those with a dementing illness, using Fairbairn's endopsychic model of the self.

Dementia is often described as an illness causing progressive loss of self. It is this loss of self and its consequences that will be the focus of my study. I have chosen a psychoanalytic model, called Fairbairn's endopsychic model of self, because it is supported by a lot of recent research outside of psychoanalysis, such as attachment theory, developmental psychology and neuroscience, as well as reflecting current trends within psychoanalysis which focus on the regulation of affect within relationships. As well as finding support both inside and outside the discipline of psychoanalysis, it is also congruent with the interpersonal view of self, which is widely used in the person-centred literature and is used to define best practice in dementia care. However, there are differences, because these non-psychoanalytic theories do not have a concept of the unconscious within which to understand relationships, nor do they have a developmental view of self. This limits their understanding of people's experience of dementia, because their view of the self is a simple unitary one, meaning they are unable to consider unconscious motivations for people's behaviour.

I work on a ward for male patients with dementia and to investigate the meaning of the question "Who am I?" from the perspective of this cohort of patients, I kept a reflective diary of my experiences on the ward. Using these diaries, I hoped to better understand the experiences of patients, as inferred from their behaviour.

I started my data analysis by grouping together behaviours that were similar, and then I reduced and organised all these behaviours into six categories, some of which were then divided into subcategories, if there were significant differences in the way a particular behaviour manifested itself. I then arranged these six categories hierarchically. Thus, category one, for instance, represented the behaviours of people with no discernible cognitive impairment (although two people did become confused during the study), while category six represented the behaviour of those with the severest cognitive impairment. I believe that it is important to see how the behaviour of people changed, relative to the severity of their illness. The next stage was to apply Fairbairn's theory to the different behaviours within each category, to try and understand these in terms of a person's sense of self, as defined by Fairbairn. This allowed me to infer from people's behaviour, how the illness has affected their sense of self.

It is also important to locate my findings relative to the work of other researchers, to see if I could find any support for my findings. I did this by carrying out a mini literature review for each of my six categories, to see if others had found similar results, and, just as importantly,

how they had understood their results. This allowed me to compare my understanding of my findings using Fairbairn, with the work of other researchers, to see where there was support for or differences between our results, which I then tried to understand.

In the conclusion, I summarised my findings and how I understood these using Fairbairn's model of the self, which enabled me to answer my research question. I then compared the answer to alternative perspectives on how dementia affects a person's sense of self and the possible consequences for nursing treatment and the ward routine. From this comparison, I developed further ideas on how to use Fairbairn's theory to enhance our understanding of the experiences of those with dementia and find improved ways of treating these patients.

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INTRODUCTION

My research question is:

> Who am I? From the perspective of those with a dementing illness, using Fairbairn's endopsychic model of the self as my conceptual framework.

This research is important, because dementia is often viewed as a disease causing a progressive loss of self in a person (Cohen and Eisdorfer, 2001), which according to The Royal College of Psychiatrists definition of dementia (1986, p. 139) is due to the impairment of higher cortical functions. It is this loss of self, framed as "Who am I?" in my research question that I explore in my PhD. This research is original, because I use a psychoanalytic model - Fairbairn's endopsychic model of the self (1952) - to explore people's experiences of living with dementia, which has not been attempted before.

In order to explore the effects of dementia upon a person's sense of self, as described by Fairbairn, I took a qualitative approach to data collection, to understand people's experiences, and how this changes as the illness progresses. I took a longitudinal approach to data collection, based upon my experiences of working on a male dementia ward. These experiences were recorded in a series of reflective diaries. The data was then analysed using Fairbairn's model of the self, to see if people's sense of self changes as the illness progresses, and what this means in terms of my research question.

To develop these ideas, I have divided my thesis into the following chapters.

Chapter one is my literature review, where I describe and critically assess some of the recent theory and practice concerning the problem of self and dementia. I focus on the following six areas: Medicine, nursing, attachment theory, psychoanalytic theory, theoretical perspectives on self (in dementia), and qualitative research into people's experiences of living with dementia. This gives a comprehensive overview of how dementia is seen to affect the sense of self from a variety of different perspectives. For instance, medicine tends to take an objectivist and materialist perspective on dementia, focussing on the brain for its causes and treatment. Sense of self is usually only introduced indirectly to account for the secondary effects of the illness, such as anxiety, depression and anger, which it views as a person's response to the effects of memory loss (attributed to the brain). However, within nursing, research into dementia care, emphasises the importance of adopting a person-centred framework, to give good quality care

to those with dementia (Dewing, 2008; McCormack, 2004). The focus is on the interpersonal nature of the person affected, and the importance of relationships in promoting their well-being and quality of life (Kitwood, 1993; 1997b). However, this approach has also been criticised within the person-centred literature (Adams, 1996; Kontos, 2005), because of its focus upon the social-psychological aspects of a person, neglecting their embodiment. This lack of consensus, regarding a definition of dementia, also appears later in the chapter, where different theoretical understandings of self are introduced to see how dementia will affect them.

There is a social constructivist view of self (Sabat and Harre, 1992), an interpersonal view of self (Kitwood, 1993; 1997a), the self as embodied (Kontos, 2005; 2007; 2011), a narrative view of self (Mills, 1998), and a quantitative view of self, based upon a person's autobiographical memory (Caddell and Clare, 2010). Despite their differences, what all these views have in common is a relational and unitary understanding of self. This unitary view of self, however, has been criticised in the psychoanalytic literature, because it lacks an unconscious dimension to understanding the human self (Balfour, 2006). Nevertheless, within psychoanalysis, the object relational school does support the fundamental importance that the above theories give to relationships, for healthy development.

However, attachment theory is different to all the above theories, because it does not make use of a concept of self. Instead, it uses the concept of internal working models (which are based upon early experiences of attachment), to understand how people relate to one another (Browne and Shlosberg, 2006). These models are believed to continue even in quite advanced stages of the illness so that people who had been "securely attached" for most of their lives, are far less likely to develop psychiatric symptoms, than those who have experienced insecure attachments during their life.

Also, as reflected in the medical, and attachment theory literature, most of the qualitative research into people's experiences of living with dementia, tend not to use a pre-defined concept of self. Instead, they are more concerned with giving first person accounts of living with the illness, often in the early stages when people can still verbalise their experiences.

In *Chapter two*, I introduce Fairbairn's model of the self, as a unique conceptual framework, that can consider a lot of the above perspectives, as well as introducing some new ideas to deepen our understanding of people's experiences of dementia.

I chose Fairbairn, because his is a psychoanalytic model, and psychoanalysis has been studying the nature of self and subjectivity for over a hundred years now (Elliot, 2003). His theories are also not contradicted by findings from other disciplines, especially those grounded in empirical research, such as attachment theory (Fonagy, 2001; Holmes, 2002), neuroscience (Solms and Salvig, 1986; Pugh, 2001; Mancia, 2004; Solms and Turnbull, 2011) and developmental psychology (Stern, 1985).

Within psychoanalysis, his model is seen as purely object relational (Williams, p. 2011), and is based on the person's need for relationship. He views the unconscious as being constituted by internalised "bad" object relations. This view of self as purely relational, fits most easily with the social constructionist and interpersonal views of self that are widespread in all the person-centred literature. His view that self is originally unitary (1994), but then splits because of frustrating object relations is like the perspective advocated by person centred theorists. They too have a concept of self that is unitary, and which gradually fragments, initially, because of dementia. This is then made worse by poor relationships with carers that further diminish their already fragile sense of self. However, because they view the unitary self in interpersonal terms only, they have no concept of an unconscious, so their ability to understand the full range of people's experiences with dementia is limited. Fairbairn offers a much deeper understanding of sense of self than is used in contemporary dementia care research, as well as giving a unique understanding of the dementia process from a purely psychoanalytic, object relational perspective.

I then give a very detailed exposition of Fairbairn's structural model of the self (1952), showing how it develops from the initial stage of infantile dependency, through to the transitional stage which "… is concerned with the abandonment of infantile dependence …" (1941, p. 35) and then to the stage of mature dependence where the defences of the transitional stage are given up, and one can relate to others realistically. I show how Fairbairn's developmental theory can be used to understand the process of dementia in two stages. First, because Fairbairn's model of the self is a structural one, it should be possible to understand the effects of dementia in a systematic way. Starting with the Royal College of Psychiatrists definition of dementia (1982), I give a detailed description of how Fairbairn's model can be used to understand the symptoms of dementia as described by other researchers. This will show how Fairbairn's theory can be related to the experience of those with dementia. Then I show how this understanding can be applied to the data I collected on a ward for gentlemen with dementia.

Chapter three is my methodology chapter where I argue that Fairbairn's object relational theory should be viewed as a psychosocial theory, and therefore be included within its framework. I start by introducing the field of psychosocial studies, and how psychoanalysis has been taken up by some researchers to understand the affective component in their data production, which they believe discursive theory is unable to do. However, critics of including psychoanalysis within psychosocial research, state they are aware that people can suffer with emotional conflicts, for instance, but these can be understood as people taking up contradictory discourses to understand their experiences.

I then introduce Fairbairn's object relational theory as a new approach that can meet these criticisms and discuss how I collected my data using reflective diaries, and how these will be analysed using Fairbairn's model of the self.

Chapter four is my data analysis chapter where I analyse the results of my data collection from Fairbairn's perspective. My data has been arranged into categories according to people's behaviour and then hierarchically ordered according to their level of confusion, I hope to give an account of people's experience of dementia - as inferred from their behaviour and using Fairbairn as my conceptual framework - from the very early stages of the illness to the last stages. This gives an overview of how people's behaviour changes as their illness progresses within the specific psychosocial environment of a hospital ward, and what these changes mean, in terms of their sense of self, as understood by Fairbairn.

Chapter five takes my findings from each category developed in chapter four, and then does a mini literature review to see if other researchers in the field of dementia care have found similar types of behaviour, and if so, at what stage of the illness these are observed. This is important for two reasons. First, by focussing on patient behaviour, I hope to keep the contextualisation of my findings as close to the patient's experience as possible, thereby avoiding making comparisons too theoretical, as when theories are compared but without the findings they are based upon. Second, because the categories are arranged in terms of increasing confusion, which I have assumed is a sign of increasing dementia, as it is important to know when comparing findings that these relate to similar stages of the illness. If I find

support for my findings in other researcher's work, this adds validity to my data, but if I cannot find support in other's work, then I would try and understand why this is so.

It is also important to explore how other researchers understand their findings, because I can then compare their understanding with my own, based in Fairbairn's theory. This type of comparison will indicate where Fairbairn's theory is able to add something significant and unique to our understanding of dementia, particularly when it is understood in terms of a person's sense of self.

Chapter six is my conclusion, where I summarise all the findings from my data analysis in chapter four, and how these have been understood using Fairbairn's model of the self.
This is then compared with the work of others, who are also studying the effects of dementia upon people. This includes work done by researchers described in chapter five, and ideas and theories from my literature review in chapter one, particularly those of the person-centred approach to dementia care, but also psychoanalytic theory too, as it has been applied to understanding dementia.

This is important, because as well as being a psychoanalytic model, Fairbairn's focus is always upon the nature of relationships, and how these affect people's experience of themselves. It is therefore supportive of the principles of person-centred care, but also critiques them with a concept of the unconscious formed from unsatisfying relational experiences. It is this more psychoanalytic view of relationships, and sense of self based in Fairbairn, that I believe, gives greater understanding of the dementing process.

My understanding of my data in chapter four from Fairbairn's perspective, also allows me to critique other psychoanalytic understandings of dementia. This will show where Fairbairn's theory offers a unique, and radical understanding of dementia, which allows for different practices of care, that might be more effective than the present regime of care.

Because I have been fortunate in my research to participate in the care of people at the very earliest stages of the illness to the very last stages, I have been able to infer from these experiences how people's sense of self changes over the course of dementia, within the specific psychosocial environment of a hospital ward and to formulate recommendations for changes to the regime of care to ameliorate dementia.

These changes in the sense of self are what gives the answer to my research question, “Who am I?” from the perspective of those with dementia and opens the possibility of alleviating the worst aspects of the illness by changing the ward environment.

CHAPTER ONE

LITERATURE REVIEW

My literature review consists of six parts, each part looking at "sense of self, and dementia" from a particular perspective.

1) Medical perspective

I will start by looking at the scientific, medical view of dementia, beginning with the Royal College of Physicians 1982 definition:

Dementia is the acquired, global impairment of higher cortical functions, including memory, the capacity to solve the problems of day to day living, the performance of learned, perceptico-motor skills, the correct use of social skills, all aspects of language and communication, and the control of emotional reactions, in the absence of gross clouding of consciousness. (Royal College of Physicians, 1982)

Dementia is therefore described as a syndrome that could be "caused" by several different diseases, (Mace, Rubins, Castleton, McEwan, and Meredith, 1985). Medically it then becomes important to determine which underlying disease is causing the dementia syndrome.

A neuropsychological assessment is able to test for most of the areas involved in cognitive function, (Rosser, 1987), and if there is evidence of cognitive impairment, then further investigations are requested, such as blood tests, x-rays, electrocardiogram (E.C.G.) and electroencephalogram (E.E.G). These primary investigations are done to rule out treatable causes of memory loss and confusion, such as infections, anaemia, dehydration and metabolic-imbalances, for instance, thyroid, kidney, or liver disorders, (Rosser, 1987). If the results of all of the above tests are normal, and dementia is therefore suspected, then scans such as Computerized Axial Tomography (Burns, Howard, and Pettit, 1995), or more recently Magnetic Resonance Imaging scans can be used to confirm a diagnosis of dementia, and sometimes what kind of dementia a person is suffering from. Treatment can then be initiated.

Anticholinesterase inhibitors such as donepezil hydrochloride, (Aricept) have been licensed for the treatment of Alzheimer`s Disease in this Country and is usually prescribed for people with mild to moderately severe Alzheimer`s Disease (Jones, 1997). But for other forms of dementia, there is no specific treatment:

As the illness progresses (of whatever kind), behavioural disturbances such as agitation, aggression, wandering, inappropriate sexual activity may manifest themselves. Initially it may be possible to "manage" these behaviours using non pharmacologic approach, such as attempting to alter the physical and social environment of the person with dementia, but if these

fail to ameliorate any of the above behaviours, then medication is often attempted, for instance, neuroleptic and non-neuroleptic medication (Yeager, Farrett and Ruzicka, 1995).

Thus, a person with dementia becomes someone to be managed, often in an institutional setting as the above behavioural disorders make it very difficult to live at home any longer.
This is a scientific and medical account of the disease as it affects a person's brain. Treatment is usually via medications, which are given to limit the effects of the disease, and to manage challenging behaviour, such as aggression, which are understood as secondary to the actual illness. It is therefore a third person, objectivist perspective on dementia, yet it's definition also includes value judgements such as the ability to cope with day to day living, correct use of social skills, and control of emotions, none of which may be causally related to dementia. Therefore, a scientific definition of dementia also includes variables that may have nothing to do with the illness. However, there are also other definitions of dementia such as "loss of self" (Cohen and Eisdorfer, 2001), which the medical perspective takes no account of in its discourse. Instead, brain and dementia are only understood in terms of physical, organic entities described within a positivistic, scientific-materialistic framework.
But self is a humanistic term. It is not an empirical term that defines empirical entities like brain and dementia. It therefore becomes problematic to define dementia as loss of self, when dementia is a scientific term imbued with the assumptions of positivism, and self is a humanistic term (i.e. one is a third person perspective, and the other first person, which are different). Although medicine appears to give a third person, scientific account of dementia, in its treatment of the diseases secondary effects such as anxiety, depression, and aggression, it actually approaches the perspective of the person, (i.e. as memory loss is accounted for by pathological changes in the brain). Medicine therefore recognizes that loss of memory affects the whole person, and does not presume that feelings such as anger, depression and anxiety are directly attributable to changes in the brain but are rather a consequence of the experience of memory loss. Thus, medicine does take a third, and a first-person perspective on dementia but may lack an adequate conceptual framework to understand how the experience of memory loss, may lead to feelings of anxiety, anger, and depression Therefore although medicine defines dementia in positivistic terms, it needs the humanistic concept of self, as an entity that has experiences, to account for all its findings.
A medical view of dementia than presupposes a sense of self, whilst at the same time, "reducing" this sense of self to one`s brain (i.e., it looks for causes and symptoms of dementia in one`s brain, then focuses on treating this brain, via drug therapies).

2) Nursing perspective, including the person-centred framework.

I would now like to move onto the nursing part of my literature review, including the frameworks of person-centred care, as they feature so much in the nursing literature on dementia. Indeed, from my review, it seems as though nursing almost automatically uses Dr Kitwood's, person-centred dementia care framework (Kitwood,1989,1993,1997a,1997b), when attempting to understand the experiences of those with dementia (Adams,1996,1998; Dewing, 2008; Downs et al,2008; Jenkins et al,1996; Kaufmann et al,2014; McCormack 2014; Penrod et al,2007; Stokes,2000).

However, nursing has developed its own generic theories of caring, (Appleton, 1996; Dunlop, 1986; Leininger, 1984, 1988, 1991; Mayeroff, 1971; Swanson, 1991; Wadensten, 2005; Watson, 1985, 1988), yet seems to have neglected these, for the sake of embracing the person-centred paradigm of care. In my review, I found only two article`s that applied nursing theory directly to people with dementia (Jonas-Simpson,2001; Touhy,2004). It is as if dementia did not exist theoretically for nursing, until Kitwood's work came along, then nursing had to catch up with these new ideas.

As previously mentioned nursing understands itself as a caring profession. There are many definitions of caring, but all tend to agree it is about understanding the "lived experience" of the patient, (Paterson and Zderard, 1976). This focus on experience, suggests one is caring about the patient`s self, i.e., as that which has experiences, although self is never defined explicitly in any of these papers. What is used however, is Kitwood's concept of personhood, which he defines "….as a standing or status bestowed upon one by others- it is a social standing, independent of any qualities, like skills and abilities" (Kitwood, 1997b, p.8). Within all the nursing literature I have reviewed, personhood is conceptualized as being constituted via its relations with others (Adams,2008; Dewing,2008;McCormack,2004; McGregor et al,1993; Naue et al,2008; Penrod et al,2007; Touhy,2004). They all emphasize how important it is for staff to maintain positive relationships with people with dementia, as it is suggested these types of relationships help to maintain their personhood, particularly against the effects of dementia, defined as loss of self or personhood (Cohen et al, 2001; Davidson et al, 1998; McGregor et al, 1993).

Nursing therefore becomes a moral/ethical activity to do with maintaining positive relations with people who suffer with this illness (Daly et al, 2014, Laakkonen et al, 2009).

In all the articles reviewed regarding nursing and dementia, they all suggest it is the patient`s personhood that is most under threat from this illness (Adams,1996;Dewing,2008; Jonas-Smith,2001;Kaufmann and Engel,2014; McGregor and Bell,1993;Penrod et al, 2007).If

nursing`s identity is defined in terms of caring, and dementia is defined as " loss of self", or " personhood", then it follows nursing should be concerned with caring for the patients self or personhood. Since self/personhood is defined relationally, then caring is about providing and supporting positive relations with the sufferer. This is the image and vision of dementia care nursing that the above authors seem to promote.

However, the concept of person-centred dementia care is not without its critics and a lot of work has been done recently critiquing it`s view of personhood or self (Adams, 1998, 2008; Dewing, 2008; Greenwood, 1998; Kaufmann and Engel, 2014; Harding and Palfrey, 1997; Hughes and Beatty, 2013; Jenkins and Price, 1996; Kontos, 2005, 2007, 2011; McCormack, 2004). These authors suggest because the person-centred view of self tends to focus only on its social psychological construction then any deterioration in self is inadvertently seen as due to the carers not providing sufficient positive, relational experiences. This then causes carers to feel guilt for a process that in fact they may have little control over.

More recent work, however, has begun to focus on the self`s embodiment and less on its social psychological aspects. Kontos's work is prominent here. She sees mind and body as complimentary aspects of self or personhood, therefore attending to the body, is also attending to the self. According to Kontos (2005, 2007, 2011), by focussing on the social-psychological aspects of personhood, the person-centred paradigm has neglected a person`s embodiment. This has had the unintended consequence of nursing, also "forgetting" about a person`s embodiment, at least theoretically, as in practice, nursing is all about caring for the patient`s body.

However, this is not just the result of nursing`s uncritical uptake of person-centred theories. It is also because nursing`s identity is founded on caring and defines this as caring for the lived experience of the person, in health, illness and disease (Benner and Wrubel, 1989). It therefore emphasizes experience and locates this in a concept of the self-defined in social psychological terms. However, because experience is always embodied, nursing theories must always consider the physical aspects of experience when caring for another. This puts limits than, on the person-centred paradigm, as an adequate conceptualization of the other`s experience.

Although there have been some changes to Kitwood's, person-centred model of dementia care, such as Adam`s (2008) "whole systems approach", Brooker's (2006) "VIPS framework", and Nolan`s (Nolan et al, 2004) " Senses framework ", these represent only slight modifications, and the basic framework of Kitwood's model remains mostly unchallenged. But nursing could develop its own theory of dementia care, using its own concepts, which could move nursing beyond the person-centred paradigm. For instance, certain constructs of caring (Greenwood et

al, 2001; Jenkins and Price, 1996; Jonas-Simpson, 2001; Touchy,2004; Wadensten, 2005; Whall,1990), Spirituality (Bogusalowski, 1979; Burnard, 1990; Carson, 1989; Cassel, 1982; Collition, 1981; Cook, 1980; Kriedler, 1984; Labun, 1988,O`Brien, 1982; Taylor and Fertzt, 1990), and the nursing models of the so called Simultaneity paradigm (Newman,1986; Parse,1991; Rogers,1990; Watson,1985), as well as nursing`s use of ideas from modern philosophy, (Cody,1995; Doering, 1992; Heidegger, 1962), and science, (Coppa, 1993; Owen, 1993), have the potential to take the theory of dementia care, far beyond the person-centred model, which has been criticized as a very naturalized, rational approach to care, with tendencies towards objectification, (Greenwood et al, 2001).

3) Attachment theory perspective.

Over the last twenty-five years, a lot of work has been done in attachment theory and dementia, and it is important to include this in the review.

According to Miesen, (1996, p.38), as dementia progresses, attachments to the external world become weakened, due to the worsening effects of memory loss. This may eventually result in the sufferer seeking comfort from their "deceased parents ", a form of behaviour Miesen calls " parent fixation ". This involves a person looking for one or both of their parents, whom they have forgotten died a long time ago. This is quite common in advanced stages of dementia and seems to occur when the person is no longer able to form any more meaningful attachments to the external world, (Miesen, B. 1996, p.44-45). And in his research of 1993, when Miesen studied the relations between cognitive function, parent fixation, and attachment behaviour, he found that people with higher cognitive function (who were therefore less demented), had higher overt attachment behaviour, and did not become fixated on their parents, compared to those with lower cognitive function (and were therefore more demented),who did become much more fixated on their deceased parents, and did not show very much overt, attachment behaviour. This indicates that at more advanced stages of the illness, people rely much more on early memories of their parents, to provide feelings of safety and security. Miesen (1996, p. 53) says parents symbolize the "…archetypal attachment of man."

Studies by (Nelis et al, 2014), suggest that Parent Fixation can also be observed when people`s attachment needs are not being met. Therefore, in hospitals, nursing homes, and society in general, if people are too busy to be available as attachment figures, then parent fixation is more likely to occur. It could therefore be indicative of a poor care environment.

Attachment theorists believe our internal world is determined by our attachment relationships early on in life, giving rise to what they call internal working models, which become our foundations for understanding experiences throughout life (Browne and Shlosberg,2006;

Evans, 2004). According to (Nelis et al, 2014) these persist even into late stages of the illness and determine how people with dementia seek safety and security.

Thus, people who had avoidant styles of attachment pre-morbidly were more likely to develop symptoms such as paranoia in dementia, and people who previously had anxious, avoidant styles of relating, were more likely to develop anxiety and depression (Browne and Shlosberg, 2006). However, people who had been securely attached throughout their lives, and are believed to therefore regulate their emotions better, are less likely to develop psychiatric symptoms in dementia. They are also more likely to seek support from others. (Nelis et al, 2014). But adults with a history of insecure attachments are less likely to seek comfort from others, so their negative feelings stay with them longer, leading in some cases to the symptoms mentioned above (Browne and Shlosberg, 2006).

Attachment theory has also been applied to the carers of those with dementia, and has found that carers categorized as insecurely attached, experienced more burden in their care-giving role, which was associated with poorer patient outcome, such as placement in a care home (Nelis et al, 2014) Securely attached carers however, experienced less distress in their care-giving role, and this was associated with much better outcomes for their cared for.

This shows how important attachment theory is for understanding the effects of dementia, not only on the person afflicted, but their carer too, and how important secure attachments are throughout life for well-being.

4) A psychoanalytic perspective

In this part of the review, I would like to consider how psychoanalysis has been applied to people with dementia, and their carer`s.

According to Hess (2004), neither Freud nor Klein, had applied their psychoanalytic theories to older people, although Klein did use some of her concepts when investigating loneliness, (but not specifically in the elderly).

However, Jung, did investigate the second half of life, via his concept of individuation (Hart, 1977), which is viewed as a person`s search for wholeness and wisdom, (as exemplified, in Jung`s concepts of the “Wise Old Man “, and “Wise Old Woman” archetypes). However, this process of individuation can be disrupted by dementia, leading as we saw in our review of the literature on attachment theory, to people searching for their deceased parents (from their personal unconscious), or symbolic parents (i.e., the archetypes of Mother and Father, from the collective unconscious), suggestive of Humanity`s universal need for attachment/relationship (Bacelle, 2004).

According to Hagberg (1997), at the beginning of dementia, when the ego is relatively intact, helping a person talk over their life, in a Life Review, is important, as it helps them feel valued by maintaining continuity with their past. And as in attachment theory, the ability to narrate one`s life coherently, without too many gaps, is suggestive of a healthy ego, that can contain, and integrate one`s life experiences, (Garner, 2004). And it is at this early stage of the illness that object-relational psychoanalysis, and our previous discussion of person-centred therapies share a lot of similarities, because they both see sense of self in relational terms (Garner, 2004), and believe that it is through a positive, supportive environment that sense of self can be maintained. Kapur and Pearce (1987) suggests therefore group work is useful, as participants can use "positive mirroring" and empathy to strengthen each other`s sense of self (via what Kohut would call an increase in their positive narcissism). However, as the illness progresses, and cognitive function worsens, these person-centred approaches that rely on a conscious level of self- understanding, may become less useful in helping the other.

According to Hausman (1996), early experiences are pre-symbolic, and are stored in the limbic system of the brain. These are called procedural/implicit memories, and often determine how we relate to others for the rest of our lives. Hausman (1996) suggests this is one of the last systems to be affected by the dementing process, and as Garner (2004) says, this could mean our emotional responses to situations remain intact, even as our cognition deteriorates. And this is where psychoanalytic ideas can really help in understanding the experiences of people with dementia.

As memory and speech continue to deteriorate, a person can still function realistically in the world, by making lists of things to do for instance, to take account of lapses in their memory. From a Kleinian perspective, one can say that despite their illness, the person is still functioning from a depressive position (Klein, 1959). Then a psychoanalyst, by focusing on the person`s feelings, and trying to make sense of these (symbolically and not necessarily in a transferential way) may become " internalized " by the other as a " good, containing object ", which may help strengthen their sense of self, against the effects of dementia (Kasl-Godley and Gatz,2000). Also, by focussing on their autobiographical memories, an analyst can help a person maintain continuity with their past, which can also militate against the effects of memory loss. However, as the dementia worsens, the role of the analyst must change, to consider their changing inner world.

To begin with, a person may deny or rationalize their lapses of memory, and although seen psychoanalytically as defences, they do not damage the ego, (Cheston, 1998). But worsening symptoms reflect increasing damage to ego functioning, and ultimately the above defences fail

to protect the ego from awareness of its own dissolution. Therefore, more primitive defences become operative, such as splitting and projection (Balfour, 2006), which by fragmenting the ego, also damage it. The psychoanalytic task now becomes one of containment i.e., containing the split off, projected experiences of patients (Treliving, 1988; Wesby, 2004). However according to (Hausman, 1996), these split-off, projected experiences can be used by the analyst for transference interpretations, but due to regression to primary process thinking (and therefore paranoid schizoid functioning),the analyst has to use their own countertransference to obtain clues about the patients inner world. And if this understanding can be communicated back to the patient, they will feel someone understands them, which can be supportive of their sense of self. Also in the paranoid schizoid phase, losses can be experienced in a very persecutory way (Klein, 1946), so it is vital for the analyst to show emotional understanding towards their patient, whose ability to face losses in an integrated, (i.e., depressive way), is severely compromised.

Psychoanalysis has also made important links between early experiences of dependency as an infant, and becoming dependent again later on in life, due to increasing frailty, and it suggests there are also links between the early, primitive mental life of an infant, and the fragmentary states of mind that occur in dementia (Malloy, 2009). Loboprabhu et al (2007), and Stephen et al (2012), have used Winnicott's concept of the "transitional object" when comparing early experiences in life with later ones, by suggesting in infancy the object (such as a teddy bear), is used in the process of separating from Mother,, whilst in dementia, it`s function is to ward off anxiety and depression, as one becomes dependent again.

A lot of articles on psychoanalysis, and dementia, apply the psychoanalytic concepts of projective identification, and containment to the hospital setting (Balfour, 2006, 2007; Dennis and Armstrong, 2007; Wesby, 2004). They all make the same point that good quality care, depends on staff being able to " contain " the feelings of patients, that are often communicated to them in non-verbal ways, such as projective identification (Cheston, 1998; Davenhill, 2007;Wesby ,2004).Via this containment it is suggested (Balfour, 2007),the patient comes to feel less anxious, and more integrated, which supports their sense of self. However, if staff feel unable to contain their own feelings, as well as their patients, then they may start to "act-out", their patient's projections (and each other`s), leading to abuse of vulnerable people. But due to illness, loss of agency is almost inevitable in hospitals, leading (via regression) to a state of dependency, (Treliving, 1988), where people become dependent upon others to meet their needs, and therefore highly vulnerable to various forms of abuse.

Therefore, it is important for staff to understand psychoanalytic concepts like projective identification, and containment, so they can remain emotionally engaged with their patients, thereby supporting their sense of self.

5) Theoretical views of self, used in dementia care.

In this part of the review, I will look at how sense of self has been defined theoretically in the dementia care field, before examining how qualitative researchers have explored the experiences of people with different types of dementia, and at various stages of the illness.

Within the literature on dementia care, there is no one view of self that is used consistently, when trying to understand the effects of dementia upon a person. However, it is possible to divide the literature into two parts, one half looking at the effects of dementia, upon a sense of self defined in qualitative terms, and the other trying to understand how dementia effects a person`s sense of self defined quantitatively.

a) Views of self, defined in quantitative terms.

Compared to qualitative approaches, quantitative research into sense of self and dementia is relatively sparse. According to Caddell, and Clare (2010), who carried out a systematic review of the effects of dementia upon self and identity, the quantitative approach breaks the self-down into the following four components, which it then sets out to measure.

Self- based on autobiographical memory,

Self- based on role identities,

Self- based on self- recognition,

Self- based on self- knowledge.

The authors found that research that took a quantitative view of self all found evidence that self is preserved to some extent in dementia. This is a neuropsychological/neuroanatomical view of self, predominately used in biomedicine where self is framed in cognitive terms (Chiong, 2011). It is therefore a rational, empirical view of self.

It has been suggested by (Katz, 2013), that framing the self in terms of thinking, goes back to Descartes, who separated mind from body, and made memory part of the brain, which could either be improved or made worse. Later it was Locke who said that memory was the guarantor of personhood, thus locating personhood in the brain. This has been called a “brain-hood ideology” by O`Connor and Joffe (2013), reducing a person to their brain, and isolating them from their social context. It has also become known as the Locke-Parfit view of identity, where identity is based on psychological continuity. This obviously makes it difficult for people with dementia to maintain their personhood.

