Boston Graduate School of Psychoanalysis

Death and life in the nursing home: The psychodynamics of nursing aides experiences of nursing home residents

Ronald P. Ceppetelli

B.A. Norwich University

M.S.W. University of Vermont

Submitted in partial fulfillment of the requirements for the degree of Doctor of Psychoanalysis

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ABSTRACT

The purpose of this project was to study the experiences of nursing home aides (aides) as they described their interactions with nursing home residents (residents) while working in a skilled nursing facility (SNF). During an externship in a nursing facility I noticed that there was an inconsistency in how the nursing home residents described their lives and the aides' attitudes toward these residents' lives. This study was designed to analyze the aides' experiences as they described interactions with residents.

The nursing home literature described psychosocial conflicts of residents and the therapies used to address those problems. Although psychotherapy has shown its efficacy in treating residents' mental health/psychosocial problems the therapy most used to address these issues has been medication. Nursing home aides were described as having several universal problems such as, low pay, high turnover, lacking in training, inconsistent responses to frustration caused by residents and greater emotional stress than other health care providers. Psychoanalytic literature posited that it was unconscious feelings developed in the preverbal period of life that motivated the human response to frustration and anxiety. The unconscious fear of annihilation and the reactions to that fear would be enacted in present day dynamics that revive these early frustrations. Psychoanalytic originated Terror Management theory (TM) described empirically researched evidence that unconscious anxiety related to how the human body looks, creates conscious and unconscious fear of death that may play a role in nursing home aides' experiences with residents.

The methodology focused on the themes that developed out of 11 videoed sessions that included five nursing home aides and the researcher. The 90 minute videoed sessions were designed using modern psychoanalytic perspectives in which the aides could describe their weekly 40 minute meetings with specifically chosen residents. The aides' comments about residents were coded, themed and analyzed according to modern psychoanalytic principles.

The results of the data uncovered five themes: environment, corporeality, management of feelings, self-revelation/identification and listening. The themes indicated unconscious archaic motivations of the aides influenced their experiences with the residents. Managing the anxiety that originates in unconscious parts of the mind appears to be one of the important contributions to the aides' experiences with the residents. Results showed that the negative parts of the aides' personalities appeared when frustration was not able to be tolerated; the residents were not like them. The aides listening to residents showed that the positive parts of the aides' personalities could emerge when the aides experienced the residents as just like them.

The results have implications for psychoanalysis and the health care industry.

CHAPTER I

INTRODUCTION

The purpose of this project was to study the experiences of nursing home aides (aides) as they described their interactions with nursing home residents (residents) while working in a skilled nursing facility (SNF). Specifically the study used data derived during the conversations of a group of nursing home aides during a twelve week psychoanalytically oriented supervision group. Each aide listened to one assigned resident for an hour each week and reported on these meetings in the supervision group meetings. This type of work has not been previously attempted with nursing home staff and may add new insights into the psychoanalytic understanding of the unconscious motivations that influence interactions between the aides and residents.

The impetus for my exploration into the unconscious motivations that influence the thoughts and actions of nursing home staff, residents and their family members emerged during an 18-month externship that introduced me to three elderly individuals who reside in a nursing home, an environment in which I had had no previous experience. My consciousness was raised by hour-long weekly sessions with each of these individuals, and I became more attentive to words spoken and actions taken by caregivers in this skilled nursing facility. What I observed surprised me. There seemed to be an incongruity between who the residents were and who the caregivers thought they were due to the caregivers having either a lack of knowledge about the residents or lack of interest in the psychological functioning of the residents. This conflicted with my other observations of the same caregivers as being very professional, compassionate, and hard-working.

I wondered what effect working, living and visiting in an institution that cared for its residents through the final stage of life would have on the interactions among these three divergent cohorts: staff, residents, and family members. I pondered further whether what I observed as negativity among staff and their disconnection from residents were natural responses to working in this environment and might even be expected when caregivers lack a more in-depth understanding of the psychological functioning of the human animal. I decided to study the theories, concepts and techniques that would enable me to give the staff members a better understanding of elderly residents and the psychological conditions that affect their behaviors.

The primary focus of my 18-month externship with three selected residents was to sit with them in a psychoanalytic manner with the hoped for outcome being twofold: first, to observe and become aware of behavior that was regressed and second, to respond in a manner so that each individual would feel understood. However, my relationship and eventual collaboration with the SNF Medical Director, a geriatrician, set the stage for expanding my focus, interest and circle of influence. I was invited to join weekly, two-hour medical rounds with the medical director and other staff members where I had multiple opportunities to interact with and observe administrators, staff, other residents and their families. Some of what I observed seemed peculiar. Often, psychosocial issues were topics of concern: for example, residents hitting or inappropriately touching staff; residents using inappropriate language; angry outbursts between and among residents and staff; and residents displaying delusional or psychotic behaviors, depression, and other psychological problems. I noted that medication was the recommended treatment for psycho-somatic issues such as for resident self-imposed blindness, bed-wetting during the

day, poor healing of well-managed pressure ulcers, and the inability to sleep. There was no discussion of the possible psychological components of these conditions. When a non-medical intervention was proposed during rounds, referrals were made to a psychiatrist, neuropsychologist or case manager, but never to a psychotherapist.

In many instances I found that my conclusions about the residents differed greatly from those of the staff. One striking example of this dissonance was an interaction that occurred when I was sitting with one of the residents, a woman who exerted tremendous energy in order to keep her eyes tightly closed, a self-imposed blindness. Unexpectedly, a staff member barged into our space, and emphatically demanded, “Open your eyes! Open your eyes!” This order conflicted directly with my approach of allowing the client to resolve, at her own pace, her resistance to solving her psychological conflicts. This staff member’s abrupt intrusion and apparent knowledge deficit squelched any opportunity for the client or me to report that the client had opened her eyes during our sessions for the past several weeks. This wasn’t the only staff member who had a bias about this client’s self-induced condition. Her physician who had treated her for a year believed that the cause of blindness was physical. My revelation to him during weekly rounds that this client was surprised that I had white hair elicited his response, “What! She’s blind!” The nurse with us responded, “No, she’s has just been keeping her eyes closed.”

I also noted that seemingly reactive responses were evident in some of the decisions made at the administrative level. In particular one intervention that originated from an administration meeting with a consultant was called “flush-it-down.” This intervention responded to aides’ concerns about the SNF by flushing the concerns back to the aides. The administration would force aides to resolve staff conflict without feedback

or other opportunities for dialog or discussion. Another observation was when there was conflict with staff; the administration would use their power managing the situation by calling for a “counseling session” in which the staff member was given a warning about his/her behavior.

Frequently, staff comments related to psychosocial issues seemed to lack reflection or evidence to support the conclusions voiced. Some of the staff members’ comments about my self-blinded client illustrate this point. Prior to my externship, this client had been delirious, paranoid, frequently panicked, and plagued by a myriad of psychosomatic issues that had greatly reduced her quality of life. On three separate occasions, one nurse described her to me as "in misery" and two other nurses, employed in this facility for more than 20 years, remarked "She's dying." I was surprised as my intervention with this resident had created dramatic changes in her symptoms and quality of life. She became a more active participant in her plan of care. Examples included her allowing staff to give her a shower, an eagerness to ambulate, a willingness to take her medications, and a new and passionate involvement in social activities. Her cooperation had multiple effects on her burden to staff, including a decreased medication administration time from a high of every four hours to a normal medication administration. It is noteworthy that this same staff person never mentioned any of these significant changes to me. Yet, this client's daughter, whom I hadn't met, called me to relate her mother's "dramatic improvements" and relief that she was finally off anti-psychotic medications. She further insisted that wherever her mother spent the remainder of her life would depend on my accessibility. The outcomes of my intervention with this client were critical to developing the pilot project I will analyze in this paper.

My interventions with the other two residents who were part of externship also resulted in anecdotal improvements in their quality of life. For one resident, Mr. X., an additional outcome included a significant change in the use of his character. Prior to our meeting, Mr. X., a self-described lifelong alcoholic and chain smoker, had been evaluated for homicidal-suicidal behavior. He was a very angry, narrow-minded misogynist who was described by others as rude, crude, and verbally abusive to staff. He spent our initial sessions angrily complaining about staff, food, and all aspects of nursing home living. Over our time together, Mr. X. developed a positive transference and identification with me demonstrated in this quote: “I like you. You and me think just alike. We should go in business together.” Mr. X. slowly made himself my self-appointed assistant who reported to me weekly and provided his recommendations of residents who needed my services. The nursing home administrator announced to me one day that Mr. X. had become the ambassador of the nursing home. This achievement of social connection and status in his community at this stage of life was the antithesis of the life that preceded his institutionalization. Evidence of the power of the attachment that Mr. X. had to me became apparent six months after the externship and our work together had been terminated. He was the resident who had said that he liked me because we think alike. I approached him in the hall and said, “Good morning.” He slowly looked up at me, paused, and then said, “I see you’ve given up on me.” I had the sense that being genuine, caring, and receptive to Mr. X’s feelings created an attachment and longing of which I had been unaware. I wondered whether caregivers working in this environment defended themselves against being receptive to residents’ feelings, and even more importantly, their own.

My experience with and reaction to my own powerful primitive feelings during a private session with a 90-year-old resident reaffirmed my hypothesis that defending against the receptivity of residents' and caregivers' feelings could be ubiquitous in this environment. Prior to this encounter, this very spirited woman had readily described her thoughts and feelings, which included anger at her current living situation but also great desire and plans for her future. Entering her room, I greeted her but received no response. Slumped over her chair, she reached to the floor in a very slow mechanical movement, picked up a piece of lint and in the same manner slowly put the lint on her dress. During this five minute period of silence, I was overcome with the strangest feeling of losing control and a very primitive feeling of needing to take action. Then, she turned to me and said, "Oh, I know you, you come on Mondays." The feelings immediately stopped and were replaced with a sense of calmness as she connected with me. Just as suddenly, she turned away and returned lint picking; the overpowering feeling returned and I soon left. As I entered the hallway, the disturbing feelings ceased. The resident died three days later. As I reflected, I wondered if I had sensed her death and this connection caused the feelings that I needed to defend against. My defense had been my disconnecting and leaving the room. Was I responding to my own unconscious death wish? Freud (1914/1960) postulated that there is an unconscious conflict between our desire to annihilate our enemies and the inability to acknowledge our own death. Do staff members defend against powerful primitive feelings working daily in a nursing home? Was the disconnection of staff from residents a logical consequence of the defense against powerful feelings?

An e-mail from a colleague provided a glimpse into a caregiver's attitude toward working with the elderly. This case manager described the following conversation with one of her new staff that occurred on their way to a supervised home visit:

> This is a very nice, caring person… and on the way over I was asking her what she had done before, and how she liked her present work. She said that she really missed working with kids because they were just at the beginning, and you could see them going somewhere, whereas with elders it was all about ending.

I interpreted these remarks as this new staff member's projection of her own conscious and unconscious representations of hopelessness for elders who now must depend upon others for assistance with their activities of daily living. I wondered if the type of attitude expressed above could explain the dissonance I had observed between residents' requests for assistance with their activities of daily living and staff members' responses. Several examples of these observations included infantilizing or inappropriate language such as addressing residents only by their first name or as "Sweetie, Honey, Darling, Baby, You Stud," using re-direct as a method to dismiss anxious residents, residents being left on the toilet long after they had requested assistance, residents' requests disregarded, arbitrary decisions made by staff with no input from residents about food choices or social activities, telling residents how they should feel, gossiping about residents in their presence, and a lack of receptivity when talking with residents.

Over the many months of my externship experience, I observed staff disconnecting from residents in a way that informed the residents' quality of life and treatment plans. Ms. Y, diagnosed with advanced Alzheimer's disease and a resident for more than four years, exemplified the impact of this disconnect. In response to Ms. Y's initial loud,

incessant, monotone of “Oh, my God, Oh my God, Oh my God,” on admission, a treatment plan was initiated for staff to “redirect’ Ms Y by giving her reading material. Her utterances ceased only as long as she was momentarily distracted by the reading, at which time she would return to the same repetitive behavior ad infinitum. Over time, she has lost the ability to read and enunciate words, and now, a loud, incessant monotone of “Gotta, gotta, gotta” echoes within and outside her room. What is most astonishing to me is that four years of “redirect” interventions during Ms Y’s decline have had no effect on the incessant sounds made during most of her wakening hours. I never observed a staff member try to engage or connect with this resident in a receptive manner during these interventions. I asked myself if staff had disconnected from this resident.

The effect of Ms. Y’s incessant sounds on the quality of life of other residents has been striking. The residents with whom I work have, *almost universally*, described how Ms. Y’s unstoppable sounds disturb them, especially during the night. One resident remarked, “Of course I’m going to have nightmares listening to that.” Another resident, obviously projecting his feelings onto Ms. Y insisted, “They should give her something or put her in a place where she can be quiet.” Many other residents have described Ms. Y’s behavior as one of the most disturbing in the facility. Of particular concern is what effect her behavior has had on Ms. Z, Ms. Y’s roommate. Ms. Z is a middle-aged woman who was institutionalized after an accident left her totally physically dependent. Ms. Z is cognitively intact but her physical appearance belies this capacity. She has an animalistic, grotesque posture that includes a distorted facial paralysis. Her flexed elbows maintain her gripped hands close to her face with her flayed fingers flexed as though prepared to attack.

Standing outside their room one day a nurse's aide approached me and asked, "I wonder what Ms. Z thinks, having to listen to this every day? She's so sweet." Yes, I've wondered that myself. The nursing home staff and administration have placed Ms.Z in the same room with a resident whose behavior is known to disturb residents throughout the facility. Why does this happen?

I was curious about how the "denial of death" may influence the behaviors of nursing home aides. Becker (1973) posited that, through evolution, humans developed self-consciousness and came to realize that death did not just occur by violent acts, but was a natural happening. The genetically appropriate tactic for preserving the species to this realization was to deny to oneself that death would eventually occur. Becker described that children of eight or nine years old learn that death is a reality and, from that time on, need to deny their own death in order to make meaning of life. How does Becker's theory of these proposed defenses against the reality of death affect those who live and work in nursing homes?

Nursing Home

A substantial number of elderly people reside in nursing homes. The Centers for Disease Control and Prevention (2004) reported that there were 16,100 nursing homes with 1.7 million beds at 86 percent occupancy in the United States. These 1.5 million residents had an average stay of 835 days. The Rubins (www.therubins.com), a website for senior citizens and those who care about them, pointed out those nursing home aides do the majority of direct care for these residents:

> According to the Centers for Medicare and Medicaid Services, nursing-home patients, on average, receive a half-hour of care per day from a registered nurse,

plus 38 minutes from a licensed practical nurse and two hours and 18 minutes from a nurse's aide. (Statistics on nursing homes and their residents, n.d., ¶ 7)

Nursing home aide retention is a major problem in the nursing home industry that has yet to be resolved. Of the 1,262,000 positions for aides in nursing homes (Health Resources and Services Administration, 2004), at any given time approximately 100,000 (Donoghue, 2009) of those positions are vacant. Nursing home aide turnover has been estimated between 44% and 168 % depending on management style (Donoghue, 2009). Shulke (Adler, 2004) reported that nationally nursing home aide turnover averages 71% and he noted:

> The high level of staff turnover in nursing homes is corrosive to personal relationships that are important to both nursing home residents and workers. Turnover directly detracts from the quality of health care for residents and raises the cost of providing care… Poor retention leads to understaffing and stressed-out nursing staff who must rush to provide very personal care to prevent pressure sores, feeding, bathing and assisting with toileting. It leads to caregivers who don't know the residents, who are always strangers.

The high turnover rate of nursing home aides is associated with the high physical and emotional demands of the work as well as the need to speed up production. The aides' low pay, poor supervision and job design as well as a lack of respect by management account for much of the turnover problems (Health Resources and Services Administration, 2004).

Although there is an abundance of information and statistics about the high turnover rate of nursing home aides, there has been noticeably little information from

nursing home aides reporting how they feel about working with nursing home residents. This study follows five aides over a period of six months and examines what they say about their interactions with nursing home residents and will study conscious and unconscious attitudes of the aides and associated psychodynamics. The data was obtained from transcriptions of 11 videotaped 90 minute supervision sessions.

Having knowledge of the issues and training of nursing home staff is essential for the researcher to understand the vicissitudes and complexities that are consistently in effect when working with a vulnerable population. Having this knowledge will be essential to understanding where, when and if effective change can be made using psychoanalytic concepts and techniques with nursing home aides and residents..

It is my intention to use the data collected about these five nursing home aides who are working in a specific environment a skilled nursing facility, to determine the consequences and outcomes derived from such data.

There are several potential practical implications that could emerge from this research project. These implications would include how to use the aides' feelings and responses to their interactions with nursing residents to improve the care of nursing home residents. Listening to nursing home residents could improve relationships of aides and residents reduce stress between both groups. The aides would better understand the residents' lives both past and present, the residents' needs and wants which could directly improve the quality of life of the residents. The quality of life improvement may also reduce the amount of medications used by residents. The improved understanding of the residents could help the aides enhance relationships with resident family members, other staff and the community at large. The empowerment of aides could also improve the

retention rate of aides as they become more directly involved with the emotional as well as physical care of the residents.

Chapter II gives an in depth literature review of nursing home aides and residents, terror management theory, and the psychoanalytic review of anxiety. Chapter III presents the methodology used to collect and interpret the data. Chapter IV presents the results of the data collection. Chapter V discusses the implications of the data.

CHAPTER II

LITERATURE REVIEW

Nursing Home Literature

Problems

A search of nursing home literature indicates that most of the research is about problems. These problems included resident lack of motivation, geriatric depression, acting out behaviors (Beck et al., 2002; Cohen-Mansfield Jiska, 1992), cost to the facility and the residents' demented capabilities, issues that consistently affect the quality of life of nursing home residents. Resident behavioral problems often involved the aides who provided much of the direct care for the residents. The lack of social contact and an escape from boredom and inactivity was often the cause of behavioral problems for demented nursing home residents. The behavioral problems were a cry for help from the residents (Cohen-Mansfield & Mintzer, 2005). Nursing home residents often resented the staff, other residents, and where they were living (Taggart, Turkle, & Kidd, 2005). Family members of nursing home residents wanted friendlier staff, less staff turnover, and information about the residents' health and activity participation (Lindman Port, 2004). The residents' issues were mainly addressed with behavioral interventions, the use of psychoactive and depression medications and social activities. Mitigating the symptoms, rather than understanding the symptoms, seemed to be the goal.

The literature also showed problems with nursing home aides, the staff who had the most contact with the residents. Resnick (2006) reported that aides often had insufficient knowledge, low empathy, poor attitudes and a job history of high turnover. Nursing home aides, who had less training than nurses (Plochg, Delnoij, van der Kruk,

Janmaar, & Klazinga, 2005), were frequently at odds with nurses and other aides, and often infantilized their patients. Aides were described as uncaring and reactive.

In a review of literature concerning compassion fatigue, (Najar, Davis, Beck-Coon, & Doebbeling, 2009) found that not only the caregivers but also the workplace staff suffers from compassion fatigue. The review found that there was little understanding of how caregivers' own history of trauma, social support, coping strategies and stress affected caregivers' fatigue.

Residents' family members also identified problems with nursing home aides. More then one third of family members reported dissatisfaction related to staff (Shield, Wetle, Teno, Miller, & Welch, 2005). Family members expressed a need for better trained staff as personal care tasks were not completed in a timely fashion, staff turnover prevented adequate knowledge of the patients, and reliable, helpful information was not forthcoming from staff members. Nevertheless, one respondent complained that she never received compassion from a physician but stated she would never forget the nurse's aide who "wordlessly walked with her to her mother's room and held her arm" (Shield, p.1654). Bauer (2006) noted that family members' participation and collaboration in making decisions, sharing responsibilities for care, and nursing home rituals were helpful in relieving the family members' guilt about placing their loved ones. Kidder (2005) suggested that there should be pre-planned and informal meetings between relatives and staff in order to provide two-way feedback and to give credit to staff for both involving relatives in patient care and for improving documentation about family involvement.

Managing behavioral problems of nursing home residents has been one of the greatest challenges for clinicians working in that field (Cohen-Mansfield et al., 2005).

Medication was the primary intervention used by physicians although non-pharmacological interventions have been shown to be efficacious. In Cohen- Mansfield's report one physician felt that treating behavioral problems non-pharmacologically was far more important than treating these problems with drugs because, although drugs do help, the side effects are dangerous. Some systematic changes recommended were hiring staff with emotional intelligence, bottom up communication, and training staff in an interdisciplinary team approach. One study in England (Fahey, Montgomery, Barnes, & Protheroe, 2003) found that the overuse of inappropriate or unnecessary drugs was very common in nursing homes. The study suggested that non-pharmacological approaches to behavioral issues should be a consideration. While there is a great deal of literature about the use of anti-psychotic medications with nursing home residents, those studies are not particularly germane to this research. For more information on the use of medications with nursing home residents see (Holmquist, Svensson, & Hoglund, 2005), (Ruths, Straand, & Nygaard, 2003), (Hanlon et al., 2004), (Lau, Kasper, Potter, & Lyles, 2004) and (Hope, 2007).

Other problems of nursing homes are related to priorities set for nursing home staff. A paucity of attention has been given to the social and health needs of the aging while special attention has been given to high technology, such as medical devices that care for the bodies of nursing home residents, in nursing facilities (Wilson & Daley, 1998). Weman (2006) noted that lack of time hinders documentation as well as meetings with family members and residents. Providing support, a feeling of security, and encouragement are essentials that make the nurses feel good about their work. Reynolds et al. (2002) reported that the emphasis of most nursing home care was on rehabilitation

rather than on excellence of care at the end of life. Family members were found to be most dissatisfied with end-of-life care for symptoms of moderate and severe pain, lack of personal cleanliness, sadness and depression, loneliness, anxiety, and other unmet emotional and spiritual needs. A desire for better communication was indicated by both staff and family members.