However this neural basis of memory and self, has been challenged by Randall (2010), who sees self and memory much more in metaphorical terms, (i.e. as the brain used to be seen metaphorically as a computer, processing information), he sees "real" memory as full of narrative complexity, meaning it has many "vices", that make it not so different to the memory of a person with dementia. O`Connor and Joffe (2013), sees this as an attempt to move away from neuroscience`s essentialist view of self, which contributes to an us and them situation.

This view of self-framed in quantitative, rational, and empirical terms, has consequences in health care too, such as clinicians understanding confabulation only in terms of memory loss, and therefore indicative of possible dementia. Other explanations that see confabulation as a social-discursive phenomena used to maintain identity (Orulv and Hyden, 2006) are than left out. And in the management of pain for people with dementia, which according to Malloy and Hadjisavropoulos (2004) is grossly underreported, maybe because staff locate all the patient's subjectivity to their severely damaged brain, so that when pain (as a subjective experience) is reported to staff they either do not take it seriously, or at worst discount.

Hence there are real consequences for people, if their sense of self is only viewed in quantitative terms.

b) Views of self, defined qualitatively.

As suggested earlier, there is an enormous amount of literature that looks at the effects of dementia upon a sense of self, defined qualitatively.

Going back to Caddell and Clare's (2010) systematic review of the effects of dementia upon self and identity, they suggest that all qualitative researchers use a "unitary" construct of self, but they do not describe what this construct is, thus making it difficult to compare results. They also say, qualitative researchers tend to use thematic analysis to understand the experiences of people with dementia, but than do not try to understand these experiences, using a particular model of self, (Caddell and Clare, 2011).

Never-the less in spite of these difficulties concerned with a lack of a definition of self, Tappen et al (1999) says qualitative researchers have found that although a sense of self does diminish over time for people with dementia, it is never completely extinguished, and persists until the end (therefore supporting the findings of quantitative research). And if there is a "loss of self" they pose the question, how much is due to the illness, and how much, to how they are treated by others.

According to (O`Connor et al, 2007), personhood (as a unitary construct) has been looked at in three different ways in the dementia care literature.

First, some research looks at the subjective experience of the sufferer. For instance, the tension people experience between attempts to maintain their sense of self, whilst acknowledging the changes brought about by the illness. This is especially true at the beginning of dementia. Other research has looked at the person's social environment (due to defining self in relational terms, therefore care now focussed on relationships), and finally research that looks at the socio-cultural context, which looks at how society influences, and shapes the experience of dementia. Most of the work in this area, tends to focus on the subjective and relational experiences of people with dementia, although two articles by Baldwin (2006) and Bartlett and O`Conner, (2007) look at personhood in terms of citizenship. Both these articles argue that as a concept, personhood is too individualistic, and a political. One needs the concept of citizenship they argue, to understand how people with dementia are discriminated against in society, and so become marginalized and excluded. However, they also say, both these concepts have been criticized for relying on essentialist understanding of identity.

Articles by Callero (2003) and Davis (2004), look at sense of self and dementia, more from a sociological perspective, understanding self as symbolically constituted, that can then regulate itself reflexively, using the discourses society provides. They tend to see self and dementia as social constructions, using the ideas of Foucault.

And according to Herskovits (1995), the biomedical view of self-framed in cognitive terms, has now largely been surpassed in all the literature, by a relational view of self, (i.e., not cognitive), which is used to maintain the humanity of the sufferer. Thus, no matter how severe the illness (Evans-Roberts and Turnbull, 2011) say that people still have feelings, and it is through focussing on feelings, (via relationships with others), that self can be reclaimed. And this is the basis of all the person-centred theories used in dementia care (i.e., to make people <u>feel</u> valued, included, and that their lives are important). However, ideas in the qualitative field of dementia care research continue to move on, especially in relation to how self is understood. For instance, both the "Situated Embodied Agential" (S.E.A.) view of a person by (Hughes,2001; Hughes and Beatty, 2013), and Kontos's (2005, 2007, 2011) concept of "embodied selfhood", whilst acknowledging all the work of Kitwood, take a much more embodied view of selfhood (personhood), suggesting it is constituted primarily, by one`s bodily, pre-reflective activity in the world, before cognition. And therefore Kontos criticises the person-centred approach to personhood, because it tends to view personhood only in psychosocial terms, and neglects embodiment. And the S.E.A. view of a person also suggests, that due to embodiment, one is always situated, and doing something, so even for someone in

the late stages of dementia, it is their body`s hubris that suggests their self persists. These ideas have been taken even further by the following authors.

Millet`s (2011) "bio phenomenological" concept of self, suggests we each create a unique, meaningful world (a "life-world " ) through our bodies, and it`s affective responses to the world around it. The implication is that people with quite advanced dementia are still in the process of co-creating a "life-world ", and therefore can still be said to have an inner-life. This inner life has meaning, due to their embodied experience of the world, rather than relying on cognition alone.

Jenkin`s (2014) "Inter-embodied" view of self, believes self is always in the process of becoming through its relations with the world, at both a reflexive, and pre-reflexive (embodied) level. This process of becoming does not require a unified self, (as in all the other approaches) therefore it challenges the person-centred model of dementia care, which it believes reifies, and naturalises the concept of an individual self, damaged by dementia, which it than tries to repair. The inter-embodied model of self does not try and do this. Instead, it celebrates and even promotes a plurality of selves, as they become manifest through the dementing process.

This view of self, as always relational and in process is reflected in the work of A.N. Whitehead (1978). Recently authors such as Schillmeier (2009, 2014), and Halewood (2015), have directly applied Whitehead`s ideas to understand the experiences of people living with dementia. And work by another author, I. Moser (2008), has looked at how dementia is constituted out of its relations with different practices, such as science and biomedicine, and how these and other events such as daily care practices, conferences, and politics all interfere with one another, so that dementia is shaped as a particular "matter of concern". An article by Sherman and Webb (1996), titled, "The Self as Process in Late Life Reminiscence: Spiritual Attributes", also uses some of Whitehead`s ideas to suggest (based on the life narratives of elderly people), seeing self as an on-going process that is never finished, and rooted in an ontological relationship to Being.

All these authors, including Millet (2011), and Jenkins (2014), tend to rely on an anti-essentialist reading of self, which is not defined in terms of memories, or in fact anything that remains at the end of the illness (Moran, 2001). Here self is constituted every moment of its existence, out of its experiences with the world. Most of the articles reviewed however, do not take such a view of self, and are therefore essentialist in some way.

For instance, Jenkins and Price (1996) suggests that what is foregrounded in dementia is the materiality of the body, which is not separate from the mind. Conversely Moran (2001) argues

a person needs an "I" or self to speak one`s memories, otherwise without a self that has symbolic expression (i.e., language) one is left with just images and sensations that are meaningless. A sense of self is essential for any form of representation to occur.

However language can also be used to define the meaning of self, and according to (Sabat, et al, 2011), this is of special significance in dementia, due to the effects of labelling, which can lead to what Goffman called a "spoiled identity" (Goffman, 1968), and to what Sabat and Harre (1992) call "malignant social positioning", where quite rational reactions to situations in life such as anger, become seen as irrational. Therefore, using adjectives like "demented other", take away a person`s sense of agency, and denies them their individuality, and unique life story. Therefore, autobiographical narratives, written by people with dementia, sometimes with the help of others, are so important in the field of dementia care. These are sometimes called illness, or chaos narratives, according to Basting (2003).Although Basting (2003) criticises some of these, for describing their symptoms rather than enacting or performing them (although she says Henderson achieves this, by writing in a non-linear way about his embodied experience of the disease), they are still very personal ways of describing people`s existential realities of living through the disease, rather than a scientific, medical account, which could be objectifying, and depersonalising. Basting makes a similar point in an earlier paper (Basting, 2001), where she describes people with dementia, as losing track of time, therefore not fitting into our global culture. She sees these people as moving away from the logic of the outside world, where language is taken literally, to one where it is seen as composite, reflecting different emotional meanings, often she says, concerned with loss and transcendence, and the unreliability of the everyday, taken-for-granted world. These are suggestive she says, of a relational view of self.

And in her article "self-care without a self" , Naue (2008) suggests we need to redefine self intersubjectively, because concepts like " self- care " become problematic for people with dementia, as they find caring for themselves increasingly more difficult. This is also true of concepts like rationality and autonomy, because these too are mostly lost as the illness progresses. But the main problem Naue (2008) argues is that they are also, all constitutive of the self, so it is almost impossible to understand oneself and others without using them. However, defining the self relationally, should reduce the value attached to these concepts, as self will not be viewed so much in terms of an independent entity.

As previously mentioned, and as (Jenkins and Price, 1996) remind us, we must not forget the body, and bodily care, as these are vital if care is to be ethical and of the highest quality. And this supports the earlier point made by Kontos (2005,2007,2011), who says that most research

on dementia, has assumed an interactionist view of self, which has had the unintended consequence of the body becoming almost redundant in terms of theory.

We therefore need as (Malloy and Hadjistavropoulos, 2004) state, a concept of personhood that enables both people with dementia, and their carers to find meaning in the experience of illness. Thus, one needs a view of personhood that considers, both our embodied and relational natures, and we can see this developing in some of the research above.

6) Qualitative research, that investigates people's experiences of living with dementia.

According to Rodriquez (2013), qualitative research is vital in dementia care as it explores first person experience of living with the illness. These accounts Beard (2004) says, can counter prevailing societal attitudes of loss, and demonstrate that people with dementia can continue to live lives that have value, meaning and purpose. Some authors suggest (Rodriquez, 2013; Harman and Clare, 2006; Beard, 2004; Mills, 1998), this can be seen in the early stages of the illness, when people will either try to maintain their previous sense of self, or adjust to their diagnosis, by attempting to normalize their illness. However, this process of adjustment can be heavily influenced by society, with what Harman and Clare (2006) call "illness representations", which can either help or hinder one`s ability to adjust. Societal attitudes also form an important part of the work of Sabat and Harre (1992) who take a social constructivist view of self and consider the effects of what they call "malignant social positioning "upon a person`s experience of dementia. And in Beard`s (2004) paper he looks at how people in the early stages of the illness, actively engage in preserving their sense of self through interactions with others. However, this can be hindered he says, not just by a medical, but also a societal ideology that sees ageing as a problem, which than becomes internalized in the form of negative stereotypes, thereby worsening people's experience of dementia. And a consequence of all this Beard (2004) says, is seeing people`s behaviour and speech as meaningless, because their sense of self has been "reduced" to their cognitive status. Better to see ageing and dementia, as a social, embodied, processual experience where people`s search for meaning involves narrative reconstruction, in the face of biographical disruption.

This links with M. Mills (1997, 1998) important work, on how memories and emotions are linked. She suggests researchers take a Rogerian, client centred approach to their work with people with dementia, as this can improve their recall of autobiographical memories, thereby helping them to maintain their personhood (which is defined narratively in M. Mills work). This process can be cathartic, she says, leading to an increase in overall well-being, as one`s sense of narrative identity is validated. This is supported by the work of (Caddell and Clare, 2011) in their systematic review of interventions, supporting self and identity in people with

dementia. Although highly critical of a lot of the research into sense of self and dementia, due to conceptual and methodological problems they nevertheless conclude, that most interventions supporting people with dementia, that rely on stimulating autobiographical memories are helpful, and supportive of their sense of self.

Of course, authors such as Kitwood (1993, 1997a, 1997b), Sabat (2002), Sabat and Harre (1992), and Kontos (2004, 2005, 2011), argue against definitions of self that emphasize cognition.

As previously discussed by (Caddell and Clare, 2010 and Rodriquez, 2013), a lot of the findings within qualitative research that investigate people's experience of dementia, can be summarized as either people`s desire to maintain their sense of self (described as self-maintenance) despite their awareness of the disease, or attempts to integrate this awareness into their sense of self (described as self- adjustment). This only tends to be true of course for people at the early stages of the illness (Mills, 1997, 1998), when they can still verbalize their experiences, even though these experiences are gradually becoming more fragmented due to continuing memory loss.

Usita et al (1998) found that when comparing the personal narratives of six people with Alzheimer`s disease, with six people without cognitive losses, the "A.D. narratives "were less chronologically ordered (particularly for recent events), had fewer detailed descriptions, omitted important events, were more repetitious, and were more likely to need help from others. However, despite these difficulties, researchers such as (Hyden and Orulv 2009), all insist on the vital importance of personal narratives for people with dementia, as a way of maintaining their narrative sense of self.

Research into the narratives of those with more advanced dementia is much sparser (Clare et al, 2008), as they have extreme difficulties verbalizing their experiences, and organizing them temporally. Therefore, the work of researchers such as Kontos (2004, 2005, 2011), who work with people who have advanced dementia is so important. As (Parsons-Suhl et al, 2000) say, remembering and forgetting cannot be reduced only to cognition, as they are all embodied experiences.

Research undertaken by (Hyden and Orulv, 2009) which looked at the "performative" role of narratives in a woman with advanced dementia, suggested that the parts in her storytelling that were repeated, were her way of sustaining important aspects of her identity (i.e. in this particular case study, as an independent, capable woman). This is supported by the work of (Holst and Hallberg, 2003) who suggest that people with advanced dementia can still experience meaning, at least emotionally, and will often confabulate to maintain certain valued

aspects of their identity. Three further studies that looked into the experiences of people with advanced dementia, either living in Residential care (Clare et al, 2008), or a Dementia care home (Tappen et al, 1999; Nouvell et al, 2011) all concluded that personhood does endure, even in those with severe dementia.

These three studies, which are also supported by the important work of Surr (2006), do not use a pre-defined concept of self, which is true of nearly all the qualitative research in dementia. They tend to use concepts like self, sense of self, and personhood, as a way of gathering themes from their data analysis, but do not define what these concepts mean.

In Chapter two, I will introduce a particular model of self that can consider a lot of the above perspectives, as well as introducing some new ideas that may contribute to furthering our understanding of the dementing process.

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CHAPTER TWO

A Summary of Fairbairn's theory of the development of mind, and its relationship to understanding dementia

Fairbairn's developmental theory of the mind

Introduction

According to Fairbairn (1946, p.148; 1954, p.15) one is born with a unitary, pristine ego, which is unstructured, but dynamic, in the sense it has energy, which Fairbairn defines as libidinal (1963, p.224). This libidinal energy, which "is a function of the ego" (1963, p.224) is reality orientated and object seeking. It's "… aim is the establishment of satisfactory relationships with objects…" (1946, p.138) that are of a loving kind. With this kind of relationship, the ego would remain in its undifferentiated form (i.e., it would not fragment), but "would represent perfect integration and absence of splitting…" (1940, p.9), and grow to realise its potential. However, this perfect relationship is never possible, and Fairbairn acknowledges "that a completely satisfying relationship between the infant and his actual mother represents a contingency which is only theoretically possible, and which never materialises in actual fact." (1954, p. 16). Therefore, the young infant will inevitably experience frustration and disappointment in its relationship to its mother, or other primary caretaker.

As suggested above, Fairbairn says the ego's orientation to the world is libidinal (1963, p. 224), which he frames as the fundamental desire "…to love and to be loved." (1940, p. 26). It is important here to also understand his views on the relationship between ego and libido, in terms of structure and energy, because he seems to suggest they are interchangeable.

"…I have come to adopt the principle of dynamic structure, in terms of which both structures divorced from energy and energy divorced from structure are meaningless concepts." (1946, p. 149).

And, "If, however, we conceive of energy as inseparable from structure, the only changes which are intelligible are changes in structural relationships and in relationships between structures, and such changes are inherently directional." (1946, p. 150).

And these "… changes are inherently directional" because "The ego, and therefore libido, is fundamentally object seeking" (1963, p. 224), where the aim "is the establishment of satisfactory relationships with objects…" (1946, p. 138).

All ego-object relations are therefore libidinal suggesting a person's sense of self is essentially a libidinized sense of self, which is open and seeking satisfactory relationships with objects.

Therefore, experiences which are not loving such as when "… the child comes to feel a) that he is not really loved for himself as a person by his mother, and b) that his own love for his mother is not really valued and accepted by her. This is a highly traumatic situation…." (1940, p. 17), that can really hurt the ego in a fundamental way.

However due to its dependency, "The infant is completely dependent upon his object not only for his existence and physical well-being, but also for the satisfaction of his psychological needs." (1941, p. 47), the very young infant cannot relinquish its attachment to someone who is not always kind and loving. In fact, Fairbairn says, "Even if they [bad parents] reject him, he cannot reject them, for, if they reject him, his need for them is increased." (1943, p. 67). How does an infant deal with these unpleasant experiences?

Fairbairn's three stages of development of the mind

i) *Stage of Infantile Dependence*

In Fairbairn's theory of development, he uses some of the principles of Freud's and Abraham's theory of psychosexual development (1941, p. 29-30), the first stage of which is the "oral phase" (1951, p. 163). Abraham divides Freud's oral phase into two parts, early and late oral, and Fairbairn keeps to this view.

"There can be no question of the correctness of relating schizoid conditions to a fixation in the earlier oral phase… Nor, for that matter, can there be any doubt about the correctness of attributing manic-depressive conditions to a fixation in the later oral phase…" (1941, p. 29).

Fairbairn goes onto say, in the early oral phase, frustrating experiences are dealt with by withdrawal, as the infant feels its love is "bad"

"If the phase in which infantile object relationships have been pre-eminently unsatisfactory is the early oral phase, this trauma provokes in the child a reaction conforming to the idea that he is not loved, because his own love is bad and destructive." (1941, p. 55).

This is a schizoid response to a perceived lack of love, and when Fairbairn speaks of withdrawal, it is withdrawal of libido attached to the external other that he speaks of. It is this libido that takes aspects of the pre-ambivalent object into the ego (1951, p. 134-135) which then sets up internalised object relational experiences. Fairbairn calls this secondary narcissism and is when aspects of the ego are in "…a state of identification with an object which is internalised." (1941, p. 46). It is also a pre-moral stage of development, in the sense its object relations are felt to be libidinally satisfying or unsatisfying, but not good or bad, in terms of right and wrong. Nevertheless "…this fact [of pre-ambivalence] is especially important in the light of the further fact that the oral behaviour of the child during this pre-ambivalent phase represents the individual's first way of expressing love…and is, therefore the foundation upon which all his

future relationships with love objects are based." (1940, p. 24). Fairbairn calls this pre-ambivalent early oral phase of development "…the schizoid position" (1940, p. 25).

It is only in the second oral stage, where an external object (i.e., mother or primary caretaker) becomes an ambivalent object to the infant. According to Fairbairn, this is because

"In the late oral phase there occurs a differentiation between oral love, associated with sucking, and oral hate, associated with biting; and the development of ambivalence is a consequence of this." (1940, p. 24).

This normal developmental stage (1941, p. 39) is partly a result of the infant developing teeth, which can be used to channel its aggression by biting the object.

"In the late oral phase, the situation is different; for in this phase the object may be bitten in so far as it presents itself as bad…. Hence the appearance of the ambivalence which characterizes the late oral phase." (1941, p. 49).

Thus, the infant can attack the object when it is frustrating and so it becomes ambivalent to the infant. This becomes, in contrast to the early oral phase, a moral stage of development, and the infant divides its experiences not just into satisfying and unsatisfying, but also good and bad (i.e., it can now attack through biting objects that are unsatisfying, therefore it becomes capable of both loving and hating objects, thereby experiencing ambivalence). (1941, p. 49).

This is very different to the object relational experiences of the early oral phase, where it can only withdraw from experiences that feel unsatisfactory, "…in which the child feels that he is not really loved as a person, and that his own love is not accepted." (1941, p. 55). Or alternatively, the conflict underlying the early oral phase is whether to "love or not to love", and in the late oral phase it is whether to "love or to hate" (1941, p. 49). Because of ambivalence in the late oral phase, satisfying experiences now become judged as good by the infant and unsatisfying ones as bad, hence this becomes a moral stage of development.

These early and late oral phases of development are also called by Fairbairn, the stage of Infantile Dependence (1941, p. 41), where the child is wholly dependent on the external other for meeting all its physical and emotional needs (1941, p. 47). Although reality orientated and object seeking (1956a, p.52), the infant's emotional relationship to its mother is based upon identification with her. Fairbairn stated that, "…the most characteristic feature of the state of infantile dependence is primary identification with the object…." and "…psychologically speaking, identification with the object and infantile dependence are but two aspects of the same phenomena." (1941, P. 41-42). This means all the satisfying and unsatisfying relational experiences with the external object are internalised (i.e., transferred "…to the realm of inner reality." 1940, p.18), and become part of the infant. This is the pre-ambivalent object that

Fairbairn speaks of in his Addendum, when he says, “The internalisation of the pre-ambivalent object would be explained on the grounds that it presented itself as unsatisfying in some measure as well as in some measure satisfying.” (1951, p. 134-135).

The internalization of object relations has the fortunate consequence of allowing the infant to carry on loving its mother (i.e., to maintain libidinal relations with her), even though the relationship can feel quite unsatisfactory at times, it therefore “…is a defensive measure…” (1963, p. 224). However, an unfortunate consequence of this, is that the unsatisfying experiences have now become part of the infant, so he takes “…upon himself the burden of badness which appears to reside in his objects” (1943, p. 66). Therefore, an external relationship that is sometimes unsatisfactory now becomes an unsatisfactory internal relationship, and due to the libidinal nature of the ego, it must find a way of “disposing” of these negative experiences.

Due to the dynamics of the mother-child relationship, and because the child is completely dependent upon its mother for meeting all its needs (1941, p. 47) Fairbairn says these unsatisfactory, frustrating experiences are of two fundamentally different kinds. One is over-exciting and the other is over-frustrating (1951, p. 135), and since both “…are unacceptable to the original ego these elements are both split off from the main body of the object [which has now become ambivalent] and repressed in such a way as to give rise to 'the exciting object’ and the ‘rejecting object’.” (1951, p. 135). Fairbairn than goes on to say that because of the libidinal nature of the original ego, the ego itself becomes split, giving rise to a ‘libidinal ego’ and to an ‘internal saboteur’, later to be called an ‘anti-libidinal ego’ in his 1954 paper, page 17. Because of their libidinal cathexes to the exciting object and the rejecting object, these split off parts of the ego also become repressed, leaving a central ego in cathexes with what Fairbairn calls an ‘accepted object’ (1951, p. 135), later called an ‘ideal object’ (1954, p. 17).

This represents Fairbairn’s “…basic schizoid position,…which is one in which….a central (conscious) ego [is] attached to the ideal object (ego ideal), a repressed libidinal ego [is] attached to the exciting (or libidinal) object, and a repressed anti-libidinal ego [is] attached to the rejecting (or anti-libidinal) object” and also where “the anti-libidinal ego, in virtue of its attachment to the rejecting (anti-libidinal) object, adopts an uncompromisingly hostile attitude to the libidinal ego…” (1963, p. 225).

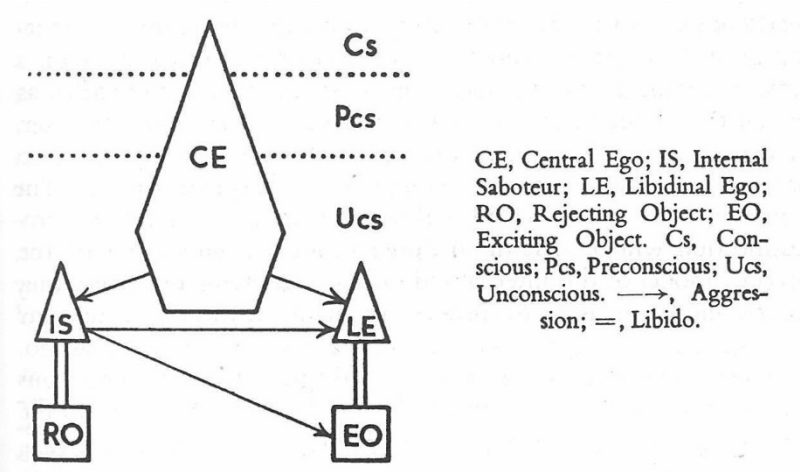

Figure 1

Fairbairn believes it is fundamentally these types of over exciting and over rejecting object relationships that are unsatisfying and 'bad' from the infant's point of view, and therefore interfere with its development. An infant needs love and nurturance to develop into a mature individual who can sustain relations with the outside world. As Fairbairn says, the greatest trauma, "…is one in which the child feels that he is not really loved as a person, and that his own love is not accepted." (1941, p. 55), and "In the absence of such assurance his relationship to his objects is fraught with too much anxiety over separation to enable him to renounce this attitude of infantile dependence." (1941, p. 39).

Infantile dependence is a very important concept in Fairbairn's theory, as he believes it lies at the root of all psychopathological states of mind (1941, p. 56). He says, "…this dependence is chiefly manifested as an attitude of oral incorporation towards and an attitude of primary emotional identification with the object." where primary identification signifies, "…. the cathexis of an object which has not yet been differentiated (or has been only partly differentiated) from himself by the cathecting subject." (1946, p. 145). He later says "…separation anxiety is a characteristic product of …. individuals who have remained in a state of infantile dependence, to make identification the basis of their emotional relationships with those upon whom they depend." (1943, p. 276).

How then, does an infant deal with separation anxiety, particularly from its mother (This is a slightly different problem to the one dealing with frustrating object relations). Fairbairn says separation anxiety is, "The earliest and original form of anxiety, as experienced by the child…." (1963, p. 224). Because it originally occurs in the stage of infantile dependence, which is also

the stage of primary identification with another (please see above), loss of libidinal contact with mother must feel to the child like it is losing its own ego, as "…libido…is the very form of energy, which holds it together." so to avert this, "…ultimate psychopathological disaster…" (1941, p. 52), the infant must internalise his love object (which is natural because he is already emotionally identified with her) and thereby set up an internal object relationship, which "… is a defensive measure originally adopted by the child to deal with his original object (the mother and her breast) in so far as it is unsatisfying." (1963, p. 224). Therefore, the infant sets up an internal object relationship to compensate for an unsatisfactory external object relationship, which also allows him to feel as if the "…situation to be more under his own control." (1944, p. 110).

As suggested earlier, Fairbairn's basic endopsychic structure, which he believes to be universal (1944, p. 101), is based upon repression of a libidinal ego attached to an exciting object and the repression of an anti-libidinal ego attached to a rejecting object, where the anti-libidinal ego also represses the libidinal ego. (1963, p. 225). Please see figure 1. Fairbairn says this is, "The earliest form of defence resorted to by the developing ego in a desperate attempt to deal with internalised bad objects…" and these "…bad objects are simply located to the unconscious." (1943, p. 65). He says this view however "…implies that there must be a splitting of the ego to account for repression." (1951, p. 168). This splitting of the ego however allows the central ego and ideal object to carry on seeking satisfying relations with objects in the external world, which is its fundamental nature (1963, p. 224), whilst repressing any "…intolerably bad internalised objects…" (1943, p. 62).

As well as repression, Fairbairn says there is "…another form of defence which the work of repression is invariably supported …" which he calls the 'moral defence' (1943, p. 66). This is when the child internalises compensatory good objects (1951, p. 165), "…to defend the child's ego against bad objects which have been internalised already." (1944, p. 93). This defence in combination with repression strengthens the central self (i.e., central ego and ideal object) by allowing for the continued internalisation of object relations, the good (i.e. acceptable) aspects of which become part of the central self, and the bad (i.e. unacceptable) aspects are repressed into the anti-libidinal self (i.e. anti-libidinal ego and rejecting object) and the libidinal self (i.e. libidinal ego and exciting object). They therefore become unconscious. This allows the infant to keep on loving its parents on whom it utterly depends "…for his existence and physical well-being, but also for the satisfaction of his psychological needs" (1941, p. 47), even if at times the relations between the infant and its significant others are quite unsatisfactory, because any badness now becomes attributed (unconsciously) to the infant. As Fairbairn says, "…the child

would rather be bad himself, then have bad objects" (1943, p. 65). The moral defence (unlike repression, which creates the endopsychic structures of the mind) comes after these endopsychic structures have been established.

ii) *Transitional Stage or Stage of Quasi-Independence*

In the next stage of development (i.e., after the stage of infantile dependence, 1941, p. 39), Fairbairn suggests the psyche develops defences other than internalisation and repression (1963, p. 224) and then later the moral defence (1951, p. 165). He calls this next stage Transitional (1941, p. 35, 39 and 41), and "… is concerned with the abandonment of infantile dependence …" (1941, p. 35), where relationships with objects are based upon primary identification. It therefore involves "…the operation of rejective techniques [as] a characteristic feature of [this] stage…" (1941, p. 35), and because by now the endopsychic structure has been established, this can involve the rejection of both good and bad internalised objects.

This is very important, because up until this time the only defences the developing psyche has are internalisation and repression of unsatisfactory object relational experiences, then later the internalisation of good object relational experiences, but now it can also project outwards these internalised good and bad object relational experiences that the developing ego has identified with. These defences can be seen to correspond to Abraham's oral and anal phases of psychosexual development (1941, p. 35). The oral phase "…is …intimately connected with incorporation of the object" both physically and libidinally (1941, p. 34, 41), and the anal phases with rejection (expulsion) of the object (1941, p. 35).

Thus, the Transitional stage of Fairbairn's theory of development involves both the incorporation and expulsion of good and bad object relations, which leads to the distorting of inner and outer reality and is therefore neurotic. Please see table below (Figure 2).

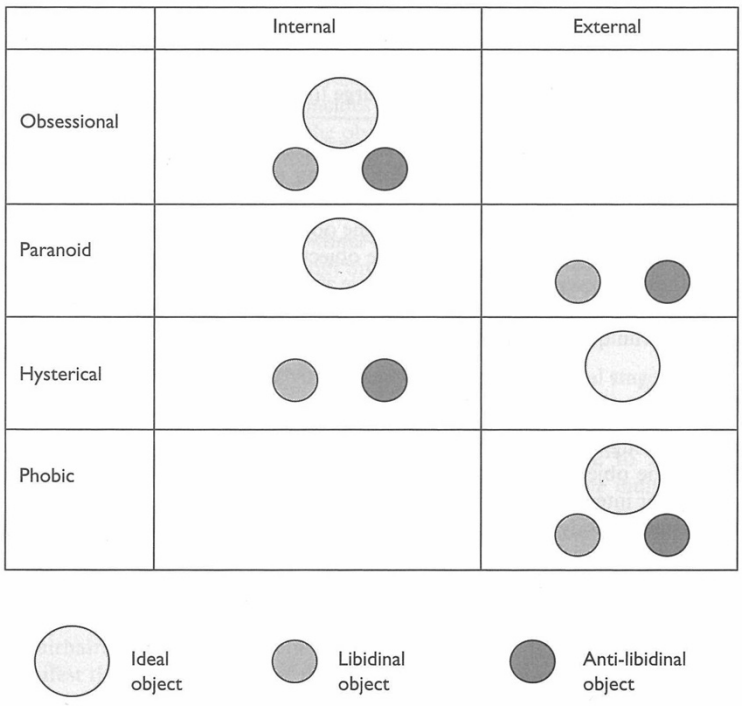

Figure 2

All the above four techniques are based "…on the quality of dependence upon the object, because there is reason to think that this is the most important factor in early relationships." (1941, p. 40), and "…in his… attempts to emerge from a state of infantile dependence, he resorts by turns to any or all four of the transitional techniques which have been described…" (1941, p. 39). These are all the different ways a child uses to try and separate (emotionally) from its dependency upon others. However, the desire to separate from the object can also lead to anxiety, therefore there are also "…desperate endeavours to achieve reunion with the object." (1941, p. 43). There is therefore constant oscillation between these various techniques, as the infant tries to negotiate its dependency upon the needed object.

Given Fairbairn's diagram of the Basic Endopsychic Structure of the Mind (Figure 1), and the above table (Figure 2), indicating how different types of object relational experiences are distributed, it is the hysterical transitional technique that most resembles Fairbairn's structural view of the mind, and this is supported by Fairbairn when he says, "…the earliest [psychopathological] states are hysterical in nature." (1944, p. 131).

Hysterical transitional technique

In his analysis of this technique, Fairbairn suggests that what is rejected in the hysterical state is a part of the hysteric's body (1941, p. 45). This would imply that this part of the body has been overly identified with (but in a rejecting way), therefore Fairbairn suggests "hysterics" reject their internal objects, but conversely, because they over value their real, external objects they accept these. Thus, the accepted objects are all externalised, and the rejecting objects internalised, which reflects the object relations of his basic endopsychic situation (1944, p. 130).

By virtue of this technique, which is "…characterised by acceptance of the externalised object..." (1941, p. 45) the infant remains predominately reality orientated and libidinal (although possibly in an idealised way) (1941, p. 38), thereby enabling him to maintain positive relations with those upon whom he depends. Nevertheless, it is defensive, because it relies upon unconscious processes of splitting and repression to keep away relational experiences that are not experienced as loving (1946, p. 147). These bad object relational experiences are kept inside the infant's self, but unconsciously, (i.e. "...the rejecting object remains incorporated…") (1941, p. 38), whilst all good object relational experiences are externalised (1941, p. 45), (i.e. are felt to come from external others) making the infant dependent upon these others. Maybe as Fairbairn says, this could be a regressive attempt, "…to establish dependency upon a more reassuring basis." (1941, p. 38), but it does support the child's dependency upon others that are needed for its survival (1943, p. 259), as well as encouraging relational experiences that are positive and affirming, and therefore conducive to central self-functioning, and not just as a defence against bad object relational experiences, as in the moral defence (1943, p.66).

Nevertheless at this stage of development, the child's central self may not be particularly consolidated (i.e. affectively cohesive), due in part to the internalisation and externalisation of object relations that it has become identified with from the stage of infantile dependence (1941, p. 47). Thus, depending on how relations with externally needed others are experienced, this technique may eventually fail, and the central self's need for libidinal relations may mean other techniques are evolved.

An example of a hysterical transitional technique taken from Fairbairn's work is in love relationships, where the other is completely accepted consciously (i.e., idealised), but denigrated, rejected (unconsciously), so "…that a rejection is being over compensated [for]." (1941, p. 44). Fairbairn also says the profound split between good and bad, can lead to dissociative phenomena where "…the hysteric over values objects in the outer world" at the expense of their own feelings of value and worth (1941, p.45).

Paranoid transitional technique

This technique may evolve in an environment that is extremely unsupportive of central self-functioning, in terms of libidinal relationships. This would eventually diminish the capacity of the central self to keep an idealised view of relations with others via the hysterical transitional technique. This could then break down into what Fairbairn calls a paranoid transitional technique (1941, p. 45), which is also defensive, because the good relations the central self needs to function are now felt to come from inside oneself, and all the bad object relational experiences are externalised (i.e., rejected), and are now felt to come from outside of oneself (1941, p 36 and 45). This technique may support the central self in terms of believing the source of its good feelings come from within itself (and therefore no longer dependent upon others who have proved to be unreliable), but it makes the external environment very bad indeed, as it now becomes persecutory. This results from projecting (externalising) internalised object relational experiences that felt libidinally bad (i.e. "… the rejected internal object…") (1941, p. 36) into the external environment, making an unsupportive environment into a persecutory one The persecutory nature of these feelings comes from the fact that these object relational

experiences that are projected are very primitive in nature, as a consequence of being repressed into the system unconscious, which is closed off via repression to further relational experiences. Please see Figure 1.

Fairbairn says, "… in externalising the rejected internal object the paranoid individual treats it as unreservedly and actively bad- as a persecutor indeed." (1941, p. 36).

Although the paranoid transitional technique is a defensive technique, and thereby neurotic, as are all the transitional techniques (1940, p. 4; 1941, p.30 and 57; 1951, p. 163), the persecution can feel almost psychotic because of these processes, and the attendant anxiety overwhelming, but it may be the only defence the central self has, if the environment is so unsupportive of its libidinal needs. However, assuming the environment is sensitive enough to meet some of the infant's needs (as it must be for the infant to survive) then another transitional technique might develop based upon a mixture of good and bad object relational experiences.

An indication of a paranoid transitional technique maybe taken from Fairbairn's example of a soldier who breaks down in time of war (i.e., a return of bad objects), so that every experience connected to army life becomes bad, even persecutory to him (i.e., "… cannot bear to be shouted at by the sergeant-major and cannot bear to eat army food." 1943, p. 81). And all his good experiences, most likely to do with home and family life, are felt to reside inside himself, hence his desire to return home at all costs.

Phobic transitional technique

In this transitional technique, all the internalised good and bad object relational experiences are externalised (1941, p. 46), and are therefore felt to come from outside of oneself (Figure 2). Thus 'satisfying parts' of the environment are felt to be very good, whilst 'unsatisfying parts' of the environment are felt to be very bad. This idealisation and denigration of different parts of the environment is a result of projecting (externalising) good and bad object relational experiences into it. The external environment therefore comes to reflect the internal environment. Fairbairn (1941, p. 44) says this technique "…corresponds in the main to a passive attitude…and is predominately masochistic" because now one feels at the mercy of one's environment, which cannot be changed. All one can do is move away from or towards different (external) objects. However at least there is an environment, where what are in fact internalised object relational experiences can now be 'played out' externally. But what happens in an environment which is lacking in stimulation, as it has become bereft of others to have relationships with. Here none of the above transitional techniques would be viable, and all a person's relational experiences would be felt to come from inside of themselves.

Obsessive transitional technique

In an environment lacking any kind of object relational experiences (and therefore possibly neglectful), all relational experiences (good and bad) would be felt to come from inside oneself, so the infant feels like she/he is relating to different parts of her/himself. Please see Figure 2.

According to Fairbairn, in "…. the obsessional state there is constant oscillation between expulsion and retention…and…the conflict [is] between an urge to expel the object as contents

and an urge to retain the object as contents…" (1941, p. 44). It therefore feels as if all objects are internal (whereas in the previous phobic transitional technique, it feels as if all objects are external). In the obsessive transitional technique, there is therefore hardly any affective relations to the outside world, just subjective relations to different parts of oneself. As one of the four techniques "…concerned with the abandonment of infantile dependence" (1941, p.35) it most risks psychosis, as all relations are based upon identification with internalised objects, that Fairbairn says are aggressively kept under the ego's control (1941, p. 44). There is therefore a lack of libidinal relations to the outside world to counter this drift into subjectivity, which could overwhelm the ego, particularly if there is a preponderance of bad object relational experiences. An example of the type of anxiety that could overwhelm an individual using this transitional technique is the "…fear of some internal disease like cancer…" (1941, p. 44).

All of the above transitional techniques reflect the various ways the central self (i.e., central ego with idealised object) deals with its inner and outer relationships, particularly bad object relationships when the central self is not very well consolidated or "…when repression fails to prove an adequate defence against the internalised bad objects and these begin to threaten the ego…" (1943, p. 65-66). And as Fairbairn's concept of self, taken to include the central, libidinal and anti-libidinal selves is always an affective self whether libidinal or not, then each transitional technique will reflect a different organisational structure of self, depending on how its internal objects are organised. Please see Figure 2. This is an important point when it comes to data analysis.

iii) *Stage of Mature Dependence*

The next stage of development, which Fairbairn calls the stage of mature dependence (1941, p. 39, 41) is where one can relate to objects that are differentiated from oneself (1941, p. 34, 42), which means the "…abandonment of relationships based upon primary identification." (1941, p. 42). All the above transitional techniques involve different ways of relating to others but based upon primary identification with internalised objects that are either projected (externalised) or internalised (1941, p. 43-46). They therefore distort relations with others, whereas mature dependence "…involves a relationship between two independent individuals who are completely differentiated from one another as mutual objects." (1941, p. 42). The basis of the move to mature dependence is to feel secure in one's love for others, and others love for oneself (1941, p. 39). If one feels secure and can therefore "…depend safely upon his real objects…" (1941, p. 39), there is little need for relations to others to be based upon the transitional techniques. Instead, one can relate to others realistically and as they are. Thus in order to be maturely dependent, which is the goal of Fairbairn's theory of development (1941, p. 34, 39), one has to have a central self that is well consolidated, i.e. secure in itself, which means it feels loved and accepted by one's real (external) others (1941, p. 39), whom it can rely upon, and is therefore free from the splitting and fragmentation of the transitional techniques that distort relations with others. However, this can be difficult to achieve, because once the basic endopsychic situation has been set up those parts of the ego that are attached to bad object relational experiences now have different needs compared to the central ego-ideal object structure, which may prevent their integration into this structure, hence the need for transitional techniques. As Fairbairn says, "…internalised objects may acquire a dynamic

independence which cannot be ignored." (1944, p. 132). Nevertheless, if relations with others are mostly of a loving kind, then as suggested above, it may be possible to give up identifications with one's internal objects in favour of a real relationship with a loving other and hence move towards the stage of mature dependence. However, Fairbairn says, "The relationship involved in mature dependence is, of course, only theoretically possible." (1941, p. 42), because "…in practice, there is no one whose libidinal development proceeds wholly without a hitch." (1946, p. 145). Thus, it would indeed be "…a bold man to claim that his ego was so perfectly integrated as to be incapable of revealing any evidence of splitting at the deepest level" (1940, p. 8). Of course, this implies there are always going to be internalised bad objects in everyone, and hence no one is safe from the risk of regression.

Examples of regression can be found in Fairbairn's work, with what he calls "neurotic soldiers." (1943, p. 286). He argues, "…it is rare to find a case [of war neurosis] in which evidence of pre-existing psychopathological characteristics cannot be detected…" (1943, p. 257), and it is this "…disturbance of the personality…[which is] part and parcel of the regression involved in that revival of a state of infantile dependence, to which, as we have seen, a war neurosis is to be ultimately ascribed…" (1943, p. 286). Thus, it is "… an attitude of infantile dependence …. present at deep levels of the psyche…" (1943, p. 260) that precipitates a war neurosis. These soldiers have therefore (in terms of their development), not been able to reach the stage of mature dependence where relationships are no longer characterized by primary identification (1941, p. 42). Regression is therefore a consequence of separation anxiety "…from their love objects and isolated from all the accustomed props and supports upon which a dependent person would obviously rely." (1943, p. 260), and the return of internalised bad objects (that he is emotionally identified with), which makes his experience of military service seem almost persecutory. As Fairbairn says, "The soldier who breaks down…. is thus characterised not only by separation anxiety, but ….by the acute anxiety which a release of bad objects inspires." (1943, p. 81). In this sense all war neuroses are regressions to a state of infantile dependence where the military becomes identified with all one's internalised bad object relational experiences, and "…reverts to the status of a bad object." (1943, p. 81), and home and family become identified with all one's good object relational experiences. The neuroses (i.e., symptoms, or alternatively in Fairbairn's terminology transitional techniques), which "…must be regarded as products of a fundamental attitude of infantile dependence…" (1943, p. 265), are all the different ways a soldier uses (unconsciously) to make army life bearable, before the onset of separation anxiety.

Given the above account of Fairbairn's developmental theory of self, and the inherent risk of breakdown, due to regression to earlier ways of relating to one's internal and external objects, how can we now relate this theory to my data of people's experiences of living with dementia.

Relating Fairbairn's developmental theory of mind to understanding the process of dementia

According to the Royal College of Physicians (1982, p. 139):

> "Dementia is the acquired global impairment of higher cortical functions including memory, the capacity to solve the problems of day-to-day living, the performance of learned perceptuo-motor skills, the correct use of social skills, all aspects of language and communication, and the control of emotional reactions, in the absence of gross clouding of consciousness. The condition is often progressive, though not necessarily irreversible."

From Fairbairn's perspective the above definition can be interpreted as the different ways a person can relate to their inner and outer reality, which he says is a function of their ego. He suggests "…the ego….has an adaptive function….relating primarily instinctive activity to conditions prevailing in outer reality...", but it (ego) also has "…integrative functions…" which include, "….the integration of perception of reality, and the integration of behaviour… [as well as] discrimination between inner and outer reality." (1940, p. 9).

In Fairbairn's theory of development, once the schizoid position has been reached, which he says is a "…. universal phenomena…that everyone without exception is schizoid at the deeper levels…" (1940, p. 8), then the part of the ego that relates to both inner and outer worlds is the central ego in relation to its ideal object (Figure 1). Therefore, one can infer from the above definition of dementia that it is the central ego in relation to its ideal object, that is most disrupted or weakened by the process of dementia.

Given that Fairbairn's developmental theory of the mind is based upon its progressive structuralisation (1963, p. 224) so that, "…the 'central ego' is conceived as a primary and dynamic structure, from which…the other mental structures are subsequently derived." (1944, p. 106), and these other structures are derived from different kinds of relational experiences (1951, p. 162) that remain dynamic and interconnected throughout life (1946, p. 148). It then becomes possible to see how changes in one structure such as the central self, will then affect these other structures, which in turn affect the central self. This is like Fairbairn's theory of dreams, which he says are "… not wish fulfilments, but dramatizations …of situations existing in inner reality… [which] represent relationships existing between endopsychic structures…" (1944, p. 99). Thus, if we view a person's sense of self as a dynamic, holistic system, and "…we conceive energy as inseparable from structure, the only changes which are intelligible are changes in structural relationships and in relationships between structures; and such changes are inherently directional." (1946, p. 150), then it becomes possible to analyse how changes in one part of this self-system are likely to affect the self. This gives an account of a person's phenomenology, which is their sense of self.

Fairbairn also describes his view of development in terms of stages a person passes through on their way to mature dependence, (1941, p34, 35, and 39). Initially there is the stage of infantile dependence, which is based upon identification with external and internal objects, then there is the stage of relating to the world using various transitional techniques and finally there is the stage of mature dependence where one recognises one's dependence upon the world, but now as a differentiated individual and therefore no longer based upon emotional identification. However, depending upon life experiences, including illnesses and trauma (e.g., The War Neuroses, 1943, p 286), a person can move between these different stages, as they are all

dependent upon experiences in the world. Therefore, prolonged negative experiences (such as chronic illness) can alter one's internal structures in such a way that earlier modes of relating become more dominant and therefore active again. As Fairbairn says, "… it would take a bold man to claim that his ego was so perfectly integrated… [that] …even under conditions of extreme suffering or hardship or deprivation (e.g. under conditions of grave illness, or…of relentless persecution…)…" (1940, p. 8) that his ego would show no signs of splitting Thus for everyone, there is always the risk of regression to earlier modes of relating to one's internal and external objects, accompanied by a corresponding degree of disintegration or destructuring of one's internal world, which could in extreme cases compromise one's sense of personal identity (1943, p. 277). However, assuming a person has reached the stage of mature dependence in their ego development (1951, p. 163), so they are capable as a "…differentiated individual for co-operative relationships with differentiated objects." (1946, p. 145), then this suggests they are reality orientated, with "…an absence of primary identification." (1946, p. 145). Hence, they are able to relate to the world, realistically and rationally.

Thus, in the beginning phases of a disease like dementia, which is defined as chronic, and progressive (Burns et al, 1995, p. 3), and usually involves the loss of short-term memory first (Burns et al, 1995, pp 35-40) one would expect a person who is "maturely dependent" to take a practical approach to their problems. For instance, they may adjust to short term memory loss, by making lists of things to do (rather than try and remember), asking others for help including their partner, avoiding new situations, and giving up activities that are now becoming too difficult (Mace et al, 1985, p. 21). In fact, research shows (Clarke, C.L. 1997, pp 8-10) that most people in the early stages of dementia do function very well in their homes, and this includes people without the support of a loved one. However, as the illness progresses and symptoms worsen (Burns et al, 1995, p. 3; Harding and Palfrey, 1997, p. 39) the anxiety accompanying awareness of this may eventually trigger the use of defence mechanisms such as the transitional techniques (1941, p. 56), to cope with the fear and anxiety. There is therefore a regression from the stage of mature dependence to the stage of quasi-independence (1941, pp 39 and 41), where relations to external (and internal) reality are experienced according to how one's internal objects are distributed (Figure 2).

For instance as one experiences increasing difficulties in day to day living (Burns et al, 1995, pp 35-40), one's view of oneself based upon the relation between central ego and ideal object (or ego ideal; 1951, p.136 and 1951, p. 179) will deteriorate, possibly leading to a state of depression, where the anti-libidinal (ego and object) join with a disintegrating ego ideal (ideal object) to 'attack' the central ego. According to Fairbairn (1954, p.18 and 1963, p.224) the anti-libidinal ego with its rejecting object, and the ideal object together form a complex structure, which Freud had earlier called the super ego. Therefore, in Freudian terminology it is the super ego which attacks the central ego. The resulting feelings of sadness and/or depression would seem a 'natural' reaction to the losses accrued to a person who was earlier functioning from a position of mature dependence. Indeed, research conducted by (Teri and Gallagher-Thompson, 1991) suggested there is a high incidence of depressive type symptoms in the early stages of dementia. However, there is also the possibility a person would avoid experiencing these depressive type symptoms by using the defensive techniques of the transitional stage of

development (i.e., would begin to regress). Thus, the rejecting object of the anti-libidinal (ego-object) pair, and the exciting object of the libidinal (ego-object) pair could be externalised preventing the central self (central ego-ideal object) from experiencing depressive type symptoms, but at the cost of experiencing persecution instead, as all the bad object relational experiences are now felt to come from outside of oneself. This is Fairbairn's paranoid transitional technique (1941, p. 45), and could lead to instances of people with dementia blaming others for losing, misplacing or even stealing items from them (Mace et al, 1985, p. 160).

Alternatively, and staying within the stage of quasi-independence (1941, pp 39 and 41), a person may start to become obsessional (1941, p. 44) to regain some control over their life when it is becoming so disorganised, due to memory loss caused by dementia. As the illness progresses and a person continues to lose the contents of their mind and its functions to dementia (Cheston, R. 1998, p. 216) I believe this technique assumes particular importance in understanding the experience of those with dementia.

However, an alternative to the obsessional transitional technique, and its opposite in terms of the distribution of internal objects (1941, pp 43-44, and Figure 2) is to expel all the good and bad object relational experiences into the external world, so the world is divided into separate good and bad objects. It is as if the world is a safer container for a person's feelings, than their own mind, which is beginning to fragment because of dementia (Hausman, C. 1996, p. 188; Kitwood, T. 1997, p. 81). This is Fairbairn's phobic transitional technique (1941, p. 43), and combined with the obsessional transitional technique, they represent two different and opposite ways of dealing with internalised objects. However, in Fairbairn's developmental theory, the quasi-independent stage of transitional techniques (1941, pp 39 and 41) is framed within the context of the development of the self (1941, p. 35), but here it is to be thought of in terms of the regressive effects of dementia upon the mind, as a person is becoming more dependent (upon others) not less dependent (Burns et al, 1995, p. 57).

Finally, another way of coping with the distressing effects of dementia, is to utilise the hysterical transitional technique, where all the good (accepted) objects are externalised, and all the bad (rejected) objects are internalised (1941, p. 45). This enables supportive relations with others, encouraging one to maintain a positive image of coping. However, this can lead to problems later in the illness, if a person starts to deny they are having difficulties coping with day to day living (Burns et al, 1995, p. 58). They can then become increasingly at risk of self-neglect, or harm from potential dangers in their environment (Phair, L. and Heath, H. 2001, p. 34). This lack of insight is a major problem according to (Fairbairn, A. 1997, p. 13) when trying to persuade people with dementia, that they do need help.

These are all understandable ways of dealing with the difficulties of day to day living because of dementia, especially the feelings that accompany awareness of the dementing process. These feelings are called the 'secondary' or associated effects of dementia and are a result of how a person responds to the primary, degenerative effects of the illness (Burns et al, 1995, pp 40-42). However, whichever technique becomes manifest would be the result of a compromise between one's psychosocial environment, and the relative strength of each of their internal

psychic structures (i.e., the two subsidiary selves, and the central self) as a person tries to cope with their experience of dementia.

Thus, in a busy environment such as a hospital ward, where staff tend to focus on meeting patients' physical needs, their psychosocial needs are going to be considered as less important (Bell, J. and McGregor, I. 1995, p. 14) and this may trigger a reaction in the form of Fairbairn's paranoid transitional technique, where it becomes relatively easy to blame others for one's misunderstandings and misfortune. Alternatively, an environment where there is not a lot of interaction between people may allow an obsessional transitional technique to manifest, where one attempts to manipulate and exert control over one's environment, but only in a limited way. A phobic transitional technique, where one's feelings are played out in the external world, dividing part of the world into all good, and another part into all bad (thereby distorting relationships and making them unrealistic) can be seen in environments where people occupy different social roles. An example might be in hospitals, where staff are seen as all good and other patients as all bad, leading these other patients to be ignored, or even treated in a hostile, sometimes aggressive manner. The hysterical transitional technique is most likely to occur in a relatively benign environment where staff have more time to spend with patients. It allows one to maintain positive relations with others and feel good, despite increasing dependency (upon others), caused by the debilitating effects of dementia.

Given Fairbairn's model of the mind (Figure 1), the use of the above transitional techniques suggests there has been a diminishment in the ability of repression to keep internalised, bad objects away from the central self, in order to reduce conflict (1943, pp. 65,66). But why should repression begin to fail?

First, relative to the central self, the subsidiary selves are becoming proportionally stronger, as the central self continues to diminish as a result of the dementing process (i.e., as the illness progresses, other cognitive functions apart from short term memory begin to be affected, such as language, abstract thinking, problem solving, various types of agnosia's, and the ability to make judgements; Burns et al, 1995, p. 37). I take these increasing symptoms as signs of a deteriorating central self in Fairbairn's theory. And the weakening of the central self can also be reinforced in environments that do not provide for sufficient caring and supportive relations. This is because the central self is constituted out of "…relatively satisfying, or at any rate tolerable aspects…." (1954, p.17), of relationships which help to strengthen and sustain it. Environments that are unsupportive and depriving will therefore not provide the kinds of relationships the central self needs but will instead reinforce (indirectly) the split-off and repressed subsidiary selves, which are constituted out of these types of unsatisfactory relations (1954, pp 15-16). Given such circumstances it is unlikely repression (of these subsidiary selves) will work for long, therefore evidence of transitional techniques should soon become apparent as the illness progresses.

In Fairbairn's endopsychic model of the mind all the internal psychic structures are relational in the sense they are connected to each other via libidinal or aggressive energies and are themselves a consequence of relational experiences. The endopsychic structure is formed at the end of the second oral phase, or "… late oral phase [which] …is characterised by a high degree

of emotional ambivalence…" (1941, p. 48), as "…the object maybe bitten in so far as it presents itself as bad. This means that differentiated aggression, as well as libido, maybe directed towards the object." (1941, p. 49), and aggression is "…the dynamic of repression directed by the central ego not only against internalised bad objects, but also against the subsidiary ego's …" (1951, p. 171), and it is this process that enables the endopsychic structure of the mind to be formed. However, the relative strength of each structure can change throughout life as Fairbairn suggests when discussing the "…moral defence against bad objects (1943, pp 65, 66), where "…To redress the state of unconditional badness [the child] internalises his good objects…" (1943, p. 66), implying Fairbairn's structures are dynamic and can change because of different kinds of identificatory experiences. However, Fairbairn is discussing the central ego-ideal object structure of his model here. Can the subsidiary selves change too? Given "…there is no one whose libidinal development proceeds wholly without a hitch…" (1946, p. 145), then "…internalised bad objects are present in the minds of us all at the deeper levels." (1943, p. 65). According to Fairbairn (1943, pp. 69, 70) these internalised bad objects can be released from the unconscious in psychotherapy, but only "…safely …if the analyst has become established as a sufficiently good object for the patient" thereby allowing the ego's cathexis of these bad objects to be dissolved. Once made conscious therefore, these (bad) endopsychic structures, "…Given a satisfactory transference situation…" (1943, p. 70) can be changed, and their devastating effects upon the mind weakened. But can this work in the other direction too, so that the ego's cathexis of bad, internalised objects becomes even stronger? Although Fairbairn does not discuss this idea directly, I think his (1943) paper "The War Neuroses-Their Nature and Significance" gives some clues as to the kind of answer he would give. When discussing one of his case studies, he says "…that the amount of stress required to produce a breakdown varies from individual to individual; and that the incidence of the war neuroses is determined not only by…infantile dependence…., but also by the nature and strength of the mental defences which can be erected to control its disturbing effects, [and]…it is only after such defences have been worn down that the underlying dependency becomes apparent…". (1943, p.265)

Considering the central self, comprising the central ego-ideal object, Fairbairn says "…whereas the central ego must be regarded as comprising pre-conscious and conscious, as well as unconscious elements, the other ego's must equally be regarded as essentially unconscious." (1944, p. 104) (Figure1). The central ego therefore mediates between external and internal reality and is also responsible for the repression of the subsidiary selves (1963, p. 224). Therefore, whatever weakens the mental defences also weakens the central self in its capacity to repress, as "…we conceive energy as inseparable from structure…" (1946, p. 150), and this can only be a lack of "…relatively satisfying, or at any rate tolerable…" (1954, p.17) relational experiences. It is therefore a lack of these kinds of relational experiences that wear the central self-down, including its ability to repress, that leaves (in Fairbairn's example of war neuroses) a soldier vulnerable to the disturbing effects of bad object relational experiences, and hence potential breakdown.

Thus, the central self can change because of its surrounding psycho-social environment, and in psychotherapy the bad internalised objects of the subsidiary selves can also change (1943, pp

69, 70). Therefore it follows that in an environment lacking in "…relatively satisfying…" (1954, p.) personal relationships, not only is the central self-weakened (and therefore its ability to repress), but also once the subsidiary selves have been triggered and become conscious (although of course, you may not attribute these subsidiary selves to your 'self', see for example the transitional techniques; 1943, pp 65, 66), these can actually be strengthened in an environment that is depriving of loving relations. Therefore in Fairbairn's case studies of soldiers who break down (1943, pp256-288), "…the regression [to a] hidden state of infantile dependence…which…a war neurosis is to be ultimately ascribed" (1943, p. 286) is due to a combination of a weakening of the central self and hence its ability to repress, but also a strengthening (in terms of energy and structure) of bad objects (composed of unsatisfying relational experiences) that have now been released from repression in an environment that is depriving of loving experiences. Hence, once under way, a breakdown can happen very quickly.

Thus, although the basic endopsychic structure of the mind is formed at the end of the late oral phase, (1951, p. 171), the relative strength of each structure can change throughout a person's life because of different kinds of experiences. Therefore, a lifetime of relatively supportive, kind and loving relations will strengthen the central self, making the subsidiary selves by comparison seem quite weak. However, a lifetime of struggle, unempathic and critical experiences will strengthen the subsidiary selves, leaving the central self poorly developed, and unable to cope with the demands of life very well. Hence the internal economy of one's sense of self is completely experiential, its dynamics determined by its relational experiences, and its structures based upon those experiences (1946, p. 151), which also determine the relative strength of each structure in terms of their energy.

Therefore, in terms of dementia, whichever transitional technique is used as a person begins to regress from a state of mature dependence to increasing levels of dependency, there is certainly a move from relating to differentiated objects in the world, to one based more on projective identification of one's internal world.

Projective identification is a very important defence mechanism that some researchers believe is ubiquitous in those with dementia, especially at more advanced stages (Balfour, A. 2007, p. 244; Davenhill, R. 2007, p. 209). It is also used in Fairbairn's transitional techniques (Figure 2) apart from the obsessional technique, where all objects are internal to self, which is an example of introjective identification (1949, pp153, 154). Projective identification allows one to locate experiences (often bad, but sometimes good) outside of oneself in others. Thus, Fairbairn describes "…the characteristic feature of the paranoid technique… [as the] …active externalisation of internalised bad objects…" (1943, p. 75) "And internalisation of the accepted object." (1941, p. 45). The hysterical technique is "…characterised by… externalisation of the accepted object and internalisation of the rejected object (1941, p. 45), and from (Figure 2) the phobic techniques is characterised by both the accepted and rejected objects being externalised. Thus, projection and internalisation (introjection) of both good and bad internalised objects is vital in terms of Fairbairn's developmental theory. Indeed, it is the "Internalisation of …. (the mother and her breast) …." that starts off the whole of Fairbairn's developmental theory (1963, p. 224). From the beginning stages of Infantile Dependence which is "…based upon primary identification…" (1941, p. 34) to the projective, introjective techniques of the transitional stage

(1941, p. 46), projective identification is a concept used throughout Fairbairn's theory to show how people deal with their relations to internal and external objects.

Given Fairbairn's endopsychic model of the mind, which he believes is a "…universal phenomena…which proves quite conclusively that everyone without exception is schizoid at the deeper levels…" (1940, p. 8), then what is projected (externalised) is the ideal object, and what is repressed are the bad object relational experiences with their attendant part ego's. This endopsychic situation (1944, p. 105) can change if "…repression fails to prove an adequate defence against the internalised bad objects and these begin to threaten the ego…" (1943, p. 65). The central ego is therefore unable to "contain" these bad objects, and integrate them into its ideal object relationship, hence projective identification and the use of transitional techniques becomes the only way the central ego can defend itself from these disturbing relations. And of course, in a progressive illness like dementia (Burns et al, 1995, p. 3) where the central ego-ideal object is becoming increasingly damaged, attempts to contain and integrate bad object relational experiences would only have the effect of weakening the central self even further. Therefore, for someone with dementia the best defence against the distressing effects of these bad objects would be to project them outwards. Hence all of Fairbairn's transitional techniques (apart from the obsessional) rely on projecting part of oneself into outer reality, which then becomes identified with what is projected. The obsessional technique relies on introjective processes where parts of external reality (good and bad) are taken into oneself and become identified as oneself (Figure 2). This can lead to obsessional routines to deal with the anxiety between expulsion and retention of objects (1941, p. 44). Although all these techniques distort inner and outer reality, they do not lead to a complete break from it as in psychosis. They are "…differing methods of…averting the onset of a schizoid or depressive state." (1941, p. 56).

What does all of this mean in terms of my data?

I have two sets of data. One is Dr M. Mills eight individual case studies and the other is my reflective diary based upon my experiences of working on a ward for people with advanced dementia.

To explore the effects of dementia upon a person's sense of self, the 'who am I' of my research question, I have taken a qualitative approach to data collection. This is because the question 'who am I' is a search for meanings, not causes, and it is the meanings people give to their experiences of living with dementia, that I will investigate. Within the qualitative research paradigm, there are many different approaches to research. Because I am exploring changes in sense of self as the illness progresses, then a longitudinal approach to data collection is required. Therefore, I will use Yin's (2003) Multiple Embedded Case Study Approach, consisting of Dr M. Mills eight single case studies, and a reflective diary, based upon the principles of participant observation on the ward I work on (Dalke, Hall and Phinney, 2015).

However, the data from the case studies is secondary. It consists of interviews with "…eight elderly people with moderate to severe medically diagnosed dementia [who nevertheless] could all respond verbally to questioning, could speak about their past life, and that they would enjoy

one to one interaction with the investigator." (Mills, 1998, p.58) Also "All informants, bar one unmarried male, lived with their spouses in the community. He lived in a local authority home for the elderly." (Mills, 1998, p. 65) I chose to use this data (with the authors permission), because it was collected over "…a period of five to seventeen months." (Mills, 1998, p. 77), interviewing eight people with dementia who attended their local Day Hospital. Dr M. Mills (original researcher) has given me copies of all her transcripts from these interviews, and it is this data I will draw upon when applying Fairbairn's theory to understanding the dementing process. This is because her study was able to investigate people with dementia over a significant time (via interviews) as their illness progressed, allowing insight into their changing experiences, which I can attempt to understand using Fairbairn's model. However, because the data is secondary, it may be biased towards Dr Mills own research question. This is because she may have already anticipated certain themes that would come from her data analysis, which may have then biased her methods of data collection. For instance, she may have anticipated a deterioration in her participants sense of self over time (as this is what the dementia care literature suggests, for instance, Bender, 2003; Cheston, 1999; Cohen and Eisdorfer, 2001), which may have influenced the kinds of questions she asked in the interview process i.e. she would be looking for evidence of a deteriorating sense of self when interviewing participants, which may have biased the data collected. Also, she uses a narrative model of self (Mills, 1997, 1998, p. 79) which is different to Fairbairn's psychoanalytic model of self. Therefore, I need to be mindful of Dr Mill's potential biases when analysing her data.