Psychotherapists have had a significant role in reducing the psychosocial stress experienced by nursing home residents and staff. Kettell (2001), a geriatric psychotherapist, who for 17 years was part of a mental health team that included a psychiatrist and a social worker (personal communication), concluded that psychotherapy could be beneficial to nursing home residents. She proposed that educating staff about therapeutic issues would further benefit residents. For example, staff understanding that elderly residents were often in conflict about losses, physical appearances, and moving from caring for others to being cared for themselves would create an opportunity for staff to “participate in the mourning process’ (p. 24) of these losses with them.

Kettell’s work (2001) supports nursing home staff having an increased knowledge of psychosocial development, to assist them in understanding some behaviors of elderly residents. Kettell posited that the reminiscent replays of life experiences should be seen as emotionally significant memories instead of pathological ruminations. For example, if a staff member was unaware of Erickson’s stages of life and heard a resident describe taking a walk with his deceased wife, the staff member is likely to assume this to be an illusion. A staff member with increased understanding of psychosocial development, is likely to consider that the resident was reflecting on a previous stage of

life and “reliving in his mind’s eye an experience as if it were real, and providing comfort” (Kettell, 2001, p. 25). Knight (1986) provided another example of how awareness of a psychosocial issue can influence a nursing home staff member’s response to an elderly resident. That is, how institutions can facilitate a high level of dependency that can initiate regressive behavior in elderly patients.

Several psychotherapists have identified the value of understanding transference and countertransference when interacting with elderly patients, Wada (2003) found the imposition of judgment a critical mistake in working with this population. Knight (1986), a geriatric psychotherapist, proposed that understanding transference and countertransference and their meaning would be helpful for psychotherapists, nursing home staff, and the community at large in their relationships with the elderly. A lack of this understanding created the danger that one’s own “problems and values would intrude in their care” (Knight, 1986, p.143). According to Knight, a great deal of emotional stress encountered by those who care for the elderly, in particular, those who are frail and dependent, are related to a lack of “awareness of transference distortions”(p.139). Knight stressed that there was life after frailty, and individuals caring for frail elderly patients needed to appreciate this.

Several researchers have described the role of psychotherapy in assisting staff who work with elderly patients to express their thoughts and feelings. Knight (1986) predicted that a psychotherapist helping staff to express their own feelings about working with this population would not only assist staff to use appropriate behavior, but also encourage more independence for the elderly residents. Semel (1990) found that hopelessness was a feeling that was often aroused when psychotherapists worked with

elderly people. She found that using Modern Psychoanalytic (Hyman Spotnitz, 1979; Hyman Spotnitz & Meadow, 1976) concepts and techniques in expressing thoughts and feelings was beneficial to patient and therapist as well. Plotkin (2000) reported that working with the elderly usually evokes the therapists own feelings of vulnerability and eventual death. These thoughts and feelings are surely aroused with most people who work with the elderly.

Solutions

Stillman (2005) noted that, to improve the quality-of-life for the elderly in nursing homes, long-term changes in institutional culture including staff attitudes and processes of care were essential. Cohen-Mansfield (2005) suggested that interventions tailored to the individual needs of specific people would be useful. “The intervention must be both individualized and systematic and the methodology must capture the means across persons, as well as the individual response and the reason for lack of response” (p. 39).

Evans (2006), a psychoanalyst and Director of Nursing at the Tavistock Institute, who has supervised nursing professionals for ten years, wrote that psychoanalytic supervision can complement other ways of managing patients and staff. This complementing approach can help reduce damaging behaviors and beliefs while supporting other interventions and clinical practices. He also noted that the “professional relationship” between the practitioner and the patient can “offer the opportunity to bring back into mind what has been pushed out of mind. This process may need to go on within the professional’s mind in the first instance before the patient can be expected to take back awareness of their own state” (p. 17). Evans posited that staff relationships with patients were prone to false alliances, deception and denial unless professionals were

willing to allow themselves to be disturbed by the patient while maintaining a professional stance. Practitioners need “training, supervision and space for reflective practice in order to support openness, thoughtfulness and creative thinking in this difficult area of work” (p. 18). Without this experience, professionals could believe that a patient’s behavior can be “managed without being understood.” (Menzies-Lyth (1988) wrote that nurses are subjected to the immediate, full, and ongoing stress associated with caring for a patient. She believed that institutions used social systems, such as being too busy doing tasks, as a method of limiting attachment to avoid the anxiety that is inherent when working with patients.

Wilson (1998) found that attachment of care providers to residents was important to the quality of care at the end of life, bringing a source of comfort for both residents and staff. To be able to talk openly with residents was important but often staff didn’t know what was appropriate to say. Turning emotions on and off was not possible, but having a place to talk about feelings was important for staff members. In a project to build relationship skills with elderly nursing home residents, junior level nursing students found that listening was one of the most important skills that students learned (McNeill, 2009).

These aspects of the nursing home literature indicated that emotions of the nursing home residents and reactions of their families and caretakers were instrumental in the quality of care and comfort for each of these three interconnected groups. Emotions seemed to guide interventions such as medications; interactions between caregivers, residents and residents’ families; as well as communication among staff members. How and why do some emotions (or feelings such as anxiety or anger) involved with the care

of a frail elderly population seem to negatively affect the quality of care, length of staff employment , and relationships among staff, residents and family members?

Terror Management Theory

Terror Management Theory (TMT) is based on the early work of Ernest Becker (1973). He took the position that humans, who have the capacity for self-awareness, also have the ability to reflect on the past and project into the future, thus becoming aware of their personal mortality. Since humans are predisposed to self-preservation, the awareness of one's death sets the stage for ambivalence over seeking pleasure and life, and not only avoiding death, but the anxiety due to the contemplation of ones' death. According to Becker (1973) these ambivalent conceptions of the self were developed through acquiring cultural beliefs and practices. He posited that when children are born, they receive all their love and attention from parents. However, as they grow and acquire language, children learn that they must meet their parents' and cultural standards to get this love and attention. As children age, they come to realize that their parents will eventually die and that other cultural standards, beliefs, groups and entities are needed for protection and nurturance. These new standards and beliefs may include attitudes about schooling, hobbies, marriage between a man and woman only, religious beliefs, fighting just wars, working and many other sources of new standards and beliefs. These experiences then provide an atmosphere and worldview in which the child can feel safe, secure, and able to develop self-esteem. According to TMT theory, feeling secure keeps thoughts of one's own death out of awareness. However, when these cultural standards and beliefs or worldviews are challenged or the child's behaviors are criticized by others, the child is susceptible to anxiety. TMT posits that it is not rationality or logic that makes

cultural worldviews so important for humans but the unconscious feeling of safety that originated with their parents and developed with time.

Denial of Death

When we realize that we are going to die, what comes up is terror, which can lead to being paralyzed by anxiety. According to TMT, death-denying cultural belief systems and practices were established in an effort to manage this anxiety. Within a culture, shared beliefs and rituals, for example, belief in an afterlife, that give structure and meaning to its constituents have been established. Thus, the terror of one's death is managed. Another TMT tenet is that strengthening one's "worldview or self-esteem" will reduce stress by avoiding specific reminders of one's death (Goldenberg, Pyszcsynski, Greenberg, & Solomon, 2000).

Goldenberg et al. (2000) agreed that TMT was developed to understand a wide range of human behaviors that were influenced by the understanding of one's mortality. Pyszczynski (2000) hypothesized that the human animal is biologically programmed for self-preservation and has the potential to be paralyzed by the terror of knowing that death is inevitability. The anxiety created in humans by this deeply rooted fear of death is mitigated, denied, or repressed by the psychological entities of faith in a cultural worldview and the self-esteem provided by believing in that worldview. A worldview consists of people's beliefs about reality that mitigate the anxiety that would develop if people focused on the only certainty in life which is death. Worldviews "provide the universe with order, meaning and value and the possibility of literal or symbolic immortality" (Greenberg et al., 1990). TMT claims that all types of human behavior are affected by the need to develop a worldview and self-esteem. Living up to a cultural

worldview provides self esteem, and a set of standards by which people can judge their behavior. This cultural worldview also provides a sense of immortality that will continue their existence in some form after death. Self-esteem is successfully maintained when a person believes he or she is meeting the standards of a particular cultural worldview. Since these standards are culturally created, people need constant validation to support their self-esteem. This makes it essential that people get positive feedback from others concerning their worldviews (Goldenberg et al., 2000).

In support of TMT theory, research by several authors(Pysczynski, Solomon, & Greenberg, 1999; Pyszczynski, Greenberg, & Solomon, 2000) has found that increasing people's self-esteem or faith in their worldview reduces anxiety in response to reminders of their own deaths, either in conscious awareness or out-of conscious (unconscious) awareness. TMT research has shown that different awarenesses produce different responses in people. When people are consciously aware of their deaths, exaggerated positions are taken to keep thoughts about death in the future; for example, "Because I don't smoke, eat a healthy diet, and get lots of exercise, I'll probably live well into my 90's" (Maxfield et al., 2007). These are normal responses in the sense that they increase people's self-esteem and feelings of safety. TMT research has indicated that it is death-related thoughts rather then the anxiety or terror that drive the TMT defenses. In other words, management of the terror happens just because people know about their death and their death is their "current focal attention"(Pysczynski et al., 1999)—they don't have to actually experience the terror. TMT posits that exaggerated conscious terror management defenses are proximal defenses, which actually push the inevitability of death into the future or at least out of conscious awareness.

The unconscious awareness of death is a different problem and it is dealt with by distal defenses. Distal defenses involve the cultural worldview and self-esteem associated with defenses activated when a person is awake and conscious. Being part of a culturally accepted group with a particular worldview is an example of this defense. Terror Management Theory posits that when people are made to think of their own deaths, they take a more polarized position. A polarized position is one in which people are considered either members of an ingroup or of an outgroup. Common examples are political beliefs, religious beliefs, rooting for one sports team versus another. However, polarized positions also include perceptions such as how one dresses or looks, for example, old and wrinkled versus young and thin (Baldwin & Wesley, 1996). Thus being an ingrouper is seen as an attempt to reduce existential anxiety by being personally viewed as a meaningful member of a culturally accepted group (p. 95). An example of this phenomenon was when Christian participants responded more positively to other Christians than to Jewish participants when writing samples were reviewed (Greenberg et al., 1990).

TMT posits that, by providing symbolic meaning for their lives through cultural worldviews and the value of self-esteem, humans keep thoughts of their own deaths out of awareness. When the physicality of the human body is brought into awareness through varying experiences such as signs of illness or old age, then cultural and worldview defenses are used to help defy the inevitability of death.

TMT and Corporeality, Aging, Animals and Culture

Pyszczynski's (2000) TMT research has shown that when evidence of death is present but out of awareness, people will directly respond to the problem by distorting or

exaggerating their response. For example, if overweight people are informed that losing weight will improve their health prognoses, “they will promise to go on a diet” (p. 157) However when there are unconscious threats to their mortality, for example standing in front of a funeral parlor, people respond by defending their cultural worldviews. In this study about people’s perceptions of how others voted, people standing in front of a funeral greatly exaggerated by nearly 100 percent (35% in actuality to 65% in front of funeral parlor) the percentage of the voting population supported their losing position. Pyszczynski posited that death anxiety increased when they stood in front of the funeral parlor, thus creating the need for the losing party voters to boost self-esteem. According to TMT theory, unconscious death-related thoughts are the impetus for “self-esteem and a cultural worldview” (p.158).

In relation to the body, Goldenberg et al. (2000) have found although people are concerned about their bodies’ physical health, they are preoccupied with cultural standards of how their bodies should look. According to Goldenberg, this preoccupation is one way in which humans are separate from and above animals (p. 201). However, when humans are reminded of the fallibility of their bodies, they respond with disgust. Also, Goldenberg reported that research has shown that when people were compared with animals—that are just destined to die—they felt similarly disgusted. For example Goldenberg (2005) found women’s likelihood of performing breast self-exams decreased when the procedure was introduced in a way that made women feel more animalistic and when mortality salience (MS)[1] was added. Koole (2005) found that concerns about

[1] In order to induce mortality salience, TMT researchers asked two questions that they consider mortality salient (MS). These questions prime the participant with thoughts of their own death or a negative experience related to their own death. The mortality salient (MS) questions are, “Please briefly describe the emotions that the thought of your own death arouses in you” and to “Jot down, as specifically as you can,

mortality facilitate increased desire for control over nature. Goldenberg (2006) noted that research has shown that people are more motivated to avoid a bodily experience when the effect is intolerable than to seek a bodily experience because the experience is pleasurable. Pyszcsynski et al. (2000) suggested that a person must have a meaningful and secure sense of reality such as the TMT model of meeting cultural standards and beliefs before a person could selectively choose a body growth experience. For example, an obese person who wanted to be a long distance runner would want to lose weight to become a more accomplished runner.

Young people's fear about aging and death was directly related to the negative attitudes and behaviors they had about the elderly (Martens, Goldenberg, & Greenberg, 2005). This attitude is related to the belief that as people age, their bodies deteriorate and become less attractive; also they have less control of bodily functions. Marten's study gave evidence of this hypothesis. Young people were given MS (mortality salience) questions, then exposed to pictures of elderly individuals and asked to do a word completion test. When these young people completed words such as "coff" which could be coffin or coffee, they were statistically more likely to use death-related words when viewing pictures of the elderly. TMT research has shown that people respond to death reminders with negative reactions when the elderly or others with different religious beliefs have a different worldview.

Further, thinking about the physical aspects of the body, e.g., body products and functions, increased the accessibility of death-related thoughts (Cox, Pyszczynski, & Goldenberg, 2002; Goldenberg, Cox et al., 2002; Goldenberg et al., 1999). Data from five

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what you think will happen to you as you physically die and once you are physically dead" (Maxfield et al., 2007).

qualitative studies has shown that disgust related to “bodily secretions and body parts, decay and spoiled food, particular living creatures, certain categories of other people, violations of morality and other social norms” (p. 21), correlated with self-reported fear of death (Haidt, McCauley, & Rozin, 1994). A TMT tenet is that humans have great difficulty dealing with the body when its excretions, appearance, and functioning do not match the illusions inherent in our cultural lives. Humans have difficulty when these cultural illusions are challenged and they are made aware of the animalistic or physical demise of their bodies.

Although disgust as an emotional, verbalizable response, and is unique to humans, it probably evolved from animals’ distaste for certain products that posed a danger to them (Goldenberg et al., 2000). However, humans respond in disgust to a much wider range of stimuli then animals do. Human disgust is very often a response to that which is deemed offensive to the self. This “superiority” position of disgust ranges from “foods and body products to political ideologies and immoral, actions” (p. 204). Research has shown that most disgust reactions are related to stimuli that remind us of our animal nature (Haight et al., 1997). According to TMT theory, when humans think of their bodies, we are reminded of animals, evoking memories of our own eventual deaths. TMT research showed that, when thoughts of death were out of but near consciousness, there was an increase in disgust to body products and functions (Martens et al., 2005). It is also the TMT position that “cultural worldviews transform the body from a creaturely flesh and blood biological entity to a cultural symbol” (Goldenberg et al., 2000, p. 214). According to Goldenberg, this is one method of denying the inevitability of one’s death by meeting the immortality cultural standards.

Goldenberg et al. (2000) reported studies that tested neurotics and found that when reminded of thoughts about their own death through the insertion of mortality salience questions, neurotics found the act of physical sex less appealing than before they were reminded of death. This disgust according to Goldenberg was due to an attempt to disconnect the animalistic act of sex from the human aspect of "being in love" (p. 209).

According to Roberts (2002), menstruation, pregnancy, and lactation connected women more closely to nature then men and therefore women were of less value than men and became subjects of derogation. Since being close to nature is animal-like and reminds humans of their death, objectifying women into idealized bodies distances both men and women from the corporeality of their bodies.

Martens (2005) reported that across studies elderly people have been viewed as less physically attractive than non-elderly people. Young people reported the idea of the elderly having sex as disgusting and view those that do as "dirty old men and women" (p. 228). Elderly people are not only reminders of death but also they are reminders of declining bodies and related stereotypes of our own physical and animal nature (p. 228).

From a TMT (Martens et al., 2005) perspective thinking about the elderly also undermines one's ability to acquire self-esteem via cultural standards. From that perspective, ageism has its roots in humans' coping with physical and mortal fears. These fears are then projected onto the elderly as a defense against the threat to self-esteem. For example, mental agility, physical beauty, work productivity, competence, strength and quickness are all common culturally accepted ways of feeling good about oneself that may fade with age. According to Martens' research, some young people respond to being

around elderly individuals with a loss of self esteem and a decrease in ability to use these symbolic defenses.

Martens' (2005) research showed that, when mortality salience was added, college age students distanced from and had negative attitudes toward the elderly but not toward teenagers. The college students also considered the elderly person's attitudes as especially different and more negative than their own. But these same college students considered their attitudes similar to teens. In contrast to college students, older people are more positive toward elderly people. However TMT research showed that elderly people were not positive about other elderly people who showed signs of forgetfulness and senility.

Psychologically we may not be able to fully accept death and aging (Martens et al., 2005). It may be better to foster symbolic bases of self-worth that do not engender ageism but nurture respect and positive feelings toward the elderly. The younger adult needs to invest in bases of self-worth that do not undermine aging (Martens et al., 2005), p. 233). Martens wrote that when mortality concerns are salient, people are much more likely to report a greater willingness to participate in activities associated with death if those activities engender a culturally valued basis for self-esteem, such as nurturing emotionally meaningful relationships" (p. 234) If activities associated with aging are culturally valued and respected, mortality concerns should not pose a barrier to positive feelings toward the elderly and may increase acceptance and respect for the elderly (Martens, 2005, p. 234).

Maxfield et al. (2007) reported that, compared to younger people, older adults are chronologically closer to death, have experienced more health problems, are more likely

to have experienced the death of loved ones, and have a greater difficulty completing tasks that at one time gave them self esteem. This is happening for older adults while living in a culture that associates success with physical and fiscal success However, Maxfield believed that older adults have a lack of defensiveness and have less aggression than younger people. Maxfield proposed that this lack of defensiveness and aggression may be due to a tendency for older adults to distance themselves from conflict and to use denial and positive reframing to minimize negative affect.

Maxfield (2007) conducted two studies of the defense of cultural worldview by older and younger adults when they were presented with mortality salience (MS) stimuli. In the first study with a quite high mortality salience stimulus, the younger adults responded with harsh judgments of moral transgressions while the older adults' judgments were not affected by the same stimulus. The second study, which included a more subtle induction of mortality salience, showed the same pattern in the younger adults' harsh punishment for moral transgressors; however, the older adults, when confronted with a subtle MS, showed even less punitive action toward moral transgressors. We can see from this that older adults' responses to reminders of death are less punitive than those of younger adults. Martens' (2005) study of moral transgressions showed that judgments by younger people given to older adults were found to not be prominent in older adults. This indicated that a subjective sense of expected death, not a chronological milestone, is the important factor. These studies showed a developmental shift in ways of coping with psychological composure as one ages. According to TMT theory, death unconsciously, for the most part, affects people's behavior throughout the lifespan and must be dealt with at all times.

Pysczynski (1996) studied whether standing in front of a funeral parlor and answering questions about one's cultural worldview would have an effect on the social validation of one's beliefs. The study tested people in a European country where 65% of the adults were against a proposed anti-immigration law while 35% of the adults supported the law. They found that subtle mortality, standing in front of a funeral parlor, had an enhanced effect on people holding the minority position. People with a minority position that represented only about 35% of the population believed that almost double that percentage of the population confirmed their beliefs while standing in front of a funeral parlor as they reported a 65% consensus of their positions. However, as opposed to standing 100m (meters) before or 100m past a funeral parlor, the minority position was reported at the identified minority position of 35%. This showed that "cultural worldviews are symbolic social constructions; they are sustained primarily by consensual validation from others" (p. 336). This study indicated that the out of consciousness (distal) awareness of one's death, standing in front of a funeral parlor, entices people to report an exaggerated validation of their own worldviews. According to TMT theory, consensus from others is one method of reducing anxiety from the unconscious thoughts of death.

The TMT studies described above show how humans defend against thoughts of their own deaths. Although people are compassionate and empathic, and cognitively care for and want to understand other humans, thoughts of their own deaths, either conscious or unconscious, create anxiety defended against through socially constructed meanings. One of TMT's (Martens et al., 2005) major positions is that "people construct a symbolic solution to the problem of death by sustaining faith in a meaning and permanence

providing worldview and procure value by living up to the standards of that worldview" (p. 224). According to TMT, that is why victims of violence are blamed, corporeal expositions create distance or disgust between people, more punishment is recommended for people who are transgressors (outgroupers), and elderly people are considered out of touch and different than younger cohorts.

Psychoanalytic Theory

This section will cover the writings and theories that help the reader understand the motivations of the aides as they interacted with nursing home residents. The review will begin with Sigmund Freud's ideas about the pleasure principle, the reality principle, life and death instincts, and his second topographical model of id, ego and superego. Klein expanded on Freud's ideas of the life and death instincts and how developing infants use these instincts to obtain a relationship to other objects in the world. Winnicott, a student of Klein, developed the ideas of "good enough mothering" and the "holding environment." Building on the work of Freud, Klein, Winnicott and others, Bion described several theories of both conscious and unconscious motivations of humans facing frustrating situations; namely, *beta* and *alpha*, and *container* and *contained*. Consideration of the uncanny, the concepts of transference/countertransference, and the psychoanalytic ideas about death anxiety will follow. These topics were chosen to develop an understanding of the motivations of nursing home staff working with perceived dying people.

Freud

Sigmund Freud, the founder of psychoanalysis, developed many psychoanalytic theories. Some of these theories include The Project, the pleasure principle, the reality

principle, the first topographical model of the conscious, unconscious and preconscious, the theory of life and death drives, and the second topographical model of the id, ego and superego.