A reflective diary (based upon participant observation) is another way of obtaining data about people's experiences of living with dementia. It is based upon my experiences of working on a ward for people with advanced dementia, who often have profound difficulties communicating their experiences verbally. It therefore complements my secondary data.

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CHAPTER THREE

A Critical Overview of Psychosocial methodologies, and an argument for a new Psychosocial approach based in Fairbairn's object relational theory.

Introduction

In this section, I will introduce the methodology that I will be using for my data collection and analysis. I will use reflective diaries as my method of data collection, and these will be a record of my experiences with patients on the ward I work on. I will then analyse this data using Fairbairn's endopsychic model of the mind (1952), which as well as being psychoanalytical (Williams, P. 2012), is also I suggest a psychosocial model of the self and can therefore be understood within a psychosocial framework. I will begin by briefly introducing the field of psychosocial studies, focussing particularly on its diverse epistemologies, and critiques of these, before introducing Fairbairn's model of self, as a new approach in psychosocial studies that is less vulnerable to the criticisms of other approaches.

Psychosocial studies and psychoanalysis

According to Walkerdine (2008), since psychosocial studies emerged institutionally in the United Kingdom in the 1980's psychosocial researchers have wanted to use psychoanalysis within their research particularly post-Kleinian psychoanalysis. This has been especially true in research involving interviews, for instance the FANI method of Hollway and Jefferson (Hollway and Jefferson, 2003; Midgley, 2006; Hollway, 2009), and in observational studies which frequently employ the psychoanalytic concepts of transference, counter transference and projective identification (Holman, Meyer and Davenhill, 2006; Ng, 2009; Ramsay-Jones, 2015). Walkerdine (2008) also suggests that the move to include psychoanalysis within psychosocial studies may have been a reaction by some sociologists against structuralism and post structuralism, which focussed on the role of discourse in producing subjectivity, although Lacanian psychoanalysis of course also emphasises language in the constitution of subjectivity But according to (Redman, 2005; Clarke, S.2006; Hoggett, 2008) it was the failure of discursive techniques to account for the affective component of people's lives that led psychosocial researchers to include psychoanalysis within its methodology. One of the first to do this was Hollway and Jefferson (2000), who used techniques from clinical psychoanalysis such as counter transference to elicit information about unconscious communication of affects that may not be expressed in text, but which never the less influence how people construct their narrative identities. A lot of psychosocial researchers since then (Redman, 2005; Clarke, S.

2006; Thomas, 2007; Hoggett, 2008; Rustin, 2008; Gough, 2009; Clarke and Hoggett, 2009; Redman, 2016) have stressed that the proper focus of psychosocial research should be emotion. These authors tend to attribute a person's emotional life and its meaning to their unconscious, which is viewed dynamically and as being mutually constituted with one's social world (Redman, 2005). Although inner and outer reality are acknowledged as different, because one cannot be reduced to the other (Hoggett, 2008; Redman, 2016), yet via processes like projective identification and introjection, they also constitute each other. Thus, in this way people are psychosocial (Hollway and Jefferson, 2000).

According to Roy (2013), this is different from a social constructionist view of a person, which he describes as a metanarrative that draws attention away from an individual's unique history. Roy (2013) suggests that inner reality is uniquely one's own and is governed by different rules (such as unconscious phantasy in psychoanalytic theory, Redman, 2005), compared to outer reality, which can be understood using social constructionism. In both cases however (i.e., psychoanalytic theory and social constructionism) theory has to be inferred, it is not obvious. A psychosocial approach, however, aims to bring together these two perspectives in terms of both their latent and manifest content (Varvin, 2011). For instance, psychoanalytic concepts such as transference and counter transference could be applied to qualitative research based upon interviews. As interviews involve people's subjectivity (Thomas, 2007) which is constituted partly out of unconscious processes and is therefore not available to them discursively, (meaning they cannot be reduced to social categories), then one needs psychoanalytic theory (usually Klein and other object relational theorists) to make sense of the data (Redman, 2016). For instance, Rustin (2008) says in object relational theory, talking is primarily determined by the relational dynamics of the participants and the unconscious intersubjective processes occurring between them, whereas in discursive psychology, talking is determined by the availability of different discourses. However according to psychosocial researchers, this "realist" focus only on the text (Hoggett, 2008) leaves out the affective component of communication i.e., what is not said, which can be just as important as what is said in terms of identity construction (Thomas, 2007). It is these unconscious themes that can be inferred from using different psychoanalytic techniques.

As well as techniques such as transference, countertransference, and projective identification (Hollway and Jefferson, 2000; Kvale, 2003; Midgely, 2006; Hollway, 2009; Holmes, 2013), which are used to elicit awareness of unconscious emotional dynamics between researcher and their subject(s), there is also the psychoanalytic method of free association, which gives the psychosocial researcher insight into the unconscious motivation and anxieties "behind" what

people say (Clarke, S. 2006; Thomas, 2007; Gough, 2009; Hollway, 2009; Redman, 2016). Free association is seen as important in psychosocial research, because it allows people to say what they want, without fear of ridicule or rejection (Thomas, 2007), thereby giving the researcher a more honest appraisal of who the person is they are interviewing. As previously suggested, what is not said can be as important as what is said therefore psychosocial researchers also look for gaps, inconsistencies, repetitions, and patterns of association in texts (Holmes, 2013; Redman, 2016), to try and detect unconscious processes and their influence on narrative construction. This more holistic view of a person, combining conscious and unconscious aspects is structured intersubjectively (Hollway and Jefferson, 2003; Kvale, 2003; Clarke, S. 2006; Frosh and Baraitser, 2008; Rustin, 2008; Clarke and Hoggett, 2009; Hollway, 2009; Varvin, 2011; Hollway and Froggett, 2012; Holmes, 2013; Roy, 2013) This means it is based on human interaction, where the relationship is the locus of knowledge (i.e. not the individual), and the knowledge produced is always intersubjective, not objective. In fact, in psychoanalysis, objectivity is seen as a defence against anxiety therefore researchers using their feelings as a way of gaining insight into the affective, unconscious processes of their subject(s) is seen as completely valid, and compatible with qualitative research in general, where all data is seen as intersubjective (Midgely, 2006).

However, to make this co-production of knowledge between researcher and their subject(s) meaningful, it must be worked through by the researcher, which psychosocially, usually means using Klein, or other object relations theory to understand the affective component in this new knowledge (Redman, 2005; Hoggett, 2008; Rustin, 2008; Varvin, 2011). This is because researchers who use psychoanalysis to understand people psychosocially believe that their subjectivity is at least partly constituted via unconscious processes (Thomas, 2007), and because these are split off and repressed (Redman, 2005), it is only via intersubjective processes, where the researcher pays close attention to their own subjectivity (Redman, 2016), that they can gain access to some of the unconscious dynamics within their subject(s), which may never become apparent in the dialogue (text).

Criticisms of using psychoanalysis in psychosocial research

Within psychosocial studies there are researchers who are critical of using psychoanalysis for data collection and analysis. Taylor and McAvoy (2015) claim that the relation between researcher and researched in a qualitative interview for instance, is different to an analysand undergoing psychoanalysis with an analyst, especially in terms of frequency and duration of contact. They argue that concepts such as transference and counter transference which depend on variables such as frequency and duration of contact are not valid in a research situation, and

so cannot be used in terms of collecting data (about the unconscious) or analysing data in terms of latent (unconscious) meaning. Frosh and Baraitser (2008) are also critical of using psychoanalytic concepts such as transference and counter transference outside the "clinic", because they say researchers are often not trained in psychoanalysis, therefore they have no experience of using the above techniques. Taylor and McAvoy (2015) support these criticisms saying that to use psychoanalytic concepts in a way that is valid, requires a much longer relationship (so trust can be built up), than is usually the case in a research relationship, where participants may only meet once or twice. And Wetherell (2005) who does not disagree with the psychoanalytic view that people do suffer from internal conflict but suggests this does not have to be understood in terms of psychoanalytic concepts like the unconscious but can instead be thought of as people using whatever discourses are culturally available to them to explain their experiences. It is when some of these discourses are contradictory that causes conflict within people. The view that data, especially text, has an unconscious latent meaning is an example of "over-subjectification", according to Parker (2015).

Even authors who are supportive of adopting psychoanalysis into a psychosocial framework are wary of its reductionistic, individualising, pathologising, and sexualising tendencies (Kvale, 2003; Frosh and Baraitser, 2008), and its view of itself as a master discourse (Hood, 2008) where the analyst is presumed to have "expert knowledge" of the analysands inner world. Frosh and Baraitser (2008) for example, are critical of object relations theory, because they say it suggests adult relationships are determined by developmental (relational) processes that lead to internal psychic structures (i.e., internal objects) that are static and confined to early development, and therefore separate from social relations. These underlying psychic structures then cause people to express themselves in certain ways that result in rather limited and predictable accounts of adult relations, that cannot be subsequently transformed by other social relations. Frosh and Baraitser (2008) are also concerned by the tendency for psychoanalysis to be used as a master narrative, thereby undermining all other narratives, with the attendant risk of reducing the social to the psyche. Hence their preference for a Lacanian (because of its emphasis upon language as constitutive of subjectivity) and social constructionist view of a person.

According to Midgely (2006), the psychoanalytic focus on the intersubjective production of knowledge has been criticised by positivistic researchers who argue that because the knowledge produced is unique to a particular researcher and their subject(s), and to the theory used, then psychosocial researchers who rely on using psychoanalysis for data collection and analysis means their findings lack objectivity, reliability, and validity. They therefore cannot

be generalised and are too theory driven. To counter some of these criticisms regarding the lack of reliability and objectivity in their findings, psychosocial researchers have included psychoanalytic observational studies (Hollway, 2009; Roy, 2013), as a way of testing hypotheses and triangulating data. This is often contrasted with psychosocial researchers who prefer using discursive strategies to analysing data, which do not rely on researcher subjectivity (Wetherell, 2005; Parker, 2015). Yet for all psychosocial researchers (psychoanalytic and/or discursive) the intersubjective production of data is important, and they all use the concept of reflexivity to support this (Walkerdine, 2008; Clarke and Hoggett, 2009). According to Clarke and Hoggett (2009) reflexivity is at the heart of psychosocial research, because it is fundamentally opposed to objectivity in social science research, believing there is no truth apart from the practices that produce it (Hollway, 2009). It therefore supports the idea of the intersubjective production of knowledge, where the researcher is completely implicated in knowledge production. The concept of reflexivity strongly suggests to researchers the vital importance of trying to understand why they have invested in a particular theory (psychoanalytic and/or discursive) to understand their data, the assumptions they are using, and how their own desires (for certain outcomes for instance) can influence their feelings in the intersubjective relationship and hence the data produced. Ramsey-Jones (2015) suggests that using a reflexive approach can support the validity of findings in qualitative research.

Defence of using psychoanalysis in psychosocial research

Thomas (2007), and Hood (2008), believe it is acceptable to use psychoanalytic concepts in qualitative research, because it is only being used for academic purposes such as theory building and testing, and as a certain way of conceptualizing narratives. It cannot be used to psychoanalyse individuals, due to a lack of transference, which takes time to develop (Thomas, 2007). Although Hood (2008) suggests even in clinical psychoanalysis interpretation can never be definitive (by definition, one can never know the unconscious). Nevertheless Kvale (2003) suggests, psychoanalysis does have a lot in common with qualitative research, particularly in terms of its case study approach based in human interaction, because the locus of knowledge production is within the relationship and not the individual, so knowledge produced is always intersubjective, not objective. What psychoanalysis adds, he says, is a way of understanding this through the concept of the unconscious and using transference and counter transference as ways of understanding this intersubjective relationship. A “realist” focus only on what is said (Hoggett, 2008) leaves out this affective component of communication, where what is not said, can be just as important as what is said in terms of the construction of identity (Thomas, 2007). It is these unconscious themes that can be detected via the above psychoanalytic techniques.

Rustin (2008) also criticises the focus on discourse in producing subjectivity, suggesting this only deals with the symbolic realm of subjectivity. As Hoggett (2008) says, feelings come first, then sometimes words. Most psychosocial researchers tend to see a reliance on discursive practices as too limited, as they fail to consider one's emotional life, which cannot always be represented in narrative (Redman, 2005; Thomas, 2007; Hoggett, 2008). Discursive approaches are also criticised for being unable to explain why people take up subject positions in their discourses (Redman, 2005; Clarke, S. 2006; Midgely, 2006; Thomas, 2007; Frosh and Baraitser, 2008; Walkerdine, 2008; Gough, 2009; Roy, 2013; Redman, 2016). According to Rustin (2008), it is people's emotions that bring the psyche and social together, therefore one must understand why people identify with certain subject positions in society, to understand their psychosocial identity. A psychosocial approach aims to bring together both manifest and latent content in its data analysis (Varvin, 2011), therefore, to do this, one needs to understand the life history or biography of the individual concerned, to see how identities have become built up and fixed via identificatory processes, including the use of specific discourses. Without including biography, one cannot link the past with the present, and thereby understand why people emotionally invest (or identify) with certain subject positions in society (Gough, 2009). This linking biography with subjectivity via psychoanalytic theory, especially object relations theory (Rustin, 2008) allows one to understand how identities are formed in society because of different relational experiences and the availability of discourses to understand these. However, discourses can also be seen as performative and misleading in nature (Midgely, 2006), and therefore not reflective of emotional truth, hence the idea of "defended subjectivities" (Roy, 2013), and the need for a psychoanalytic approach when attempting to understand how a person's identity is constructed. A psychosocial framework is critically important here, because it can transcend the dichotomy of individual and society by bringing them together (Frosh and Baraitser, 2008). According to Redman (2005), the most suitable form of psychoanalysis to be adopted within this framework is object relational theory, because it suggests the psyche and the social constitute each other, via processes of introjection and projective identification. Thus, relational dynamics and unconscious processes occur together (Rustin, 2008). Some of these relations can be represented discursively (i.e., symbolically), but other experiences cannot be represented in language, and can only be communicated affectively, via projective identification, for instance (Holmes, 2013). Hollway and Froggett (2012) discuss Bion in relation to this, suggesting un-symbolised emotional experiences can become thinkable through the analysts/researchers' alpha function, which is an intersubjective, affective process. This alpha function depends on the analyst/researcher feeling "contained" them-selves, as

thinking is said to depend upon adequate containment. Therefore, experiences which cannot be communicated verbally to the researcher can using various psychoanalytic techniques be detected and made meaningful by the researcher, who may (or may not) communicate these back to the subject. In clinical psychoanalysis the analyst would be ethically obliged to communicate these meanings back to the analysand, to help them understand their experiences, but in a research relationship this is not necessarily the case.

As was discussed previously, Frosh and Baraitser (2008) do criticise object relations theory, because it suggests adult relationships are wholly determined by early developmental processes that lead to the formation of internal psychic structures that are separate from social relations and are therefore static. They argue these underlying psychic structures then cause people to express themselves in a limited and predictable way that cannot be transformed by any subsequent social relations. However, within the same article, when they consider how psychosocial researchers using Kleinian theory make sense of narratives, they suggest it is in terms of paranoid-schizoid and depressive position functioning, which implies internal object relations are not static, but can in fact change very quickly, even within the space of one interview. Also, their view that all knowledge is intersubjective and co-constructed with the researcher (Frosh and Baraitser 2008), suggests the researcher does influence their subjects, which implies researcher and subjects are not closed systems, but must be open, dynamic systems, so the possibility of transformation, and hence unpredictability in people's narratives, must always be taken into account, suggesting psychic structures can change.

A New Object-Relations Approach, Based in Fairbairn's Endopsychic Model of the Mind

An example of an object relations model that considers both the criticisms of a view of the internal world as both static and beyond change and challenges some of the points regarding its determinism is Fairbairn's endopsychic model of the mind (1952). In his (1944) paper, Fairbairn suggests that the self is originally unitary, but becomes structured as a result of internalising object relationships, and where these are unsatisfactory, they are split off and repressed to form the psychoanalytic unconscious. This results in a diminished central self, and an unconscious constituted out of over exciting and over-frustrating object relations, described by Fairbairn as libidinal and anti- libidinal. In Fairbairn's model, the unconscious does constitute a closed system, held in place by the central self's aggression towards these bad, internal object relations (1944), suggesting it would be hard to change. This could be the point Frosh and Baraitser (2008) are making when they criticise object relations theory for its view

of internal object relations as separate from social relations and therefore static. However, in Fairbairn's theory all these internal psychic structures are dynamic (1944). They are energetic, not static. Viewed as a whole, the endopsychic structure is a dynamic system, open to the world via the central ego and its ideal object, which can change because of new experiences, and some of these experiences may even begin to change the more repressed, primitive object relations, by bringing them into consciousness, where identifications with bad objects can be given up. If this happened there would be no need for Fairbairn's transitional techniques (1941) as a way of dealing with bad object experiences. This could be truly transformative, and challenges Frosh and Baraitser (2008) position that internal object relations are divorced from social relations. Although Fairbairn's view of the self, is a relational/structural one (1946), it is also very much a dynamic view, where every "part" is in constant interaction with all the other "parts". Of all the object relations theorists, Fairbairn is best able to meet the criticisms of adopting this approach in psychosocial studies, particularly the critique advanced by Frosh and Baraitser (2008).

According to Kvale (2003), object relations theory and psychoanalysis in general, has also been criticised for its reductionistic, infantilising, sexualising and pathologising tendencies. Can Fairbairn meet these criticisms better than other object relational theories? His theory of how the endopsychic structure of the mind develops does leave him open to the above criticisms, but for different reasons to other psychoanalytic theories. In contrast to Freud and Klein, Fairbairn says libido is primarily object seeking (1944, 1963) rather than pleasure seeking as in classical psychoanalytic theory therefore the most fundamental need of the ego is for satisfying personal relationships. Any unsatisfactory object relations are expelled from awareness, via unconscious processes of splitting and repression, which in infancy are intensified due to the infant's vulnerability and dependency (1941). These unsatisfactory object relations are what constitutes the unconscious. Thus, Fairbairn does not view the unconscious as something everyone is born with but is instead a consequence of relational experiences that are never quite loving enough to prevent fragmentation of the ego. Discursive psychologists also see self as fragmented, but this is because of contradictory discourses (Gough, 2009), rather than unfulfilling personal relationships. Therefore, from Fairbairn's perspective, the earlier criticisms of psychoanalysis are understood as secondary to poor object relations, suggesting the possibility of better, more loving relationships being able to heal the splits in the self that have led to its fragmentation which have resulted in it being characterised in the way Kvale (2003) describes.

Compared to Lacan, who views the unconscious as always being produced in language (Frosh and Baraitser, 2008) and therefore never static, Fairbairn's model could be seen as essentialist in some respects, for instance, theorising everyone is born with a unitary, pristine ego (1944). Nevertheless, he views the ego as a dynamic, open system (1954), continually interacting with its environment, and inner object world. It is therefore never static (Clarke, G. S. 2006) and depending on one's "real" relations with the external world, there is always the possibility for growth.

Thus, Fairbairn's theory does successfully meet the challenges put forward by psychosocial researchers who are critical of including psychoanalysis, particularly object relations theory, within a psychosocial methodology. His model of the self also fits most naturally within a psychosocial framework, because he views the self as completely relational (Greenberg and Mitchell, 1983). Thus, at the beginning of life, the ego is unitary, object seeking and libidinal (1944), desiring relations with others that are loving and nurturing. However, due to the inevitability of experiencing frustration and disappointment in its relations with others then according to Fairbairn these experiences will lead to the splitting of the ego, and the repression of these unsatisfying object relations (1963), which then becomes the (system) unconscious. Therefore, the psyche and social in Fairbairn's theory are mutually constituted, as psychosocial researchers suggest they are (i.e., both those who support a psychoanalytic approach and/or discursive one), and neither approach can be reduced to the other (i.e., the social into the psyche, via psychoanalysis, or the psyche into the social, via discursive practices), (Wetherell, 2005; Redman, 2005). Fairbairn's theory can transcend the dichotomy of individual and society, which is what a good psychosocial theory should do, according to (Frosh and Baraitser, 2008). It also suggests a novel approach to methodology.

Although psychosocial researchers who use object relations theory, employ concepts like counter transference, projective identification and containment during their data collection and analysis (Hollway and Jefferson, 2000; Kvale, 2003; Redman, 2005; Clarke, S. 2006; Holman, Meyer and Davenhill, 2006; Midgely, 2006; Thomas, 2007; Rustin, 2008; Walkerdine, 2008; Hollway, 2009; Ng, 2009; Holmes, 2013; Ramsay- Jones, 2015; Redman, 2016;), they actually have no way of knowing what in particular they are looking for, when applying these concepts in an interview, or an observational study for instance. Their only source of information/data becomes their own subjectivity, which then leaves them open to the criticisms of qualitative researchers who take a more positivistic approach to research (Wetherell, 2005; Midgely, 2006; Frosh and Baraitser, 2008; Hood, 2008; Taylor and McAvoy, 2015). However, Fairbairn's theory of self is a structural one (1946), suggesting changes in one "part" of the self-system,

will result in changes to all the other parts. It is this view of self, which gives the psychosocial researcher something to look for, when collecting and analysing data. There is in this sense no need for the above psychoanalytic concepts, which risk the accusation of data being too subjective (Taylor and McAvoy, 2015), relying more on researcher subjectivity, than the actual account given by their subject(s) (Frosh and Baraitser, 2008). According to (Midgley, 2006; Varvin, 2011 and Holmes, 2013) this makes the results of data collection and analysis ungeneralizable because they are dependent on the subjectivities of a specific researcher and their subject(s) in a particular moment in time, using certain theoretical constructs.

In Fairbairn's structural theory (1946), there are quite specific changes to a person's sense of self that the psychosocial researcher can look for. There are the four transitional techniques (Fairbairn, 1941) described as obsessional, paranoid, hysterical and phobic, which are the different ways the ego relates to its internal objects (Clarke, G. S. 2006). These are the characteristic (neurotic) defences the ego uses against being overwhelmed by the split off and repressed subsidiary selves (i.e., the libidinal and anti-libidinal selves) which would lead to psychosis (Fairbairn, 1941). Therefore, a psychosocial researcher using Fairbairn's model of self, does not need to depend upon their own subjectivity to either collect or analyse data. Instead, unconscious processes become apparent via the use of the above transitional techniques, or in displays of unprovoked, and disinhibited episodes of an aggressive or sexual nature (i.e. as evidence of the above defences failing, and the breaking into consciousness of the repressed, subsidiary selves). Methodologically, it is therefore stronger than other psychoanalytic models, because in both the collection of data (whether this is by interviews, observations, or both) and its interpretation, there is no reliance on researcher subjectivity to gain access to latent, unconscious meanings in either text or behaviour. These become apparent as the researcher looks for evidence of either the transitional techniques or the subsidiary selves in text or behaviour. It is the application of Fairbairn's model that guides research, not researcher subjectivity (i.e., in the sense the researcher does not have to use their own feelings as a source of data for the unconscious of their subject(s)). Thus, a psychosocial researcher undertaking an observational study on a dementia ward need not think of themselves as a "container" for the split-off and projected feelings of the people with dementia, which they would try and understand using concepts like counter transference (Holman, Meyer, and Davenhill, 2006; Ng, 2009; Ramsay-Jones, 2015). Applying Fairbairn's model, one would be looking for evidence of the use of transitional techniques, as a defence against further regression to possible psychosis, which if it did break through, would become observable as unpredictable and unprovoked episodes of verbal/physical aggression, and/or sexual

disinhibition. This requires straightforward observation (and empathy) on the part of the researcher. It is therefore more objective, and the findings more valid than an approach that relies on the feelings of the researcher. In relation to the transitional techniques, I will assume (as other psychosocial researchers do who use object relations theory), that talking is reflective of underlying object relations and the relational dynamics of that encounter (Frosh and Baraitser, 2008; Rustin, 2008). Thus, if someone is "using" (unconsciously) the transitional technique of paranoia, this should be apparent in their speech (and possibly behaviour). The researcher does not need to infer paranoia from their own feelings (i.e., as a counter transference reaction). And the same should be true of all the other transitional techniques- they should be "observable" in the researched persons/patient's speech and/or behaviour. This enhances the validity and reliability of any research findings, as other researchers could apply Fairbairn's model to the data, to see if they agree with the results of previous research. It also means the psychosocial researcher does not have to use their own feelings, as a guide to the subjectivity of the persons researched, therefore avoiding the criticisms of psychosocial researchers who prefer to use discursive approaches (Wetherell, 2005; Frosh and Baraitser, 2008; Hood, 2008; Parker, 2015), as well as qualitative researchers in general, who are very critical of using techniques from clinical psychoanalysis (Wetherell, 2005; Midgely, 2006; Frosh and Baraitser, 2008; Brock, 2011). Since Fairbairn's model of the self is structural (1946), it should be possible to understand changes in sense of self in a systematic way, allowing for the testing of hypotheses, which can either support, or refute the validity of his model. In the psychosocial research literature, some authors use the concept of reflexivity, to encourage researchers to reflect upon their own assumptions, regarding choice of theory, methods of data collection and analysis (Frosh and Baraitser, 2008; Fellenor, 2010; Brock, 2011), but this has also been criticised because it encourages splitting of the ego, where one part of the ego reflects upon another part (Hood, 2008). The application of Fairbairn's model to the data does not involve using a concept like reflexivity, and it also allows other researchers to test the results of any data analysis, because data collection, analysis and interpretation are not reliant upon researcher subjectivity.

Thus, Fairbairn's model, as well as being the most psychosocial of all the object relations theories, is also the one that is the most rigorous, in terms of its objectivity, because it allows for the generation of hypotheses that can be tested by other researchers.

Conclusion

In this chapter, a relatively new approach to doing qualitative research has been introduced, which is called psychosocial (Kvale, 2003; Walkerdine, 2008). It attempts to transcend the dichotomy of individual and society by bringing them together (Frosh and Baraister, 2008) through its various methodologies.

In the psychosocial literature there appear to be basically two ways of bringing psyche and social together. One is discursive, focusing on people's use of discourses to understand their experiences, and included within this approach is Lacanian psychoanalysis, because of its emphasis on language in the construction of subjectivity. The other is psychoanalytical, usually using post-Kleinian, object relations theory to understand subjectivity. Both approaches have their critics. Discursive approaches are criticised for having no adequate theory to explain why people take up subject positions in society, even when they are harmful to a person, and psychoanalysis is criticised (mostly) because of its over reliance on researchers using their own subjectivity in their collection of data, and its analysis. This is because they assume data has a latent, as well as a manifest meaning.

These are broadly the main criticisms of each approach, and Fairbairn's model of the self was introduced as a theory that could meet these criticisms. Being psychoanalytical (Williams, P. 2012) it can account for why people emotionally identify with certain discourses in society (even if harmful to self). It is also a structural/relational model (Fairbairn, 1946), so in a research encounter, such as an interview, how a subject relates to a researcher reflects (in Fairbairn's theory) a specific configuration of internal object relations (i.e., a structure). This does not have to be inferred using the researcher's own subjectivity, although it may have an effect on their subjectivity. It is the application of his model to the experience of the encounter that is the basis for understanding, not researcher subjectivity. Fairbairn's model can therefore counter the criticisms of over-subjectification and lack of objectivity that other psychoanalytic models have been accused of.

Fairbairn's view of self as being completely dependent on internalised object- relations makes it the most relational of all object relations theories and therefore the most psychosocial too.

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CHAPTER FOUR

Methodology for the collection of data, and its analysis into categories

Introduction

My PhD is an attempt to understand how dementia effect's a person's sense of self. I have a model of self, based in Fairbairn's object relational theory of mind. In chapter two of my thesis, I introduced Fairbairn's structural model of the mind and using the definition of dementia given by the Royal College of Psychiatrists I argued that dementia is an illness that mostly effects the central self of Fairbairn's model, leading to increasing levels of confusion as the illness progresses. However, as well as the central self, there are also subsidiary selves within Fairbairn's theory, which the central self defends itself from, because they are damaging to the idealizing types of relations that constitute the central self (i.e., they are over exciting and over rejecting), and therefore 'bad' from the central self's viewpoint. As the central self continues to be damaged by the dementing process, these subsidiary 'structures of feeling' become relatively stronger (in terms of affect), and therefore play an increasing role in how a person with dementia relates to others and themselves. When the central self eventually becomes so weakened, then one or other of these subsidiary selves may become the dominant way of relating internally and externally.

My method of collecting data was motivated by the belief that by looking at people's behaviour on the ward where I work (which is a ward for men diagnosed with dementia), and observing how they relate to each other, the staff and the ward in general, I could infer from this data what is happening to a person's sense of self who has dementia using Fairbairn's model of the mind.

Rationale for using Reflective Diaries as my method of data collection

Since I already work on a ward for men diagnosed with dementia, the most appropriate method of collecting data about my experiences would be via keeping reflective diaries. This does not involve interviewing anyone, but instead writing a reflective diary describing my experiences at work. This is a most appropriate method I feel, especially as those who are experiencing dementia (and those in hospital tend to be at the more advanced stages) often suffer with communication difficulties, making it harder for them to put into words their experiences. It therefore seems unreasonable to try and interview these people about their life experiences, so because of this I feel keeping a reflective diary of my observations at work would be the best way of collecting data about these people.

In total I kept fifty reflective diaries, starting from 13/06/2016 to 6/07/2018, therefore nearly two years, but with a four-month gap between 8/11/2016 to 3/04/2017, and just over a year gap between 29/05/2017 to 25/06/2018. The year gap was taken because of pressures at work, and therefore difficulty keeping up with my PhD studies. The diaries cover different kinds of shifts over a twenty-four-hour time, and for different days of the week. I tried to write my diaries as soon as the shift had finished, but this was not always possible (i.e., after a late shift for instance), but they were always written up by the following day at the latest. I tried to include as much detail as I could in each diary. They varied in length, but an average would be about a thousand words each diary.

Since where I work, is also the site of my data collection, means I can carry on working in my role as a nurse, and do everything I normally do, but then afterwards I can write my reflective diary, based upon my experiences that day. This seemed to work well. Of course, my diaries only describe some of my experiences on the ward, but during every shift, I am involved with every patient in some way or other, therefore I feel my diaries do give a fair and honest representation of what it feels like to be on the ward.

Rendering my data meaningful

Once I had completed my fifty reflective diaries, which altogether consisted of about fifty thousand words, I had to reduce all this data into something that was manageable, but also meaningful. I always wanted to stay as true to my experiences of events on the ward as possible so when I try to infer from these events what others are experiencing, and what this means in terms of their sense of self using Fairbairn's model, I am being as true to that lived experience as possible, which consists of me as researcher, and everyone else involved in that event.

My first step in making all the above data manageable, but without losing its meaningfulness was to read through each diary, and record events such as medicine rounds, mealtimes, personal care, paperwork, when this was completed, I had fifty-eight patients and fifteen events recorded in my diaries.

The following stage took the longest, because I had to summarise every entry for each event. I then had to summarise these summaries. I did manage to do this, condensing all my summaries for each event into about one paragraph each. This did mean leaving out some detail, but I realised in a lot of my entries I was only repeating myself, so it was not unreasonable to condense a lot of my entries for each event into one paragraph. But this still left me with seventy-three 'bits' of data to analyse, so I had to reduce this again. I went through my summaries for each event looking for similarities between them, and by focusing on what was similar, I was able to condense my seventy-three summaries down to six (quite large) categories,

which would encompass all my summaries. These categories are summations of events where I describe patients who are:

(1) cognitively intact upon admission to hospital (2) who deteriorate in hospital, (3) who become sexually disinhibited (4) who exhibit aggressive behaviour, (5) who wander (6) and who withdraw (based upon my experiences of those who have a very poor diet and fluid intake, and who are also the most confused).

And within each category, because of all my entries for each event, I can give lots of examples. Due to the progressive and debilitating effects of dementia upon a person, I do believe these categories can be ordered in a way that reflects this. Thus, at the earlier stages of the illness, we have the category of those who are still quite cognitively aware, then the category of people who deteriorate in hospital, then the category of those who wander, then the aggressive and sexually disinhibited categories, and finally the category of those who appear to have withdrawn from external relations. These categories are in themselves meaningful, as they reflect the experiences of people with dementia (but specifically in a hospital setting), as the illness progresses. It is to these six categories that are the results of making the data of my reflective diaries more manageable and meaningful, that I will analyse.

Summarising my data analysis for each category and subcategory

Categories

1) People who are cognitively intact

In this category, there are some people who deteriorate, and some who do not. In those that deteriorate, some become more confused, others develop obsessional routines, and some begin to experience intense periods of separation anxiety. Using Fairbairn's framework, those who are becoming more confused suggests there is further weakening in the affective integrity of their central selves due to dementia and the response of their ideal self to this diminishment, which is to feel overwhelmed. The inability of their central and ideal selves to contain these very anxious experiences, leads to the increasing fragmentation of their central self, therefore disrupting their ability to remain reality orientated, and causing even greater confusion. Their response to this devastating situation was to seek out good object relational experiences, which would help to sustain their ideal and central selves and defend against further fragmentation caused by their repressed bad, object relational experiences coming into awareness. Therefore, some patients wanted to go home to be with their loved ones, but because this was not possible,

staff often ended up substituting for patients loved ones and there was at least one occasion when a patient followed me all over the ward. However, others who initially functioned quite well in hospital, quickly seemed to deteriorate, as if their sense of self had fragmented causing deterioration to a state of infantile dependency and becoming completely dependent upon nursing staff to meet all their needs. In one case even resorting to constantly stripping their clothes off to keep staff's attention. No doubt in all these cases, dementia continued to damage their central self, and its ability to remain object related to the world and people's response to this is completely understandable using Fairbairn's model of the self, and within the context of the social milieu of the ward.

There was no evidence that the others who deteriorated ever had dementia, as they were certainly never confused. Their deterioration is I believe a direct consequence of the effects of the psychosocial environment of the ward, upon their ideal and central selves, particularly their ideal self. For instance, some people started to become obsessional, and I believe this was a consequence of regressing to Fairbairn's obsessional transitional technique in order to both defend and support their ideal and central selves (however, not from dementia), but from the psychosocial environment of the ward which offered them no positive, validating relational experiences to make them feel worthwhile. Their routines became their way of doing this. When other patients started to experience episodes of extreme tearfulness, I believe this was due to both very intense feelings of separation anxiety from their loved ones, whilst also feeling rejected by them too. The effects of their regression to intense feelings of separation anxiety also increases their risk of infantile dependency, so in moments of extreme tearfulness I believe they are feeling the intensity of all their rejected ego-object nuclei of what was their anti-libidinal self. However, their separation anxiety is also constituted out of a lack of positive, and supportive relational experiences on the ward, which would have helped to maintain the integrity of their ideal and central selves, thereby minimising their risk of regressing to feelings of intense separation anxiety. Hence without these supportive kinds of relational experiences people become more anxious and fearful, contributing to their desire to go home. This is supported by my experiences that their tearful episodes are only ever short lived, and they would soon appear to "come back together" again, and appear fine (i.e., their central and ideal selves would be integrated once more) suggesting regression to feelings of separation anxiety is a consequence of an inadequate relational environment on the ward, and not dementia.

The remaining people in this category did not deteriorate. Most spent their time in their bedrooms, but a few did spend a significant amount of time in the ward environment. If as suggested above, the relational nature of the ward environment lacks the kind of relationships

that are necessary to maintain the integrity of a person's ideal and central selves, then why did those who spent most of their time in this environment not deteriorate? I believe this is because they are still able to form supportive and positive relations with at least one other. This could be with their spouse, for instance, or with another patient that they could help but what was important is that these relations were always good enough to maintain the cohesiveness (i.e., affective integrity) of their ideal and central selves, and so act as a 'buffer' to the paucity of relations on the ward. However, challenging the hypothesis of the necessity of a supportive environment to prevent deterioration in object relations is the case of a person who was always verbally abusive towards others, and he did not deteriorate. I believe this was because he already had deteriorated to an anti-libidinal relationship to others, so his only relational need is to reject others, which he does continually on the ward. He has no need of positive relationships, and he would only reject these, as depicted in Fairbairn's model of the relationship between the anti-libidinal and libidinal selves. All the remaining people in this category who did not deteriorate take a defensive stance towards maintaining their ideal and central selves, by avoiding the ward environment and staying mostly in their bedrooms, thereby isolating themselves from others, as they perceive relationships on the ward to be damaging. This could be understood in terms of a regression to Fairbairn's various transitional techniques such as the paranoid transitional technique for instance, keeping the 'bad' outside, to preserve the good inside (and where their bedroom comes to symbolise their ideal self). However, this kind of behaviour could also be seen as a rational response to being in an unfamiliar environment full of strangers. It need not necessarily be seen as a sign of regression to earlier modes of relationship. In fact, all the people who tended to stay in their bedrooms were never unkind to the other patients. They always treated them with respect. It could be in those moments, these people felt more integrated, and were able to relate to others from a position of mature dependence. However, at other times, they may have felt less integrated, and therefore more defensive, and could only relate to others using various transitional techniques.

2) People with cognitive deficits who deteriorate in hospital

All the people within this category have cognitive deficits caused by dementia, and they all deteriorate whilst in hospital. I believe, it is those who already have a weakened central self that deteriorate the quickest and I think their vulnerability comes from experiencing a lifetime of disappointing and invalidating relational experiences that leave them with chronic feelings of humiliation and rejection. They therefore never achieve an integrated sense of self, which is dependent upon loving, supportive relations. Once in hospital, they find themselves in an environment that can feel quite strange and isolating, especially if their cognitive deficits

include difficulties with using and understanding language, which can then compound feelings of isolation and even rejection, particularly if staff cannot understand them. Under these circumstances and with little support from the psychosocial environment of the ward their sense of self would quickly collapse, deteriorating to a late oral stage of infantile dependency, where the anti-libidinal relational structure could come to dominate their experiences, leading to physical aggression. However, those with a more integrated sense of self (i.e. either their dementia is less advanced, and/or they have experienced relatively satisfying relations during their life) can still become aggressive, but this is more likely to be due to regressing to the transitional stage and using a paranoid transitional technique, for instance, which would be less intense and of a shorter duration compared to those who due to the vulnerability of their central self, quickly break down and deteriorate to a late oral stage of infantile dependency, from which they may not be able to recover.

Others in this category who also deteriorate seem to experience separation anxiety quite quickly, but they do not become aggressive. I also noticed they could still communicate their needs to staff. They could therefore make staff understand what they wanted, and I believe this was enough to keep them object related to the world, and therefore maintain their central and ideal selves from being overwhelmed by bad object relational experiences, and potentially becoming aggressive.

Then there were others, who although confused, only slowly started to deteriorate in hospital. This suggests their sense of self was in fact quite integrated despite the ravages of dementia. They only slowly began to deteriorate. For instance, despite their confusion, they were originally settled and only slowly began to wander. This change in behaviour suggests it was the effects of a less then optimal psychosocial environment upon their ideal and central selves that was beginning to make them feel anxious, and their defence against this was to search for good object relational experiences using the hysterical transitional technique.

Finally, those with cognitive deficits who began to spend more and more time in their bedrooms do appear to deteriorate in hospital but only as far as the stage of transitional techniques. They do not appear to regress beyond this stage and seem to be using an obsessional transitional technique to maintain their sense of self.

3) Aggression (verbal and physical)

As I originally divided my analysis of the data in this category into four subcategories, I will therefore do the same here, and write a summary for each sub category

a) Restless in afternoon

This can be understood as the failure of the hysterical transitional technique to maintain repression of its bad object relational experiences, so as these become conscious, there is increasing anxiety between the central and ideal selves, and these subsidiary selves. This conflict is managed by adopting an obsessional transitional technique, which becomes manifest in people when they start to move furniture around. They are therefore attempting to control their feelings, by taking control of items of furniture.

b) Hoarding

Based upon prior arguments made in my original data analysis I believe we can arrange the people in this subcategory in terms of the level of integration of their sense of self.

Thus, those who hold onto their dirty clothing whilst staff are helping them with their personal care have the most integrated sense of selves. They employ an obsessional transitional technique to defend their ideal and central selves from the demands made upon them by ward staff. They will not go along with their interventions and be passive whilst staff care for them. They have a sense of self that feels good so long as it remains identified with and in control of, its internal and external objects, and will not release control of these, because to do so will mean experiencing considerable anxiety. However, aside from personal care their object relations do not appear to deteriorate, and they appear to function in a mostly integrated way.

Those that collect physical objects and put them inside their clothes, have sense of selves that are less integrated than those who hold onto their dirty clothing. They are employing Fairbairn's obsessional transitional technique to consolidate their central selves by collecting various objects on the ward and identifying with them. Due to their cognitive impairment caused by dementia, the actual objects they collect and identify with, are physical objects they can exert control over. Since they do not appear to deteriorate further and experience separation anxiety, for instance they never tried to leave the ward, hoarding (as a particular manifestation of Fairbairn's obsessional transitional technique) might function as a defence against separation anxiety.

Those that hold onto their dirty plates and cups at mealtimes appear to have the least integrated sense of selves of anyone in this subcategory. They seem to have deteriorated (at least at mealtimes) to a stage of development Fairbairn calls the late oral stage of infantile dependency. However, although their behaviour at mealtimes might suggest this, and they all have advanced dementia, it is highly unlikely that their sense of self has disintegrated to such an extent it resembles that of a young infant. Therefore, the pleasurable experiences they associate with mealtimes are in the service of consolidating they're already existing endopsychic structures, particularly their central selves that have been built up over a lifetime of experiences, although

now seriously damaged by dementia. And of course, to defend against their bad object relational experiences that are still a part of them. They also seem to relate to the world, much more passively than other patients. For instance, they always need the assistance of staff when eating and drinking. This implies there has been significant deterioration in their orientation to external reality, suggestive of a less integrated sense of self.

c) Verbally aggressive

In chapter two, and from a theoretical perspective, I have argued dementia mostly effects the central self of a person. Therefore, as the illness progresses their central self will deteriorate, and as language is one of its functions, the more deteriorated their central self becomes, the less able are they to verbalise their experiences. With only limited resources to use language to communicate their feelings to others, they are left to contain these feelings by themselves, which could lead to agitation and physical aggression, particularly if these feelings are associated with their subsidiary selves, which may start to become dominant as their central self is diminishing. We would therefore expect an inverse relation between verbal ability and physical aggression, and there is a 'trend' in the data for this subcategory that supports this. For instance, those who were articulate were hardly ever physically aggressive, but those whose dementia was more advanced, and were therefore less able to verbalise their experiences were frequently aggressive. But what is verbal aggression in itself? In some, it accompanies separation anxiety, but in others, there appear to be different reasons. For instance, some patients shout for attention, others shout if they do not get what they want, and others shout at staff to be left alone. There is therefore another trend here. Those whose dementia is less severe shout for their loved ones, those whose dementia is more severe shout to get their own needs met (i.e., for staff's attention or wanting things), and those whose dementia has advanced the most only shout when they feel impinged upon.

Considering separation anxiety first, in patients who are verbally aggressive, this only becomes apparent when they are separated from their loved ones. This could be understood as the effect of their subsidiary selves becoming more prominent in consciousness and their only way of mitigating this is to find their loved ones. They seem unable to use transitional techniques to manage their internalised bad object relational experiences. Separation anxiety therefore represents a stage beyond the transitional stage, but it does not necessarily imply a person has poor cognition. Rather it reflects the affective intensity of their subsidiary selves. As dementia progresses, it seems verbal aggression is then used to focus attention back onto the self (i.e., the central and ideal selves) due to feelings of increasing vulnerability as a result of their subsidiary selves coming into awareness. It is as if staff are acting as substitutes for loved ones,

who are no longer available. This also follows from the progressive effects of dementia upon a person, as they begin to find relations with the external world increasingly difficult and confusing, so they begin to withdraw libido from external relations and focus it instead on their self, making their own self their libidinal object. It is this reorientation of their libidinal aim that leads to their verbally aggressive and demanding behaviour, always wanting staff to do things for them. However, as the illness progresses and the central self becomes weaker and weaker, so all relations become internal ones, and the only time there is verbal aggression now is when these internal relations are impinged upon by external demands as in the case of people with severe dementia. Verbal aggression is now an expression of a desire to be left alone, rather than earlier when it was a desire to be acknowledged, or even earlier when it expressed a need for their loved one.

Thus, verbal aggression is always relational, and is either an expression of a desire for a loved one, to be acknowledged, or finally to be left alone.

d) Physically aggressive

Apart from the occasional patient who did not have dementia, and appeared instead to be suffering from psychosis, everyone else in this subcategory has severe dementia, and they are all physically aggressive (but only during staff intervention). No one has good verbal skills, and this reflects the finding from the previous subcategory that those with poorer verbal skills, also tend to be physically aggressive, and have a greater degree of dementia. I have suggested that most of the people in this subcategory have regressed to the late oral stage of infantile dependency, because they are only physically aggressive during staff interventions, otherwise they are mostly fine. The only exception to this are those who relate to their internal and external objects via a paranoid transitional technique, and in these cases their aggression is longer lasting, and every nursing intervention only seems to make their aggression worse.

4) Sexual disinhibition

The most concise way of summarising these findings for people who are sexually disinhibited is in terms of their object relations. Thus, patients using a paranoid transitional technique, as in the case of the gentleman who was alternately very flirtatious, or otherwise quite destructive, (but never aggressive), are the most object related of all within this category. They relate to their material and psychosocial environment via their libidinal and anti- libidinal selves, but there is still an object relation. The only female patient in this study has regressed beyond the transitional stage as a way of managing her relational experiences, and instead experiences separation anxiety. However, her frustration at not being able to see her husband (or forgetting she has seen him, due to dementia) is managed by taking her husband as her ideal self. However,

because her libidinal-self is now more conscious because of a weakened central-self due to dementia this bond becomes even more libidinised, resulting in her relations with others becoming over libidinal, which may come across as sexual disinhibition. The patient who became psychotic has regressed even further and become completely identified with his libidinal self. There is no separation anxiety, and he experiences the world through the intensity of the excited ego aspect of his libidinal self, so everyone around him becomes an exciting object. There are therefore still object relationships, but all external ones are based exclusively upon his libidinal self. Hence, his belief he has had sex with everyone, and is now pregnant. He therefore appears to have regressed to the early oral stage of infantile dependency.

Thus, sexual disinhibition increases as object relationships break down, which is almost inevitable for someone with dementia. However, object relationships can break down for many reasons (i.e., not just dementia), as can be seen when comparing the patient who became psychotic with the female patient, because his sexual disinhibition was far greater than hers, yet his dementia was not as advanced. Nevertheless I do believe advancing dementia does make sexual disinhibition more likely, because of its devastating effects upon a person's sense of self, particularly their central self, weakening its ability to repress the subsidiary selves.

5) Wandering

Wandering can be understood in three different ways depending upon the anxiety that accompanies it, and the defences used to ameliorate this anxiety. Initially there is wandering based upon the hysterical transitional technique, and people are looking for good object relational experiences to support their ideal and central selves. However, in an environment that is lacking in validating, relational experiences, this technique may eventually fail, leading to awareness of what were once repressed bad object relational experiences, which then invokes a phobic transitional technique as a way of disposing of these bad object relations. The externalisation of all object relations (good and bad) can lead to agitation though, as a person tries to flee from bad object relations in a desperate attempt to find good object relations. Wandering can then feel quite anxious, and if a person cannot find any positive relational experiences, the anxiety can become overwhelming, and the person might then feel compelled to make serious attempts to leave the ward. Here wandering becomes dominated by separation anxiety, and the person risks psychosis if they continue to deteriorate to the stage of infantile dependency.

6) Withdrawn

In this last category of people who are withdrawn, which I experienced in terms of their very poor diet and fluid intake, I have suggested it is Fairbairn's concept of infantile dependency

that best describes how they relate to themselves and the world around them. The main difference between people in this category, is between those who derive pleasure from their diet and fluid intake and will even try to prevent staff taking away their dirty plates and cups, (as these have become symbols of their pleasurable experiences), and others who seem to experience offers of diet and fluids by staff as an impingement upon their sense of self and will turn away. The first type of behaviour was understood using Fairbairn's concept of the late oral stage of infantile dependency, where relational experiences deemed bad, such as ones depriving people of pleasurable experiences, could be responded to aggressively. However, in the second kind of behaviour, it is actual relationships to the external world that are experienced as overwhelming, so a person deteriorates even further to the early oral stage of infantile dependency, where the strongest relationships are all to internal objects, particularly libidinal objects as these are the last ones to be affected by dementia. Hence, my analogy to dreaming.

CHAPTER FIVE

A contextualisation of my data analysis with the work of other researchers.

Introduction

In Chapter four, which is my data analysis chapter, I had fifty reflective diaries to analyse. It took a very long time to do this, but I was able to condense the contents of my fifty diaries into six categories or "themes" based upon my observations of people's behaviour on a ward for male patients with dementia. These categories were than arranged hierarchically, starting with those in category one, who showed no evidence of dementia, to those in category six, who were at the last stages of the illness. Thus, going from categories one to six, there is a steady deterioration in people as they become more confused, and this deterioration is marked by changes in their behaviour, which is what I observed. To understand these changes in people's behaviour from a unique perspective, I applied Fairbairn's concept of self to my findings. This is a psychoanalytic theory, which is also object-relational, meaning it focuses upon the nature of relationships, and how these become incorporated into a person's sense of self, thereby influencing their thoughts, feelings and behaviour. However, in Fairbairn's model, some of these relationships can feel overwhelming to the developing ego, and are therefore split-off and repressed, so the ego can carry on interacting with the world. It is this development that makes Fairbairn's theory psychoanalytic, but it is his emphasis on the importance of relationships to the constitution of a sense of self, that also makes his theory relevant to the contemporary field of person-centred dementia care with its emphasis upon the relational nature of self, which is reflected in the importance they give to the nature of interactions between the person with dementia, and those around them. Therefore, by applying Fairbairn's theory to my findings, I can give a uniquely psychoanalytic understanding of these, but also develop the person-centred approach by including a relational view of the unconscious, which will allow for alternative and "deeper" understandings of the nature of relationships between people with dementia, and those around them.

However, it is also important to compare my findings with those of other researchers, who have observed how dementia affects people, and how they have than understood these changes, whether for instance, from a medical perspective, or a person-centred one. I can than see if my findings, regarding the changes I observed in people with dementia as their illness progressed, are supported by other researchers work, and how they have come to understand

these changes. This is important, because it will show my findings are valid, as there is no one else to check my observations. It is also necessary to compare my understanding, based in Fairbairn, with others, again to see if other approaches support my understanding of dementia, but also to see what Fairbairn's theory can add to this understanding, which other perspectives might not be able to do. Hence, the importance of contextualisation, not just in terms of checking my findings, but also in terms of how I have understood these in terms of Fairbairn's model of the self.

Category One

Based upon my reflective diaries everyone in category one is cognitively intact when they are admitted into hospital. There is no evidence of confusion. However, as time passes, some people do appear to become confused, and others develop neurotic type symptoms, but the great majority of people in this category do not appear to deteriorate and remain cognitively intact.

Research by (Treliving, 1988; p. 3) suggests that hospitalisation always leads people to regress, whether they have cognitive difficulties or not, because it encourages dependency in people as they try to adapt to hospital staffs' expectations of them. Also being separated from loved ones and a familiar environment can lead to confused and disorientated behaviour, as well as regression to earlier modes of relating (McKenzie-Smith, 1992; p. 2).

However, it was suggested in Chapter four that those who became confused, was because of dementia, and not because of regression. In other words, they had experienced a deterioration in object relations, not a regression of object relations, and this deterioration is manifested as increasing confusion, the cause of which I believe to be psychosocial. An example of a deterioration in object relations is given by Fairbairn when he speaks of, "…explicit pleasure –seeking represents a deterioration of behaviour…rather than of a 'regression' of behaviour…" (Fairbairn, 1946, p. 139-140). However, according to (Kitwood, 1997, p.36), it is possible to reverse some of the deterioration caused by dementia, by altering a person's interpersonal environment, so they can recover, "… some of the powers that had apparently been lost." The importance of the external environment particularly to the behaviour of someone with dementia is discussed in work done by (Stephens, Cheston, and Gleeson; year?) who suggest that a person's ability to regulate their feelings decreases as their dementia increases, because they find it harder to access their (good) internal objects, and so seek security instead in external objects. The authors use Winnicott's theory of transitional objects (Winnicott, 1951, p230, 231)

to understand why people with dementia, who are becoming more dependent use external objects as a way of ameliorating their anxiety.

Therefore, a lack of access to their internal objects, which are most likely to be damaged because of dementia, makes it harder for people to maintain object constancy, and so regulating their feelings becomes more difficult. It is this that motivates people to seek security in external object relations, and according to (Evans, 2008; p. 162 and Stephens, Cheston and Gleeson, 2013) this can lead to "following" type behaviour which is typical in the early stages of dementia. However, I also believe a lack of object constancy can be caused by a poor psychosocial environment, which is unable to provide enough supportive and reliable relationships that could maintain the stability of a person's internal object world. The gentleman mentioned in Chapter four, who slowly started to become confused and follow me around the ward, (13/08/16 and 9/09/16) could be understood as searching for security and reassurance in external object relations. However, I could find no research that supported my finding of a very rapid deterioration in a gentleman who returned to the hospital after initially being discharged to a nursing home (19/09/16). Articles by (Treliving, 1988; and McKenzie-Smith, 1992) found that separation from loved ones and moving to an unfamiliar environment can cause emotional regression, but I did not find any research that reported the rapid deterioration in behaviour that I noted in my reflective diaries, particularly for someone who initially functioned so well. There was an article by (Edvardsson and Nordvall, 2008), who found that when people are moved into institutions, a lot of the symptoms that they go on to develop are not caused by any underlying disease but are really to do with loneliness. If I translate their finding of loneliness into Fairbairn's concept of separation anxiety, then this might provide some support for the very rapid deterioration I observed in a gentleman who initially presented so well. However, he never tried to leave the hospital, and if his rapid deterioration into a state of severe confusion was a result of separation anxiety, one might expect some attempt to leave. Also in Fairbairn's developmental theory, but particularly in relation to his paper on the 'War Neuroses' (Fairbairn, 1943; p. 286), separation anxiety could also be understood in terms of regression, and the articles by Treliving, (1988) and McKenzie-Smith, (1992) mentioned earlier, do say that people regress upon admission to hospital. However, none report the very rapid deterioration I observed, suggesting this was not a result of regression to separation anxiety, but instead a very rapid deterioration in object relations caused by the psychosocial environment of the hospital ward, which greatly accelerated the advance of his dementia, and from which he sadly never recovered.

In fact, most researchers do not use the concept of regression when discussing the effects of a poor psychosocial environment upon people with dementia. I found only one article that did (McKenzie-Smith, 1992) where the author discussed how an old lady had regressed to a child-like state because of staff misunderstanding her but was then able to regain her capacity to think again with the psychiatrists help. Instead, most research focuses on how negative interactions with staff can lower residents self- esteem (Brooker, 2009) and how repeated experiences of being unseen, and unheard can lead to escalating anger, but ultimately to a feeling of despair and with drawl (Ramsay Jones, 2019). This also happens when care remains custodial (Kelly, 2010) and people feel unrecognised and unsupported by staff, leading to anger and frustration, sometimes aggression. According to Kelly (2010) this is because staff focus on patients' physical needs at the expense of their psychosocial needs. Some researchers (Datler, Trunkenpolz and Lazar, 2009) suggest this is because staff are not interested in the inner world of patients, as this would interfere with their task of meeting patients' physical needs. However, (Heggestad, Per Nortvedt and Slettebo, 2015) believe most researchers in their work do emphasize the vital importance of confirming, person centred relational care in order to maintain a person's dignity and personhood, and they contrast this with care that is task orientated, meaning the patient becomes objectified, and care becomes instrumental.

Regarding the development of neurotic symptoms in gentlemen with dementia that I observed in category one, I could only find one article that was relevant to these findings (Evans, 2008). However, I did find articles suggesting seeing the behaviour of people with dementia, not as symptoms of a disease, but as ways of coping, particularly with threats to their identity (Bruce, Surr, Tibbs, and Downs, 2002) and seeing their behaviour not only in concrete terms, but as symbolic of their inner world too, which according to (Ng, 2009) would help staff to understand them better. The article by Evans (2008) suggests that hysterical type behaviour is common in the early stages of the illness (p.155), and regression may also appear to make the symptoms of dementia worse (p.160). However, and specifically in relation to my findings in category one, indicating the development of obsessive type behaviour after admission to hospital, I could not find any research reflecting this finding, therefore I must assume, and in agreement with the above articles by (Bruce, Surr, Tibbs and Downs, 2002) and (Ng, 2009) that this is a way of coping these gentlemen have developed over the years, especially when they have encountered stressful life events. These behaviours are a consequence of regression as in Evans's work (2008) but whether a person regresses to obsessional ways of coping compared to hysterical must be a result of individual life experiences, and how these have affected (structurally) their sense of self.

The gentlemen who appear to "break down" intermittently and then recover have also regressed at these times, but their temporary regression goes beyond neurotic techniques, to the infantile dependency stage of development. This is reminiscent of a patient described by Ng (2009, p.100) whose antisocial behaviour was a way of testing the environment of the ward to see if it was able to "contain" and care for her, and I believe the above gentlemen when they break down and regress to very early stages of development are also seeing if the ward staff truly care for them.

Patients who appear to be cognitively intact upon admission to hospital, and do not deteriorate, yet share the same psychosocial space as the people above who do deteriorate, have found a way of maintaining their sense of self and preventing regression, and they do this by forming positive, supportive relations with others. Interestingly they never formed these types of relations with staff. Instead, they met their psychosocial needs via their family, or with other patients on the ward. According to (Scales, Bailey, Middleton and Schneider, 2017; Ramsay Jones, 2016; and Datler, Trunkenpolz and Lazar, 2009)) this is because staff focus all their time on giving physical, personal care, so the psychosocial needs of patients are not met. However, this can then lead to very disruptive behaviour such as anger and depression (Ramsay Jones, 2019) or even aggression (Kelly, 2010). A lot of research stresses the importance of staff for setting the emotional tone of ward environments (Edvardsson, Sandman, and Rasmussen, 2011; Scales, Bailey, Middleton and Schneider, 2017; Ramsay Jones, 2016; Buse and Twigg, 2018; Bruce, Surr, Tibbs, and Downs, 2002; Heggestad, Per Nortvedt and Slettebo, 2015; and Ng, 2009), but all this research is for patients diagnosed with dementia. The gentlemen in my diaries who did not deteriorate, did not, as far as I could tell, have dementia, therefore they did not have to rely solely on staff to meet their psychosocial needs, but were able to initiate for themselves relationships that they found positive and supportive. It is this I believe, that prevented their regression to a point where disruptive behaviours became more likely.

Although as suggested above, a lot of challenging behaviour in hospital is believed to be the result of inadequate environments not meeting the psychosocial needs of patients, there was one gentleman in category one, who was verbally abusive all the time, and this was not the result of staff being unable to meet his relational needs. He seemed to have already withdrawn from relationships, and just wanted to be left alone. Any interference was met with verbal abuse, and he did not have dementia, nor did he deteriorate. His anti-libidinal stance towards others almost made him free from the effects of the ward environment, so he appeared not to need anything from others. I cannot contextualise this finding with any other research. He seems to

have regressed before coming into hospital, therefore the hospital environment seemed to have little effect upon him.

Finally in this category are the gentlemen who would spend most of their day in their bedrooms. They did not appear to have dementia, nor did they deteriorate. I understood this behaviour from Fairbairn's perspective as being indicative of a regression to the transitional stage of development, and their use of various transitional techniques to maintain their sense of self. Research by (Treliving, 1988 and McKenzie-Smith, 1992), support the view that admission to hospital often leads elderly people with or without dementia to regress, although they have no examples of this leading people to isolate themselves in their bedrooms. However, there is research by (Ramsay Jones, 2016 and Ng, 2009) that shows people will withdraw into themselves, if the ward milieu offers no satisfactory relationships where people feel valued and accepted. Although this research was based upon observations of people with dementia, who it has been shown by (Stephens, Cheston, and Gleeson, 2013; Edvardsson, Sandman and Rasmussen, 2011; Evans, 2008, and McKenzie-Smith, 1992), rely much more on others to regulate their feelings, nevertheless this research does show that people will withdraw from relations on a ward if they do not feel valued and supported. Therefore, the above gentlemen in my study had withdrawn into their bedrooms, because they felt the ward environment offered no validating relational experiences, and at times could even feel quite persecutory.

Category two

All those in category two did have dementia and experienced some degree of confusion, due to cognitive deficits. However, their deterioration in hospital is not in terms of increasing confusion, as would be expected from the progressive effects of dementia. Instead, their behaviour changes in quite specific ways such as becoming agitated, aggressive, wandering or isolating themselves. This suggests their changes in mood and behaviour are a result of regression in their object relations, and not a deterioration of these caused by dementia. I believe it is the psychosocial environment of the ward that causes people to regress, and there is a lot of research to support this. For instance, in her study of elderly people without dementia, who were admitted to a functional ward, Treliving (1988) found that feelings of loneliness can lead people to regress, and develop inappropriate dependency relationships, such as wanting staff to do their personal care, when in fact they were capable of doing it for themselves. Another observational study by McKenzie-Smith (1992) gave an example of a woman who was very independent upon admission to hospital, but who then quickly regressed to a state

like that of a young child, fearing she will never return to her familiar and loved objects. In the same study McKenzie-Smith (1992) gives another example of a very independent man who was admitted to hospital, but who then seems to give up, because of his physical problems. She says he had regressed to the point of just wanting to be kept physically alive, "Mentally he had died some time ago…" (p.12). She suggests that in both cases, if staff had listened to these patients, and provided them with emotional support, then their outcomes may have been a lot better.

Research by Evans (2008, p. 160) suggests "…there maybe functional states of mind that cause severe regression, which may mimic dementia or exacerbate pre-existing impairments…" It is certainly true that regression to some of the transitional techniques, such as the hysterical transitional technique in terms of wandering for instance, or the paranoid transitional technique in terms of suspiciousness or even aggression, would mimic some of the symptoms of dementia. It is also possible that if regression were to the infantile level of development where the mind is much less structured (Fairbairn, 1943; P. 286) this could be analogous to the effects of advanced dementia upon the mind. Therefore Evan's (2008) research does support the hypothesis that the effects of regression could mimic some of the signs and symptoms of dementia, which is how I understood my findings in category two. Evan's (2008) also says anxiety is very common in the early stages of dementia making the regulation of affects more difficult, yet what is "…of particular interest…" is how quickly these states of mind can be calmed by other people. This is a particularly important finding in relation to the gentleman in category two, who staff could not settle, because of his expressive and receptive aphasia. If he did not have this deficit then staff may have been able to offer him more support and containment of his anxieties. Also, and in relation to people with language difficulties, Evan's (2008) says art therapy can be a very useful way of helping people to reflect upon their experiences. However, for those with this deficit in category two, they were already too agitated to be helped in this way. Although the difficulties in understanding caused by this language impairment cannot be attributed to the ward staff, other approaches to communication and managing agitated behaviour could have been tried. Instead, patients were given extra medications to calm them. Research by Brooker looked at various observational methods to evaluate quality of care in institutional settings for people with dementia and found that Dementia Care Mapping (D. C. M.) as developed by Kitwood and his colleagues was the best method to identify excellent practice. According to Brooker, (2009) this is because (D.C.M.) is underpinned by Kitwood's theory of personhood, which Kitwood defines as a:

"Standing or status that is bestowed upon one human being by others, in the context

> of relationships and social being. It implies recognition, respect and trust. Both the according of personhood, and the failure to do so, have consequences that are empirically testable." (Kitwood, T.1997, p. 8)

This is a social psychological theory of a person, which argues that people with dementia will disintegrate (psychologically and emotionally) if their psychosocial environment is destructive, which Kitwood describes as:

> "…one of alienation and estrangement… [where] …we are distanced from our fellow human beings, deprived of our insight, cut off from our own vitality. The old culture is one of domination, technique, evasion and buck-passing." (Kitwood, T. 1995, p. 11).