In the quasi- neuronal research, The Project, that eventually led to the development of the pleasure principle, Freud (1886-1889 (1950)) theorized that the main function of synaptic neurons after building an accretion of stimulus was to discharge and return to a state of inertia. He connected this biological process to the psychic process he noticed in some of his patients. Freud noticed that the pathological behaviors of hysteria and obsessions had a quantitatively greater amount of energy than necessary that was displaced in various ways including stimulus and discharge. His patients' excessively intense ideas came into consciousness without events to justify the intensity, and these accretions of affect disturbed their train of thought. His experiences indicated that these neurotic patients appeared to deny some form of reality because they found it unbearable and unpleasant (1911/1968).

Freud (1911) first used the term *pleasure principle* to explain his belief that the human psyche is always seeking to move away from unpleasure to a more pleasurable feeling, as his patients would "tear themselves away from distressing impressions" (p. 219). The development of his first topographical theory of the conscious, unconscious, and pre-conscious came into play with the pleasure principle. Freud believed that one method humans developed to deny the existence of unpleasant feelings was explained by this topographical model. Both the primary (unconscious) and secondary (conscious) systems were at work in this process including repression of unpleasurable experiences (ideas). Freud (1925-1926) believed that the unconscious was where repressed

experiences existed. Freud also believed that no concept of an individual's death existed in the unconscious and only representations of "things" (p. 83) or ideas in the unconscious became available to consciousness.

The reality principle followed as Freud (1911/1968) posited that, as humans developed, they needed to respond to the real world outside of the individual and not just the internal accumulations of stimuli. Freud explained that an infant began in a narcissistic state of pleasure and then developed as it came into contact with reality. The reality principle showed that infant's initially only responded to internal stimuli to reduce unpleasure and hallucinated pleasurable experiences. But as hallucinations to relieve unpleasure failed, the infant had to respond to the effects of the real world. He posited that when an infant was stimulated by internal demands of unpleasure, for example its hunger for food, it cried as a warning to its mother. If those warnings were not heeded, then the infant would scream and kick its feet to hallucinate and discharge unpleasure. Freud termed this need for self-preservation the *reality principle*. He believed that the pleasure principle coming into contact with the real world was the beginning of the creation of the mind.

Thinking now became an important factor as the mind had to determine through the use of the sense organs whether it should respond immediately to sense impressions or tolerate sense impressions until a later time (Freud, 1911/1968). As part of the reality principle, pleasure is given up in the present for pleasure at a later time. Reality created the need to be able to think about waiting until satisfaction could be attained. The developing child needed consciousness to become aware of internal states as well as to monitor external states to respond to internal needs and demands. Further, the child

needed a system of *notation* to remember the results of the interactions of internal and external events. This notation or memory could be conscious or unconscious. Freud saw neurotic patients responding internally to an external threat that was not really there. He noted that unconscious memory was evident in neurosis when a person treated an internal sensation as though it was an external threat. Furthermore, increases in unpleasurable neurotic experiences could have adverse effects on how the mind was used.

Freud (1914-1916) understood one way his patients protected themselves from external threats, whether present or not, was to become self-absorbed. He believed that narcissism or self-love was a normal development for humans and could be self- (ego) or other-directed. Initially, primary narcissism developed at birth when self and other were one. Freud believed that this initial impression never really fully disappeared. He thought that immediately after birth an infant saw himself and the breast as one and the same. As infants grew and developed, they perceived a separate external world. When this happened, libido or love could be directed outward and invested in external objects and less libido was directed toward the self. To replenish the ego, libido (love) needed to be returned by the external object. If the love wasn't returned, then self-regard was diminished. This explains why some people do not invest libido into external objects and instead just seem to love themselves. Freud pointed out that, for humans, narcissistic images of reality—what we think and feel about ourselves and the external world—were more important then reality itself. He believed these images of reality, whether correct or not, could override the pleasure principle and create a state of unpleasure. For example, a person could perceive another person or object as bad without any reality-based knowledge of that person (object).

Freud (1912) wrote *Totem and Taboo,* taking an ontogenetic view on the development of primitive man to the socially conforming modern man, and developed his idea of the uncanny. Freud took the position that in this developmental process, totems or inanimate objects were revered and treated as though they were alive, in response to patricide. He believed that in primitive cultures, in response to the sons killing their fathers in order to marry their mothers, laws of incest developed and guilt needed to be reduced or repressed. Honoring the dead father through rituals and totems was clearly a response to guilt that has remained throughout time.

Totem and Taboo (1912) laid the groundwork for "Beyond the Pleasure Principle" (1920) by introducing the concept of the *double* in an article on the uncanny. Freud explained *taboo* itself had two meanings. First, taboo was connected to honoring a dead person by creating a totem animal or object that represented that person. Taboo then represented something that was "sacred or consecrated" but taboo was also uncanny, that is, "dangerous or forbidden" (1912, p. 18). A taboo was then put in place in primitive times to prevent a person from doing something that in an earlier time was acceptable. Thus, uncanny feelings arrived through the use of doubles, a sacred inanimate object representing a dead person. Also, uncanny feelings of danger to the extent of life or death followed if the taboo was violated in some manner. The doubles seen in mirrors, shadows and spirits created immortality but also became the portents of death.

In a later paper, Freud (1920) described the *uncanny* as a feeling that originated from a time when the instincts had far less to control because there were fewer social and cultural constraints at that time. Freud associated the "uncanny" with a sense of helplessness in that the person had no control over the feeling (p. 236). When individuals

experience the uncanny, they often defend by projecting the feelings from their cultural pasts into the present situations. At a primitive time when the ego and the external world were not in so much conflict, these feelings could be acted on. With more social constraints, the feelings have come to be repressed and unconscious reminders of these primitive feelings now feel uncanny.

Freud (1919) believed that uncanny senses and feelings from these early primitive developments were evident in varying situations such as birth, death, menstruation, and animism along with totem figures such as kings, the very old, and such people as mystics or seers. There was a double meaning attributed to the uncanny senses. For example, in animism an animal that did not have human qualities was given human qualities, such as a soul. A king, who was just another human, was given powers of a god. Menstruation, which was and is instrumental for human life, was often treated as though originating from a non-human being. These examples show either the inanimate becoming animate or vice versa with all having an uncanny sense of something emerging from the past. Freud postulated that these uncanny, primitive internal senses responding to external events in an unconscious manner could infiltrate the thinking process.

The uncanny also relates to children's omnipotent thoughts of dolls being alive or coming to life, which in this sense is a wish or infantile belief. With dolls, children can make doubles of themselves or someone else in their lives. Doubles, Freud wrote, are reflections in a mirror, or belief in the soul that had immortality and the fear of death. Often a child will give human qualities to inanimate objects as Freud noted in the play "The Sandman." In the play the child created a double out of a doll. The child gave the doll lifelike qualities which confused reality with fantasy – was it real or not, certainly an

uncanny feeling. An uncanny feeling is a feeling in the present that originated in primitive times and has been carried along in the collective unconscious.

Freud (1919) also described the uncanny as something that incites fear in general but a fear that "should have remained secret and hidden but has come to light" (p. 224). Freud (1915) believed that the unconscious could not contemplate its own death but took pleasure in the murder of its enemies and had ambivalent feelings about the death of a loved one. He wrote that modern man's accretion of cultural and social constraints helped to repress those primitive feelings but did not eliminate them. Freud suggested that modern man would benefit greatly from giving attention to these primitive feelings. He thought that modern people should recognize the truth about these primitive instincts and give more value to the unconscious instincts rather then continuing the illusion that they had been left behind. Freud also felt that the development of tolerance for frustration caused by primitive instincts would become one of the greatest accomplishments of mankind.

Beyond the Pleasure Principle

Freud believed that the pleasure and reality principles along with uncanny unconscious senses was the nexus of thinking. The mind had to deal with what was real, and even what was disagreeable, not just with what was agreeable, Motor discharge due to the accretion of stimuli that affected the pleasure principle could be restrained by the process of thinking in response to reality. With thinking, pleasure could be given up in the moment for pleasure in the future. Sublimation of instincts by displacement was involved in the thinking process (S Freud, 1923-1925). He believed that the reality principle led to repression of instinctual wishes that often came to light in dreams. He

understood dreams to be wish fulfillments of the pleasure principle, which could not always be exposed in reality.

Freud posited that the unconscious was the nexus of free flowing instinctual impulses and thus a primary process. A person's everyday waking life would be a secondary process. The secondary process would need to bind instinctual impulses or a neurosis would develop. Neurosis developed when internal erotic impulses were denied but displaced to fears of non-existent external events. Freud (1920) added that the compulsion to repeat was a manifestation of this principle when the conscious ego resisted unconscious instincts repressed from the past and they conflicted with reality. The repetition compulsion developed when culturally accepted sublimations of these instincts such as having enjoyable work failed.

Freud (1920) explained his idea of the compulsion to repeat by describing his famous "fort da" observation (p. 15). He believed that there was a compulsion to repeat in situations not only as an attempt to take control of a past situation in which there was no control but also to exact some revenge on a party unconsciously considered responsible. He went on to explain that the loss of love and the failed control over the parent can never be recovered even though the compulsions were repeated again and again. Manifestations of the compulsion to repeat then have an instinctual quality that is in opposition to the pleasure principle, as seen in children who keep repeating unpleasurable experiences in their play as an attempt to master their conflicts and seek to take revenge on other children or objects.

Freud (1920) believed that children needed to master unpleasure before pleasure can take effect (p. 35). That was why children repeated games and experiences over and

over. Here one can visualize the uncanniness of children's play as they will often assign the unpleasurable experiences to another child who would then experience the displeasure repeatedly. For Freud (1920), protection against stimulation was as important as the reception of stimulation. For example, when internal stimulation was too great, the psyche could defend against it, although its origin was external, via projection.

His discovery that the compulsion to repeat overrides the pleasure principle and secondary process led Freud to posit that the compulsion to repeat was an instinctual process designed to return us to an earlier inorganic state by some "daemonic power"(p. 36). Thus Freud proposed two classes of instincts: the death instinct and the life instinct. He (1923-1925) believed that all organisms have a life-conserving instinct and that development occurred because of the influence of the outside world. On the other hand, the death instinct's purpose was to return the organism to its original inorganic state. Freud developed the understanding that when a single cell divided repeatedly to form a multi-celled organism, that original cell is no longer distinguishable. For him that meant that the original cell was dead. This meant that the death instinct could be projected into the world. It was from that belief that Freud determined the death instinct could then be used as an aggressive force when an external threat was perceived.

Freud (1920) described a second class of instincts needed for creation and preservation of life. He termed these instincts *Eros* or *life instincts*. These life instincts provided the opportunity for an organism to take its own path to death. The life and death instincts were not independent of each other. When working together, they were considered fused and when not working together, they were termed diffused. He believed that the quantities of each instinct determined whether the effect was life-enhancing or

self-destructive. Freud began to understand the life and death instincts and the quantities of these instincts as fused or defused as he observed the obsessions, psychoses and neuroses of his patients. It was his belief that both instincts were found in all living substances in varying quantities depending on which instinct was necessary at that time. He observed that, for the purpose of discharge, the death instinct could be used by Eros. For example, he noted that sadism used for discharge of the death instinct, was a needed fusion of both instincts. The sadist gains pleasure from another person's displeasure. However, perversion indicated the destructiveness that de-fusion of the life and death instincts could cause as there is no consideration of the other person. Freud made note that the death instinct by itself was always mute and moving toward inertia and the life instincts of self preservation were needed to fend off this inevitability. The injection of sexual satisfaction by the id was an example of this process. Freud believed that once sexual satisfaction was complete, then death was the only possibility left until this process repeated itself. These beliefs led Freud to understand how people use defenses to manage these instincts. For example, sublimation was used to delay gratification and develop the tolerance for frustration.

Transference

Freud (1923-1925) unveiled his new theory of the mind that included the id, ego and superego. The id contained the instincts and drives while the ego mediated between the internal world and the external world. The superego was the critical part of the mind that was responsible for feelings of guilt. Freud (1923) also determined that the id was the true reservoir of libido. The topographical model of conflict between the ego instincts and the sexual instincts replaced the qualitative understanding of the conflict. Now the

conflicts were determined by the economics of quantity in the dynamics of these three agencies.

In leading up to his uncovering of a new class of mental structures mostly in the unconscious, Freud (1901-1905) discovered what he called transference. He described transference as “new editions or facsimiles of impulses and phantasies which are aroused and made conscious during the progress of analysis” (p.115). He explained that the analyst takes the place of the person from the past. Freud believed in the unavoidable necessity of reviving a whole series of psychological experiences from the past during analysis. For Freud the goal of analysis was the interpretation and resolution of these transference experiences. How transference was responded to in sessions was most important and, if treatment was not successful, Freud believed that it was the responsibility of the analyst. Freud (1925) also believed that transference was a universal experience that dominated the whole of each person's relationship to his human environment. Lagache (1953) wrote that transference was not only the activation of unsolved conflict but was an attempt at reparation of that conflict.

Freud (1910) also recognized countertransference as those feelings influenced by the patient in the unconscious of the analyst. However Freud believed that an analyst needed to overcome these feelings through his/her own analysis. In 1910, Freud had not yet developed a theory about how to take advantage of countertransference feelings.

Tower (1981) defined transference and countertransference as “unconscious phenomena based on the repetition compulsion…derived from significant experiences, largely of one’s own childhood, and…directed toward significant persons in the past emotional life of the individual” (p.163). These phenomena derive from deep

unconscious conflicts from an earlier time in the person's life when strong emotions were present. Tower believed that there were no relationships between any two people in which transference and countertransference were not at work at some unconscious level, and these phenomena must always be taken into account.

Fliess (1981) wrote that an analyst needed the capacity to share the patients' experience "not like our own but as our own" (p. 236n) and that ability to experience the patient's experience would enhance the analyst's ability to understand the meaning of those experiences.

Spotnitz (1963-1964; Hyman Spotnitz & Meadow, 1976) identified two types of countertransference reactions. The first was subjective countertransference, which he defined as insufficiently analyzed distortions in the analyst. In the countertransference reaction the analyst would transfer feelings of distinctive figures from his past onto the patient. In the second type, objective countertransference, the patient's real feelings were experienced by the analyst as induced transference feelings coming from analysand. These feelings could be confusion, disgust, helplessness, hopelessness, anger, sleepiness, etc. (Hyman Spotnitz, 1976b). He believed that psychoanalysis was dealing with the *unreal* thoughts and feelings induced by the patient (Hyman Spotnitz, 1995). By *unreal* thoughts and feelings Sponitz meant that the patient, through transference of real feelings for someone in the patient's past, induced in the analyst those now *unreal* feelings. For Spotnitz it was vital for the analyst to recognize these *unreal* feelings. Green (2005) noted that clinical work should not only refer to the one who is suffering but also to the one who listens to the suffering, which conjures up transference and countertransference.

Defenses used to protect one from the dangers of the inner world were a major concept in Freud's thinking. Freud (1894) first mentioned defense mechanisms in a letter to Fleiss in which he described a case of paranoia. Freud believed that paranoia originated with a repressed thought that was incompatible with the ego. This repressed thought was then projected onto someone external. According to Freud, a reference to oneself was an important aspect of paranoid projections. He believed that projection of internal states was a normal expression, however when the internal state was denied, the outside world was then blamed as the cause. Paranoia was then a defense used to protect the ego from this unwanted reproach. (S Freud, 1923-1925) later posited that the attack by the external object of the paranoia was needed in order to respond with aggressiveness in return. Identification was one possible result to this paranoid response.

Other Psychoanalytic Thinkers

Klein (1946) expanded on Freud's drive theories by introducing the "object" – the mother—into her thinking (p. 99). She believed that from birth infants developed object relations with their mothers. The object relations began with the qualities of a breast "split" into good breast and bad breast, love and hate, internal and external (p.). She also believed that both introjection and projection were defenses available at birth. Klein's experience with children also showed that psychotic experiences were a part of development for all humans. Klein agreed with Winnicott (1945) that the early ego was unintegrated and liable to disintegration or falling apart. This was opposed to Fairbairn's (1946) idea of a central ego and subordinate egos. Preventing the disintegration of the ego became one of the roles of the mother.

According to Klein (1926), a child tries to discover its bodily organs in everything it encounters. This identification with its libidinal connection is instrumental in symbol formation as well as in the development of speech and eventually in the substitute of sublimation for the libidinal drives. Thus, the pleasure principle underlies identification. In opposition to Freud, Klein (1946, 1948) believed that her observations of children showed an "unconscious fear of annihilation of life" (p. 116). Klein (1946) believed that anxiety originated from the death instinct and was an infant's response to a fear of persecution or annihilation. Much of the infant's hatred of parts of the self was now directed toward the mother through oral aggression. However, through introjection, the death instinct would also turn on internal bad objects creating a fear of disintegration or splitting of the ego. The infant projected the split off bad internal objects onto the mother as a method of preventing disintegration. Klein believed that disintegration and splitting eventually affected thought processes.

Klein (1948) called the initial object relations phase of an infant the paranoid-schizoid position (p. 119). In this phase the infant knew only part objects that were either dangerous or life giving while denying the existence of inner and outer reality. Part objects were idealized or feared for their persecutory or annihilating possibilities. Fear was alleviated by splitting the object (mother's breast) into good and bad objects with good objects introjected internally or/and bad objects projected externally. Thus splitting could cause both thoughts and situations to be separated off from one another. Projection would rid the infant of bad objects while good objects could be introjected to defend against anxiety. Klein also took the position that the more severe the pathology, the more the infant's projected objects were used to control or hurt the mother. This projection

then developed into an aggressive identification with the mother or mother's bad objects, which Klein believed was an important factor in the development of personality. Klein differed from Freud concerning hallucinatory gratification as she believed that frustration as well as persecution was denied. This denial, which also split the idealized object, was performed because of infantile omnipotent thoughts that could deny psychic reality. Most importantly object relations were destroyed with the internal annihilation and denial of the bad object by the death instinct. According to Klein, hallucinatory gratification conjured up the idealized object and situation while annihilating the bad object.

> Also the attacks on the mother's breast develop into attacks of a similar nature on her body, which comes to be felt as it were as an extension of the breast, even before the mother can be conceived of as a complete person….the predominantly oral impulse to suck dry, bite up, scoop out and rob the mother's body of its good contents. (Klein, 1948, p. 102)

In a reference to this developmental stage Spotnitz (Hyman Spotnitz & Meadow, 1976) wrote that people were not really evil but that ugliness of the unconscious was derived at a time when people were helpless and dependent and couldn't cope with the experiences at that time.

Although Klein (1946) emphasized projection of bad objects and introjections of good objects, she made it clear that both good and bad objects were internalized and expelled. In times of anxiety or persecution, introjection of good or idealized objects helped the infant avoid persecutors and "break through schizoid states" (p. 103). In the schizoid state the violent splitting of the personality and its projection externally creates the impression that the object is a persecutor. In an example of the projective process

Klein believed that when mother was not available this created loneliness and the fear of the destructive impulses that have been projected into the parted object. The fear of the aggressive aspects of the projected impulses would then weaken the ego and create dependence. Klein's development of the term *projective identification*, which meant that an infant could project bad parts of internal objects into the mother and then identify with those bad objects and try to control the mother, became a cornerstone of psychoanalytic thinking. She wrote, "This leads to a particular form of identification which establishes the prototype of an aggressive object-relation… [the] term 'projective identification'" (p. 102).

Bion (1957), one of the most prominent psychoanalytic writers, expanded on Freud's (1920) theory of the reality principle as well as on Klein's discovery of projective identification and its value to the development of a child's psyche. For Bion, projective identification differed from Klein's idea in that he believed actual "things" were projected rather then just bad objects.

Bion (1957) theorized that all personalities contained both psychotic and non-psychotic aspects, which affect the process of thinking. Neurotics had more non-psychotic aspects because the id (life instinct) was suppressed in response to the reality principle while the psychotic withdraws the id from part of reality and thus attempts to destroy the mind (death instinct). Bion believed, as Freud did, that thought was a necessary function to be able to tolerate the frustrations of reality. Bion believed that the mind developed out of the reality principle as opposed to Freud's (1920) belief that the mind was always present.

Bion (1957) hypothesized that an infant's excessive projective identification into reality (object) prevented its thought process from functioning in a manner that could tolerate frustration. His position was that the inability to tolerate frustration during the thought process prevented the development of curiosity and the ability to learn. Bion (1959) explained:

> This lack of progress in any direction must be attributed in part to the destruction of a capacity for curiosity and the consequent inability to learn…the patient appears to have no problems except those posed by the existence of analyst and patient. His preoccupation is with what is this or that function… there is never any question why the patient or the analyst is there, or why something is said or done or felt… Since "what?" can never be answered without "how?" or "why?" further difficulties arise…. (p. 310)

Bion (1959) believed that the origin of or lack of developing a tolerance of frustration affected the development of a thought process that began at birth. He wrote that an infant communicates with the mother through normal projective identifications. The mother in return needs to develop a curiosity about the projections. The infant needs the mother's curiosity to then introject as the basis for establishing tolerance for frustration. Bion also noted that the inability to tolerate frustration was seen in adult patients who have a hate for emotion and life itself. This is similar to what Klein termed the paranoid-schizoid position when only part objects were available for infants and the process of linking developed. Since there were no real concrete objects in the infant's mind at this time, only part objects, a link was necessary to connect awareness of feeling with an emotion.

Bion was a supporter of Winnicott's (1971) idea of a "good enough mother" who was able to allow the child just enough time to build up the ability to bring up her image in the inner psyche when she was gone. When the mother's time away became too long, Bion believed she was considered dead by the still developing child. The accompanying anger may never have been experienced as the child waited for seeing, feeling and smelling the real mother's return. Winnicott also believed that a mother could symbolically appear to be dead, as in depression, even when she was present with the child. He suggested that one of the ways an infant dealt with either of these dead mothers was to blank out the painful experiences through repression. These experiences were foreclosed, leaving only a blank space in the psyche, which could have an effect on the thought process. The negative or what was not present, the mother (away dead or present "dead"), interfered with the infant's thought process.