It is this understanding of the effects of a poor relational environment upon people's sense of self that informs my understanding of why people in category two regress.

Kitwood was the first to develop an alternative understanding of dementia (Kitwood, 1990; Kitwood and Bredin, 1992), and move away from a purely biomedical framework, where dementia was understood only in terms of brain atrophy (Downs, Clare, and MacKenzie, 2006, pp 240-241). However, in my experience, it is still the case that patients such as those in category two, who are at the early stages of dementia and deteriorate, are still seen by staff as suffering from the inevitable and progressive decline associated with the disease, which suggests the biomedical model still prevails as the organizing principle of care (Harding and Palfrey, 1997). The transformation of dementia care that was started by Kitwood, and promoted by person centred theorists since, has not been realised in practice, as has been attested to by many authors (Ramsay Jones, 2019;). One reason for this is given by (Scales, Bailey, Middleton and Schneider, 2017) who suggest it is because care staff themselves feel disempowered and are therefore unlikely to challenge institutional norms of practice, (due to risk of disciplinary action, for instance) which maybe contradictory to the principles of person-centred care. Thus, because of social positioning (Scales, Bailey, Middleton and Schneider, 2017) say that care staff are also more likely to see the losses associated with dementia, as an inevitable part of the disease, and not, as I am suggesting, also a regression linked to the psychosocial practices of staff.

This is supported in findings reported by Kelly (2010), who undertook a three-year observational study in three continuing care wards of a psychogeriatric hospital and found that ward staff did not generally work in a person-centred way (Kelly, 2010; p. 112). There were some positive interactions between staff and patients, but these were often brief, because they

were time and task orientated, and minimal (Kelly, 2010; p. 112). These observations were than contrasted with those taken during creative sessions with Occupational Therapists, where interactions were found to be predominantly positive. The author concludes that if staff were to recognise and support their patient's selfhood, this would "…lead to qualitatively different staff behaviour with consequences for the well or ill-being of people with dementia…and…has the potential to transform practice and the experience of people with dementia in receipt of care…" (Kelly, 2010; p.103)

A similar approach is taken by (Bruce, Surr, Tibbs and Downs, 2002; p. 336) who stress the "…lived experience of dementia … [and] … assume that people with dementia are continuing to respond to, and seek meaning in the world around them, despite their disabilities… [and] …behavioural symptoms are understood as attempts to communicate needs and feelings." An implication of this point of view is that "…the action of staff … has a crucial role in determining the well-being of people with dementia." (Bruce et al, 2002; p. 336) Also, and in support of my own ideas, (Bruce et al, 2002) believes behaviours that are often dismissed as symptoms of dementia, can also be understood as ways of expressing agency and a sense of control. For instance, wandering could be understood as an expression of agency, rather than labelled and pathologised. They also make the point (Bruce et al, 2002, p. 343-344) that trying to understand patient's difficult behaviours, such as aggression, only in terms of dementia, is mistaken, because it fails to consider the finding, that these behaviours are more likely to occur among people with lower levels of well-being, who have a history of recurrent, negative life experiences (Bruce et al, 2002; p. 343-344). These findings accord with my hypothesis in category two, that people who deteriorate quickly in hospital, and become physically aggressive, may have always had a weakened ideal and central self, long before the onset of dementia, due to repeated patterns of negative life experiences, leading to feelings of humiliation and rejection. Although Bruce et al (2002) never discussed their findings in terms of a concept of self, but instead used Kitwood and Bredin's (1992a) framework for positive well-being, their understanding of the increased likelihood of aggression in people with dementia, who have suffered recurrent negative life experiences is exactly the same as mine. The only difference is that I used Fairbairn's concept of self to understand how negative life experiences could affect a person's sense of self, thereby increasing the possibility of aggressive reactions to perceived threats.

In research carried out by Ng (2009) on a ward for people with dementia over a ten-week period, she highlights one patient and notes her deterioration over a period of three weeks since admission. She records how staff are often inpatient with her when she asks them questions,

sometimes even ignoring her. Ng (2009; p. 98) notes how she loses her confidence, and becomes more uncertain of herself, especially when approaching staff, as if she expects to be refuted in some way. She starts to withdraw into herself, Ng says, as interaction with anyone on the ward only makes her feel worse.

In category two, I did notice some people begin to isolate themselves in their bedrooms, and I understood this as a schizoid withdrawal from external relations and onto internal relations, due to increasing difficulty in forming attachments to people in the outside world. I felt this was more to do with the devastating effects of dementia upon their cognitive functioning and the resulting deterioration in their object relations, then with the psychosocial environment of the ward. However, according to Ng (2009), it is the response of others that is the most important reason why people with dementia withdraw from interactions with others in a ward environment, and then often regress because of this. An excellent piece of research by (Edvardsson et al, 2011) shows just how important the staff are in setting the emotional tone of a ward's psychosocial environment. Based upon their observations in a ward for people with dementia in Sweden, they noticed that if staff were fully engaged with patients all the time, and not just during personal care (Edvardsson et al, 2011; p.1139) then patients experienced well-being. However, if staff were present, but not interacting with patients (i.e., they were focussed on getting physical tasks done), then patients became anxious, and sometimes disruptive. And if staff were physically absent from the ward, then patients' anxiety could quickly increase, so if for instance, a patient started to become restless and agitated, this would easily upset all the other patients, as they would not know what to do, without staff being present (Edvardsson et al, 2011; p. 1140). According to these researchers, the above behaviours are not the result of dementia, but are due to the regressive effects of the ward's psychosocial environment upon people with dementia, either when staff are totally absent, or if present, their quality of interaction with patients is very poor. This supports my findings in category two, where I suggest that changes in people's behaviour are the result of the types of interaction they have with others on the ward.

An article by (Datler et al, 2009; p. 73) which also supports the above findings, used observational techniques to explore the subjective well-being of residents with dementia in nursing homes, and found that staff and residents hardly communicated beyond what is essential to complete personal care. They suggest this is because staff are trying to avoid contact with the patient's inner world by focusing instead upon their physical, bodily care. This protects staff from experiencing powerful, primitive emotions, which if they were to become conscious, would interfere with their ability to do their work (Datler et al, 2009; p. 78). This finding

suggests why caring for people with dementia can create a certain kind of psychosocial environment. However, it is staff's disregard for patient's feelings, that according to the person-centred literature accelerates their deterioration, conceptualised as loss of self. This is discussed by (Small, Froggatt and Downs, 2007, pp110-111) when they suggest how person-centred approaches to dementia care use a social constructionist view of self, where self is constructed in relationship with others. Therefore, Kitwood (1997) "… places the onus for loss of self on the other people in a person's life." and (Sabat, 2006) believes, "Loss of this kind of self has its roots in the social world, not in neuropathology." However, proponents of the person-centred perspective do not understand this loss of self in terms of regression (because they do not have a developmental view of self). Never the less, the deterioration in people's behaviour they describe, is similar to my own observations in category two, where I have used the concept of regression to understand changes in people's behaviour. I would also add that when staff avoid patient's feelings by focussing on their physical care, they are also avoiding their own feelings, which may help them get through all their work, but leaves the patients still feeling distressed and without support, which may then lead them to regress as a way of coping with all their difficult feelings.

Category three

All the articles I reviewed in relation to sexual disinhibition in dementia did support my finding of a very low incidence of sexually disinhibited behaviour in people with dementia. In fact, work by (Cipriani, Ulivi, Danti, Lucetti, and Nuti, 2016) suggests indifference to be the major change in sexual behaviour in dementia and this seems to be the case in my own research. However, research by (Cipriani et al, 2016, p. 148) found that (Baike, 2002) had reported "A significant positive association was found between ISB and severity of dementia" and (Series and Degano, 2005, p. 425) report that Burns et al (1990) had found "There was a significant positive association with severity of dementia" and sexually inappropriate behaviour. Therefore, these other researchers had found that inappropriate sexual behaviour increases with the severity of dementia, but apart from the lady who was very confused, suggesting her dementia was severe, my own findings do not reflect this. Instead, I observed a gentleman who believed he had had sex with everyone, and was now pregnant, and another gentleman who could be quite destructive if a particular female member of staff was not on duty, but this behaviour would stop if she was on duty, and instead he would follow her, and try to touch her. Neither of these men were particularly confused, and both appeared orientated to time and

place. Therefore, although at the end of my conclusion to category three in Chapter four, I wrote that I do believe sexual disinhibition increases with advancing dementia, and so agree with the above findings reported in (Cipriani et al, 2016) and (Series and Degano, 2005), the only people I could collect data on, who were sexually disinhibited, did not have advanced dementia, apart from the lady. Thus, I do not believe their sexual disinhibition was a direct result of dementia. In the case of the second gentleman, I believe his behaviour was a response to all the losses he had endured from his various illnesses (i.e., dementia was not his only illness), and also being admitted to hospital. All these experiences I believe caused his sense of self to weaken, and begin to fragment, leading to regression to a paranoid transitional technique, allowing him to act out aggressive and sexual feelings. This behaviour may also be a means of asserting his masculinity, and gain some control over his environment (Brink, 1979, p. 43 and 275), which would compensate for his losses, and increasing dependency. Also, according to (Cipriani, et al, 2016) physical aggression may occur, if sexual needs are not met. In the first gentleman's case, his sexually inappropriate behaviour was I believe evidence of a weak central and ideal self, that had never the less remained the dominant part of his sense of self, until admission to hospital. He had a history of alcohol abuse, and without access to alcohol in hospital, his subsidiary selves became more dominant particularly his libidinal self, which manifested in very excitable speech and behaviour, but also delusional beliefs about sex. However, I also believe this behaviour protected him in an environment where he felt lost and vulnerable, as when he says he is pregnant, as if to say do not harm me.

Compared to the above gentlemen, the lady mentioned in my diaries was much more confused, suggesting her dementia was more severe. Therefore, her sexual disinhibition is supported by the work of others, who suggest there is a strong relationship between severity of dementia and sexual disinhibition (Cipriani, et al, 2016 and 58). My understanding of her behaviour in terms of separation anxiety may also be applicable to others whose dementia is more advanced.

In an observational study of forty men with dementia living in institutions (Zeiss, Davies, and Tinklenberg, 1996) and therefore like my own research, (although I have far fewer numbers), the authors found inappropriate sexual behaviour was very uncommon, and when it did occur, it was brief and minor. For instance, appearing in public only partly dressed is ambiguous behaviour they say, and is more likely to be due to deficits in the ability to care for oneself. My own findings suggest inappropriate sexual behaviour is also uncommon, but when it did occur, it was sustained over a long period of time. I think the discrepancy between my findings, and those of (Zeiss et al, 1996), is because in their observational study they are

describing behaviours that are ambiguous, meaning the researchers were unsure whether they were intentional or not. If they were not intentional, but a result of disorientation for instance (i.e., thinking the lounge was the toilet or bathroom), or confusion (i.e. not being able to dress appropriately) these behaviours would be easier for staff to accept and try to change. Whereas the behaviours I describe are far less ambiguous, much more explicitly sexual, and therefore reflect more determinate states of mind, such as structured by a paranoid transitional technique, or experiencing separation anxiety, or one which has regressed to primitive object relations within the libidinal self. This might be the reason for the difference between our findings.

Another difference is in terms of how our findings are understood. All the following articles (Higgins et al, 2004; Cipriani et al, 2016; Zeiss et al, 1996; and Serces et al, 2005) believe sexually inappropriate behaviour has a biological origin, although they do consider psychosocial factors such as needs for intimacy, or feelings of loneliness. However, my understanding of my findings suggests where behaviours are explicitly sexual such as in the gentlemen discussed previously, these are more likely to be due to subjective responses to the losses they have endured, or ways of coping in an environment where they feel vulnerable and with limited internal resources (i.e., a sense of self that has never fully matured). Their sexually disinhibited behaviour is therefore not a function of how dementia has damaged their brain, but a subjective response to their whole experience, including hospitalisation. The lady who staff believed to be sexually disinhibited, was very confused, suggesting dementia did have a significant effect upon her functioning, but this does not mean her perceived sexual behaviour was solely caused by the biological effects of dementia. It was her response to all her losses and confusion that was perceived as inappropriate, because it was sexual, when in fact, I believe, she was trying to maintain a libidinal relation to the world via her husband, to prevent further regression, and it was this desire that led to her sexually disinhibited behaviour, not dementia.

In my review of articles and chapters in books to do with sexual disinhibition in dementia, I found only one with a detailed case study (Bilbao and Bonavitacola, 2016). This was a psychoanalytical article, regarding the effects on a male patient of staff denying him sexual relations with a female patient (apparently consensual) and how this led to his regression and development of symptoms of dementia. This is an important article, because it is a detailed psychoanalytic case study, describing the effects of denying certain kinds of relationships in institutions, and how this can affect a person's sense of self, particularly in terms of the progression of dementia. Although based in Freudian metapsychology, their ideas are like my own. For instance, the lady who was very confused did experience a lack of libidinal relations with her husband, causing her to regress, and experience separation anxiety, and a further

deterioration in her object relations, leading to greater confusion. The gentleman, who excitably believed he had had sex with everyone, and was now pregnant, did not in fact seek a libidinal relation with anyone. It is as if his central self is unable to integrate the libidinal part of himself into itself, and thereby have a libidinal relation to the world. He also did not regress whilst in hospital. His behaviour remained the same, which is why I do not think his sexually disinhibited behaviour is related to his diagnosis of dementia. Also, the other gentleman who was prevented from having any libidinal relations with a particular female member of staff did not regress any further, but instead became destructive, as would be expected for someone relating to others with a paranoid transitional technique. Therefore, although his desire was for a libidinal relationship, it was really a part object relationship, within a paranoid transitional technique. Although in the above psychoanalytic article (Bilbao and Bonavitacola, 2016) the patient had dementia, he was described in a way suggesting he was more integrated than the above gentlemen in my study, therefore denial of libidinal object relations might indeed lead to regression, as his central self withdraws libido from external object relations, and onto internal object relations. Thus, the psychoanalytic case study is supportive of the lady searching for her husband, but because the sexually disinhibited behaviour of the two men in my study was not directly related to a libidinal aim, its denial did not cause further regression.

What then, are the available treatments for sexually inappropriate behaviour? According to Higgins et al, (2004) and Cipriani et al, (2016) neuroleptic (i.e., anti-psychotic) and anti-depressant medications are often the first line of treatment. This is because, inappropriate sexual behaviour is believed to be caused by dementia (Cipriani et al, 2016), and as suggested by (Bilbao and Bonavitacola, 2016) something that has an organic cause, needs an organic treatment. Although some researchers such as (Serces and Degano, 2005) believe behaviour modification techniques, and distraction are useful, (Cipriani et al, 2016) suggests staff prefer to use drugs, because they are quicker to administer, and are seen as more effective. However, whichever treatment method is preferred, (Series and Degano, 2005, p. 426) reports that there are no drugs in the United Kingdom that have been licensed for the treatment of sexually inappropriate behaviour and also no published data about which behavioural approaches work best. This suggests a combination of pharmacological and non-pharmacological interventions are probably the best strategy to treat this disorder, but they also agree with (Cipriani et al, 2016) that sexually inappropriate behaviour is one of the most difficult and least understood behavioural manifestations of people with dementia.

A very different approach to treatment then those advocated above, which rely upon a biomedical understanding of inappropriate sexual behaviour in dementia according to Bilbao

and Bonavitacola (2016) is to apply Fairbairn's theory to this behaviour, not just in terms of understanding it, as has been done so far, but also in terms of ameliorating it. Fairbairn himself states that:

> "…explicit pleasure-seeking represents a deterioration of behaviour…because if object-seeking is primary, pleasure seeking can hardly be described as 'regressive' but is more appropriately described as partaking of the nature of deterioration." (Fairbairn, 1946; p. 139-140)

Therefore, what might help ameliorate this behaviour are relationships that are experienced as being restorative of the true object relational needs of the person, which would allow for the integration of the pleasure-seeking object relations within the central self, which remains reality orientated (although compromised by dementia) and this would reduce any sexually inappropriate behaviour.

The application of Fairbairn's theory to the amelioration of sexually inappropriate behaviour in the two gentlemen, and one woman I have focussed upon here would take too long, therefore I will include this discussion in the appendix.

Category four

I have divided the category of aggression into four subcategories. This is because of its length (i.e., number of words), but also because when I was analysing my reflective diaries into categories and themes, I realised the category of aggression consisted of many different kinds of behaviours that were aggressive, therefore it seemed natural to divide the category into sub categories, according to the type of aggression displayed. "Restless in afternoon" is the first subcategory, because it is the least aggressive of all the behaviours, and not because the people in this sub category are the least confused.

a) Restless in afternoon

Although I have included restlessness as a subcategory of aggression, there are other researchers such as (Hi-Kong, 2005) who see it as a subcategory of agitation, which I accept is a better categorisation, as not everyone who is restless becomes aggressive, but it would be fair to say they are agitated. According to (Sloane, Mitchell, Preisser, Phillips, Commander and Burker, 1998) restless and agitated behaviour are prevalent in people with dementia, and (Kolanowski, Hurwitz, Taylor, Evans and Strumpf, 1994) says restless behaviour occurs 20.6%

of the time. There are many reasons for this according to Hi Kong, (2005), such as severity of dementia, impaired communication skills, conflicts between patients and staff, noise and unmet needs. Also, staff attitudes have been highlighted by (Sloane et al, 1998), and (Cotrell and Schulz, 1993) suggests it is a way of avoiding a stigmatising identity, such as becoming a burden. It could also be a way of responding to a new and unfamiliar environment (Kolanowski et al, 1994), or using the concept of sun downing, which is defined as a "…worsening of disruptive behaviour in late afternoon or evening…" (Bachman and Robins, 2006) restlessness could also be understood as being due to boredom, unmet physical or psychological needs, or fatigue in the evening, leading to increased irritability and agitation. Some of these findings also support my own. For instance, I found that it was the people who were more confused that were most likely to become restless in the afternoon, and this is supported by all the research mentioned above. I also found restlessness to be a risk factor for aggression in some, but not all people, and this is supported by Hi Kong, (2005). Research by Moniz-Cook, Stokes and Agar (2003), and Cotrell and Schulz (1993), also make links between psychosocial factors such as attitudes of staff, and restlessness, and this supports my general finding that it is the psychosocial environment of the ward that is responsible for causing some people to regress and become restless. However, it is only the article by Bachman and Robins (2006) on sun-downing that relates restlessness to the time of day, and only Hi Kong (2005) that suggests it can be a precursor for aggression. All of these findings from my own, and other people's research are important, because fundamentally what I believe is that the sub category of "restless in afternoon" is a result of an internal struggle between different parts of a person's sense of self that is played out externally, for instance in moving pieces of furniture around. However, if this way of coping begins to fail, then people will start to become aggressive, which is what I observed. Seen in terms of (Hi-Kong, 2005, and Bachman and Robins, 2006) use of the term unmet need, then the need was for satisfying relations during the morning (but also all day), which could have maintained their sense of self. Without these, and with the effects of dementia causing confusion, their sense of self begins to fragment, so by the afternoon, what one sees is restless behaviour. This behaviour is therefore the effect of trying to manage a fragmenting sense of self using an obsessional transitional technique. If this fails, there is likely to be further regression to an infantile stage of dependency and aggression.

Without considering the time when this behaviour occurs, and what might follow from it, other researchers have tended to consider this phenomenon in isolation, rather than understanding it as the result of patients spending long periods of time by themselves, or in instrumental relations with staff. Understood longitudinally, researchers could appreciate the

likely effects of different kinds of psychosocial relations upon people, and so phenomena such as restlessness, could be understood not as isolated incidents, but as a behaviour that is more likely to occur at certain times of the day, and which could also lead to aggression in some people. However, this understanding can only occur, if a person's internal world is also considered, where relational experiences are crucial to a person's sense of self, and well-being. None of the above research considers the internal world of people with dementia, therefore although it can suggest antecedents for restlessness, none of which I would disagree with, it can only consider those that are present at the same time as the behaviour. It is therefore difficult to see restlessness on a continuum, where the antecedents may have been in the past, and no longer present with the behaviour, except in the person's inner world. This means their ability to offer any form of amelioration is limited to either removing or reducing the effects of these antecedents that are observed at the same time as the behaviour.

b) Hoarding

The next subcategory is hoarding, which I have divided into three different types. The first type is when patients particularly in the afternoons will collect any items, they can find on the ward and put inside their clothes. However, I am not sure whether they are also trying to conceal these items or not. When (Akhtar, 2019; p. 148) lists the differences between people who hoard, and people who collect, he notes, "…The collector relishes displaying the consequences of his pursuit, the hoarder conceals the product of his malady…collecting possesses an identity conferring capacity, which hoarding lacks." Although the above was not written in relation to people with dementia, it may suggest that the above gentlemen in my study were trying to conceal the items they had hoarded. From a phenomenological perspective, Akhtar (2019, p. 148), also differentiates hoarding from Obsessional Compulsive Disorder (O.C.D.) suggesting hoarding testifies to a loss of control, whereas O.C.D., "…is a clear statement of the premium the subject places on control…" I appreciate the above understanding, but for people with dementia who are truly losing control of their lives, both internally and externally, I think hoarding is a way of trying to regain control in their life. Therefore, in contradistinction to Akhtar (2019), I believe hoarding should be seen as a particular manifestation of O.C.D. According to (Bicerkanat, Altunaz, Kirici, Bastug, and Kizil, 2016) hoarding has recently been classified as a separate entity, and with a different diagnosis to O.C.D. supporting Akhtar's (2019) claim. However, to do this, "…DSM-5 suggests excluding other psychiatric and medical diseases, including neurocognitive diseases, for the diagnosis." (Bicerkanat et al, 2016, p. 2),

meaning the above re-classifying of hoarding, does not apply to people with dementia. Also (Bicerkant et al, 2016, p. 2) says, work done by Hurang et al in 1997, and in 1998, report prevalence rates of hoarding behaviour in people with dementia of 36% and 22.6% respectively. It is therefore quite a common disorder, and (Bicerkant et al, 2016, p. 2) says DSM-5 "…emphasizes that the onset of hoarding behaviour is insidious and late in degenerative disorders like frontotemporal dementia or Alzheimer's disease…", therefore supporting my findings that the gentlemen who hoarded did have advanced dementia.

An interesting case study by (Schroepfer and Ingersoll-Dayton, 2000) shows how staff in a nursing home were able to cope better with a resident's hoarding behaviour by understanding how that behaviour related to an incident earlier on in her life. The incident occurred when the resident's farmhouse where she "…lived with her husband burned to the ground and all their possessions were lost…Her daughter reported that since the farmhouse burned, her mother had been adamant about never giving or throwing away her belongings…" (Schroepfer and Ingersoll-Dayton, 2000, p. 111). This study therefore illustrates the value of trying to link current difficult behaviours with past experiences, which should then help staff achieve a greater understanding of behaviour that at first may seem irrational. It may also increase staff's empathy for the residents. However, the study did report there were no changes in the resident's hoarding behaviour, only that staff found it less difficult to deal with (Schroepfer and Ingersoll-Dayton, 2000, p. 112).

Although I did not find any research applying psychoanalytic concepts to understanding hoarding behaviour in people with dementia, I did find articles by (O'Connor, 2014 and Brien, O'Connor and Russell-Caroll, 2018) who described hoarding behaviour in adults without neurological impairment, using psychoanalysis. Both articles emphasize the salience of loss for the hoarder such as "…becoming alone in their homes, that is, after the death of the remaining parent, or …. the death of [a] partner."(Brien et al, 2018, p. 272). It is "… a particular way of dealing with a painful loss…" (O'Connor, 2014, p107), "…whose unconscious logic rests on how a relation to the inanimate can offer a substitute for the live human to human relationship" (O'Connor, 2014, p.110). It also gives a person a feeling of being "…in control of things…" (O'Connor, 2014, p.111), as well as acting as "…a kind of defence against parting, in the context of unresolved, unprocessed loss" (Brien et al, 2018, p. 271). One reason why people are unable to come to terms with their losses is because they lack "…a container, an active processor of material" (Brien et al, 2018, p.276) without which they regress, and rely upon objects to compensate for a lack of psychic containment (Brien et al, 2018, p.277).

I accept that people with dementia are also hoarding as a defence against loss, but their loss is an internal loss, and not an external one as described in the above research by O'Connor, (2014) and Brien et al, (2018). This difference is vital, because the losses experienced by the gentlemen in my findings, meant they were losing control over their lives, and hoarding was one way they could compensate for this, as it was something they could do, and the hoarded items were theirs, which they had control over. Hence their desire to hide them from staff. However, the hoarded objects are substitutes for lost objects (O'Connor, 2014, p. 109) that have not been properly mourned (Brien et al, 2018, p. 275). The only difference is that in my study, the lost objects are internal. This also means the process of hoarding is just as important as what is hoarded, because they are active agents during the process, and this activity is a consequence of Fairbairn's obsessional transitional technique. They are trying to repair their damaged self-esteem, via identification with the objects they are hoarding.

There is also no mention of aggression in these studies, if others attempt to take away their hoarded items, whereas in my own research staff encountered a lot of aggression when they attempted to do this. This could reflect a greater degree of identification with the hoarded items in people with dementia, compared to those without the illness, and this could be because of their greater vulnerability to fragmenting types of experience.

As was true with the previous subcategory of people becoming restless in the afternoon, these hoarding behaviours also only occurred in the afternoons, suggesting the psychosocial environment of the ward has a strong influence on this behaviour. This is not in terms of an external object loss however, as in the above two psychoanalytic articles, but is I believe, a continuous process of losing internal (good) objects in an environment that cannot compensate for these losses. This then leads to a failure of repression, and the "use" of other techniques to try and control the return of bad, object relational experiences. In the gentlemen who hoard, it is the obsessional transitional technique that comes to the fore, as a means of collecting objects on the ward, that through identification, become the good, internal objects that are being lost through dementia.

The second type of hoarding concerns people who will not let go of their clothing when staff are attempting to do their personal care. I did not observe this behaviour very often on the ward, and in fact in my review of the literature on dementia care in institutions and nursing homes, I could not find any examples of this kind of behaviour. However, in support of my hypothesis, that people who engage in this type of activity have a more integrated sense of self then those who hoard objects, I shall start by quoting from the summary of research done by (Kolanowski, Hurwitz, Taylor, Evans and Strumpf, 1994, p. 78) who say their "…study showed

that as competence of frail elderly decreases, impact of the environment takes on greater importance in determining behaviour". This is reflected in my findings, when those who hoard objects only do this in the afternoons, whereas those who cling onto their clothes, will behave like this at any time of the day. It is therefore a specific response to certain kinds of intervention by staff, whereas those who hoard objects are responding to the cumulative effects of a poor psychosocial environment upon their sense of self, suggesting they are much more vulnerable to the ward environment, compared to those who hold onto their clothes, and whose behaviour does not change over time. I therefore believe these people have quite integrated sense of self's, which they are trying to defend. It is about their dignity, and staff changing their clothes, must feel like a loss of dignity to them, which they must resist. According to (Seedhouse and Gallagher, 2002, p. 371) this is because institutions tend to focus on "…quantifiable priorities …and … [make sure these] …are protected at the expense of the less tangible (such as caring and promoting dignity)". Hence personal care as an overt activity becomes prioritised, and people's dignity often then suffers. It is during personal care that I believe these people suffer their greatest loss of dignity, as they feel they have lost all control over their lives, and staff can do whatever they want. Hence their resistance and an obsessional transitional technique seems most apt when they are trying to defend themselves from feelings of losing control.

Finally, there are those who particularly during evening mealtimes will not let staff take away their dirty crockery. Since this only happens in the evening, I can infer it is an effect of the ward's psychosocial environment upon their sense of self, in the same way that those who hoard objects, only engage in this activity during the afternoon and evening. When I reviewed the literature regarding disruptive behaviour at mealtimes in people with dementia, I could find no other research with similar findings. There were studies on hyper-orality and dementia, but these all focussed upon people with either frontotemporal dementia (F.T.D.) or semantic dementia. They found that "Gluttony and indiscriminate eating were characteristic of F.T.D. whereas patients with semantic dementia were more likely to exhibit food fads" (Snowdon, Bathgate, Varma, Blackshaw, Gibbons and Neary, 2001; p. 323). However, none of the patients in my study were overeating, nor did they ever show symptoms of F.T.D. or semantic dementia. Their response to staff removing their dirty crockery was a reaction based upon the effects of dementia, but particularly the psychosocial environment of the ward, upon their sense of self. Their behaviour is characterised by a libidinal relation to food, and an anti-libidinal response to staff when they try to deny them this. As suggested earlier, I can find no research that either supports or challenges these findings, or my understanding of these, based in Fairbairn's theory.

However, there is research, showing people with dementia do become agitated at mealtimes, therefore providing some support for my findings, but they do not specify in what way people become agitated. For instance, a very good review by (Liu, Cheon and Thomas, 2014, p. 24), which "…comprehensively summarised and evaluated interventions on mealtime difficulties in dementia since 2004…" discusses agitated behaviours but does not delineate these into various types. There could therefore be studies with findings like my own, but because researchers tend not to differentiate between different kinds of agitation, it is very difficult to compare their findings to my own.

c) Verbal aggression, and verbal and physical aggression.

The next subcategory consists of two parts. Verbal aggression, and verbal and physical aggression. Considering verbal aggression first, there is the example of a gentleman, who continuously shouted at other patients if they got in his way or did anything to annoy him. He did not appear to have dementia, and whatever staff said or did made no difference. According to (McMinn and Draper, 2005) verbal aggression can often be quite idiosyncratic, and (Holst, Halberg and Gustafson, 1997, p. 148) believe continuous shouting maybe related to an individual's life history, and previous personality, noting "the most important finding in the study was that the previous personalities of vocally active patients…were more often described as ? introverted and emotionally controlled" (Holst et al, 1997, p. 152). Thus if because of illness a person finds it harder to control their emotions, then disruptive behaviour is more likely. Research by both (McMinn and Draper, 2005) and (Tible, Mendez and Gunten, 2019, p. 1297) link vocally disruptive behaviour to depression, caused by a history of insecure attachments, and separation anxiety. The gentleman in question had no visitors throughout his stay in hospital therefore it is possible he was unable to form any secure relationships during his life. However, his verbal aggression never deteriorated into physical aggression as has been suggested by (Keene, Hope, Fairburn, Jacoby, Gedling and Ware, 1999, p. 544 and 546). Generally, I believe this research is supportive of both my own finding and understanding of this gentleman using Fairbairn's theory. For instance, he did abuse alcohol throughout his life, and I believe this was to suppress his feelings, and from Fairbairn's perspective, particularly his anti-libidinal feelings. Then when he was admitted to hospital, he could no longer use alcohol, so his anti-libidinal feelings came to the fore, leading to his verbally aggressive behaviour. It is also most likely that experiencing a number of insecure attachments would lead to feelings of separation anxiety and then depression in one's life, and (as far as I know) he did

not have any secure attachments when he came into hospital. Therefore, he does have a lot of the risk factors that other researchers have found, for verbally aggressive behaviour.