Winnicott (1956) also wrote that the infant was totally dependent on the environment, which was critical for the infant to establish defenses against anxiety. He called this environment the "holding environment," which included the actual holding of the infant by the mother and the father's relationship with the mother. The holding environment was critical as the infant moved from being merged with the mother to using instinctual experiences in the development of object relations. It was evident to Winnicott that for this process to be beneficial, the infant needed memories of dependable and reliable maternal care. The care was needed to reduce the child's anxiety due to the threat of annihilation it felt when the mother was not present. There needed to be "continuity of being" (p. 590) for the infant while the mother was away. For Winnicott the holding environment was crucial during this time as it ushered in the "dawn of intelligence and

the beginning of the mind" (p. 589). Anxiety and the threat of annihilation needed to be at a minimum in the holding environment to create the most favorable conditions for the infant's mind to develop. Winnicott noted that it was vital that mothers, who needed to provide the holding environment where there was good enough care for their infants, were themselves cared for in a way that acknowledged the responsibilities of their task.

Bion's (1957) position was that the ability to tolerate frustration was the key to the thought process. He gave as an example a child's fear of dying being projected into the mother and the mother responding with confusion or some other reaction to the fear instead of taking in the child's fear and experiencing its dread. An understanding of the child's fear of dying is what was needed by the child but experience taught Bion that the mother's most prominent response was denial. The mother's denial then slowed the child's developmental process and allowed for an excess of projective identification which eventually became the "link" (p. 269) of communication. According to Bion linking was the necessary process for the psyche to connect one object impression with another object impression to create a new mental object. Bion believed that two elements were at work here: first, the child's inborn characteristics of hate and envy and second, the environment that prevented the attacks on linking. According to Bion, linking was the ability for a child to link an unconscious primal "thing" (p. 267) to a more available conscious feeling or thought.

Green built on Winnicott's concept of a blank space and Bion's concept of linking. Green (1975b) wrote that, in borderline states, the dual contradiction caused by intrusion anxiety, which is persecutory, and separation anxiety and its depressive results was in response to the psychic dilemma of delusion or death. He called this fundamental

psychotic kernel *blank psychosis* where nothing exists but the object that was not there. This blank psychosis had as its effect an attack on the formation of thought by the linking of thoughts. The mind does not have the ability to construe an absence where an object once was. For example, when a feeling cannot be tolerated, then an emotion cannot be experienced and linked to the feeling. Something that has never been present can never be absent and therefore cannot be thought about. The response to this was projecting what the mind could not tolerate onto an external object.

Bion (1957, 1959) believed that only through projective identification could a child express feelings that he could not express in language. Then denial by the mother or environment of the child's projective identification thwarted the child's "impulse to be curious upon which all learning depends" (1957, p. 313). The result of this attack on linking was excessive hatred caused by external reality (environment) against all emotions including hatred itself and finally, hatred of life itself.

Green (1975a) supported Bion's and Winnicott's positions on linking when he wrote that, in object relations, the relations are united by actions or the effects of these actions and not by specific words that are used. Communication took place in this transactional space. Bion (1957) believed that patients had no interest in the causes of their pain and, therefore, did not appreciate responses that indicated why they felt the way they did.

Beta and Alpha Elements

Bion (1962a) was interested in how analysts could "think" (p. 307) about what was unknown in the analytic encounter. He described two elements, *beta* and *alpha,* that were part of sense impressions. These elements were vital for Bion because they

indicated how a person's attention to each could modify frustration versus evade frustration. First were beta elements, which were emotions that were felt as "things in themselves"[2] (p. 6) and not amenable to the thought process. Bion described beta elements as undigested facts that were not in the unconscious and were available only for acting out or manipulation through projective identification. According to Bion (1970, 1983), what could appear as a compulsive behavior was actually, beta elements "confined to the domain action" (p. 121) instead of becoming thoughts. When the feeling of "helplessness was overwhelming, omnipotent thinking would take the place of tolerating frustration and action would take the place of thoughts" (1970, p. 121).

Alpha elements were transformed sense impressions and emotions of which the subject could be aware consciously or unconsciously (Bion, 1983). These elements were stored in the unconscious and were available for dream thoughts and unconscious awake thinking. Alpha function was needed for conscious thinking and reasoning and eventually making conscious thoughts unconscious – such as learning to walk. The importance of Bion's work rested on the position that if alpha process or "the awareness of emotional experience"(1962a) is disturbed for whatever reason, it becomes inoperable. Then only beta elements are available for use by the subject with the result that he will not be able to interpret sensory stimuli. The ability for conscious contact with himself or others as "live objects" is destroyed and therefore the now inanimate objects are "endowed with the qualities of death" (p. 8). If only beta elements are available, then what is available are only fear, hate and envy that are so disturbing that a splitting occurs that

> …makes breast and infant appear inanimate with consequent guiltiness, fear of suicide and fear of murder, past, present and impending. The need for love,

[2] Bion (1962a) referred to Kant's theory that "things in themselves" are unknowable by man.

understanding and mental development is now deflected, since it cannot be satisfied, into the search for material comforts. Since the desires for material comforts are reinforced the craving for love remains unsatisfied and turns into overweening and misdirected greed. (p.10)

The inability to transform beta elements into alpha would lead a patient to take a course of action that is futile but of which he is unaware. Since the patient refrains from contact with live objects, only beta functions are available and since they are unwanted, they are projected out. Bion (1962a) believed these projections by the patient, the origin of much countertransference in the analyst, were an attempt to reduce the buildup of stimulation. People who were are speaking from a reaction to beta elements are in effect speaking without thinking.

Bion described how beta and alpha elements work when he wrote about the thinking process. He (1962b) included the process of thinking as the apparatus that would process thoughts. It is important to note that he believed that thinking developed from the pressure of alpha elements or thoughts on the psychic apparatus. That was quite different than thoughts being developed from the process of thinking. Thoughts would be developed through "pre-conceptions, conceptions or thoughts, and finally concepts; concepts are named and therefore fixed conceptions or thoughts. The conception is initiated by the conjunction of a pre-conception with a realization" (p. 306).

Bion (1962) hypothesized that a "definitory process" (p. 67) explained that something either was (alpha) or was not (beta). If something was, then it could be taken in and then a pre-conception was developed. However, if a person could not tolerate any amount of frustration, then something was not and had to be annihilated to be no-thing.

The “no-thing” then became hallucinations (which are things in themselves) due to intolerance of frustration, and a desire of empty space, which would prevent the possibility of a pre-conception. The lack of a pre-conception would only leave negative implications or no realization at all.

Bion (1962a) also noted that there were substitutes for learning by experience. Bion wrote that a thought developed out of a pre-conception mating with a frustration. The example he used was a baby who, when hungry, finds no breast or an absent breast. The capacity to develop thought would then be the baby’s ability to tolerate frustration and realize “no breast” and hence the development of thought and, most important, the beginning of a thinking apparatus. According to Bion, the ability to tolerate frustration created thoughts that enabled frustration to be tolerated for a longer period of time. Green (1973) noted that thoughts turned into language do not eliminate frustration but come out of frustration and are an indication of the ability to tolerate frustration.

Bion used the term *constant conjunction* to explain when a patient’s realization returns to a specific theme repeatedly. When constant conjunctions occur, a person who has the ability to recognize the constant conjunction will be able to label it in some manner. Bion (1970) believed that people who cannot recognize a constant conjunction are intolerant of frustration or pain and are unable to recognize a feeling that pain induces. In the place of the unrecognized pain they experience “a thing that is not there.”(p. 9) The thing is indistinguishable from a hallucination; Bion labeled this thing a beta element. It was beta elements that had the possibility to eventually be replaced by thoughts, which he labeled alpha elements. Bion attributed mental space or the place where beta elements originate, “where the breast was,” as the place where thoughts can

originate from the development of alpha elements (p. 11). In contrast, beta elements are pre-verbal material because they are intolerable as they haven't yet had the constant conjunction to become thoughts. When a person cannot tolerate frustration and is unable to represent alpha elements in thought, then the reality principle is threatened. A substitution for thought will be represented but it will not be thought, according to Bion.

According to Bion (1965), a *container* was necessary to hold and tolerate primitive emotions of an infant. The container for an infant would be the mother who was needed to contain the fear and helplessness of the infant. Containing and tolerating would "detoxify" (p. 141) the emotions and make them tolerable for the infant. If the container is not able to tolerate the primitive projected emotions of the infant and evacuates them forcefully, then there will be an acceleration of emotions and a reciprocal and more critical response by the container. The mother needs to contain the projected emotions of the infant, process them, and respond in a manner that makes them tolerable for the infant. Spotnitz (1976) noted that, as one method of responding to the inadequacy of the container, in place of acknowledging feelings of helplessness, hopelessness or inadequacy, babies use tension- reducing defenses in order to eliminate the sources of their unpleasant feelings.

Fisher (2006) expanded on Bion's theories to posit that there was an emotional experience of curiosity. He believed, as did Freud, that human experiences were "instinctual experience recast in terms of emotional experience" (p. 1222).

Fisher (2006) further wrote that Bion's "container" and the "contained" (p. 1230) were the psychoanalytic experience of being able to think. According to Fisher, attacks on verbal thought begin when the object (parent) of the projective identification rejects

the projective identification, which creates in the child a projective identification rejecting object. The projective identification rejecting object thus thwarts the child's instinct of curiosity. The result is a blow to the child's curiosity and promotion of the development in the child of a severe and ego destructive superego (p. 1228). This, Fisher believed, corresponded to Bion's (1956, 1957, 1959) theory that splitting and projective identification were attacks on verbal thought. The importance of this concept in the psychoanalytic relationship involves the answer to a question by the analysand. Does the answer complete the question or does the answer create curiosity and expand the question and the analysand's thinking process? Fisher wrote that the analyst must contain the projections of the patient and create an opportunity for the emotional experience of curiosity to develop.

Billows (1999) believed that, to bring subjective meaning into experiences, individuals need to understand their primal feelings both consciously and unconsciously. These primal feelings were not understood or experienced when the "psychotic part" (p. 633) of a person's personality attacked the emotional experience, thus preventing mental pain and the further development of the linking process to understand one's thoughts and feelings. Without being aware of these emotions and by defending against them, individuals would not be able to try to understand why they were having these feelings and thus make meaning of the here and now experience.

The Uncanny

Sveneaus (1999) added to Freud's thinking about the uncanny by positing that it derived from a feeling of lack of control, of not being at home, of being controlled by someone or something other than oneself. Sveneaus also believed that the infant's loss of

the mother was the foundation for the development of the ego. The universal trauma connected to this event is the origin of the uncanny feeling. The feeling of homelessness that develops from the loss of the mother “is the very quality that makes the child into an ego - an ego that will never be (and indeed as an ego never was) quite at home. He wrote that “the child will forever be sensitive to this a priori homelessness of existence which will announce itself in the uncanny” (p. 251).

Perlman (2001) wrote that the uncanny is an unconscious memory of not being fully differentiated when an infant is in the primal stage of separating (p. 90). The uncanny is a feeling of the past when we were less different and comes from a time when humans were more animistic. This is where the uncanny feeling originates.

Feigelsen (1993), writing about people’s responses when someone they love has had a traumatic head injury, described their feelings as uncanny. The object of their affections now becomes a double. The ego is exposed to “spooky” external events because an object that was once a source of life and vitality is now both here and not here and familiar and not familiar (p. 332).

Svenaeus (1999) understood that uncanny feelings were unhomelike feelings or feelings that were dangerous, strange and ought to remain hidden (p. 240) and out of consciousness. He also saw uncanny feelings deriving from the uncertainty of whether someone was alive or dead or something alive being controlled by “dead” processes (p. 242). There is certainly something that is not “right” (p. 243) about the person. For Sveneaus, uncanniness “comes from this feeling of lack of control, of not being at home, of being controlled by someone or something other than oneself. The repetition itself could be viewed “as a mechanical, unfamiliar principle regulating the self beyond its

possible control and comprehension" (p. 247). Billows (1999) felt that the uncanny cuts off the ability of a person to be curious.

Psychoanalytic Views of Death Anxiety

Langs (2004), a proponent of the universality of death anxiety, believed that there was an emotion-processing mind. It was his belief that the function of the human mind and its emotional component was to monitor and adapt to external threats to its survival. These threats could be natural or emotionally disturbing events caused by living beings including humans. However, he noted that internal events may also have the same emotionally disturbing effect as external events.

Langs (2004) believed, as did Freud, in conscious and unconscious process. Langs differed in several ways, first, that there is a deep unconscious part of the mind with biological underpinnings. In this deep unconscious mind, inherited and universal archetypal attributes operate the "emotion processing mind" (p. 32). These attributes are holding, soothing and self-satisfying while being morally sound and having ground rule preferences. He also postulated that the conscious mind is only committed to defense and to poorly thought out adaptations to death anxiety (Langs, 2003, p. 570).

Langs (2004) believed there were three types of death anxiety that were the "driving force for human emotional suffering and human creativity": existential death anxiety, predatory death anxiety, and predator death anxiety (p. 44). Existential death anxiety, the belief that we are born and that then will die, was a human condition derived from the acquisition of language. He stated that denial was the most often used defense, both mentally and physically. Denial was often manifested in rule and boundary violations as well as unconscious delusions and illusions. It was clear to Langs that frame

modification, the way people unconsciously change the rules of a situation, such as being late for appointments, was one of the most important and least understood defenses in the denial of death.

Predatory death anxiety, or the fear of being killed, is a response to threats to one's existence – fight or flight. Mental and physical adaptations reduce this threat. Predator death anxiety is activated when a person actually harms another living being. According to Langs (2004), predator death anxiety was unconsciously equated with murder while guilt was the symptom due to its violation of the unconscious moral codes of committing murder.

Langs' (2004) position was that these three anxieties are responsible for the actions of human beings. In opposition to Freud's belief that the move toward death was an unconscious wish, Langs believed that all fears are an unconscious fear of one's own death. Langs also believed that the root of all anxiety was the fear of death and not castration as Freud had proposed. Langs also believed that to reduce death-related anxiety, people adapt both consciously and unconsciously, to external emotionally laden threats.

In making a case for psychoanalysis addressing existential anxiety, Hoffman (1979) challenged Freud's (1915) position that the unconscious does not know mortality. Hoffman believed that awareness of one's death was the organizing experience propelling people to action. He posited that the belief in death created thoughts of immortality.

Zilboorg (1938) posited that there was an overemphasis on cultural influences over primitive sexuality. He wrote that the primitive ideal of immortality has evolved

over thousands of years into a sense of immortality as though it were a powerful impulse that has been elaborated in theories of social and cultural salvation. According to Zilboorg, what is left out of these theories is the foundation of:

> cultural forces, social ideals, social traditions, and sociological Utopias [that] themselves all spring from the perennial tragedy of incest, murder, and blood-guilt. These cultural forces would never be able to exist and still less exert the influence they do on the individual if it were not for the individual's responsiveness to incest, murder, and blood-guilt—a responsiveness that comes from deep and stirring experiences of his own childhood (p. 199).

He argued that by relating ourselves to society, an immortal entity itself, we are able to relieve ourselves of the sense of guilt, buy our ticket into the millennium and not have to address our infantile sexuality or the forces of "plain murder" (p. 199).

In an analysis of Freud's writing, Piven (2004) concluded that mortal terror was an unconscious fear of death in all humans displayed in neurotic anxiety, castration anxiety, helplessness, annihilation, terror, shame, humiliation and abandonment—all great wounds to our narcissism (p. 159). He believed that modern people continued to display many primitive beliefs to ward off the effects of the terror of their own deaths. The childhood phylogenetic development of anxieties, fears, helplessness and the need to be loved created the defenses to ward off the uncanny perceptions of one's own death. External events that interfere with pleasure and security are connected with internal representations, usually helplessness, associated from our earliest experiences that create death anxiety.

Piven (2004) wrote that humans' consciousness can not tolerate death. He pointed to religions' tenets of immortality, along with monuments that will never change such as the Great Pyramids, as illusions that humans use in an effort to deny the awareness of death[3]. Piven believed that some humans used repression to deny death anxiety, as shown by the lack of emotions to the horrors of war and the fascination that people have with media events that depict horror, violence and death. However, when asked to discuss death in detail, people's anxiety and anger immediately surface. He pointed to Freud's defenses of denial and isolation (although many others are also used) as the two common methods to obliterate the awareness of death. Piven believed that the feeling of helplessness originated from the time of birth. At that time the infant experiences terror due to the fear of abandonment and annihilation. The methods adults use to confront this hopelessness are at the root of death-denying delusions and behaviors later described by adults.

It was Piven's (2004) position that the most feasible way to address angst about the fear of death is for humans to acknowledge and encounter this reality by examining their fears and distortions and how they affect reality. And humans must refrain from offering advice to others because this sense of rescue is in itself only an illusion. Each individual must dissolve their "defenses against psychological annihilation and death becomes the means to buoy the ego within the unconscious imagination" (p. 233).

Not offering advice to patients was a key component in the work of Hyman Spotnitz. Although many patients come into therapy to be happy, a better definition of cure according to Holmes (2009) was the "ability to free associate or say everything" (p.

[3] Yalom (Piven, 2004) believed that Freud denied the unconscious knew death because Freud wanted to become immortal by discovering a radically new idea (p. 149n).

75). Spotnitz (2004; Spotnitz & Meadow, 1976) believed Freud's idea that the "primary functions of neuronal systems" (2004, p. 57) were discharge, and that process was reflected in the psychoanalytic rule of "saying everything" (p. 57). It was what the patient said, not what the analyst said, that was most important. Spotnitz believed that repetitive maladaptive patterns of discharge that detrimental to a person's development. These patterns needed to be deactivated and new patterns of discharge activated for emotional maturity to be achieved. Spotnitz posited that, when a patient had intense feelings, the same patterns of discharge were repeated. However, by saying everything the patient had the possibility of creating different patterns of discharge for these intense feelings instead of resorting to what was once an accretion of tension.

Meadow (1981) believed Freud's model of dual drives explained how to work with patients who had emotional conflicts. Freud's pleasure/pain model with an emphasis on "tension reduction and overstimulation" (p. 141) explained the patient's lack of sufficient amounts of libido to cope with the excessive amounts of tension. Holmes (2009) wrote that a patient's primary process thinking is activated by using language. Use of language is one of the "most important characteristics of secondary process thinking" (p. 75). By being able to say everything, a patient was able to manage primitive impulses and reduce tension in a mature manner.

According to modern psychoanalytic concepts and techniques, examining one's fears and distortions and the defenses used as protection against those fears and distortions takes time and the ability to put all thoughts and feelings into language (Hyman Spotnitz, 1976a; Hyman Spotnitz & Meadow, 1976). In writing about Spotnitz's group psychotherapy methods, Rosenthal (2009) stated that it was critical that the

dissolution of defenses and the acknowledgment of reality must be done very carefully. The degree of excitation to which group members are exposed must be carefully monitored by the leader. The group members must be protected "against a sudden or too intense mobilization of feelings that can overrun defenses and that cannot be adequately expressed in language" (p. 55).

And what indicates if people have been successful in examining their fears and distortions? According to Spotnitz (1997), they will be able to report "sincerely and honestly that they are having a healthful satisfying and happy life" (p. 40).

Summary of Literature Review

It is my intention in this paper to try to understand why nursing home aides respond to nursing home residents in non productive ways. Nursing home literature indicated that nursing home residents' behavioral problems are related to a lack of engaging social contact. According to the literature, nursing home aides, who have the most intimate contact with the residents, respond to the residents' behavioral problems in ways that indicate a lack of knowledge and training. The literature review illustrated that nursing home aides may behave, think and respond to nursing home residents in ways that appear hostile. The literature on Terror Management Theory and psychoanalytic theory were presented as a basis for understanding the research data with nursing home aides analyzed in this study.

Terror Management Theory research has provided evidence that powerful unconscious motivations create fear and anxiety when humans are confronted with out-of-conscious awareness of conditions that remind them that their own deaths are inevitable. According to TMT, reactions to these unconscious feelings propel people into

defending personal worldviews that create anxiety reducing self-esteem. This worldview response has as an effect of separating the anxiety-producing situation into people who represent the worldview called *ingroupers* and those who do not represent the worldview, called *outgroupers*. Although not psychoanalytic in their origins, the TMT tenets do represent unconscious processes, which are the foundation of psychoanalytic thought. Psychoanalysts study the unconscious motivations of people.

The literature showed that Freud believed the unconscious did not represent time and space, which meant that feelings from primitive man could be manifested in modern man. Modern man could encounter unconscious uncanny feelings that represented primitive modes of functioning. With fewer social constraints on instincts, primitive man had much more freedom of direct expression of these basic instincts. Modern people, however, having many social and cultural limitations on spontaneous display of instincts, could still experience an uncanny anxiety when these primitive feelings were unconsciously aroused. These uncanny feelings could be erotic, destructive or ambivalent. It was Freud's position that paying attention to primitive uncanny feelings could be humankind's greatest achievement.

Winnicott believed that the environment was essential, providing a space where fears of annihilation and abandonment could be tolerated long enough to secure a sense of being safe until the mother returns.

Bion wrote extensively about the importance of the toleration of primitive feelings in determining whether responses to existential threats were expressed in language by a *thinker* or actions by an *unthinker*. The development of curiosity was

essential in creating tolerance for frustration that was needed by a thinker to create language by a thinker.

The methodology described in the next chapter will show the process I used to determine the factors involved in unconscious descriptions of primitive feelings when there is a threat to existential existence.

CHAPTER III

METHODOLOGY

This is a psychoanalytic study to determine what nursing home aides say about their interactions with nursing home residents. Nursing home staff members have the task of supporting people who are in their last stage of life. Data shows the average nursing home stay at around two years (835 days) of their admittance into the facility(Health Resources and Services Administration, 2004). Additionally, nursing home staff have a turnover rate many times greater then most other service careers (Donoghue, 2009). This study will attempt to interpret the motivations for what nursing home aides describe about their interactions with nursing home residents.

The design of the study was to randomly assign five nursing home aides a nursing home resident for a weekly for 40 minute meeting over a 24 week period. During that meeting the aide was to listen to the thoughts and feelings of the nursing home resident using the modern psychoanalytic concepts and techniques described in Appendix F. After each meeting the aides were to e-mail me a brief summary of what had gone on in the meeting.

I met weekly for 90-minute videotaped sessions with nursing home aides after their work day during the same 24-week period. The group discussion was based on aides having a safe place to say whatever they wanted during each session. Initially, I waited for staff members to comment about what was being discussed. Then I made comments when they finished. I answered questions they might have, or I asked them questions. I did this to give them practical help with their assigned residents. At times, questions were asked of an aide to clarify feelings and help the aide and me to understand them.

Protection of Participants

The proposal was reviewed by the hospital review board, and the project was accepted as a training/pilot project. The meetings with the patients were held in a private area of the SNF where the patient is comfortable. In addition, any patient information and identification was secured at all times in a locked cabinet. The information was used without any identifying data, and any personal descriptions were disguised to protect identity. The nursing home aids were each assigned a color to protect their identity. Data were combined to give general outcomes with no identifying material. The bi-weekly group meetings with the aides and the researcher were held in a private area. Although nursing home staff knew the nursing home residents, there were no negative consequences for either staff or residents for participating in the project. The nursing home paid the aides for the 90 minute bi-weekly meetings and the one hour weekly time with the residents.

Criteria for Participation

Criteria for nursing home aides to participate in the study were that they spoke English; were nursing home aides licensed in the rural Northern New England state where this 50-bed skilled nursing facility (SNF) was located; and were employed fulltime by this same facility. Participation was voluntary. Each aide would be paid by the SNF for the extra time required to participate in the weekly sessions with the resident and the group during the 24 weeks.

Criteria for nursing home residents to participate in the study were that they were residents of this same SNF; understood and were capable of speaking English; and understood and were capable of consenting to voluntarily participation Each resident had

a psycho-social issue as defined by their case worker and/or were taking psychotropic or anti-depressant medications. There was no financial compensation provided for the residents.

Nursing home aides and residents gave written permission that the information shared could be used for educational purposes. Nursing home aides gave written permission that the video-taped group sessions could be used for educational purposes. This convenience sample was recruited from a target population of predominantly Caucasian aides and residents who lived and worked in this SNF. This limited racial diversity is representative of the population of rural Northern New England.

Recruitment

The source of the data used in this project was obtained from the transcripts of the 11 videoed 90 minute group sessions. The potential mostly Caucasian participants worked at the same 50 bed nursing home (SNF) in northern New England.

Recruiting Aides

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The recruitment of the staff members' participants began when I announced the project at a monthly staff meeting. Immediately following the meeting, I posted recruitment flyers throughout the nursing facility. The next week, approximately six weeks before the project was scheduled to start, I began asking aides if they would be interested in participating in the project. All the aides approached stated that they were interested in joining the project. I accepted the first seven aides for interviews and testing. One member quit her job at the facility before her meeting was convened, and another member quit her job one day before the project started. The five remaining staff members were accepted as participants. One week after the project started, one of the

project members quit his job to take a position at another facility. Since there were only four aides left, an LPN was accepted who had volunteered to participate.

The six aide participants in the research were assigned names of colors: Blue, Brown, Green, Yellow, Pink and Red, to protect their anonymity. One participant (Red) attended only the first session. Of the remaining five participants, one person attended eleven sessions; one, ten sessions; one, nine sessions; one, eight sessions; and one, the first six sessions, but met with her resident for the entire six months. Five participants were women; one participant was a man. Participants' ages ranged from 23 years old to 53 years old. The length of time participants worked at SNF ranged from three months to over 26 years. Four participants had biological children and one had step children. All participants were high school graduates, one was an LPN and two were enrolled in an LPN program.

Recruiting Residents

I recruited the nursing home residents by asking a case manager for a list of nursing home residents who were designated with psycho-social issue or taking psychotropic or anti-depressant medications. I met with nine residents individually explained the project to them and all agreed to participate. During these interviews each resident signed an informed consent. Then, the case manage called each of the resident's guardians to ask for their consent. One guardian did not consent, and the resident did not participate. The remaining eight guardians received a mailed consent form that they signed and mailed back. The residents' names were then put in a blind draw, and I assigned each resident to an aide. One aide switched residents' part way through the project.

Six nursing home residents participated. Four of them were women and two were men. Their ages ranged from 62 years to 86 years. Four were diagnosed with dementia and a fifth with second stage Alzheimer's.

Nature of Participation

Initial interviews with nursing home aides included a thorough explanation of the project, its length and the aides' responsibilities and commitments. They included:

1. Meet with one resident for 40 minutes weekly for 24 weeks;
2. Meetings with residents were to be held in a private setting;
3. All meetings with residents and group were confidential;
4. After each weekly meeting with residents, aides were to email the researcher (without identifying the resident) their thoughts and feelings about the session;
5. Meet with the group (researcher and other aides) for 90-minutes weekly for 24 weeks
6. Information shared during meetings with residents was discussed only during the weekly 90-minute group sessions;

Participating aides agreed to all responsibilities and commitments and signed consent forms. The written consent included permission for all 90-minute group sessions to be videotaped for use in collecting data and education.

I met with nursing home staff for 90 minute sessions every other week for six months. The first meeting with staff began with "why are you here?" Subsequent sessions began with "how should we begin today?" or "what are you thinking about?". The questions were intended to provide the staff members an opportunity to talk about anything on their minds at that time. This was a vital aspect of the project because

allowing the staff members to talk about anything they wanted was a model for how they were to be with their residents

Data Analysis

Transcription and Data Cleaning

The videotapes were transcribed by a professional medical transcriber. The ability for the aides to speak spontaneously in the 90 minute sessions caused problems for transcription. Since the video equipment contained only one microphone, talking over, interrupting, and giggling and laughing created many challenges in transcribing. The professional transcriber question- marked those instances. Since I had been present at the meetings, I spent many hours reviewing the tapes to fill in as many of those questions as possible. Areas I could not understand, I left blank. Then I re-read the transcribed data several times to determine the emerging themes.

Themes

With a psychoanalytic approach to the data I wanted to understand the underlying motivation for the aides' behaviors in language and action during their session with the residents. My initial question in reviewing the data was "What's going on in each session?" The answer to that question was easy and somewhat surprising. It also eventually changed the focus of this project. What was going on in my first impression was that the aides were overly self-absorbed as they discussed their work and interactions with the residents. With this in mind I initially began by separating the data into self-absorbed or resident-focused comments. It quickly became evident that most of the aides' comments about their interactions with the residents were self-absorbed; i.e., "I don't like her." Then I began separating the data into various categories, including codes that

described comments that were resident focused. For example, “X told me a story about his father.” All data were further coded into categories such as negative or positive, identifications, aggressive or passive, avoidance, conflict, empathy, judging, projection and sexual. Under each code I placed the comment made by the aide using session # and lines as in the following example, (3. 345-356), session #3 lines 345 through 356.

The data were analyzed in the various codes and determined that much of the aides’ descriptions of their interactions with residents indicated strong emotions. Analysis of the coded data determined that with further study the codes could be identified with certain themes. Among these themes were environment, corporeality, identification/self-revelation, managing feelings, and listening.

Environment. The environment was both a physical place were the aides provided care for the residents, a place where other activities for the residents were performed, and other therapeutic and social activities occur, as well the sights, sounds, smells that occur in the environment. Also the environment includes the performance of accepted as well as understood protocols for providing care that effect aides’ thoughts and feelings about their interactions with residents. An example would be “He was trying to talk and there was X screaming in the background” or “its next patient, next patient, next patient….there’s no time”

Corporeality. Corporeality is the body as separate from a human being. I noted specifically when aides were describing negative comments about residents they quite

often described a corporeal aspect of the resident. For example, “I can’t stand to look at her teeth” or “… a skeleton…a tinker toy…”

Managing feelings .This theme was ubiquitous in the aides’ descriptions of interactions with residents. Managing feelings was incorporated in most other themes as well. For example, “This work is so emotional…you want to run down the hall” or “That woman… I wanted to rip her head off...” Or “When I feel like that I snap the curtain…”

Identification/Self Revelation. This theme involved the aides’ comments that identified with residents’ behaviors or revealed personal issues conflicts. For example, “I would be one (resident)that would pee on the floor” or “ Maybe she (resident) did something…I’m not talking to my grandmother until she apologizes…” Additionally, this theme revealed patterns of behaviors and comments by aides; for example, one aide was nearly obsessed to find out why a resident’s children didn’t visit.

Listening. This theme emerged from the aides describing their 40 minute sessions with the residents. It was quite noticeable that when describing their meetings the voice of the resident was heard which was remarkably different from the aides describing their normal workday interactions with residents in which the voices of the residents was almost never included in the comments about the interactions. However when listening to residents and then reporting the voice of the resident was clearly evident as noted in the following examples, “She described her home (long description of what the resident said)” or “She said I’m Mrs. X… what do these young kids have a right coming in here and calling me

(first name)" or "he said his father whipped him with a twitch…". A second listening theme was curiosity, which again was unique as the aides usually did not indicate any interest in why a resident might be saying or doing something; for example "Why, why does he get up. Why not just lay their and do nothing"? Or "From doing this work (listening) I realized… what does he have…"?

Dual use of data. I want to make note that the material used may fall under more then one theme. For example, "It was disgusting…her skin was like a sheet… a tinker toy." This material could be used under environment theme (sight) as well as corporeality theme.

Other Findings

One of the other findings was a specific type of comment that was made by nearly all the aides, "it's cool" when a resident either made a comment about wanting to talk to an aide or said something that made the aide feel positive.

CHAPTER IV
RESULTS

Chapter IV presents the analysis of the data revealed as the aides described their interactions with the nursing home residents. These findings are discussed under the categories of the environment and how it was described by the aides, corporeality or the body and how the aides used those depictions, the methods the aides used to manage their feelings, the various ways the aides identified with the residents and made self-revelations, and the aides' descriptions of their listening sessions with the residents. Some vignettes are presented in more than one section where relevant**.**

Environment

The environment at the SNF included the building, furnishings and rooms as well as sights, sounds and smells. It also included people: residents, their family members, aides, nurses, management and supervisors, and other caregivers. Less obvious but equally important in the environment were the protocols, tasks, cultural beliefs, expectations, norms and feelings, and institutional anxieties. Although the aides did not seem to be consciously aware of the effect the environment had on their interactions with the residents, throughout the group sessions the aides commented on the influence that the environment had on them Although the aides appeared to be acclimated to an environment that most people never witness, when given the opportunity to express their thoughts and feelings openly, the aides were able to describe the consequences that this environment had on their interactions with residents.

At times the aides were able to reference the environment when describing stress and anxiety. One aide described the environment as affecting her world outlook, "Oh

yeah, we are in the environment, you know, we see sickness so much that we can see it in other people outside the hospital" (9.186-188).

The physical space of this environment was described as being "on the floor." "On the floor" included residents' rooms, intersecting hallways, nurses' stations, bathing areas and dining room. In this space the activities of daily living (ADLs) were carried out by aides, residents, nursing supervisors and other interdisciplinary staff. On the floor, aides tried to perform their duties in meeting the needs of a varied, complex and vulnerable population within a time constraint that they consistently found burdensome. They described the pressured environment of being on the floor as tasks to be completed; rules to follow; the sights, sounds, and smells of SNF life; and conflicts with residents, staff, supervisors and families.

Institutional Pressure

The stress of time, workload and staff shortage appeared to cause constant pressure and frustration for the aides and affected their work and relationships with residents and other staff. The stress of time and workload was revealed by one aide: "You feel like… next patient, next patient, next patient…It is the workload… I had seven or eight residents and now I am up to 11… It makes a big difference…you have six minutes per hour…per person… that's it… boom, you are out the door" (1.62-73). Another aide indicated the exhausting work added to the pressure, "I have never worked as hard" (1.90).

The pressure to perform and complete tasks was exacerbated by staff shortages. For example, one aide reported, "The floor is horrible. I mean we are so out straight until 3:15. It is crazy. If we get our ambulations done, it is a miracle… like today we were

short one and I volunteered to catch up on vital signs…we have been out straight" (11.462-468).

A second aide described how performance of tasks overshadowed the residents' (whose home is the SNF) desires and created conflict. For example, an aide described a situation where residents might be waiting for the aides to take them for a cigarette break: "They will sit outside the room waiting for me… I say, 'No, I have to go to another room'…they will both be outside waiting. 'Are you ready to go now?' They get mad at me. I don't have the time" (1.347-350).

Finally, the hard-working aides with their focus on completing tasks seemed to have little understanding or consideration of residents' behaviors, as noted in this example: "I can't think of a way… I see that as disrespect…the disrespect is that we are, you know, hard-working. We are trying to do a good job and she [resident] is playing little games" (5.497-499).

Supervision Environment

The pressure to complete tasks was felt throughout the SNF. The aides described an environment where the stress to meet protocol seemed to prevent dialog or discussion between various staff members and administration. The aides never mentioned a place or time where there could be a healthy discussion about the difficulties of providing care for this vulnerable population. This lack of discussion resulted in reactive, hostile and sometimes childish responses by supervisors and the aides.

An aide described how she enacted a little revenge towards nurses whom aides have conflict with in their daily work, concluding with "…It is kind of fun bugging the nurses" (8.1141). A second aide used sarcasm and blame as a defense, "…it's been hard

because we have so many Staffing Solutions [temporary help] and there are so many morons in there" (5.770-772).

The environment was also infused with antagonism and reactive behaviors between supervisors and the aides. As described by the aides, the supervisors did not appear to have the skills, knowledge or understanding of emotional communication to respond effectively. Aides described their responses to supervisors who were reactive to the aides' emotional communications, "…I snapped and got very sarcastic to a nurse and I walked away… I said [to my supervisor], 'she is still alive' …but I have learned to not to yell and scream which is a big step for me" (9.409-421). A second aide described a reaction from a supervisor over an apparent minor change, "and then she threw a fit because I switched breaks" (11.1-3). Finally, it appeared that even harassment on the job was considered just part of the environment as one aide reported, "She called me white trash (laughing)… I pretty much got told that I suck at my job" (11.54-58).

It appeared that supervision at all levels was affected by the environment. The environment appeared to be one where getting the tasks completed far outweighed the human condition created by this same focus. The aides' descriptions of interactions with supervisors indicated the lack of understanding, "it's like sometimes I feel like I am being talked down to…I just give up... Don't give a shit…get somebody in there that cared about us" (11.770-804).

It appeared that management did not understand how their responses to aides' concerns affected the environment An aide reported the outcome of her attempt to ask a supervisor to intervene with another aide who was having difficulty with a resident: "I was told I was wrong….this person fell out of bed, it was all your fault and… when this

person choked, that was all your fault … This was an abuse case I went to them for. It got turned around on me. I will go to the State [ombudsman] before I walk into that office again" (11.761-770).

Residents ***[SPACE BELOW DOESN'T MATCH OTHER HEADERS. MAKE THESE ALL CONSISTENT. PREFERABL;Y, NO EXTRA SPACE, AS IN PREVIOUS CHAPTERS.]***

The residents often displayed regressed and challenging behaviors that the aides had to manage in many different ways. The residents were not all docile and accepting of the aides' care. The aides described hostile, psychotic, or sexually inappropriate behavior by residents that they had to manage as they cared for the residents.

With a hostile resident what would most often be considered a normal gesture had to be noted and managed as reported by this aide, "He had a remote….[I said] if you throw that remote, X, I am walking out of this room, wham….I left the room" (2.94-96). At times psychotic behavior would be tolerated until a judgment needed to be made to take action as this aide described, "she threatened me about hitting her with the axe one day…she said, 'You tried killing me with the axe. Get out of my room right now.'[I left.]" (2.762-764).

Inappropriate sexual behavior by residents could appear at times when the aides were most vulnerable to these behaviors. Aides needed to make each other aware of these moments as noted here, "She wants to cop a feel once in a while. You have to stay out of her reach. 'Cauz there's that, you know, when you are transferring her… she tries to grab you" (2.298-305). Other residents seemed to understand how they could use their power

to manipulate aides as one aide described, "and she was saying that she is going to scream out, you know, because I am molesting her" (8.1033-1034).

Demented residents were a special concern as they created anxiety throughout the environment. They often spoke in bizarre, incoherent language, or screamed out loudly, complained of pain that they could not describe, struck out wildly at staff, or wandered off premises. It was as though the helplessness of these residents created a constant anxiety in the environment as aides had no clear understanding of how to interact with these confounding residents. This encompassing anxiety was revealed when other staff attempted to blame the aides for residents' emotional pain without any knowledge of the situation. It seemed blaming others was a method of reducing anxiety inherent in the environment as noted in the following anecdote. An aide described a situation where another staff member blamed another aide for the resident's behavior. The staff member heard the resident screaming while an aide was working with a resident. Without getting any information the staff member concluded that the aide was causing the resident's discomfort. Blaming an aide for the resident's discomfort was the staff member's way of dealing with her own anxiety (6.795-800).

The aides discovered methods to change the environment and reduce the anxiety of residents. The effect of this change was to control the resident to meet the demands of the protocol, as mentioned in the following example of an aide's work with a demented resident: "You get some people joking around, and playing around, and she laughs…And kissing her neck and she starts laughing and you can do anything you want" (8.364-367).

Death Environment

The aides' thoughts about the death that they encounter as a normal part of their work were only revealed experientiality. Self-referencing comments by the aides did have a clear communication about what life was like in the SNF from their point of view. They did, however, refer to death through their accounting of various experiences. This indicates a very important arousal that was out of their focal awareness. These experiences seemed to describe an environment where they experienced horror, fear, anger, the aloneness of death, and their often unrecognized attachment to the residents. As noted in the following example, an aide described the anxiety she had that a resident might die: "She eats in bed. She is lying flat…If she chokes to death, wouldn't we be liable?" (8.305-309). A second aide described her fear of the resident dying: "she drives me crazy with that [eating in bed]" (8.331-332).

The fear of someone dying was something that could arise at any moment and cause great anxiety and fright as the following example showed: "I am like, 'X [resident], don't do this to me'…I am like 'don't'… [she] wasn't breathing… [it happened] twice and we had to resuscitate her… her eyes were like this purply color and I was like, 'X'… She is going 'what?'…[I said] 'you just scared the living shit out of me'"(11.520-535).

The environment was a place where residents didn't get better. The SNF seemed to be just a place to get a job rather than a place where aides enjoyed working, as reported in the following comments:

> It is not that I like [the] old…I work on acute, I work on Rehab. I like working on Rehab. The reason I work in geriatrics so much, it is easy to get into… You know you'll get a geriatric job… If I had a choice, I would work in Rehab because I like them getting better and going home… I would see them get better. (10.531-539)

The experience of caring for people who die alone had a profound effect on aides, including how they felt about residents' deaths. Thinking about being alone without family or loved ones was horrifying for one aide as she explained her thoughts about these residents,

> The last time I drove home from [SNF]… and [SNF] called me that I had a patient…who was dead in a few hours and there was nobody. There was no family there. There was nobody there. I swore I'd never do that again. I'd stay. I'd go off pay. I don't care… I thought that was horrible. (6.598-601)

That same aide appeared to be projecting her feelings onto residents when she reported, "… but we had two deaths just recently. And there is some grieving going on" (4.319-321).

Aides often identified experiences in the SNF with their own personal experiences. These experiences also included the deaths of residents. Aides may need as much or more support as other residents or the family members when a resident dies as indicated by the following example:

> I think it was nice that all three children were there and I went in and say goodbye and I had a few hours left to work and she said, "Come in." They all jumped up and gave me a big hug. My parents died at home… and I haven't experienced anything like that. People to open their doors to all of us. (4.355-357)

Sights, Sounds and Smells

The sights, sounds and smells of the environment were described by aides in a multitude of ways that indicated a constant emotional stress that needed to be defended against.

At times both residents and staff were both treated as objects without feelings. The aides had to overcome the stress of the sights, sounds and smells in order to perform their tasks. Action often seemed to be their only resource to deal with these constant environmental stressors. Aides described what they saw on a daily basis that seemed to affect their psyches, as indicated in the following examples: “Three, four staples. She looked like she just rose from the damn grave” (7.1105). A second aide became angry by what she saw, “Her dirty teeth, I think that is what makes me angry” (11.144). A third aide seemed to be trapped without resources to intervene in what she saw a resident do to his wife, “I have seen him kick her. When she was walking, he would kick her when she passed” (4.747-748). Finally, an aide appeared spooked by a resident, “She gives you the chills when she is mad at you…She got great, great hairy eyeballs, evil eye” (8.1024-1025).

The noise of the SNF was an ongoing experience for the aides. They tried controlling the anxiety it created in various ways, for example, “You need some Ativan for that damn yelling” (5.384). The noise in the environment was intrusive and almost de-humanizing at times as noted in the following example: “The noise…when I was in with [resident] M …I couldn’t take the noise… I fled out… I ran out of the room. I was screaming because they were doing the report outside her door and they were talking about her” (6.768-770).The level of noise seemed to be a constant. It appeared to affect this aide’s anxiety, “the noise level gets to me too….especially [resident] X… Ohhh… Through all that, it is exhausting” (8.668-678).

The smells also affected the aides as noted in the following example: “I tell her every once in a while she stinks and she needs to get washed up” (7. 124-125). The

environment created situations that were disgusting for the aides. The following example indicates the personal disgust aides had to manage to perform their work: "Her room is cluttered. She smells. She doesn't clean herself properly. Just the thought of her makes me vomit" (3.44-45).

The aides described an environment that few people experienced on a regular basis, one where they have to work and care for people they do not like. "I can probably count on one hand how many times I have gone in that room and you know, (big sigh), and go to work"(11.217-218). A second aide continued to talk about residents that challenged her sense of smell, " How many do you got on the floor right now that you don't like going in to their rooms?... Three… That's it…I actually have to take a deep breath before I go into the room" (11.226-230).