Patients such as the one described in my diary entry (13/09/16) who become verbally aggressive when their loved ones have to leave are I believe, suffering from separation anxiety, and this is supported in work done by (Tible et al, 2019, p. 1297) who does link verbally disruptive behaviour to separation anxiety. Also as previously mentioned, (Holst et al, 1997, p. 148) considers it vitally important to consider a person's life history and premorbid personality when trying to understand their vocally disruptive behaviour. As quoted in the above reflective diary (13/09/16) none of the staff thought this gentleman had dementia, therefore it is in terms of his life history and previous personality, including any vulnerability to experiencing separation anxiety that reasons for his verbally aggressive behaviour should be sought. Other patients who did have dementia also appeared to be suffering from separation anxiety, but their behaviour was much more intense, and lasted all day, compared to the gentleman described above. No amount of reassurance by staff seemed able to alleviate their anxieties. In some cases this could be due to the fact their relatives never visited (i.e. because of distance), and although they did have dementia, it appeared to be at the very early stages, so their very demanding and continuous shouting is most likely due to feelings of acute separation anxiety (Tible et al, 2019, p. 1297), which is a significant risk factor for vocally disruptive behaviour (McMinn and Draper, 2005, p. 17) and not because of cognitive impairment. Those who use verbal aggression to keep others away (but excluding the gentleman, who was mentioned first in this sub category), all have dementia, which according to (McMinn and Draper, 2005, p.17; and Keene et al, 1999, p. 542, and 546) is a known risk factor for vocally disruptive behaviour. Also, their wish not to engage with others may reflect an "…introverted and emotionally controlled" personality, which is an important finding in research carried out by (Holst et al, 1997, p.152). This would also support my hypothesis that those who use verbal aggression to keep others away are employing an obsessional transitional technique. Finally, there are those who became much noisier in the afternoon. According to (McMinn and Draper, 2005, p.17; and Keene et al, 1999, p. 542 and 546) verbally disruptive behaviour worsens, as cognitive impairment increases, and it is certainly true, that those who became noisier in the afternoons had more advanced dementia, than others who were verbally aggressive. However, none of the research I reviewed, discusses verbally disruptive behaviour in terms of the time of day when it occurs, but I believe time is very important. This is because of the cumulative effect of the ward's psychosocial environment upon people, particularly those with dementia, whose sense of self is very vulnerable to the effects of their environment (Kolanowski et al, 1994, p. 74 and 78).

Although I cannot find any research which directly supports this finding of a link between verbally aggressive behaviour and time, I do believe (taking Fairbairn as my conceptual framework) that the cumulative effect of the wards psychosocial environment upon people is to weaken their central and ideal selves, leading to regression to a paranoid transitional technique, as a way of managing their bad object relational experiences, which is manifested as verbal aggression. Also, regression itself may cause some degree of cognitive impairment, thereby increasing the risk of verbally disruptive behaviour as suggested by McMinn et al, (2005) and Keene et al, (1999).

The next part of this subcategory is verbal and physical aggression, and the above finding is significant, because those who become verbally and physically aggressive tend to do so in the afternoons, as was the case with verbal aggression. They are also very confused. Research by (Lachs, Rosen, Teresi, Eimicke, Ramirez, Silver, and Pillemer, 2012, p. 662) found that aggression towards staff by residents in nursing homes, was associated with higher levels of cognitive impairment, and verbal and physical aggression was in fact the second most common form of aggression after verbal aggression. This finding is supported by research quoted in (Kuester, 2012, p.709), which shows that most of the aggression is verbal (76.5%) followed by physical (54%). Also, a paper by (Keene et al, 1999, p. 544 and 546), shows how "Verbal aggression was more likely to precede each of the other types of aggressive behaviour…. although there is much individual variation." Thus verbal, and verbal and physical aggression are closely linked, and both are related to the degree of cognitive impairment. These results support my findings but indirectly, because they assume increasing cognitive impairment is a result of worsening dementia. However, my findings show a regular pattern to verbal and physical aggression, because it happens every afternoon and evening by the same people, who tend to be settled in the morning. This suggests that it is the cumulative effect of the ward's psychosocial environment upon their sense of self, weakening their ideal and central selves, causing regression and worsening cognitive impairment that leads to their verbal and physical aggression, which, I believe, is a protest to staff to be acknowledged. The fact this behaviour is repeated by the same people every afternoon and evening, suggests it is due to regression caused by the ward environment and not dementia, which would lead to progressive and permanent changes in their behaviour. From my findings in Chapter four, another reason why people with dementia may become verbally and physically aggressive, is due to feelings of separation anxiety from their loved ones. Some people seemed to experience these feelings for most of the day, whilst for others it was only after their loved ones had visited. I did not find in the literature any research that specifically delineated aggressive behaviour in

terms of whether their loved one(s) were present or not. However, a paper by (Tible et al, 2019) which uses a phenomenological approach to their individual case study, does suggest a causative link between separation anxiety and what they call melancholic type (M.T.) depression, and vocally disruptive behaviour. They say that "Separation anxiety may well explain the patient's M.T. (melancholic type) expressed by V.D.B. (vocally disruptive behaviour)" (Tible et al, 2019, p. 1294). Although none of the patients described in my two diary entries (8/05/17 and 12/05/17) appeared to suffer with depression (although, this is not uncommon in people with cognitive impairments, according to (Cottrell and Schulz, 1993, p. 205), and (Gormley, Rizwan, and Lovestone, 1998, p. 113)), they were all vocally disruptive. This was either, after their loved ones had left, or throughout the day, when they were trying to leave the ward to go home. It maybe these patients had an underlying depression that was not detected by staff, but at least the above research does show separation anxiety can be causally linked to verbal aggression. Also those whose agitation lasted all day, were much more confused than those who only became intermittently distressed, and this finding is supported by the following research, showing that as cognitive impairment increases, so does the likelihood of agitated and aggressive behaviour increase (Hi Kong, 2005, p. 526; Sloane et al, 1998, p. 862, 865, 866; Mahler Jr. 2004, p. 129; McMinn and Draper, 2005, p.18; and Lacks et al, 2012, p. 662). Also, their confusion made it harder for them to understand staff (Hi Kong, 2005, p. 532) when they were trying to reassure them, and alleviate their separation anxiety, meaning they were distressed for long periods of time, which could then escalate into agitated and aggressive behaviours. There is therefore some evidence for my hypothesis that separation anxiety in dementia can lead to verbal and physical aggression, although I could not find any research suggesting a relationship between the intensity of separation anxiety, and the degree of cognitive impairment. In fact, I do not think the risk of separation anxiety increases with cognitive impairment, because there were patients in category two, who were far less cognitively impaired then those in this category, yet their behaviour was understood using the concept of separation. It is only if a person were to develop separation anxiety pre-morbidly and were than later to get dementia that their responses to separation and loss could lead to behaviours perceived by others as aggressive. Nor do I think separation anxiety is a risk factor for dementia. However, if it leads to aggressive type behaviours, then it is certainly a risk factor for hospitalisation, as aggression is the most common reason for admission (Hi Kong, 2005, p. 526; and Gormley et al, 1998, p. 109).

Another example of verbal and physical aggression is when this occurs at mealtimes. For most of these patients, this is the only time they become aggressive. According to (Whear,

Abbott, Thompson-Coon, Bethel, Rogers, Hemsley, Stahl-Timmins and Stein, 2014; p. 185, and 192), people with dementia do exhibit increased levels of agitation at mealtimes, and this is because "…Stress and anxiety…is often more common at mealtimes" (p. 186), but they do not say why this is the case. However, in terms of treatment, they report that in all the eleven papers they reviewed, there is a consistently positive effect of playing music at mealtimes on patient's behavioural symptoms, especially verbal and physical aggression (Whear et al, 2014; p. 189 and 191). Whether playing music would have ameliorated some of the aggressive behaviours at mealtimes described in my reflective diaries is uncertain, but I believe it is worth considering as an intervention, because some patients did become very aggressive, and on one occasion an alarm had to be pulled to call for assistance (diary entry, 23/05/17). My understanding of these behaviours using Fairbairn's conceptual framework was to suggest that the pleasure they derived from eating and drinking was a substitute for loving object relations. Although I could find no research in the psychoanalytic literature specific to understanding aggression at mealtimes in people with dementia, I did find an article on eating disorders (Elder, 2019, p.464), which suggests that people with anorexia or bulimia are using food as a way of regulating their feelings, by controlling how much they eat and drink. These disorders have replaced the symbolising activities of thinking and self-reflection, according to (Elder, 2019; p. 464) with a very concrete activity that acts in a mode of de-symbolisation. Although (Elder, 2019, p.465) sees the origins of both disorders in "… the same traumatic failure in the caretaker- child relationship, namely a failure of the container/contained dynamic…" I see de-symbolisation as a product of both increasing cognitive impairment due to dementia, and a failure by staff to understand and act as containers for patient's feelings. If this view is correct, then as dementia progresses the likelihood of eating disorders may increase, and in relation to my diary entries of people demanding more and more to eat and drink (4/05/17 and 23/05/17), this can be understood as a very concrete activity, where relations to loving objects have become replaced by relations to food. This is not a symbolic relationship, but one that expresses a desperate need these people must take in something that makes them feel good. Hence their aggressive response to staff, if they are denied, (possibly) the only thing that makes them feel good, because then all they are left with, are relations to bad objects. There is support for these ideas in (Akhtar, 2019; p.150), who suggest that people with a "basic ego weakness" maybe using food as an external source of goodness, and of course, with the progressive damage to the central and ideal selves caused by dementia, via the loss of good, internal objects, this would also lead to their increasing weakness and the desire to compensate for this in whatever way they can. Also, these losses are likely to be experienced continuously, not only because of

dementia, but also because of the ward's psychosocial environment, where relationships with staff might be experienced as instrumental and invalidating. Patient's aggressive behaviour at mealtimes might then be a response to this, by trying to exert some control over their lives (O'Connor, 2014, p. 105), and thereby affirming their sense of self (Akhtar, 2019; p. 153).

The last part in the subcategory of verbal and physical aggression, concerns those with the most advanced dementia, whose hostility comes from the need to be left alone. A review of the literature by Clare (2010; p. 22) focussing on awareness in people with severe dementia, found that although the expression of some emotions declined with advancing dementia, "…there were no changes for other emotions (anger, fear). The expression of emotion was observed to be meaningful and could be linked to specific events. For example, anger was most often seen during routine personal care activities…" This supports my hypothesis that by this stage of the illness, people prefer to be left alone, and will respond with verbal and physical aggression if disturbed. This idea of wanting to be left alone, is also given indirect support in a psychoanalytic paper written about the dying process (Hagglund, 1981; p.46) where the author suggests that successful mourning, "…gives the dying person the final experience of giving up the body which has become worthless, and of moving into the fantasy world which for some time already has been felt as a longed for place" He also links these fantasies with dreams. "The dreams and fantasies of a dying person are, in fact, very often unhidden wishes of reunion with the childhood parent or of symbolical return to mothers lap or her breast" (p. 47). These ideas also support my findings that people at advanced stages of the illness do not appear distressed if left alone (4/05/17 and 16/05/17), and this could be because they are "…merging into the fantasy world which becomes highly cathected" (Hagglund, 1981; p. 48). This is very similar to my own understanding based in Fairbairn, where I suggest their relationships become focussed upon internalised libidinal objects, so their experiences are not dominated by negative affect.

d) Physical aggression

The final subcategory is physical aggression, and there are three parts to this. Beginning with those who did not appear to have dementia but seemed instead to be suffering from psychosis. Their internal world, and in contradistinction to those with advanced dementia, seems to be overwhelmed by negative affect, leading to their physical aggression. According to (Gormley et al, 1998; p. 112, and 113) the presence of delusions are a very significant and independent risk factor for physical aggression, and although this paper was written in relation

to people with Alzheimer's disease, I do believe it is also applicable to people with psychosis, who do not have dementia. This is because (Gormley et al, 1998) says delusions are an independent risk factor for physical aggression, therefore it is the presence of delusions, and not the underlying cause that is important. Also, all the gentlemen in my study who were experiencing psychosis were elderly, and like those with dementia had experienced many losses in their lives. The gentleman described in my two diary entries (3/04/17 and 5/04/17), appeared to experience delusions almost continuously, and they were usually very grandiose. My understanding of this using Fairbairn was that his delusions were a consequence of identifying with his ideal self, and that this was a defence against being overwhelmed by all his bad object relational experiences. However, this was never successful, and he became, and remained verbally and physically aggressive. Reassurance and help by staff, never reduced his aggressive behaviour. He seemed completely overwhelmed by his anti-libidinal self, and others in his psychosocial environment meant nothing to him at all. He has therefore failed to protect his good objects from his bad objects, and his identification with his ideal self, means he has now become the only good object, thereby treating all others as bad, and with contempt. According to (Rossouw, 2009; p. 65 and 66) Klein views "…mania as a defence against the anxiety and despair provoked by the inability to protect the good object against hostile feelings…There is no guilt… neither is there concern for the object." This is like my own understanding of mania, based in Fairbairn, and perfectly reflects how the gentleman quoted in my diary, behaved towards other patients and staff on the ward. However, a paper by (Gambogi, Guimaraes, Daker, Souza and Caramelli, 2016; p. 776) found there were many overlapping features between mania, and a form of dementia called behavioural variant frontotemporal dementia (b v FTD), suggesting that some patients who appear to be manic may in fact have dementia. However, in (Gambogi et al, 2016; p. 776) list of diagnostic criteria for b v FTD, they make no mention of features such as delusions and physical aggression, which were the above gentleman's main symptoms, therefore it is unlikely he has this form of dementia, but is instead suffering from a psychotic breakdown, where mania is the most important symptom.

Returning to our analysis of people with dementia and considering those who were agitated and aggressive for long periods of time, especially during the afternoon and evening, this was understood using Fairbairn's concept of a paranoid transitional technique. This means all their bad object relational experiences have been projected either into staff, particularly during personal care, or into items of furniture, which they would move around, or turn upside down (22/08/16 and 7/09/16). Any interventions by staff, would only intensify these disruptive behaviours, and they would become even more agitated. A paper by (O'Leary, Jyringi and

Sedler, 2005; p. 401) found that "Delusions and paranoia were both associated with general physical aggression and general verbal aggression, but not physical aggression against a caretaker." A caretaker in this study is their partner, as all the subjects were living in the community. There is therefore a link between paranoia and verbal and physical aggression, and of course people can suffer with delusions that are paranoid. According to (Gormley et al, 1998; p. 111), the most common form of delusion is in fact suspiciousness. However, the verbal skills of those in my finding (diary entry) were very poor, and I was unable to determine whether they had delusional beliefs, which were contributing to their behaviour. There is also the potential problem of whether the meaning of the term paranoia, which is not defined in other researchers work, is the same as Fairbairn's in his concept of a paranoid transitional technique. However, if Fairbairn and these other researchers believe that a person "using" a paranoid transitional technique, or is suffering from paranoia, experiences all events as malign, and in some way threatening to their sense of self, then it would seem likely there is common understanding about the meaning of the term. In spite of the relation between paranoia and aggression, (Gormley et al, 1998; p.113) found, "…the majority of aggressive episodes occurred during personal care or patient redirection…" and based upon this finding they concluded that aggressive behaviour is caused by an "…intrusion into personal space … [which]… supports the view that aggressive behaviour in dementia patients is more frequently a defensive response to perceived threat than an expression of anger…" (p. 113). This understanding of aggression, I believe, would apply to those whose dementia is most advanced, but for those whom I understand to be "using" a paranoid transitional technique, who were agitated and aggressive for long periods of time, then I believe this behaviour was motivated more by a feeling of anger. An alternative explanation of my finding that some peoples agitation and aggression gets worse in the afternoons and evening is via the clinical concept of "Sun-downing", which according to (Bachman and Robins, 2006; p. 500) is the "…tendency for some patients to exhibit a peak in disruptive behaviour during the late afternoon or evening hours… [which] …suggests that some patients with dementia do show a diurnal pattern in agitated behaviour…" There have been many theories to explain this phenomenon according to (Bachman et al, 2006), such as "… unmet physical or psychological needs…" (p.501) or increasing fatigue in the afternoon and evening leading "…to increased irritability and agitation." (p. 503). Thus, Sun downing would fit my description of people becoming more agitated in the evening, but in my findings these people were agitated throughout the day, just getting worse in the evening. Therefore, the clinical concept of Sun downing would not be adequate to explain the findings in my study. However, (Lacks et al, 2012; p. 664) found that

physical aggression is also associated with "…higher levels of mood disturbance" so for people whose relation to their inner and outer objects is based upon a paranoid transitional technique, their mood would likely be disturbed in such a way as to make aggression more likely. Also (Keene et al, 1999; p. 546) found that physical aggression is often preceded by excessive activity, and I did observe this in people who I understood to be functioning from a paranoid transitional technique (7/09/16). They were very agitated for long periods of time, often moving furniture around, before becoming physically aggressive, which was often provoked by staff attempting to do their personal care. As mentioned earlier, physical and verbal aggression is also associated with paranoia (O'Leary et al, 2005; p. 401), and this too supports my hypothesis, that those who are aggressive for long periods of time, independently of any staff intervention, are consistently relating to their internal and external objects via a paranoid transitional technique.

A paper by (Buchanan, Christenson, Ostrom and Hofman, 2007; p. 418) advocates a functional analysis approach to understanding people's aggressive behaviour. This means considering their past, pre-morbid history and developing individual interventions based upon this. They say this approach is often very successful, and it may help staff to understand someone's behaviour based upon how they dealt with stressful situations in their past. Appropriate staff training is however vital for this to work (Buchanan et al, 2007, p. 416-417). This approach to ameliorating aggression is very similar to that suggested by (Bird et al 2009), who looked at forty-four people with dementia and challenging behaviour, and through using psychosocial interventions such as "…changing care practices, changing the social or physical environment, and support and education for nursing staff or family carers…" (p. 76) were able to ameliorate aggression with a 65.9% success rate. They stress "…the aetiology of behaviour by people with dementia which causes distress is very diverse and case specific" (p. 73), therefore by focussing on aetiology they can design treatments that are specific to everyone, and it is this approach they say, that accounts for the efficacy of their approach (p. 79). I also think an individual approach based upon a person's history will help staff to be more understanding of a patient's behaviour, and therefore less defensive. They would then be better able to act as "containers" (Fonagy, Moran and Target, 1993) for patient's projections (i.e., as in a paranoid transitional technique), thereby alleviating their distress.

There is therefore a lot of research linking paranoia in people with dementia to physical aggression, thereby supporting my hypothesis that people who become more aggressive during the day, and which is then made worse by staff intervention are functioning according to Fairbairn's paranoid transitional technique. However, I did not find any research showing

people's agitated and aggressive behaviours becoming worse as the day goes on. The work that comes nearest to this uses the clinical concept of "Sun-downing", but this only looks at agitated and aggressive behaviours beginning in the late afternoon and evenings (Bachman and Rabins, 2006, p. 500). However, those in my findings were agitated and aggressive for very long periods of time, only getting worse in the afternoons and evening. A possible reason why this behaviour has not been observed by other researchers is because their research tends to be cross sectional, meaning they look at what is happening in a hospital ward or nursing home, for instance, but only for very brief periods of time. They do not seem interested in tracking changes in people's behaviour over time, which is exactly what I am interested in, in my research.

The final part of this subcategory concerns those people with advanced dementia, who only become aggressive during personal care, otherwise they appear fine. A paper by (Gormley et al, 1998; p. 113) found that the "…majority of aggressive episodes occurred during personal care…" and the most common form of aggressive behaviour is "…being uncooperative or resisting help" (p.112). This is what I found in people with advanced dementia. Also (Gormley et al, 1998; p.113) understanding of aggressive behaviour as "…more frequently a defensive response to perceived threat then an expression of anger", although not psychoanalytic, is like my own understanding based in Fairbairn, where I suggest (but importantly, only for people with the most advanced dementia) their aggressive reactions to personal care are an anti-libidinal response to being disturbed. Once the disturbance subsides, this part of the self then resumes internal relations with the other endopsychic structures. Hence there is no lasting aggression, as there is with those who are aggressive because of a paranoid transitional technique. In that case aggression is maintained, and even intensifies during personal care, because of a state of mind where all external object relations are felt to be threatening (i.e., not just during personal care) and are responded to with aggression.

Research by (Buchanan et al, 2007; p. 413 and 419), (Kuester, 2012; p. 709) and (Keene et al, 1999; p. 541) all found that personal, intimate care is the main reason for aggressive behaviour. However, for those with the severest cognitive impairment (Keene et al, 1999; p. 546) suggests there may be far less aggressive behaviour because they are less aware of their environment, and no longer see interventions as threatening. Apart from nursing interventions, the patients in my study with the most advanced dementia were not aggressive, suggesting they also did not feel threatened by the ward environment. However, because they could still be aggressive during personal care, suggests their level of cognitive impairment was not as severe as those in (Keene et al, 1999) study above. Research by (Graneheim, Norberg, and Jansson,

2001, p. 257), which was based upon staff's interactions with a lady with severe dementia, who could not speak, and was very aggressive during personal care, came up with the following four themes. These were privacy, identity, autonomy, and security. All of the patients in this subcategory have advanced dementia and they also found verbal communication very difficult, and I suggested their physical aggression was an anti-libidinal response to being disturbed. This is because I believe they have become mostly withdrawn into their internal worlds and their aggression is a response to having their internal world disturbed. This seems a very different understanding of aggression compared to the themes mentioned above, which suggest a level of self- awareness that sadly I do not think the patients in this subcategory still have.

Category five

According to (Lai and Arthur, 2003; p. 175), the percentage of people with dementia who wander can vary from 11% to 24%, even to 50% in some studies. Other researchers such as (Algase, Moore, Vanderweerd, and Gavin-Dreschack, 2007; p. 697) and (Halek and Bartholomeyczik, 2012; p. 411) suggest this discrepancy is due to their being no clear definition of what wandering behaviour is. It lacks conceptual clarity according to (Dewing, 2006; p. 239 and 240), and there are currently seventy definitions of wandering (p. 241). In the past, it was subsumed under the term agitation (Dewing, 2006; p. 247) and (Halek et al, 2012; p. 404), but recently there have been attempts to define the term scientifically, so that it refers to a specific behavioural phenomenon in dementia (Algase et al, 2007; p. 687). However, challenging this objective, scientific understanding of wandering behaviour are researchers who are person-centred, and they argue that any reconceptualization in the definition of wandering needs to be "…based on what wandering means to the person with dementia … [so it] …takes account of the person with dementia's lived experience of wandering…" (Dewing, 2006; p. 246 and 247). This perspective is relevant of course to my own understanding of wandering. Nevertheless, in spite of these differences in interpretation what all these studies in wandering have in common, is that it is shown to be correlated with cognitive impairment (Lai and Arthur, 2003, p. 173 and 175), and (Halek et al,2012; p. 407) so the more cognitively impaired a person is, the more likely they are to wander. However, (Algase et al, 2007; p. 688) suggests it is not an inevitable symptom of dementia. In a lot of the more recent studies into wandering there is the suggestion that it may not even be a manifestation of dementia (Lai et al, 2003, p. 176; Algase et al, 2007, p. 697; Andrews, 2017, p. 323; Dewing, 2006, p. 242), but could be an adaptive behaviour in a person who is looking for security, or a reflection of a

person's premorbid active lifestyle (Lai et al, 2003; p. 176). According to (Dewing, 2006; p. 242), wandering should be seen as a "…natural activity that is used to adapt to living with dementia." Therefore, in a lot of this more recent research, wandering is now more likely to be understood, either as a way of coping with stress, or as reflecting previous work roles. It is no longer viewed as aimless or random behaviour, but now has purpose (Andrews, 2017; p. 322). The problem for staff, is they do not know what that purpose is. In their professional role, nurses and carers tend to focus on managing risk to people (Dewing, 2007; p. 15), and therefore tend to view wandering as a problem behaviour (Dewing, 2006; p. 241). However, a more person-centred approach would be to see, "…wandering behaviour as a normal human activity, which most people do during their life. Thus, wandering can be the natural consequence of a search for something familiar, safe and pleasant in a world, which is strange and threatening for a person with dementia" (Halek et al, 2012;, p. 406).

This also accords with the definition of wandering behaviour used by the North American Nursing Diagnosis Association, which says it is, "…persistent locomotion in search of 'missing' or unattainable people or places…" (Algase et al, 2007; p.687), and this could be to alleviate feelings of loneliness and separation, according to (Lai et al, 2003; p.177).

These ideas regarding the motivation of people with dementia to wander are very similar to the understanding of wandering, developed in Chapter four, using Fairbairn's theory. All the people in the category of wandering, had severe cognitive impairment, and wandered for significant amounts of time. However, their behaviour was not attributed directly to the effects of dementia, which would cause increasing confusion. This is because confusion does not necessarily lead to wandering type behaviour but searching for object relational experiences where a person feels secure and safe might well do. Wandering could therefore be seen as a specific response to dementia, particularly at the later stages, where people are desperately searching for good object relational experiences, to alleviate feelings of fear and insecurity. Hence their regression to a hysterical transitional technique, in the hope of finding a sense of security in external, and good object relations. Sadly, for those with severe dementia, their memory loss could be so profound, that the people they are searching for may no longer be alive, so their wandering becomes a perpetual searching that never ends. Although, I believe, the above hysterical transitional technique does not cause people with dementia to wander, it is what maintains their search for good, object relational experiences. However, if their searching is unsuccessful, then as suggested in Chapter four, their wandering will become more frenetic, and this is due to repression breaking down, and people becoming aware of their bad, object relational experiences that are then unconsciously projected onto others. The hysterical

transitional technique thus becomes transformed into a phobic transitional technique, and, wandering becomes motivated not only by the need for good, object relational experiences, but also by the desire to get away from bad, object relational experiences. This can cause considerable anxiety in those who wander. According to (Lai et al, 2003; p. 177) anxiety increases in those who wander, the more confused they become, but this is not to be seen as restlessness or agitation suggests (Algase et al, 2007, p. 688). Although earlier research into wandering subsumed this behaviour under the term agitation (Dewing, 2006; p. 242), because it was considered very difficult to manage (Halek et al, 2012; p. 404), but it was also because researchers thought they had found parallels between wandering, agitation and delirium (Halek et al, 2012; p. 409). However (Dewing, 2006, p. 241) suggests this could be because there are many different types of wandering. There is therefore in other researchers work, some support for my finding that people who wander may start to become agitated, and although some of the above research understands this in terms of the progressive effects of dementia causing greater confusion, a more psycho-social approach that reconceptualises wandering as a "…natural activity that is used to adapt to living with dementia" (Dewing, 2006; p. 242), might see this change in behaviour more purposefully, and even as goal directed (Halek et al, 2012; p. 407). It is from this perspective therefore, and not a biomedical one that I understand the phenomena of wandering in people with dementia. However, my understanding of why people wander and become more agitated is based in Fairbairn's psychoanalytic theory, so their change in behaviour, particularly in terms of becoming more agitated is not under their conscious control, which means it is not wholly purposeful or goal directed. Instead it is a result of an inner conflict between different parts of the self that the person is trying to manage. This is a major difference, I believe, between a person-centred perspective, and a psychoanalytic one. The person-centred approach does not consider unconscious parts of a person, that may deliberately usurp more conscious parts (and hence contribute to and maintain a person's anxiety) that a person has little control over but can only try to manage. Therefore the agitation I observed in people who wander is the result of an inner conflict caused by the effects of dementia upon their ideal and central selves reducing their ability to repress their subsidiary selves, and a poor psychosocial environment unable to provide sufficiently positive relational experiences to support their central and ideal selves, leading not to increasing confusion, and hence to aimless or random behaviour (Andrews, 2017; p. 322), but instead to behaviour motivated to seek out relationships that are supportive of a person's central and ideal selves, and away from relationships that are felt to be damaging, particularly to the ideal self. These relationships are of course based upon projection within Fairbairn's model of a phobic transitional technique,

but this means a person's psycho-social environment has a deep influence upon how their good and bad object relations are distributed, and whether bad object relationships can be ameliorated. Thus, Fairbairn's model fits perfectly well with the trend to reconceptualise wandering in terms of what it means to the person (Dewing, 2006; p. 239 and 246), and is also able to provide an understanding of how this behaviour can lead to anxiety and agitation, which the literature on person-centred care is unable to do. Although I cannot find any research that describes wandering type behaviour leading onto physical aggression, earlier research conducted into wandering, often included it under the term of agitation (Dewing, 2006; p. 242). Also, as discussed previously within the category of aggression, it was found that as a person's dementia worsens, they are more likely to become physically aggressive (Lachs et al, 2012, p. 662), but according to (Lai et al, 2003; p. 175) they are also more likely to wander as their cognitive impairment increases. Therefore, it is not surprising, that as a person's illness progresses, they are more likely to both wanders and become physically aggressive. This is not necessarily to assume a neurological link between wandering and aggression, it is just a correlation. It is also not an explanation in terms of the lived experience of the person (Dewing, 2006; p. 247). If however, wandering is understood "… as an adaptive behaviour looking for security…" (Lai et al, p. 176), or searching "…for something familiar, safe and pleasant in a world, which is strange and threatening for a person with dementia" (Halek, 2012; p. 406), than if these attempts at finding good object relational experiences where a person feels safe are unsuccessful, there is nothing in the psychosocial environment to prevent further regression to separation anxiety, and the intense desire to get away from there. If staff try to prevent this, then a person may become physically aggressive. However, this does demonstrate that even in those whose dementia is quite advanced, their wandering does have meaning and can even be goal directed (Halek et al, 2012; p. 407), and is therefore not just confused, random behaviour. All the researchers reviewed here, argue for a scientific definition of wandering, as they say the concept lacks clarity (Dewing, 2006; p.239 and 240), and because of this (Halek et al, 2012; p. 404) says, "At the moment there is no conclusive definition of wandering, there are no obvious causes for it, and therefore no clear intervention recommendations."

However, from a psychosocial perspective, I believe, Fairbairn does give a clear and comprehensive understanding of the subjective experience of wandering for someone with dementia.

Category six

The final category in Chapter four is withdrawal, and this is based upon patients with the most advanced dementia who have a very poor diet and fluid intake. Of course by this stage of the illness, "Loss of appetite and difficulties with eating…are almost universal and expected complications of progressive dementia…Eating problems associated with dementia include difficulty chewing and swallowing, pocketing or spitting, and loss of interest in food…" (Arcand, 2015; p.338) There may also be behavioural problems at mealtimes too, "… such as wandering, pacing, refusal behaviour, apathy or indifference…" (Liu, Cheon and Thomas, 2014; p.15) However, some of the causes of poor intake at mealtimes can be reversible, "…such as excessive drug sedation, altered mental states due to undetected dehydration , and painful swallowing due to thrush…" (Arcand, 2015; p. 338) Also "…mental and cognitive impairments, physical disabilities and psychological factors…" (? Arcand, 2015; p. 338) can also cause difficulties at mealtimes, although there is no actual discussion in these papers of how these factors cause the problems they then describe. A study by (Majic, Pluta, Mell, Treusch, Gutzmann and Rapp, 2012; p. 1779-1789, abstract) showed that depression increases with the severity of dementia, and that this was associated with both verbal and physical aggression. This is an important finding, because it means some of the agitation and aggression I observed at mealtimes in people with advanced dementia could have been due to underlying depression that was not detected. Instead I understood their refusal of diet and fluids, using Fairbairn's concepts of a paranoid transitional technique, or an obsessional transitional technique. However, within the psychoanalytic literature there is indirect support for techniques such as these to be 'used' by people with severe dementia. According to (Evans, 2008; p. 168), "The catastrophically wounded ego of the patient protects itself by splitting and projection rather than repressing and denying; a function that it is no longer capable of…" and later on Evans (2008; p.170) says that from an, "…Attachment Theory perspective. In advanced dementia some people appear to give up their attachments to real people in order to pursue a continued attachment to an internalised earlier attachment object…Individuals may relate less and less to formal carers and …[more to] …phantasized early objects through heightened primary process thinking."