Finally, an aide reported that her inability to accept the residents' complaints about the SNF environment affected her ability to understand the residents, "I have two people… what about manipulating other people. I have a hard time going into [their] her rooms. I don't want to believe them" (11.311-312).

Aides' Perspectives of the Environment

The main focus of the aides' work in this environment was to complete tasks for the residents. The aides' descriptions of their interactions with residents revealed two common perspectives. The first perspective was that the environment of the SNF had a most important influence on the aides' management of the lives of the residents. The sights, sounds and smells of the environment along with the protocols that were mandated affected how the aides interacted with the residents. The aides did not describe many, if any, interactions with the residents in which the protocols or tasks were changed because

of the residents' desires. One aide described how the environment controlled the residents, "They can't leave, they can't go anywhere…Everyone tells them what they can do, when to eat, when to go to the bathroom… Breakfast is here…Okay, great" (3.562-566). A second aide described how she controlled a resident's basic needs, which would allow the aide to accomplish her prescribed tasks, without listening to the resident. "She has asked me several times to get up at 9 o'clock in the morning and I am like… no way. No way, I am not getting you up at 9 because you will want to go back to bed in ten minutes, and how do we [I] actually know that?"(5.474-476).

The aides also expressed that the SNF was not the environment that they would want at the end of their own lives. This perspective seemed to indicate that the aides' connections with the residents were more emotional then either they or the management of the SNF were able to realize or understand. The aides intuited this perspective in various ways. One aide in particular did not view life in an SNF as conducive to her vision of a "final journey." For another aide the SNF was a place to get a job. Yet for a third, suicide was a better option then life in a nursing home.

The other manner in which the aides indicated an emotional connection to the residents was when they described their views of what life was like for a resident in the SNF from an as if "I put myself in their place" perspective. The aides' perspectives indicated a great deal of anger and frustration shown by their projections onto the residents concerning life in the SNF. The aides projected their sympathy for the hopelessness and helplessness of the residents' lives. The aides also indicated an unconscious identification with the residents as they compared their experiences as workers in the SNF with the lives of the residents. The aides described the SNF as

confining and controlled, like a "prison," where the residents' lives were so orchestrated that even their eating and going to the bathroom were controlled.

Aides generalized and projected what residents' lives were like before they lived in an SNF. As one aide reported, "I can't think of a soul in there that has had an easy life…You know what I mean, they have all had some sort of trauma and sadness" (8.1184-1186).

The environment of the SNF seemed to make the aides angry when they identified with the residents' lives, as the aides considered their own lives as residents. One aide expressed her anger about the environment as she identified with the resident's life and then compared life in the nursing with a prison.

> He is one that I know that he has issues. He is another angry man who I imagine had to work all his life and look what he has. Nothing! I would hit people with canes, too. I am sorry. I would. I don't know if I could deal with it…Don't let me work as hard as I have worked all my life and put me in a prison. (4.621-622)

A second aide described her violent anger when she identified and sympathized with a helpless resident, whom she had manipulated and controlled,

> She wants her coffee heated up and I always find myself going, "you know what [resident] X, if you get your butt out of bed when you are supposed to…" Then when you think about it, why are they supposed to...? You know. I would hate to be disturbed….I would kick them when they do that to me. (3.569-573)

The aides consciously and unconsciously identified with residents. In the following example one aide consciously empathized with the resident's frustration while unconsciously identifying and empathizing with the life and, of course, working in the

controlling environment: “Everybody dodges her all the time and they ignore her and they don’t get her what she needs. I understand where she is coming from… I was like, wow. It is really shitty living in here, isn’t it?” (5.417-420).

It appeared that the controlling environment affected the aides’ perceptions of what life was like for the residents. Aides admired residents who adjusted to the SNF environment but they did not identify with that group. SNF life was not for the aides. One would choose suicide before choosing accepting life in the SNF, as reported in the following example:

> Yeah, I admire the residents that come in here and make the best of it… I could never be that person. I would be one of those angry, horrible…I don’t know how they do it…. Oh yes, some of them are delightful. I mean, they are just so settled and accepting…. It is amazing. (Made suicidal gesture with hand as gun to temple then said,) KAPOW!(1.122-137)

Another also showed her displeasure with accepting life in the SNF, “she has made this place her home… She is getting, her needs are being met. She gets her three meals a day …I would cry” (4.583-588).

The aides were more identified with the hostility of residents in the SNF environment as reported in the following dialog between two aides: Aide #1: “Oh, I would probably hit the staff. I am going to be one of these people that take my clothes off and pee on the floor…” Aide #2: “Well, it depends on how many times my roommate yelled at me, too” (1.113-120).

The aides appeared to try to distance themselves from the environment of life in the SNF as indicated in the following conversation between two aides: Aide #1:“To be

equal with them… Like, we are pretty much… I feel like I am equal with them sometimes…" Aide #2: "I don't at all [feel equal] because I'm not living there…Maybe as people but maybe not a situation. I feel equal as a person with them …" Aide #1: "But I can't, I have never lived in a nursing home…." Aide #2: "I don't even go there" (9.917-926).

The environment of the SNF was very different from the environment that most people are involved with on a daily basis. The environment was one in which the aides had to administer to frail and failing bodies and then witness the actual deaths of the residents who inhabited those bodies. Being in an environment where they were involved in the dying process on a regular basis gave the aides a unique perspective of death. The following report of a dialog between a long time aide and another long-time staff member from the nursing home indicated that each wanted to die in an environment that was quite different from some commonly accepted understandings of what an environment should be like when a person is in the dying process. Their conversation seemed to indicate that they only wanted life. Death was not to be accepted but fought. And they didn't mention a dying process -- only living -- and after living, nothing:

> Z [staff member] and I were talking today about dying and what we want…what we want is curtains open, the sunshine coming in, people laughing and talking and telling dirty jokes with the TV on, while we are laying there comatose. I want that…. Don't do it to me. Start talking. Give someone a hard time and fight. I want to lay there and hear that…I don't want a vigil companion. I don't want somebody sitting there holding my hand…. I am going to go out kicking and screaming… don't go out wimpy. (11.887-906)

Corporeality

The aides described the corporeal bodies of the residents they cared for in various ways. The SNF was occupied (for the most part) with residents who had old, wrinkled, feeble, dysfunctional bodies and minds. There was no place else where these bodies could get the care and nurturing necessary to keep them safe and functioning at their highest levels. In providing care and comfort to the residents who occupied these bodies, the aides dealt with the consequences of failing bodies and minds. The corporeal deficits of the residents were reflected in how the aides described them when discussing residents. The physical challenges of the residents created emotional challenges for the aides. The emotional challenges were in part created by a lack of resources for aides to address the challenges. The following example illustrates this dilemma for an aide: "He was talking,…and very open and I felt bad because you know, because I couldn't understand what he was saying and I really wanted to engage with him…" (6.252-255). Such interactions with residents usually created feelings of anxiety, frustration, or anger that aides often responded to with either a discharge of feelings or going into action in some manner.

One important theme to come out of this project was how corporeal deficits affected the aides' descriptions, thoughts and interactions with the residents. In the following example an aide described her feelings about a resident because of how the resident smelled: "I hate her because she is a dirty, dirty woman. And I do not like dirtiness. Her room is cluttered. She smells. She doesn't clean herself properly. Just the thought of her makes me vomit."

The body descriptions reported by aides included the unproductive whole body of an old person, the sounds made by failed body parts, the consequences of failed body parts, the terrors of a failed mind, the smells of uncontrolled bodies, and the disgusting sights of these failed bodies. In these examples the aides' feelings were always in the forefront as they discussed a resident with Alzheimer's who was talking: "I felt kinda bad…because I couldn't understand what he was saying and I really wanted to engage with him" (6.253-256)

The residents, who are human beings, were presenting body deficits that are not what one normally encounters in interactions with people outside of an SNF. If these deficits were encountered in everyday activities in the world, one could usually manage to avoid or ignore such distressing sights, or sympathize with the people for a few moments and then retreat to another environment. However the aides seemed to have an unconscious system that separated the residents into two groups through corporeality, as shown in this example that compares oriented residents to demented residents: "They are manipulators. They are masters and they do it for the sake of the other patients… if they were demented like [resident] X [or] on their way, but they aren't" (11.328-332).

The oriented residents were criticized even though they had severe emotional as well as corporeal deficits. The oriented residents were helpless to change while the demented were hopeless to change.

For the aides working in the SNF, the residents' bodily deficits were not only unavoidable but the aides had to engage them on a regular and intimate basis. When interactions with residents created strong negative feelings in aides, they often described corporeal deficits in what appeared to be an attempt to manage those feelings. It was as

though criticizing the corporeal deficit avoided the humanness of the resident. The dehumanizing of the residents appeared to shut down the aides' capacities for ambivalent thinking. For example, in criticizing a resident who had annoying, repetitive, difficult to understand speech an aide said, "I can't understand him for crap… I just don't want to deal with all of that stuff [difficult to understand, repetitive speech]…over and over…he has one good arm and one good leg…. [his] speech is just laziness" (1.266-310). The frustration in these sarcastically given comments and blaming the resident for the consequences of his body deficits appeared to be an attempt by the aide to manage feelings.

A resident with lack of impulse control (sexual comments), disauthorized speech (difficult to understand) and paralysis disgusted many staff members. While most aides would not work with this resident, one aide changed him into a dog so she could find him likable and not have to respond in disgust and avoidance:

> His legs start shaking….just like a little dog…. it goes a million miles an hour…. "What is up with that leg, [resident]? You are just like a little dog when you see [staff] Z" and he is like (resident makes a noise) and he is so funny. Scratch him behind the ears…He's a riot. I wish we all had the same relationship with him. Some people won't even go near him.... (4.1000-1015)

When an aide described an interaction in which the aide appeared to be overwhelmed with emotion, the corporeal was injected into her response about the residents. It was as though the corporeal gave the aide permission to be angry at the resident. The resident's body deficit was attributed to something other than a normal human and could be subjected to criticism: "Her dirty teeth, I think that is what makes me

angry" (11.146).

The corporeal was also substituted with a more appealing body or something other then human, in several situations. At times of stress the aides would dehumanize the resident's body, one method for them to discharge strong negative feelings. In relating the horrific sight when bathing a disliked resident, an aide described the resident's body as follows: "… absolutely disgusting. You are looking at a skeleton… a tinker toy…hips like a skeleton… a sheet covering a skeleton…a sucked in sheet covering the skeleton… it is nasty…. Oh my god!... Her hair is… it used to be this thick gorgeous…" To be able to express her strong feelings, the aide compared the resident to a toy and, of course, the bones of a dead person. The hair, which the aide did not describe in non-human terms, was changed into a pleasant description.

Changing an old failing body into a more appealing and acceptable body was another tactic used by the aides to distract themselves from the corporeal images they confronted on a daily basis. This strategy was even more important if the resident was diagnosed with Alzheimer's disease. If the aide could imagine a more appealing picture of a resident (body image with value, not just taking up time of hard working aides), that brightened the aide's outlook toward the resident. In an argument with another aide about a resident whom they did not respect, one aide described what she liked in another SNF where she had once worked: "I worked in an Alzheimer's… pictures of each resident on their doors…when they were very young…it showed them in a different light…not just as an old person…saw them as productive people at one time" (5b.425-532). This aide made a clear distinction about the type of body, and what she valued in a person whom she wished to have in her mind.

The aides would criticize and judge residents by using the consequences of the deficits as the reason. In a response to a “needy” and “obnoxious” (5.379-380) resident wanting to telephone a family member, the aide used the resident’s corporeal deficits as an excuse to neglect her duties and get some relief from her angry feelings: “Yeah and he wants to call but he can’t hear and he can’t talk. And I’m not going to call her” (5.395-396). There was a sense of hopelessness and helplessness in the aide’s responses. The lack of ambivalence appeared once the aides were overwhelmed with strong feelings. Then only the discharge of those feelings was possible.

The body deficits of the residents had an effect on how the aides thought about the residents and the residents’ behaviors. It appeared that aides believed residents should feel hopeless and helpless about their lives. Aides identified with the effects that the deficits would have rather then empathizing with the residents. Sometimes aides believed death was much more appealing then living with corporeal deficits. In one case the aide revealed her thoughts about a resident after learning that the resident, with multiple corporeal deficits, had attended lunch in the dining room: “I thought why is he, why, why do they get up, would I have gotten up, with that sort of medical diagnosis? With that sort of pneumonia just lay flat and die, be done with it. Why get up? What for?” (2.436-441).

When residents were unable to communicate well, the aides were easily frustrated. In a following session it appeared that the above aide was barely able to veil her wish for his death as she described the effects of some of his corporeal deficits, “He is really hard to understand…I think he is going to progressively go downhill and I often wonder if he is even going to last long enough to see this thing out. He is very gurglely. He is failing rapidly” (3.297-300).

Further comments from the aides indicated that the residents' body deficits encouraged the aides to act impatiently without listening to the residents and without any conscious empathy. One resident, in a long and what seemed emotional expression, described a history of physical abuse by his father. That abuse included being whipped with "twitches" (small whiplike branches) as a child and other grossly violent acts. The aide's report of this incident included several comments that indicated she either did not believe the resident, wanted him to admit he deserved the beatings, or that was just how it was in those times. The aide's only connection to the resident's personal situation during her telling of the story about the resident's beatings was her difficulty understanding him because of his deficits: "he picks and chooses his words; it's hard for him to get them out." The only compassion the aide expressed was when the resident brought up horses at the end of the story, as noted in her comments

> …His father hit him across the head. He hit him across the neck and he hit him across the cheek … [I asked], "Did you guys deserve to get twitched?"… [When] he brought the horses into that… I kind of shoot around it because I don't want to hear about animal abuse. (4.734-746)

This very old, deficit-ridden resident was not able to engender compassion from the aide. The aide needed to essentially redirect her feelings about the resident to a horse. For the aide, who unconsciously wished for a hopeless and helpless resident to die, hearing about that resident's horrible abuse as a young, hopeful child was overwhelming.

Alzheimer's or other dementias were "things" that essentially transformed a person into something that was non-humanlike. A person with dementia could respond in an appropriately acceptable manner but the "dementia" was what was emphasized by the

aide. An inference by an aide seemed to imply that a demented person was something other then really human, because of the hopelessness of the disease: “I mean, she is sweet, she’s social and she says hi to everybody but I really think she is demented.”

When discussing residents with Alzheimer’s or dementia, the aides had a sense of helplessness and hopelessness. The residents’ yelling and inability to tell the aides “where it hurts” caused the aides great anxiety. In one situation an aide wished that a resident with Alzheimer’s would quickly move to a more advanced stage so he could end the “torture”: “It is almost like ya just want the disease to progress and get it over with… to get there ‘cause…where he is right now… is bad…..torture…yeah, it is a form of torture, I’m sure”(5.392-395).

Alzheimer’s was a thing that caused a person to be non-person-like, a very understandable defense against the hopelessness and helplessness the aides felt in the presence of residents. That message was reflected in this comment by an aide, “Like if he didn’t have Alzheimer’s,… he could be a real good buddy. .. Like a guy you’d like to hang around with (giggle)… he has a nice way about him” (6.202-204). Another aide remarked, “I worked in an Alzheimer’s [unit]… but it was pictures of them when they were very young…it showed them in a different light… you saw them not just as an old person. You also saw them as productive people at one time” (5.416-422).

Working with the corporeal deficits of the very old was challenging and often induced strong negative feelings in the aides. Often when aides spoke of the physical deficits of residents, they compared the images in their minds of a younger, more productive person to the physical reality of the resident in the room. The comparison seemed to create an internal conflict that at times produced overwhelming anxiety that

led to the aides dehumanizing the residents. The corporeal deficits became the focus of the aides' reaction. Projecting their negative images of the residents then created an avenue for the aides to discharge negative feelings without needing to consider the residents with those deficits.

Managing Feelings

When aides described their interactions with residents, they frequently used language that expressed strong emotions or feelings. In listening to their stories, it appeared that the management of these feelings was their primary objective. They seemed unaware of this objective. It was during the time when aides assisted residents in completing their activities of daily living (ADLs) that these feelings were most likely to emerge. The aides' emotions seemed to be directly connected to the comments they were receiving from the residents. When the aides had uncomfortable feelings during these interactions, they viewed the residents as antagonistic and hostile or helpless and hopeless. In these situations the aides acted as though they were victims of an attack, being manipulated or feeling helpless. In contrast the aides viewed some residents positively—they "liked" them or considered them "friends."

One aide summarized the prevalence of the emotions by stating "this type of work is very draining because there are so many emotions" (Appendix A). The range of these feeling states included anxiety, anger, frustration, sadness and "cool" (7.928, 3.143) or friendly feelings as they communicated with residents who had multiple physical and mental difficulties. At times, the aides were aware of the feeling states they were experiencing, but at other times it appeared they were not. It became apparent that the perceptions aides had about residents directly influenced how they responded to their

own and the residents' feeling states. In most cases, the feelings that emerged within the aides were attributed to particular behaviors by the residents. Aides described three categories of residents' behaviors or attitudes that triggered feelings: antagonistic/hostile, helpless/hopeless, and friendly. The first two of these categories can be identified as eliciting negative feeling states in the aides.

Negative Feelings: Antagonistic/Hostile

Throughout the 12 group meetings, aides expressed negative feelings about the nursing home residents. Early on in the initial session the aides began expressing negativity, including anger, pain, hostility, disparagement, resentment, fear, anxiety, hopelessness and helplessness. This negativity emerged as verbal attacks on the residents. The aides even believed that some residents were deliberately strategizing to evoke these feelings. Anxiety was an ongoing presence and seemed to be an underpinning for most of the other negative feelings. Expressions of these negative feelings emerged as patterns of behavior that included comparison, aggression, and avoidance, which resulted in their being able to emotionally separate themselves from the residents.

Aides often used comparison to express negativity. Comparisons were made between the residents' ideas and beliefs and the aides' ideas and beliefs, between the actions of one resident and another, and between aides' projections onto the residents of what the residents' behavior should or should not be in a given situation. These comparisons extended to the residents' family members and other aides' interactions with residents. Aides became very angry and disparaging toward residents when the residents' behaviors were different than what the aides believed the behaviors should be. The aides disparaged the residents' methods of expression, self-care, needs and views of life. When

these comparisons put the residents at odds with the aides' beliefs, the residents were blamed as the cause of the aides' distress. Aides vented their anger by describing residents as regressing physically, provoking them, "dirty," "manipulative," or "obnoxious." Aides revealed that their anger toward residents led to their being aggressive toward them. This caused the aides to refuse, deny, and delay care or to respond sarcastically and even physically express their anger in caring for residents.

The first category of negative feeling states was perceived by the aides to be caused by residents who were antagonistic or hostile. In Appendix B, there are numerous examples of this category. In one example, an aide complained about a resident's attitude, saying that "she tries to make somebody else upset" (2.341-342).The implication was that the resident was deliberately trying to make the aide feel uncomfortable. Another aide attributed her feeling state to a resident's sinister motivations: "we are trying to do a good job and she is playing little games" (5.497-499). In both examples, the aides believed that they were victims of sinister intentions by antagonistic residents. The residents' antagonistic behaviors were then attributed to be the cause of the aides' negative feeling states.

Antagonistic relationships may set the stage for the development of the extreme feeling states within the aides. When an antagonistic relationship developed, almost any request by a resident could be perceived as an attack. The following excerpt illustrates an aide's reaction to a request made by a resident whom the aide had identified as hostile: "…and I cannot stand that whole 'Can you get me this?' I am like, oh my God!.... I am going to frigging die!" (11.230-233).

When aides were confronted by residents they had perceived as antagonistic, aides reacted in two unique ways, by either leaving the scene or by responding with hostility to those residents. An aide reported an interaction with an antagonistic resident in the following manner: "Last Thursday, last Thursday, yeah. I almost ripped her head off! I told her, woman, you are wicked! You are mean!" (7.1092-1093). The aide gave herself permission to react with such hostility. In the next example an aide responded to an antagonistic resident by leaving the scene: "He rings… his bell again... [I said] 'am I still incompetent?' He is like 'yeah.' [I said] 'See you later!'" (9.373-375). The aides often described responses like the two above as methods of managing feeling states when the behavior attributed to residents appeared antagonistic.

Negative Feelings: Helpless and Hopeless

Many of SNF residents cared for by the aides were helpless and had little or no hope for improvement. The causes of their incapacitation were physical diseases or various stages of dementia and Alzheimer's disease. When working with these helpless and hopeless residents, aides often described feeling states (Appendix C) in which they felt just like the residents, as noted in the following example: "When I feel she is feeling uncomfortable, I feel uncomfortable." Apparently, the feeling states of the residents directly affected the feeling states of the aides. The aides' methods of responding to these uncomfortable feeling states were attempts to change the feeling states of the residents: "Most of the time I am feeling like how do I make her feel better? How to make her feel better?" and another response, "when somebody is upset, it is like, okay how do I fix it?". Both statements illustrated that the aides have negative feeling states that are the

same as the residents' feeling states. The aides' attempts to change hopeless and helpless feeling states had a dual purpose as noted in the following aide comment: "They are getting calming and we are getting calming" (11.230-233).

Although the aides' motivations for calming the residents were to change the uncomfortable feeling states of the aides as well, their primary intentions may have been to control the residents. The aides' responses to managing the residents' uncomfortable feeling states appeared largely limited to trying to do something to change the residents. It appeared aides needed more training and resources to manage the vast array of these uncomfortable feeling states they encountered in their daily work. They reported attempts to control residents' feeling states by using unconventional methods. It appeared to them that if they controlled the residents, there would be no uncomfortable feeling states. In the following example, an aide confirmed this hypothesis:

> …[that's why I make] bath salts… because they are getting calming and we are getting calming…It makes everybody else calm… Calm everybody down. ….in every room….That way you could do anything you want with them and they wouldn't even know it…And we would be happy too. We'd be happy not doing anything." (8.725-740)

Apparently, the uncomfortable feelings of aides working with this population were so overwhelming that, at times, any intervention to calm the residents gave them relief.

Positive Feelings

The aides generally attributed their positive feeling states to the residents saying or doing something that made the aides feel good (Appendix D). This could be a resident complimenting an aide or just accepting care without complaining. Positive feeling states

were simple signs that an aide was happy or content. Aides noted when residents responded to the aides' care giving without complaining or when they could identify with the resident in a positive way. The aides also enjoyed residents they could identify with positively through life experiences or children. It was remarkable that the identification was with events outside of life in the SNF. When describing positive feelings, the aides described much more language from the residents: "she was a tomboy…, I was too. I could relate to her" (3.439-440), "feeling like going to your neighbors, having tea. I feel like I am having tea with a friend" (9.776-780), "It is like a couple of buds sitting there at the bar" (8.962-965), "She was really teaching me to stand up and do it… It was just fun" (6). When aides described interactions with residents that were positive, stating what the resident said or did was an important part of the interactions.

Aides as Victims

It was noticeable in both attributions of uncomfortable feeling states, "hostile" or hopeless and helpless, that the aides were, in a sense, victims, in two different ways. There was something about the residents' behaviors or actions that caused the aides to have feelings that were uncomfortable. With "hostile" residents the aides' responses were as if they were being attacked in some manner by the residents and thus victims of hostility. In describing the "hostile" residents' interactions, the aides used language such as "alert and oriented" (1.231), "manipulators" or "mean." Aides assumed that these residents were not helpless and hopeless but were, in a sense, their antagonists who were trying to cause the aides' negative feelings. Again, the residents were people who could be attacked. An aide seemed to describe that relationship with a resident when she said, "We despise each other" (3.37).

With helpless or hopeless residents the aides were clearly victims of ignorance or lack of knowledge and resources. With the helpless or hopeless residents the aides responded differently by trying to take some action in trying to manage the residents and their own uncomfortable feeling states. The problem was that the aides seemed to lack the resources or understanding necessary to respond in a manner that was beneficial to the residents. An aide described this lack of understanding and resources with demented residents: “How can you, how do you relate to a person who has dementia? I don’t know what is in her mind. I don’t know what is going on” (8.606-607). Aides often responded to hopeless situations by taking some type of action. When a resident reported that she felt as though she was dying, an aide offered to get her a wheelchair. Without knowledge and resources to respond to uncomfortable feelings, the aides became the victims of unrelenting anxiety and frustration. It was clear to me that, when listening to the aides describe their work, the aides as well as the residents were constantly wrestling with feeling states that were uncomfortable and often intense. The aides’ methods of responding to the constant and varying feeling states appeared to be limited to taking some kind of action to mitigate the uncomfortable feelings of the resident. One aide seemed to capture the essence of their skills, understandings and limitations in these responses, “I couldn’t help her in some way…” (8.551-553) … “I don’t have those skills, the knowledge or whatever to make her get better. I want to make her feel better.” (8.451-452). The aides’ responses to their own and the residents’ helplessness indicated that they lacked the knowledge and resources to respond more appropriately.

The feelings attributed to the hopeless and helpless residents seemed to be causing the aides to have anxiety on a spectrum from annoyance to terror, as described by one aide,

> I think this type of work is very draining because there are so many emotions…so many personalities,…the noise level gets to me too...it is exhausting…so irritating…you just have to go somewhere…you can't deal with it. Run down the hall. (8.668-678)

As aides worked with this needy population, some level of anxiety was a constant feeling and could be raised to such an overwhelming level that fright could take over.

Resident's Voices

Another pattern I observed was that, when uncomfortable feeling states were attributed to residents by the aides, the residents' voices were usually missing or interpreted by the aides. Rarely did an aide report the language of an interaction that described what the resident actually said or did to cause the aide's uncomfortable feelings. One aide who was angry at a resident reported the reasons for her anger: because "[he] just wants everything, he is so needy and he is so obnoxious," while her angry response to his hostility was "you don't want to even look at him" (5.377). In neither of the aide's responses was there any description of what the resident wanted or needed that made him act obnoxiously. Nor was there any understanding of what made her not want to look at this resident. In another instance an aide described an interaction where she was criticizing a resident's lifestyle. The contrast between what she said and the resident's responses show that the aide appeared to have no interest in any response from the resident. "I said ...She just looked at me…I said…She looked at me, and I

said…She just looked at me" (6.717-723). Strong feelings limited the language available to the aide in the first example. In the second example only what the aide had to say carried any significance for the aide. Neither of the residents' thoughts or feelings seemed to be of any importance to the aides. The feeling of the aide seemed to determine the response. It was apparent that the aides' feeling states controlled the aides' responses. The process of venting anger or criticism on the resident in response to the attribution of the hostile feeling state seemed to be the intention of the response by the aide (Appendix E).

Lack of Curiosity

Another theme in discussions of uncomfortable feeling states was the lack of curiosity about why a resident might be behaving in a certain manner. The aides did not seem to have any interest in exploring the resident's perspective. Rarely did an aide wonder why a resident might be behaving or communicating in a certain manner. They rarely asked questions to consider why a resident did not leave her room, why a resident threw his remote at his roommate, or why a resident had obnoxious behavior. The important aspect of these incidents seemed to be the effect it had on the aides. The aides mostly made concrete statements or generalizations that excluded any curiosity and led to judgments about residents such as "I don't want to believe them…I will not agree with some of the things they say…" (11.311-312). At other times the aides made judgments about residents' behaviors such as "she's playing games," (5.499) or generalizations such as "they are manipulators," (11. 328) and "he is just a pain in the ass you don't want to even look at him" (5.377-396). The lack of curiosity was most evident when the aides described hostile or helpless feelings.

Curiosity

Aides did not display curiosity in their daily interactions with residents. However, curiosity developed as the aides began discussing their individual meetings with the residents. It was as though the group meetings gave the aides an opportunity to think about their interactions with residents without having the strong feelings they had during their normal daily work. In the following example an aide was curious about her own behavior: "But how hard is it to go in there and say, 'Hey Mrs. [resident], you know. What do you like to be called?' And I know in the past two years I have been here I haven't asked her that" (5.551-553). Another aide commented about a demented resident who remembered the previous week's conversation with her: "I am wondering what his problem is, you know, because if he had dementia, he wouldn't be able to remember the conversation two seconds ago" (5. 250-251).

Curiosity was contrasted with the aides' usual expression of feelings which were often just positive like "I like her" or just negative like "he is a pain in the ass." The curiosity was shown as the aides began wondering about the residents' thoughts or feelings as opposed to negative or positive feelings which appeared to create a self-absorbed focus by the aides. The following example shows an aide moving from self-absorbed thinking to being curious about the resident's life:

> So I told him I would call… ten hours – shit, I forgot about the watch. And I thought if I was an aide…I would say forget about the watch…but doing this I actually did go out and ask [staff member] if she had found the watch and you know, it is the silly little things but like logic is gone. Things that are important to

him you know, you look around his room and what has he got in his room? A couple of pictures, not much. (5.814-819)

Identification/Self-revelation

This section will present data that demonstrate the aides' uses of identification in their interactions with residents. Aides responded to interactions with residents by comparing them with objects in their own minds. These objects could be positive or good objects or negative or bad objects. When talking about their fantasies of being nursing home residents, the aides identified with antagonistic behaviors of the residents. All the aides identified some behaviors of residents as being like those of children. When talking about their interactions with residents, aides often brought up unresolved conflicts from their own families. The aides could not identify with their own deaths when working with nursing home residents.

Objects in Their Minds

One of the ways the aides responded to the objects in their minds was to compare the interactions with the residents to their own intentions or to those of people from their own lives. These identifications usually were invoked when there was a feeling that appeared to connect the interaction with a resident to an image in the aide's mind, for example, "I'm going to be like her…oh God, I am like her" (9.891-894). Sometimes the aides described their identifications in a more subtle manner, for example, "We went through her closet and she talked about how women our age need to wear high collared things because our necks are… I said 'darn, do you mean I have to throw away those tube tops and, you know, things like that'?"(9.113-115). At other times they identified with

object in their mind from their families, for example, “It is like my grandmother. She wants to think it is the farm that is keeping the family apart and not her” (9.1215-1232).

Positive and Negative Identifications with Residents

As aides listened to residents’ life stories, they identified with certain complementary characteristics of the residents as in the following example: “Oh, another thing she told me she was a tomboy when she was a kid, which I was too. I could relate to her” (3.409-410). Aides also identified unconsciously with residents’ complementary characteristics, as this aide seemed to be reporting, “He was hard-working all his life… He would drive people…He was just helpful…He felt needed down there” (3.350-359).

At other times aides’ identifications with residents appeared to be a projection of their own beliefs rather then the residents’ characteristics,

> I was thinking about [resident] the other day actually…he was sick…and I didn’t know what was going on with him. I’d go in there and tell him he had to get up for his meals…and he did he started getting up. And I thought…why do they get up? Would I have gotten up? With that sort of medical diagnosis…just lay flat and die, be done with it. (2.436-441)

Aides also described feelings thay had for residents. An aide who disliked a resident described that resident as manipulating her. Another aide had murderous thoughts about the resident. One aide identified with the pleasure she felt by punishing the resident--her attempt at killing this resident in her mind:

> She’s fun though to keep on track when you go in and she wants something. She’ll go for the rest of the day if you let her… so it’s fun to bring her back, keep bringing her back and bringing her back, I have a blast with that. It probably isn’t

nice but…[blocks face with arm looking at camera]. I shouldn't be saying this. (3.476-479)

The aide evidently felt shame when she realized that she was talking about a resident, not just an object in her mind. The pleasure the aide felt had outweighed the responsibility she had to care for the resident.

Identifying with Antagonistic and Angry Residents

The aides identified with the behaviors of the antagonistic, stubborn, defiant or angry residents in the SNF. Some residents appeared to be making attempts to gain some control over events in their lives. These residents were the ones that the aides most often complained about as causing them distress. However it was these residents that the aides identified with when fantasizing about life in an SNF. The following examples illustrate the aides' perceptions that having people take control of one's ADLs was a persecution to be fought against. When imaging herself as nursing home resident, an aide said, "I would hit people with canes, too… I don't know if I could deal with it…Oh, I would probably hit the staff…I am going to be one of these people that take my clothes off and pee on the floor" (1.114-119). Another aide, who identified with a tired and sick resident, said, "Leave me alone" (1.319). In another group meeting an aide identified with a resident who didn't want to get out of bed: "I said nope, I'm not dressing. I'm not getting dressed. I'm not taking a shower. I'm staying in my bedroom" (6. 113-116). Another aide responded, "I would kick them when they do that to me" (5.571-573). Another aide identified with a resident who had angry outbursts when she said, "It's really shitty living in here" (5B.691). Finally, one aide identified with resident life as "This must seem like a prison to them…It would feel like a prison to me" (3. 589-597).

The identification with bad objects in the aides' minds also appeared to be connected to residents in ways that were not obvious at times. The feelings the aides had when working with residents were not directly connected to a specific event or interaction: the resident was being used to resolve a personal conflict in the aide's mind. There seemed to be joy in the identification as in the example of aides giggling and laughing when one aide described having "murderous thoughts" in her mind. Another aide proud fully described "snapping the curtain" when a resident made her "feel that way." Another aide imagined "snapping the neck" of her mother-in-law as a comparison to the feelings she had about a resident.

Residents as Children

All the aides identified some behaviors of the residents as like those of children. More specifically, in several cases aides reported the ages of the identified behaviors as those of young children, 2 or 3 year olds: "she's still a little child" (6.401-402), "it's like a three year old-- the more you tell them 'no,' the more they're gonna damn do it whether you like it or not…"(6.575-583). Another aide spoke of a resident as a child when she said, "it is hard because you get stuck there and then it is like to get yourself out of that defensiveness mode and I don't care how old they are or how young they are. I do it with my own daughter" (9.370-384). When working with a resident with Alzheimer's, an aide stated, "It is not fun…hearing the same thing…I sort of feel like my daughter who sits there and tells me all these things and I just say 'yeah, yeah, yeah, good, great'" (7.502-504). When discussing a hostile resident, an aide said, "I would probably be a child and do the same exact thing" (1.113-123).

It was also noticeable that the antagonistic behaviors that aides identified with when they fantasized about living in a SNF were behaviors that could easily be described as those of young children. It appeared that there was a connection between residents' childlike behaviors and the identifications of the aides.

Unresolved Conflicts from Aides' Own Families

The aides described interactions with residents that indicated personal conflicts were projected onto the interaction without the aides being aware of their actions. The aides identified the interactions with unresolved personal conflicts that seemed to guide their responses to the residents. The aides' responses to these identifications appeared to be an opportunity for the aides to attempt to resolve the personal conflicts. The residents were an avenue for aides to project bad objects from their minds. For example, when an aide was strongly criticizing an "alert and oriented… but manipulative" resident, she identified her disabled son as "not manipulative," an identification with the apparent feelings associated with both individuals or objects in her mind. This example showed how the aide connected both her son and the resident to feelings that she wanted to rid of while retaining feelings that were more pleasing. The resident became the bad object and her son was the good object.

At times the aides would respond to a resident's complaints and criticisms when they identified an object in their minds with a resident's comment. In the following example an aide reacted to a resident's criticism of her own granddaughter by identifying with the granddaughter as she reported a conversation with the resident: "She is a little slut, she told me. I am like, 'It's your granddaughter.' She is like, 'Well that is what happens when you sleep around.' I am like, 'Okay, I have got to leave now.'" (7.743-

748).The aide's identification was with the granddaughter and she responded to the criticism of the granddaughter, which the aide appeared to take as a personal attack.

It was apparent that strong feelings were induced at times when aides identified unresolved personal conflicts with comments made by residents. The aides' responses to these identifications indicated an attempt was being made to get rid of bad objects or images in their minds. There were also attempts to retain images of good objects. In the following example an aide responded in a discussion about a resident whose children do not visit. She said,

> What if she did something? Because I will tell you what. My grandmother comes into the nursing home, she will never see me until the day she apologizes to me. She was bad… maybe it was something she did…Maybe she needs to pick up the phone and call her kids…say… "I apologize" or if "I didn't call on you…" That increases her quality of life… a lot, just being able to talk to her kids. (5.949-955)

It appeared that the aide saw a bad grandmother (bad object) whose children didn't visit her, while she wished that her own grandmother would become a good grandmother (good object).

Identifications were personal and varied and rarely universal. An example is another aide's identification with the same resident mentioned in the previous paragraph. At times the aide seemed obsessed with why the resident's children didn't visit and at one point the aide wanted to write a letter for the resident to the children. Finally, in one group session the aide reported,

> I kind of feel for her I guess, because I am a mother. If there was anything I could do to try to work things out with the relationship with her kids…I don't think there was

anything that woman did that was ever bad. My oldest son hasn't talked to me because of his wife. (10.28-32)

Identification with Living [SPACE BELOW]

Identification with living was easy to understand with aides who care for people at the end of their lives. How aides identified with life instead of death was shown in several examples. The aides had difficulty thinking about the deaths of the residents. When the topic of a resident's death came up, one aide blurted, "I block." Other responses by aides also indicated that the end of life process leading to one's eventual death was not tolerable. This was indicated when aides were discussing various types of residents in the SNF. There were residents who were compliant and accepting of life in the SNF and other residents who were antagonistic as described earlier. It was noteworthy that the aides did not identify with the residents who were compliant and accepting of life in a nursing home facility—or waiting to die. For one aide waiting to die was not living. She identified death as her choice rather then waiting to die in the facility. The pain of thinking about waiting for death was much worse than immediate death as she reported, "I know that I could never be that person….We do have some of them…It is amazing. [Makes suicidal gesture with hand as gun to temple] POW!" (1.124-134). To this aide the process of dying or waiting to die was unimaginable and intolerable. This aide identified with living rather than with the process of dying.

The aides saw their own lives as different from the waiting-for-death lives of the residents. Residents waiting for death should just let the living aides do what they want as reported in the following example, "… you could do anything you want with them and

they wouldn't even know it… And we would be happy…not doing anything" (8.737-740).

It seemed that working with dying people did not make the aides more accepting or understanding of the process of death. The images the aides described of their final hours of life were clearly at odds with the accepted and practiced rituals used by the SNF when residents were in their final hours of life. The aides described how they want the process of death to be in the following dialog:

> We want curtains open, the sunshine coming in, people laughing and talking and telling dirty jokes with the TV on, while we are laying there comatose. I want that….Don't do it to me. Start talking. Give someone a hard time and fight. I want to lay there and hear that…I don't want a vigil companion. I don't want somebody sitting there holding my hand….I am going to go out kicking and screaming. (11.887-906)

The aides were not accepting of death in the way that they believed some of the residents who were "accepting" of their lives in the SNF. They seemed to only be able to identify with living and death was to be fought against, somewhat similar to the behaviors of the antagonistic residents described earlier. Death was to be fought against as though it was an intruder, to be feared, and only living could be imagined.

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Listening ~~[NEEDS TO BE WITH NEXT TEXT. NEVER HAVE HEADER END PAGE. USE paragraph/Line and page breaks/pagination SO THAT THEY STAY CORRECT IF FORMATTING CHANGES.]~~

As the aides described and discussed their interactions while listening to the residents for 40 minute sessions, several changes occurred in how the aides described

their interactions with the residents. These changes included the aides providing much greater detail about the residents' comments, quoting or paraphrasing residents, empathizing with residents, developing ideas to improve the quality of life of the residents, learning about the residents' lives, developing curiosity about the residents, and considering the perspectives of the residents.

The amounts of time, as measured by number of transcribed lines, aides used to describe their interactions with the residents during the listening sessions were far greater than when the aides described interactions with the residents that were not about listening sessions. Although the aides had a lot to say about their interactions with residents in their general discussion, very little of their descriptions included quotes or paraphrases of what the residents had said. A typical example would be two or three lines of transcript. However, during the aides' descriptions of their listening sessions, the aides used as many as 259 lines of transcript to describe these interactions, often quoting or paraphrasing the residents. Equally as great a change in the sessions with aides was the aides' inclusions of the voices of the residents in their descriptions of the interactions. This was in direct contrast to the aides' descriptions of their non-listening interactions with the residents. Descriptions of non-listening sessions rarely included the voices of residents. In describing the listening sessions, the aides commonly quoted or paraphrased what the residents had said during the sessions. In their descriptions of the residents all aides reported on various life situations described by the residents, such as life histories, families, job histories and how the resident got to be at the SNF. Discussions of the listening sessions included revelations of abuse, psychological problems, joking, singing,

and judgments or opinions by the aides as to how or why a decision was made by a resident.

Another unique feature of the descriptions was the development of curiosity by the aides as they learned new information about the lives of the residents. When reported by the aides, this new information seemed to cause the aides to think and wonder about the residents' lives. The aides advocated for the residents, became friends with residents, and learned, from listening to other aides, how to work with the residents in a more accepting manner. Additionally the aides began to describe their thoughts about the lives of the residents as they lived in the SNF. Finally, new information about the residents caused the aides to discuss ideas and thoughts about how to improve the quality of life for the residents.

Listening to the residents seemed to open the possibility of adding a new dimension to the relationship between the aides and the residents. Responses by residents to the aides about the listening sessions appeared to indicate that the residents recognized the aides as more than just people who provided care.

Discussion of Listening Sessions

The long discussion of the listening sessions seemed to give the aides the opportunity to describe their own thoughts and feelings as they responded to descriptions of what residents said during the sessions. All aides appeared to be pleased that the residents wanted to talk. As an aide began describing the session and what the resident said, other aides gave their opinions about what was being discussed. At times aides' opinions contradicted or criticized the resident; however, in most instances the presenting aide defended the resident. The following is an example of an aide describing her

pleasure: “she will ask me… ‘when’s our next meeting?’... but it is neat that she’s…will stop me just to ask…” (5.365-370). As this above session evolved, the aide quoted the resident, “She is like, ‘I hate it when they call me Mary…I have always been Mrs. Smith’” (5.389-390). Later other aides gave opinions or judgments about the resident, “I thought she was a pretty casual kind of lady…” Another aide commented, “I think that she is just being kinda flip or just being sarcastic” (5.391-394). The listener aide then defended her resident: “No, I don’t think she was being sarcastic…She just doesn’t feel like that she is being respected...every one of us is younger than she is and… we treat her as equals and technically she’s not…. But how hard is it to go in there and say, ‘hey Mrs. Smith’…?” (5.401-424).

Listening to the residents gave the aides an opportunity to hear stories directly from the residents about their lives. Also, the residents were able to report to the aides their thoughts and feelings about life in the SNF. As the aides in the group listened to the residents’ stories either directly or as reported in the group, they commonly began to tell their personal stories. These stories were varied but usually included a thought or feeling that the aide was having while listening to the residents’ stories. In the following example an aide told a personal story that seemed to derive from a feeling the aide was having about the work, a resident and young aides, “the work load, it is hard …to know each resident individually, I worked in an Alzheimer’s Unit…pictures of each resident on their doors…when they were very young…you saw them…not just as an old person…,[but]as productive people at one time”(5.416-423).

Aides described how listening to residents seemed to have them thinking differently about the residents. Aides developed empathy as they listened to their stories.

They began to have new thoughts about the residents. That is clearly explained in the following example of three aides discussing listening to residents: "…it has been kind of neat. You can learn…about your residents and how they feel…" "You kind of step into their shoes …people would be more accepting of their grumpiness…" "The more we know…, the better we are able to be sympathetic towards some of their ways" (11.647-654).

Aides quite often reported dramatic new information about a resident's life when describing a listening session. These descriptions often revealed much about the aide's character. As these interactions were described, often aides use their characterological defenses to tolerate the negative feelings that the resident' stories induced. For example, one aide seemed to not want to feel the horror of what the resident reported.