These quotes I believe do support the use of Fairbairn's concepts of a paranoid transitional technique, and an obsessional transitional technique in people with advanced dementia, who were refusing offers of diet and fluids. For example, in some cases it was because they believed staff had poisoned their food, and in other cases they showed no interest,

and had to be assisted by staff. However, in Chapter four, I suggested people with the most advanced dementia had regressed to the stage of infantile dependency, particularly to the early oral stage, and were mostly withdrawn into themselves. According to (Clare, 2010; p. 27), awareness in people with dementia does decrease with the severity of the illness, but even in cases of severe dementia, (Clare, 2010, p. 20) says sensory and perceptual awareness can still be detected. For instance, (Clare, 2010; p. 24) says people with severe dementia can still tell the difference between pleasant and unpleasant stimuli and are also able to express emotions that are appropriate to their context, such as anger during personal care (p. 22). Clare (2010; p. 20) says part of the problem in assessing awareness in someone with dementia, is that its expression depends upon a person's environment, and the nature of caregiving interactions. Thus, a noisy and unpredictable environment such as a hospital ward could cause people to withdraw into themselves, leading to reduced communication with carers, and the assumption (by carers) that the person is no longer aware (Clare, 2010; p. 22). Never the less Clare (2010; p. 20, 21, 22, 24, 25, and 29) believes all people show some level of awareness, no matter how severe their dementia is, and can never completely withdraw into themselves. Therefore, based upon this Clare (2010; p. 23) believes a person's sense of self can never be completely lost, even in severe dementia. All these findings are very important, because they do support my own, as well as my understanding of these using Fairbairn's model. Therefore, although Clare (2010) does not discuss her findings within a theoretical framework, I believe Fairbairn's model does provide such a framework, and gives a very comprehensive understanding of the processes occurring in a person with severe dementia, that gives rise to their behaviours. For instance, if as Clare (2010) found, people with severe dementia can react differently to pleasant and unpleasant stimuli and are able to express emotions appropriate to their situation, then this supports my observation of people with severe dementia becoming aggressive when staff attempt to take away their dirty crockery. This was understood by using Fairbairn's model and suggesting that these people had regressed to the late oral stage of infantile dependency, so could still take pleasure in pleasant experiences, but could react aggressively if denied these. Even people with the severest dementia, who had regressed to the earliest stage of infantile dependency, had not lost their sense of self completely, because they could still react aggressively towards staff if, for instance, they persisted with their personal care suggesting they still retained some awareness of the external world. I also accept Clare's (2010; p. 22) argument, that a noisy and unpredictable environment (such as a hospital ward) could result in people withdrawing into themselves, therefore leading carers to believe people are less aware than they are. This could mean some of the behaviour I conceptualised as with drawl, could in

fact be due to the psychosocial effects of the ward environment upon people. However, understood psychoanalytically, I do not think a person's sense of self depends entirely upon awareness of their self in relation to their environment. If someone has an internal world, they have a sense of self, because they still have internal objects they can relate to (Hagglund, 1981; p. 47), which in the final stages of dementia, maybe their last links to life. The loss of all internal objects would undoubtedly lead to the disintegration of a person's self (Hagglund, 1981; p. 47), but from Fairbairn's perspective, I believe this is highly unlikely. This is because (and as was argued at the end of Chapter two and Chapter four) the libidinal part of the self's endopsychic structure is the last part of that structure to be affected by dementia, and by this stage will have become wholly cathected to the ego and object nuclei of the central and ideal selves. Even if at the very end of dementia, the libidinal self begins to decompose into its constituent ego-object relations, I cannot imagine a person losing all their internal object relations, so their sense of self completely disappears. Thus, even if others cannot detect any signs of awareness to various stimuli, in people with advanced dementia (Clare, 2010; p. 29), this does not mean they have lost their sense of self, but rather that their sense of self is now contained within all their internal object relations, like a dream, which is as real to them now, as the external world was once.

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CHAPTER SIX

Conclusions

I have started to think about the results of my data analysis from Fairbairn's perspective, and what this understanding suggests about other theories.

For instance, there is no evidence in my data analysis of Freud's or Klein's death instinct, but rather a withdrawal of all object relations to their internal world, which is not dominated by negative affect due to a death instinct, but instead appears to be imbued with positive object relations of the libidinal self.

I also believe, using Fairbairn's terms, there is a superposition or fusion between the libidinal and central/ideal-self leading to various levels of integration. This is occurring all the time at advanced stages of the illness and supports a person's sense of self against the fragmenting effects of dementia, and poor interpersonal relations. However, because of their high needs for personal care, patients with dementia are always involved in relations with staff, which means the integrity of their sense of self is always vulnerable to staff attitudes, and therefore by the afternoon and evenings, all the disruptive behaviours described in my categories occurs. The disruptive behaviours are not caused by dementia, because if they were they would be permanent, and time would make no difference. Therefore, care needs to be a lot more supportive of people's psychosocial needs in the morning, because if it isn't, their sense of self will begin to disintegrate, leading to all the transitional techniques and disruptive behaviours observed in the afternoons.

Therefore, I believe all the literature on psychoanalysis and dementia, where they apply concepts such as projective identification and containment, are only therapeutic if used in the morning, because by the afternoon when people have deteriorated to using transitional techniques (although mostly based upon projection), it is too late, and too difficult for staff to act as containers. Transitional techniques are a sign containment has failed. If staff had been more containing of patients experiences in the morning, then they would not have deteriorated in the first place, and by the afternoon when their behaviours can be quite disruptive, staff certainly do not act as containers, in fact, due to imbalances of power, I believe staff actually project their unwanted feelings into patients (also not mentioned in the psychoanalytic

literature applied to dementia), reinforcing patients transitional techniques, or even leading to behaviours based upon instances of infantile dependency. Therefore, people's behaviour becomes so much worse in the afternoon and evenings.

Therefore, I then look at work done on dreaming, not just at the very last stages of the illness, but for all patients who use transitional techniques during the day. This is because at night, when patients are not involved in external relations with staff and others, their various object relations to do with their endopsychic structures can become more integrated (i.e., their dreaming takes on the containing function that staff should have done during the day, integrating their projections), so in the morning when staff are assisting them to get up, they are often fine, and cooperative to all care.

All the neuroscientific work on dreaming, suggest it is for memory consolidation, and affect regulation, and I think my data and analysis support this. It is sad, this only appears to happen at night, but it explains the cyclical nature of the behaviours in my categories.
As an aside, I looked at Padel's view of sleeping and of course he may not have meant dreaming, where he says the day's experiences are sorted into the respective endopsychic structures at night, but this would involve repression, and my view of dreaming is they are generally integrative of object relations, so that when patients wake in the morning they have a more integrated sense of self, which I think my data reflects. Of course, Padel is correct, that if unsatisfactory experiences are repressed into the repressed endopsychic structures at night, then a person would feel more integrated in the morning, but my data suggest a degree of integration (in terms of patient's functional ability) that is less likely to be because of repression, and more likely due to integrative factors within their self.

I also thought of using David Scharff's ideas of applying complexity theories to my data, especially in view of the fragmenting effects of dementia and interpersonal relations upon the psyche, and of course it would be useful to do this, but I realised if all psychic structures are based upon the internalisation of relational experiences (i.e. object relations) then every experience everyone has, must involve a "bit" of the ego as part of that experience, therefore applying scientific theories like chaos and complexity theories to the psyche, might miss out upon the degree of subjectivity that is always involved in every experience.
But I hope to develop these ideas further later.

Getting back to improving care practices upon the ward, if staff were better containers for patients projections, there might well be far less suffering in terms of disruptive behaviours, and this is where knowledge of Fairbairn's theory is useful, because it suggests these disruptive behaviours are based upon techniques/ defences that are not volitional on the part of the person involved, and if staff could understand this, then this understanding could help them to be more accepting of patients behaviour, and thereby more containing, and less judgemental.

I have done a lot of work along these lines, and in other areas too, such as suggesting Fairbairn's transitional techniques are preconscious defence mechanisms instigated to defend the preconscious ideal self. This comes from applying Fairbairn's ideas to people with fronto-temporal dementia, where memory remains largely intact, but their personality drastically changes, and they become almost like different people.

I have also thought about how memories might be distributed all over a person's sense of self but become affectively concentrated according to Fairbairn's endopsychic structures.
That internalisation of experiences occurs right up to the end of the illness, hence the on-going vital need for care to be always sensitive.

Also, who a person is (my research question), which I believe is based upon identifications throughout one's life, and constitutes the object relations of the central/ideal self, is supported (especially towards the end of the illness) by what a person is (i.e. the object relations of the libidinal self), therefore giving hope that people's memories of their lives, and what is important to them actually remains, but what is lost is access to all these memories, which is also supported by some neuroscientific theories.

Also from the above, it can be seen Fairbairn goes so much further then person centred theories, which concentrate their theories upon who a person is, and trying to maintain this, but Fairbairn also has a view of what a person is (i.e. a libidinal, relational being), which goes beyond a social construction of human identity (the who am I, of my research question), and which my research shows is always present, right up to the end of the illness.
I have also been considering further, the view of the preconscious as the "place" where psyche and social come together supporting my suggestion in Chapter three, that Fairbairn's is the most psychosocial of all the psychoanalytic theories.

APPENDIX

A pilot study involving the secondary analysis of case study interviews by Mills (1998) using the analytic framework developed from the object relations work of Fairbairn (see Chapter three).

Considering my secondary data first, which consists of eight single case studies of elderly people, all diagnosed with dementia, who can still talk about their lives to the researcher (Mills, 1998, p. 58). This suggests that in the beginning phase of Dr Mill's research all participants had a good Long-Term Memory, were able to translate these memories into words, and did not engage in difficult behaviours at home (i.e., they all lived at home with their partners apart from one participant). Given Fairbairn's model of the self, attributes such as memory, language and behaviour, could all be inferred to be functions of the central ego, because "…the central ego must be regarded as comprising pre-conscious and conscious, as well as unconscious elements, the other egos must equally be regarded as essentially unconscious." (Fairbairn 1944, pp104, 105). Therefore, it can only be the central ego that has access to Long Term Memories (probably stored pre-consciously), and language and behaviour too, to the extent they are reflective of conditions in external reality. This is supported by Fairbairn's assertion that "…the central ego corresponds to Freud's 'ego'…" if we leave out the repression of internalised objects (Fairbairn 1946, p. 148). As Fairbairn would know, when making this comparison, Freud defines the ego, in part, as that which "… represents what may be called reason and common sense, in contrast to the id, which contains the passions." (Freud, 1923, pp 363-364), and "We have formed the idea that in each individual there is a coherent organisation of mental processes, and we call this his ego. It is to this ego that consciousness is attached..." (Freud, 1923, p.355). Therefore, translated into Fairbairn's structural model, it is the central ego that contains the functions Freud attributed to the ego, although in Fairbairn's model, the repressed, subsidiary selves also possess consciousness, because they consist of part of the original ego repressed with part of the internalised ambivalent object (Fairbairn 1963, p. 224), both of which Fairbairn says are dynamic structures (Fairbairn 1951, p. 177). Thus, given the above, and Dr Mills criteria for inclusion of informants in her study, it can be suggested that all her eight participants at the start of her data collection process, had central self's that (despite a diagnosis of dementia) still functioned reasonably well. However, given the progressive nature of the illness (Royal College of Physicians, 1982, p. 139; Burns et al, 1995, p. 3), we would expect to find changes in her data reflecting changes in the functioning of the central self. For instance,

as dementia increasingly effects "…higher cortical functions, including memory…., all aspects of language and communication…" (Royal College of Physicians, 1982, p. 139), we should expect to find increasing loss of narrative in all of her participants as the illness progresses, which Dr Mills says is the case "These stories of the self, gave informants a sense of narrative identity which was lost as the illness progressed" (Mills, M. 1998, p.79). This would suggest a diminishment in central self-functioning, as its energy becomes dissipated, and the functions of memory and language become increasingly damaged. However, because Fairbairn says "…the central ego represents the central portion of an original unitary, dynamic ego structure." (Fairbairn 1946, p. 148), which is fundamentally object seeking (Fairbairn 1963, p. 224) and its "…behaviour…[is] orientated towards outer reality, and thus determined by a reality principle from the first." (Fairbairn 1946, p. 140), the central ego may compensate for its diminishing functions (without trying to defend against these) by engaging with reality in new and novel ways. Thus, as has frequently been reported on (Mace et al, 1985, p. 21), a person may make a list of things to do, rather than try and remember them all; they may avoid learning new skills or going to places they have not been to before, and they may begin to withdraw from certain situations if they appear too complex. They may also begin to depend more and more on their partner (if they have one) to perform day to day tasks which they used to do for themselves. There is therefore a fair amount of rational adjustment the central ego can make to the changes it perceives are happening to itself, which can help the person (with dementia) meet the demands of external reality, so they can carry on functioning in the world.

However, as well as being reality orientated and libidinal, the central ego also has a defensive function, in the sense of keeping object relational experiences that feel bad, away from itself. It can do this via internalisation and repression of an external object in so far as it is unsatisfying (Fairbairn 1963, p. 224), or alternatively if internalised bad objects begin to threaten the ego (central), then the aforementioned transitional techniques can be used (Fairbairn 1943, p. 66). There is also at this stage the moral defence of internalising good object relational experiences as a defence against bad internalised objects (ibid.).

Therefore, in Dr Mills case studies we should see evidence of a rational adjustment to the losses of dementia, as well as a diminishment in her participants narrative sense of self, all of which are suggestive of primary changes to their central self-caused by dementia. However, there should also be evidence in her data of her participant's central ego acting defensively against awareness of these changes wrought by their illness. Since Fairbairn's endopsychic model of the mind is a structural model, where "…the only changes which are intelligible are changes in structural relationships and [in] relationships between structures, and such changes are

essentially [inherently] directional." (Fairbairn 1946, p. 150 and Fairbairn 1951, p.176), then any changes to the central self will also result in changes in its relationship to the rest of the self, and these changed relationships will lead to different kinds of experiences, as "…changes are …. directional" (Fairbairn 1946, p. 150 and Fairbairn 1951, p.176). These changes in people's experiences Fairbairn calls transitional techniques (Fairbairn 1941, pp 39 and 41) and could be regarded as "…expressions of the personality as a whole" (Fairbairn 1951, p. 177).

In Dr Mills case studies, there is clear evidence of the progressive nature of dementia (Royal College of Physicians1982, p. 139; Burns et al, 1995, p. 3; Harding and Palfrey, 1997, p. 39), as all of her participants begin to lose their narrative sense of self over time. From Fairbairn's perspective, this can be seen as the gradual dissolution of their central self. However, this has consequences for the psyche. As suggested earlier, at the beginning of dementia, a person may be able to compensate for their increasing cognitive losses rationally by writing things down, asking family and friends for help, avoiding situations that are becoming too difficult (Mace et al, 1985, p.p. 21-24). This is an example of how the central ego is reality orientated (Fairbairn 1946, p. 140), coping with the demands of external reality in as dignified way as possible, to maintain its independent functioning. However, in most cases of dementia one of the first symptoms is the loss of Short-Term Memory (Burns et al, 1995, p. 35) and this would have the progressive effect of weakening attachments to the outside world, as this world is becoming more and more unfamiliar (Miesen, B. 1996, p. 53). This would have profound effects upon the libidinal (Fairbairn 1963, p. 224) and reality orientated (Fairbairn 1946, p. 140) nature of the central ego, leading to withdrawal of libido from external objects, which would effectively lead to regression, and the increasing use of transitional techniques (Fairbairn 1941, p. 52) to relate to internal and external objects. And this regression can only be made worse by awareness of a damaged ideal object and faltering central ego, that in its capacity for repression (of bad object relational experiences) is becoming weaker and weaker. Thus, in Dr Mills longitudinal studies as well as a loss in a narrative sense of self, there should also be increasing evidence of regression to the stage where transitional techniques are becoming the dominant mode of relating to one's internal and external objects.

If this is true, then how are we going to find evidence of Fairbairn's transitional techniques in Dr Mill's data?

Given Fairbairn's model of the mind, which he says is universal (Fairbairn 1940, p. 8), because everyone has internalised, bad objects at some level of their mind (Fairbairn 1943, pp 64-65), then this structure must hold true for everyone at the beginning of dementia. Any variations between people (in terms of this structure) will be a result of the degree to which internalised

bad objects have been integrated into the central self or not (i.e. to what extent a person has achieved a "…'synthesis' of the structures into which the original ego has been split…") (Fairbairn 1958, p. 380), but the basic structure of the mind stays the same. In other words, to what degree has a person achieved the stage of mature dependence (Fairbairn 1941, p. 34).

Given the similarity (schematically) between Fairbairn's Basic Endopsychic Structure of the mind (Chapter Two, Figure 1) and his concept of the hysterical transitional technique, in terms of the distribution of internalised object relations (Fairbairn 1941, p. 46, and Chapter Two Figure 2), we would therefore be looking for evidence at the beginning of dementia for relationships based upon the hysterical transitional technique. What would this mean in terms of data analysis? According to Fairbairn, the hysterical transitional technique, "…is accompanied by an idealisation of the love object motivated, in part at least, by a wish to establish dependency upon a more reassuring basis." (Fairbairn 1941, p. 38). This idealisation may become apparent in the relationship between Dr Mills and her research participants as they come to rely more and more upon her, not just as a researcher to help them make sense of their experiences, but also as a "…friend [whose] …role was therapeutic in that all informants experienced increased levels of well- being" (Mills, M. A. 1998, p. 173). Thus, instances of idealisation may occur more frequently and with greater intensity as the participants illness progresses, as they look to Dr Mills for increased emotional support. However, idealisation is a function of the hysterical transitional technique, therefore it is only operative whilst a person remains within this technique. Nevertheless, as the illness progresses and people become more dependent upon others to help them meet their daily living needs (Mace et al, 1985, pp 21-24), then the hysterical transitional technique maybe increasingly relied upon, to deal with relations with others upon whom one is becoming more dependent. Another consequence of the hysterical transitional technique is that it can act in such a way, as to deny the progressive and worsening effects of dementia, because it relies upon the "…internalisation [and repression] of the rejected object" (Fairbairn 1941, p. 45). Therefore, it acts by repressing negative experiences, thereby giving an impression to others (and to the person with dementia) of someone who can function quite well in the world, and so long as there remains some degree of reality orientation, then as a defence at the early stages of dementia it is a very useful coping mechanism. However, if relied upon excessively, a person may not be able to make the necessary adjustments in their daily lives to compensate for their increasing memory loss, leading to a lack of insight into their difficulties (Fairbairn, A. 1997, p. 13), which can put them at increasing risk of self-neglect, or harm from potential dangers in their environment (Phair, L. and Heath, H., 2001, p. 34). Also, because the hysterical technique relies upon the

internalisation and repression of negative relational experiences, this can lead to "…a form of self-depreciation…" (Fairbairn 1941, p. 45), attributing blame to oneself, which can eventually lead to depressive type symptoms. According to (Teri and Gallagher-Thomson, 1991, pp. 413-416), this is quite common in the early stages of the illness. Therefore, applying Fairbairn's concept of the hysterical transitional technique to Dr Mills data, we should expect to see participants coping well at the beginning of their illness, even though dependency upon others is increasing, but as their illness progresses this technique may eventually break down leading to depressive type symptoms in her data. Given Fairbairn's structural model of the mind the occurrence of depressive type symptoms, as the hysterical transitional technique breaks down (due to the weakening of the central ego, which is the instigator of repression, i.e. "This attitude of rejection adopted by the central ego constitutes repression…" (Fairbairn 1944, p. 116)) does follow logically from his model. This is because the anxiety that accompanies the realisation of an increasingly damaged central ego and ideal object may lead to the excessive use of the hysterical technique to deal with this anxiety. This will have the effect however of strengthening unconscious structures of the mind, (as in Fairbairn's model all of the structures of the mind are built out of relational experiences i.e. "…relationships with objects…" (Fairbairn 1951, p. 162)), particularly the anti-libidinal structure, which may now be strong enough (energetically) to overcome the repressive barrier and join with an already damaged ideal object, to reject (i.e. attack) the central ego, leading to depressive type feelings.

However, and concurrent with feelings of depression, the participants of Dr Mills study may also try to defend themselves against depressive type feelings, by projecting the bad object relational experiences of the unconscious outwards away from the central self. Therefore, rather than becoming depressed, her participants instead feel paranoid, as they now feel persecuted by these bad object relational experiences. This is called the paranoid transitional technique (Fairbairn 1941, p. 45 and 46; Chapter Two Figure 2) and by treating "…the rejected internal object….as unreservedly and actively bad- [it becomes] a persecutor indeed" (Fairbairn 1941, p. 36). Therefore, as the central ego, in its relation to its ideal object is becoming further weakened by the progressively damaging effects of dementia, then its ability to repress object relational experiences that feel bad is also weakened, therefore it may have no recourse but find to use projection instead of repression to keep these kinds of object relational experiences away from itself. This is because (Chapter Two Figure 1) projection may require less (in energetic terms) of the central self than repression, because in the paranoid transitional technique, the part egos attached to the bad objects are neither repressed nor projected but are now in consciousness. In other words, the amount of energy required for projection maybe less

than the energy required for repression, therefore as a mechanism of defence projection maybe more likely to occur, as the central self is becoming weaker and weaker. Hence as the illness progresses, and the hysterical transitional technique begins to break down, there should be increasing evidence of depressive type symptoms and/or paranoia (in Dr Mills data) as the central ego tries to maintain good object relational experiences, to sustain itself (Fairbairn 1954, p.17). This is supported by the work of Hausman, C. (1996, p. 188) who suggests that as the ego suffers more and more losses, and repression begins to fail, than other more primitive defences like projection are likely to come to the fore. But according to Hausman, the effect of this defence is to further weaken the ego, denying to itself potentials that are now located in others such as close family or care givers.

Another consequence of an increasingly damaged central self (i.e., central ego and ideal object) is the effect of this upon the ideal object (ego ideal), which rather than being an object the central ego can rely upon ("…safely love…" (Fairbairn 1951, p. 135)), now becomes a very damaged object that cannot be relied upon; therefore the central ego may project this too. In fact this is likely to happen, because the central ego relies upon "…relatively satisfying, or at any rate tolerable aspects…" (Fairbairn 1954, p.17) of relational experiences therefore a relation with a progressively damaged ideal object, is likely to feel intolerable to the central ego (which is itself being damaged via dementia), and may therefore be projected outwards, especially onto aspects of the surrounding psychosocial environment that seem good and/or helpful, in order to strengthen the central ego. This is called a phobic transitional technique by Fairbairn (1941, pp. 43 and 46; Chapter Two Figure 2) and may be observed in Dr Mills data as the way in which participants value and denigrate different parts of their environment, for instance, home as all good, hospital as all bad. This is supported by the work of (Balfour, A. 2007, p. 244 and Davenhill, R. 2007, p. 209), who suggest that as dementia progresses, there is an increasing reliance upon the mechanism of projective identification to communicate affects that can no longer be symbolised and communicated using words.

As the illness progresses, relationships with external others are becoming more confused (Cheston, R. 1998, pp. 213 and 216; Kitwood, T. 1997, p. 81) as the central ego is losing many of its abilities to relate adequately to the external world. In this very weakened state, there are virtually no libidinal relations to objects in the external world, only relations to part objects inside oneself. And any relations there are with the outside world, are based upon the relations between these internalised objects. This is called the obsessional transitional technique by Fairbairn (1941, pp. 44 and 46; Chapter Two Figure 2), which he also defines as a state of secondary narcissism (p. 48). Applying this technique to Dr Mill's data, we would be looking

for evidence of increasing social isolation, as "… all libidinal links with outer reality are surrendered, all interest in the world around fades and everything becomes meaningless." (p. 50), and for people with dementia this would be exacerbated by increasing loss of cognitive function (Royal College of Physicians, 1982, p. 139) with which to understand the world. There may also be more time spent on recalling past life experiences (i.e., reminiscence) (Mills, M. 1998, p. 14), although from the perspective of Fairbairn's obsessional transitional technique, time spent reminiscing may act defensively against awareness of an intolerable situation in the present. And of course, reminiscence depends upon a working Long-Term Memory, which does decline as the effects of dementia worsen (Mills, M. 1998, p. 32). Also, because this technique focuses on internal object relations (Chapter Two Figure 2), there is also the likelihood of people at this stage of the illness and using this transitional technique to concentrate their thinking on their own bodies, and bodily processes. (cf. Fairbairn's example of fearing "…some internal disease like cancer" (1941, p.44). In fact, this does happen to people with dementia as the illness progressively effects more and more of the higher functions of the mind (Harding and Palfrey, 1997, p. 39). Their lives are often reduced to a focus on their bodies, as they find it increasing hard to understand their experiences (Cheston, R. and Bender, M. 1999, p. 205), and so may look to their own bodies as a source of reassurance and security in an increasingly confusing world. Thus, the obsessional transitional technique can act defensively to alleviate anxiety for someone who is finding it increasingly hard to cope with the demands of external reality. And from a psychosocial perspective, it may also protect one from a paucity of validating emotional experiences in their surrounding environment. Given Fairbairn's object-relational view of the mind one would expect to see greater reliance on internal object relations to maintain a sense of self, as external relationships become increasingly difficult to maintain for someone with increasing memory loss. This could lead to identification with one's deceased parents as a way of finding security and reassurance in an increasingly uncertain world. This is known as 'Parent Fixation' in the literature on attachment theory and dementia (Miesen, B. 1996, p. 38), and is quite common in advanced stages of the illness. It seems to occur when a person is unable to form any more meaningful attachments to the outside world (Miesen, B. 1996, pp. 44-45). Thus, from Fairbairn's perspective, 'Parent Fixation' could be seen as a specific case of an obsessional transitional technique. Therefore, in Dr Mills case studies, we would be looking for instances of participants not only talking about their parents as if they were still alive (because this could be due to 'simple' memory loss), but actively trying to seek them, for reasons of safety and security. Thus, when nearly, everything has been forgotten, and the world seems very insecure, what remains is this primary

relation to one's parents, and this is what we need to look for, towards the end of Dr Mills case studies.

According to Burns et al (1995, p. 42), one of the biggest risk factors for admission into hospital is verbal and physical aggression, and Mace et al (1985, pp. 152-153) suggest that as the illness progresses there is a higher incidence of aggression. Certainly, most of the reasons for admission onto the ward where I work (which is for men with dementia), is because of aggression at home or in a nursing home. And Fairbairn's model of the mind helps us to understand this.

Staying within the obsessional transitional technique (Fairbairn 1941, pp 43-44) of the Transitional Stage of Quasi-Independence (Fairbairn 1941, pp 39 and 41), then the main effects of dementia will still be upon the central ego and its ideal object, in terms of its ability to be reality orientated and "…adaptive…to conditions prevailing in outer reality…" (Fairbairn 1940, p. 9). Therefore, this remains the most damaged of all the structures in Fairbairn's model of the mind. It would not be surprising then, to suggest that the anti-libidinal structure consisting of an object that is rejecting and an ego that feels rejected (Fairbairn 1963, p. 224) now becomes the most 'powerful' structure within Fairbairn's model of the mind. There are many possible reasons for this. First, given the Royal College of Physicians definition of dementia (1982, p. 139), and the descriptions of the effects of dementia by other researchers such as Burns et al (1995, pp 35-40, p. 57), Harding and Palfrey (1997, p. 39), Cheston (1998, p. 216), they all seem to be describing the effects of dementia upon the conscious mind. They do not consider the possibility of unconscious processes. Therefore, a paradoxical effect of the splitting of the mind (as conceived by Fairbairn) is that those structures that are split off and repressed (and therefore constitutive of the unconscious) are protected from the effects of dementia, at least for long periods of the illness. It is only when a person has regressed to a point where the transitional techniques become operative that these (unconscious) structures also become susceptible to the effects of dementia. Nevertheless, most of the damage is done to the central self, thereby making the libidinal and anti-libidinal subsidiary selves (affectively) a lot stronger in relation to it. Given the chronic and often progressive nature of the illness (Royal College of Physicians, 1982, p. 139), and the stigma attached to it by society (Small et al, 2007, p. 115; Innes, A. 2009, pp 73-75, and p. 92), a person is likely to experience increasingly negative relations with others, as they become more confused and dependent upon others (Burns et al, 1995, p. 57). According to Fairbairn, not only is the central self-weakened by such experiences, as it is essentially libidinal (Fairbairn 1963, p. 224), but they will also strengthen the anti-libidinal structure, as it is constituted out of such negative, relational experiences. Thus, from

a relational perspective, as the illness progresses, the central self is becoming weaker, and the anti-libidinal self becoming stronger. Therefore, it is not surprising that when someone has regressed to the point where the obsessional transitional technique predominates, that the anti-libidinal structure can overwhelm the central self (and still maintain its repression of the libidinal self (Fairbairn 1954, p.17-18; 1963, p. 224)), meaning the person will feel, think and possibly behave from this part of themselves, which could be aggressively. Unless there is a 'container' for these feelings (Davenhill, R. 2007, pp. 216-217), through which they can be transformed, the person may eventually be admitted to hospital. And once in hospital, care-staff tend to focus on meeting the physical needs of patients, and often ignore their psychological, emotional needs (Bell, J. and McGregor, I. 1995, p. 14), thereby making relationships less than satisfactory, and possibly strengthening the anti-libidinal self. Therefore, it is not surprising to see an increase in aggressive type behaviour in hospital, not only because of the damaging effects of dementia upon the central self, leading to greater levels of confusion (Cheston, R. and Bender, M. 1999, p. 105), but also because of a poor psychosocial environment that does not properly meet the needs of patients for emotional understanding (Balfour, A. 2007, pp. 245-246).

From Fairbairn's perspective, instances of verbal and physical aggression, especially if unprovoked and intense, would suggest the dominance of the anti-libidinal structure in terms of a person's sense of self, which would also imply there has been further regression beyond the Transitional Stage to a point where all relationships are to internalised bad objects, in this case rejecting objects, therefore leading to psychotic 'relations' to the external world. Of course, this stage of regression could almost become permanent. However there is evidence to suggest that even at the end stages of dementia, a person still retains a certain level of responsiveness to the outside world (Bell and McGregor, 1995, p. 14), which implies the central self in its ability to be object seeking (Fairbairn 1963, p. 224) and reality orientated (Fairbairn 1940, p.9) does survive to the very end of the dementia process, although this could be hugely dependent upon the kinds of relational experiences that are available to it. As well as rejecting objects there are also exciting objects in this stage of regression, which Fairbairn calls the stage of Infantile Dependence (Fairbairn 1951, p.163). However, the structure containing these exciting objects and excited ego is also indirectly repressed by the anti-libidinal ego therefore "…powerfully reinforcing the repression of the libidinal ego by the central ego." (Fairbairn 1963, p. 224). However as argued earlier, the ability of the central ego to repress the libidinal ego has been greatly diminished by now, due to the devastating effects of dementia upon it. Nevertheless, the anti-libidinal ego in its dominance will still continue to repress the libidinal

ego, but by this stage of the illness this maybe the only force acting against it, therefore there will be times when the libidinal self is able to express itself. This could result in sexually disinhibited behaviour such as stripping off and masturbation and this kind of behaviour could oscillate with the aggressive outbursts due to the anti-libidinal self. Therefore, in the reflective diaries based upon my experiences of working on a ward for men with dementia, there should be increasing episodes of unprovoked verbal and physical aggression, interspersed with sexually disinhibited behaviour. Both these kinds of behaviours would suggest further deterioration in central-self functioning, as the subsidiary selves oscillate from anti-libidinal to libidinal forms of expression. As suggested earlier, staff on wards tend to focus on patients' personal care needs such as washing, dressing, toileting, and often neglect their psychological and emotional needs (Bell and McGregor, 1995, p. 14; Balfour, 2007, pp. 245-246). Given Fairbairn's model, these types of instrumental relations would likely increase the efficacy of the anti-libidinal self, compared to the libidinal self. Thus, in terms of data analysis, there are likely to be more episodes of unprovoked aggression, than sexually disinhibited behaviour, and from the perspective of Fairbairn's model of the mind, these would be evidence of fluctuations between the (mostly dominant) anti-libidinal self and the libidinal self, as the central self continues to deteriorate because of dementia.

However, there is the suggestion made earlier, that dementia appears to affect only what is in consciousness, therefore those parts of the mind that are repressed may in some way be protected from dementia. There is no evidence for this, it is only conjecture, but given Fairbairn's model of the mind, it would suggest that the libidinal self, because it is also indirectly repressed by the anti-libidinal ego (Fairbairn 1963, p. 224), would be the last structure in Fairbairn's model to be affected by dementia. Thus, at the very end stages of the illness, it may be the libidinal self that remains and given Fairbairn's object seeking view of the self (Fairbairn 1963, p. 224), it seems appropriate that even dementia cannot take away the fundamental relational nature of a person. In terms of data analysis, this maybe expressed in instances of sexually (inappropriate) disinhibited behaviour, but to the degree staff can understand these behaviours in terms of unmet need for satisfactory relationships, then they can be ameliorated, and even a degree of integration achieved, which may effectively reverse (if only for a while) some of the disintegrating effects of dementia.

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