> …and he didn't think that was right. He didn't think he…should be getting hit across the head and I asked him if his father hit his sisters… ''Why did your father hit you? Did you guys deserve to get twitched?' and I said, 'what did you do to get twitched?' He said he really shouldn't have been hit across the head and the face -- that really bothered him…he said his mother was rocking him one time in a rocking chair and his father shot the rocking chair…I said, 'how do you know that?' I was like, 'wow, that was so big'…He brought the horses into that and I kind of shoot around it because I don't want to hear about animal abuse. (4.726-758)

Aides' descriptions of listening sessions also revealed the ongoing anxiety of the SNF environment. Listening to residents seemed to be as helpful for the aides as it was for the residents, as the difference between resident and provider seemed to disappear. In

the following example it appeared that the aide was using the listening session and her identification with the resident to obtain relief from the anxiety of the environment:

> I have been having a party with X… been awesome…We laughed and laughed and talked and sung. We sat there and sang songs… it was a blast. …She goes, "sing something…:" I sang this old song. I missed a couple of words and she corrected me. She was really teaching me…I was getting lessons….just fun…Not one negative thing …Not one negative. (11.614-634)

Another aide was clear about how she felt about the resident she described in her listening sessions, "I think of her as a friend. I feel comfortable with her. I don't know how else to say it" (11.508-510).

Curiosity

As the aides described what residents were saying about their lives in and out of the SNF, the aides began to become curious about the residents and their lives in the SNF. One aide described in the following example when she heard about a resident's missing watch during one of her listening sessions:

> I told him I would call S, you know, ten hours – shit…and I thought if I was an aide, [and] he told me, I would say, "forget about the watch"…but doing this I actually did go out and ask S if she had found the watch… it is the silly little things but like logic is gone. Things that are important to him you know, you look around his room and what has he got in his room, a couple of pictures, not much. (5b.813-818)

Aides became curious about their own thoughts and actions as they listened to the stories of the residents. Listening to the residents' stories gave the aides more insight into how the residents view their lives in the SNF as shown in the following example: "it gives you a little better understanding of them…now that B [aide] has said those things about X [resident]…[I]actually think, what's gonna make me act more respectful to her… to know more about what these people want…instead of…they're a pain in my ass" (6.554-558).

The curiosity that developed was extended to the most demented Alzheimer's resident. Listening to the resident appeared to generate new thoughts and feelings about him. Not only were the aides curious about the resident, they also became curious about how the resident was being treated and interventions that might improve his condition. There was now some hope for the resident as reported in the following discussion:

> When I went to talk to X [resident], he remembered the whole conversation…I was shocked....for him to remember that and…say something like that…I am wondering what his problem is…if he had dementia, he wouldn't be able to remember the conversation two seconds ago…

The aide went on to say that when she listened to him she realized that he was really trying to tell her something. She could tell a lot from his expressions. She became aware that he was emotional about things and really thinking. She wondered if listening to him would slow him down and give him time to gather his thoughts. She concluded "nobody really sits down and listens to him" (5b.188-344).

Advocating for the resident as well as having new thoughts about how aides responded to residents were other results of the curiosity. Aides also identified with life

as a resident living in an SNF. In describing her interactions with a resident, an aide relayed that everybody dodged the resident and ignored her and they didn't get her what she needed. As a result of listening to the resident, the aide realized that the resident wanted to be respected as an adult who had knowledge: "I understand where she is coming from....I was like, wow. It is really shitty living in here" (5b.395-529).

As aides reported on their listening sessions, they became curious about what the residents were saying and seemed to be wondering why residents were behaving in certain manners. One aide reported that she had the feeling a resident was angry that her diabetic husband's death was connected to his poor diet. The aide then wondered if the resident was doing the same thing to herself (3.487-493).

The aides also became curious about how they were controlling the residents as noted in this example,

> She has asked me several times to get [her] up at 9 o'clock in the morning and I am like, "X, no way….No way,…I am not getting you up at 9 because you will want to go back to bed in ten minutes," and how do we actually know that? (5b.592-594)

Solutions ***[HEADER AT BOTTOM OF PAGE.]***

As the aides described the residents' problems and dilemmas, they came up with ways to help the residents. For example, the aides brainstormed together about how to approach the resident who did not like to be called by her first name (5b.548-561).

As the aides listened to the residents' stories, they were able to think about, discuss and become excited about improving the quality of life of the residents. They wanted to connect with the residents. A resident needing more ambulation was discussed

by the aides and they quickly developed a plan. In their discussion they realized that the residents needed to be ambulated more and that two people were necessary for that activity.

> It is just as important as getting your lunch… Let me talk to C. I will pull C aside to see what she can work out…You know, you learn so much when they are walking… (5b.894-920)

Listening to residents and then being able to discuss the sessions appeared to show that the aides had new ideas about improving the quality of life for the residents. For example the aides decided to contact a former recreation staff member to reestablish "some cool ideas" she had for activities for the residents. The aides also discussed "recruiting volunteers to come in if you don't have enough staff because there are so many people out there that would come in and just offer programs for these people that we are not even… initiating" (5b.925-958).

New Thoughts

Listening to residents and then discussing the sessions appeared to have an effect on some of the thoughts the aides had about the residents and the residents' lives as the following example indicated:

> I find myself even doing that with X [resident]…She doesn't like eating breakfast until noon…I always find myself going,.. "if you get your butt out of bed when you are supposed to…" Then when you think about it, why are they supposed to?…I would hate to be disturbed. (3.597-602)

Aides were able to have different thoughts about residents as they listened to their stories:

> That is it with him…and I never knew the man before the stroke and I thought maybe this anger and this striking out and whatever was part of his stroke…but apparently he is like that and it just made it worse. (4.755-758)

Listening gave aides the opportunity to think about the residents differently.

> Don't you think it is true of everybody, though like someone like X, who annoys the hell out of us as aides but when you get to know her and get to know anybody's story then it is the same thing, you know…It makes you more accepting. (4.179-182)

In the following example an aide seems to have new thoughts about working with demented residents:

> But wouldn't it be better for them if they are demented all the time to just join them…and heal and be their little slaves and whatever and make them feel better and they aren't going to get better? (9.941-945)

When listening to other aides describe their listening sessions, aides discovered new ways to work with these residents as reported in the following example: "…Being here and listening [to] how everybody else feels, you know, how they interact, gives me more ideas how to… work with X [resident]" (5.118). In the following example an aide appeared to realize that opinions of residents change when you get to hear their story: "… not making judgments about people and realizing that you really need to spend time with people to find out who they really are" (3.422-424).

Recognition

The listening sessions seemed to create a different relationship between aides and residents. Residents appeared to recognize the aides as more than just caregivers. Most of

the aides reported that the residents were excited to talk to the aides on a regular basis (5b.284-.290).

Listening to the residents developed into relationships and the aides appeared to describe some type of reciprocal relationship that was not present prior to the listening sessions as explained in the following dialog: "… kind of like a friendship…she knows me…maybe he just wants to be somebody's friend." "I know what you are saying. I feel it is like getting a part of you back. Kind of taking a two way streak [street] sort of back and forth…" (5b.662).

The following examples shows definite friendships. All of the aides reported a special feeling when describing listening to residents. "I sat with her last week and she told me this real cool story" (3.143). "Last week I had a good time with her. She was very bright… It was wonderful…she went, 'do you own a barbecue?'…she started giving me recipes and started talking about drinks, and shrimp salad, very good… and so it was good" (9.98-103).

Conclusion

The results of this project indicate that providing direct physical care to nursing home residents is also an emotional experience for the residents and the aides. The nursing home is a challenging environment where policy and procedures are in place to provide a safe structure for the delivery of care to the residents. However the stress of following these same policies and procedures creates the possibility of emotional conflict between the aides and the residents. The emotional conflict that is created does not appear to have a safe and productive means for a beneficial resolution.

Corporeality or the physical deficits of the residents seemed to be used by the aides to create a barrier between the aides and residents. The failing bodies of the residents would often be used as a tool by an aide when criticizing a resident.

What appeared at times to be harsh criticism of the residents were actually the aides' methods of trying to manage overwhelming feelings that develop while doing the difficult work of caring for very old and sick residents. In conjunction with the criticism, the aides identified with the same residents for whom they had harsh criticism. During the harsh criticism of residents the aides often reflected on their on personal lives to compare or judge the residents' behaviors. It was also noteworthy that the use of the residents' bodies, self-revelations and the management of feelings were often described together when the aides described negative feelings about a resident.

Finally the aides' listening to the residents created a relationship between the residents and the aides that appeared to be mutually recognizing and beneficial. The residents liked when the aides listened to their stories. When reporting listening to the residents, the aides did not express much hostility about the residents. Additionally, the aides became curious about the residents and the residents' perspectives of what their lives were like before and while living in the SNF. Listening also showed that the aides had many creative ideas about how to enhance the care of their residents.

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CHAPTER V

DISCUSSION

The results from this study indicated that unconscious motivations and feelings of nursing home aides (aides) had a strong influence on their interactions with nursing home residents (residents). A key finding of the study is the extent and constancy of conflict revealed by aides when they described these interactions. The noxious environment in which they provided care and the emotionally unsupportive system that repeatedly failed them created their own unique stresses. The sights, sounds and smells ubiquitous to this environment, although rare for those outside of this setting, were commonplace and had an unconscious effect on aides' thoughts, feelings and actions. Aides described interactions and thoughts about residents that appeared hostile, impulsive or reactionary. Upon analysis, these apparent hostile interactions can be described as irrational, primary process-focused thinking attempts to manage the overwhelming feelings the aides experienced in working with the residents.

This study was organized around the process of scheduled group sessions where aides were free to put their thoughts and feelings about any topic, including residents,

into language. This process revealed aides' individual mental conceptions of how they viewed life in a nursing home. These conceptions indicated that the aides had personal biases regarding how residents should respond to the care and the environment in which they lived. Additionally, the aides' expressions of unconscious transference feelings were often at the core of negative and positive emotional interactions with residents. This study supported the idea that the psychoanalytic concepts of transference and countertransference, essential within an analytic session, would also be useful to understand aide resident interactions in the non-analytic setting of the nursing home.

When aides were able to listen to residents describe their lives, significant change occurred. They described relationships that included more positive attitudes and behaviors toward the residents and less conflict about their relationships with them. With less conflict being described, aides were less concrete, rarely hostile, and more infused with secondary process thinking. This thinking was more thoughtful and considerate of the residents as human beings who had their own thoughts, feelings and even desires. Aides were also able to take the perspectives of residents and communicate more clearly when describing interactions with them. It appeared that the opportunity for aides' to listen to residents allowed both the residents and the aides to share positive feelings about each other. When aides and residents focused on listening, they developed a mutual positive identification. The aides' identification with the residents resulted in an increase in curiosity about the residents and their lives. Curiosity was evident as the aides' focus included not only what happened, but why residents were saying or doing certain behaviors and how a resolution might be attained, a process described by Bion (Bion, 1959).

This chapter reflects on key findings about environment, corporeality, managing feelings, identifications/self-revelations and listening in the context of existing theory. It concludes with implications for proposed changes in the nursing home culture and the psychoanalytic significance of the research findings.

Environment

Within the SNF environment with its unique sights, sounds and smells, the primary focus of daily work for the aides was "getting things done." Their focus was on the tasks provided according to defined protocols within a distinct period of time. The environment did not include a process, place or vehicle for aides to manage the anxiety and conflict inherent in caring for the vulnerable, degenerating elderly population living in the SNF. Aides reported being treated as things that only performed tasks, within an environment that failed to acknowledge emotional consideration involved in the care of these residents. Aides often resorted to irrational thinking during stressful encounters within this environment. These irrational responses or primary process focused thinking elicited an independent, by the "seat of their pants," self-absorbed response when the environment became too stressful. Residents also treated the aides as things. They demanded services, criticized them, and behaved in thoughtless ways.

The environment was not limited to the physical environment alone but included the "total environment provision" that includes the "three dimensional or space

relationship” (Winnicott, 1956, p. 588).This was a space containing all kinds of objects and relationships upon which projections can be placed. This arena where the completion of processes, conscious and unconscious, took place involved aides and residents. Although the care appeared to be physiological, it was actually emotional. The aides’ tasks involved residents whose physical bodies revealed what humans’ minds want to deny – their own deaths. This meant that aides and residents were engaged within an environment where the denial of death (Becker, 1973) was an ongoing challenge. The evidence in this study supported that the environmental provision included the emotional interactions of the residents and aides alike. The problems that aides described were not about the care they provided, but rather the conflict created by the behavior and emotional responses of residents to that care. This conflict was most troublesome for the aides. The environment provided for the residents’ care and security but did not allow the residents “room to be independent, emotionally” (McKenzie-Smith, 1992). The nursing home failed to provide training and supervision of aides to address and understand the inherent conflict created in this setting. Winnicott (1956) proposed that a holding environment was critical if anxieties were going to be able to be tolerated. There was no “holding environment” or safe place for aides to understand and tolerate the anxieties created by the emotional experiences they encountered on a daily basis as they confronted their own and the residents’ fears of death. Bion (1962a) reiterated that the environment needed to contain and process emotional experiences. Further support for the provision of a secure environment was provided by Spotnitz who proposed that “people can’t express rage until they have affection…they need to feel safe, to feel loved, to feel secure” (Shepherd, 2009)

The aides' difficulties in tolerating frustration and their inabilities to develop curiosity were exacerbated by the lack of a container in their environment. That is, what was missing was a supportive environment provided by someone who was competent in listening to the aides and responding in a manner that would help the aides understand and make sense of their own as well as the residents' behaviors in this challenging environment. Aides were unable to understand, process or "become containers" of the overwhelming feelings they felt while working in the SNF environment. Aides lacked, yet needed a consistent and safe place to express their thoughts and feelings in language. This researcher provided the "holding environment/container" that would first be receptive to emotions such as rage, helplessness and hopelessness, and then contain and allow for the processing of these emotions. Aides revealed the scope of emotions and feelings they experienced when working with this often helpless population with little hope for improved health. The group process allowed them to experience these emotions with the researcher responding in a receptive manner that was developmentally appropriate to each individual aide.

Corporeality

A significant factor that increased conflict and unconscious anxiety in the nursing home environment was corporeality or the failing bodies and minds of residents. This frailty was a constant reminder to aides that they were caring for people at the end of their lives. Exposure to these elders seemed to affect the aides' normal defense systems at times. For example, one aide reported that when a resident she disliked put her call light on, she would tell that resident that someone else would be by to answer the call light. This was the aide's normal defense to avoid her disgust aroused by this resident.

This same aide later reported a stressful occasion when she screamed at a resident, “You are wicked and you are mean!” This aide reported that she wanted to “rip the head off” this resident. This murderous aggressive behavior was an example of an emotionally overwhelmed aide using a dehumanizing phrase (“rip your head off”) to derogate a resident with harsh criticism. This dehumanizing behavior separated the human aide from the “headless” and now un-human resident. The use of such dehumanizing terms was a common practice when aides appeared to be overwhelmed with negative feelings.

Aides were consistently reminded of their own mortality during the process of providing care to residents’ with failing bodies. They described both conscious and out-of-conscious awareness (unconscious) anxiety. For example, one aide reported that she “blocked’ feelings when residents died. Another aide reported that she liked working in a rehab unit as compared to the SNF because in the rehab unit people got better. A third aide could only giggle when she reported a resident’s rage because she called him “such a stud” as she gave him a bath. There were many anxiety-filled interactions described as the aides reported on their work with the failing bodies and minds, and the residents’ byproducts of feces, urine, puss and blood.

When aides shared negative interactions with residents, they often described conflict laden responses about residents’ demands. For example, an aide described her disabled son as not manipulative and then compared a resident unfavorably to this son. This emotionally distraught resident became a “manipulator” who could be severely criticized because the resident did not meet the standard set by the aide’s teenage son. This comment seemed an irrational self-absorbed response to a helpless person.

Aides' self-absorbed responses often described only their views of why the interactions caused anxiety. Rarely, did an aide consider or report a resident's point of view of the incident. Self-absorbed responses appeared to separate the resident from the aide. These responses often included complaints about the residents' unacceptable body parts or functions that appeared to be the aides' attempt to gain control over residents and unconscious attempts to reduce the their own anxiety of the immediate situations. Aide's self-absorbed views often seemed omnipotent, as in the following example, "He can't hear and he can't talk and I'm not going to call her (the resident's daughter)." This use of a corporeal statement appeared to place the residents in the position of an "other" or outlier or "zombie." An "other" could then be seen as different and possibly dangerous. A dangerous person would need to be controlled or manipulated for the completion of the aides' tasks. These examples indicated that the aides' use of corporeality were attempts to manage the conflict between the needs of the resident and the needs of the aides by making residents the cause of the conflict.

I propose that the "living" aides' daily intimate contact with "dying" residents created an increase in unconscious death anxiety. Researchers have shown that the unconscious has an influence on the conscious cognitive processing of humans (Gilhooley, 2008). Terror Management Theory (TMT) supports that an increase in death anxiety would occur in the aides who care for this population. TMT research (Goldenberg, Pyszcsynski, Greenberg, & Solomon, 2000) suggested that humans have culturally accepted images of how the human body should look and perform. Residents' bodies are often the antithesis of these accepted images and become reminders of our diminished qualities. The corporeal statements by aides seemed to echo many of the

tenets expressed in Terror Management Theory (TMT) (Pysczynski, Solomon, & Greenberg, 1999; Pysczynski et al., 1996; Pyszczynski, 2004; Pyszczynski, Solomon, & Greenberg, 2002) about the bodily experience and its relationship to the human defense against unconscious death anxiety. TMT theory (Goldenberg et al., 2000) has suggested that humans have learned to reduce their inherent death anxieties when confronted with unconscious anxieties of their own deaths by culturally accepted beliefs that raise self-esteem. When shared by others within a belief system, these beliefs or worldviews create an internal reality that is supported when one is considered a valuable member of that system. In essence, being a valuable member is one way of feeling good and creating self-esteem. In this situation, there is no conflict. When one's world view is challenged, however, there is conflict. When conflict occurs, what was originally a personal conflict - fear of death anxiety - becomes an interpersonal conflict (Menzies-Lyth, 1988). One way of resolving this conflict while defending one's worldview and buffering one's anxiety is to denigrate someone with an opposing worldview or image. When residents' bodies and minds did not match the aides' valued worldviews, there was interpersonal conflict. In these situations, the aides appeared to use the residents' corporeality to help manage this conflict. The shared views of the aides, e.g. disgust regarding the old bodies, were forming a new version of their worldview that encompassed denigration as an acceptable defense mechanism against death anxiety and the misery of caring for old unacceptable bodies

The body can be a source of existential conflict because it can be a harbinger of death or a vitality-enhancing source of life (Goldenberg, Kosloff, & Greenberg, 2006).

The vitality-enhancing source of life gives meaning and fosters self-esteem. These were the same qualities that gave us self-esteem when we were younger and were how our professions defined us and our work (Martens, Goldenberg, & Greenberg, 2005)). Caring for elderly frail and failing bodies and minds, with their diminished qualities, created this existential conflict. That is, a reminder of death and not a source of life and vitality.

Martens (2005) proposed that elderly people remind us of our diminished qualities and may be the most obvious threat to culturally accepted immortality beliefs as their symbolic selves are overshadowed by their physical selves. Martens' supports the interpretation that aides were confronted with unconscious death anxiety due to their work with frail and failing bodies. This death anxiety was not consciously apparent to the aides. The feelings became apparent only when the aides were confronted with images in direct opposition to their own. When such a confrontation occurred the aides became overwhelmed with emotions and attempted to separate from residents. The conscious method that the "living" aides used was to claim that the residents' "dying" bodies were not acceptable. Since the aging body was in opposition to the aides' symbolic belief that a human body is a source of vitality, the resident could be derogated. Corporeality appears to be the vehicle aides used to justify their attacks on residents.

Psychoanalytic theory and research further support the significance of one's worldview on an individual's interactions and behavior. According to Adams (1995), worldviews are formed by preconceptions and self-senses "which we take for granted" (p. 473) instead of a give and take between self and the world. The worldview then distorts our present perceptions by using past experiences as a guide to the present experience. We only see what we believe. Adams believed that this defense was used for

self-preservation and gratification. Piven (2003) proposed that people "are more defensive, rigid, and aggressive in the application of their worldviews" (p. 232) when death anxiety is present.

Aides' negative responses to the corporeality of residents suggested an uncanny or out of normal awareness feeling. Freud (1915) called uncanny feelings foreign or dangerous in that they were not understood or expected. These feelings originated in our past at a time when society had far less influence on our instincts. Freud related the feeling of uncanny to doubles. By doubles Freud meant that humans and objects could be ascribed human and un-human qualities. For example, a king was both a human and a god or a child's doll was a thing or alive. Aides' negative responses to the residents' bodies indicated that the residents were at that moment "foreign" objects that did not warrant being acknowledged as frail, helpless human beings. To the aides, residents became "doubles"—they were in reality human beings who needed care, but were unconsciously seen as foreign or different from the aides. It appeared that, when the residents were perceived as alien or foreign, the aides were able to dehumanize them by focusing on a failed body part such as "he can't hear and he can't talk and [I] don't even want to look at him." According to Freudian theory, these uncanny feelings in the aides were "un-homelike" feelings that indicated strong negative feelings about the residents. More importantly, the aides' discharge of these feelings looked like hostile, negative or reactive responses. It was as though the aides were responding emotionally to a self-preservation threat of fight or flight, rather than conscious cognitive processing.

Another example of "un-homelike" feelings or "doubles" was an aide's comment that a resident's body looked like a "tinker toy"… "a sheet covering a skeleton." The aide

labeled this resident a “manipulator” when the resident’s reality, did not match the aide’s concept of a good resident., Once given the label of manipulator, this resident became someone the aide could denigrate. This denigration of the resident was a method for the aide to raise her self-esteem and reduce her anxiety. The aide could not attack a good resident but could verbally abuse a manipulator.

Aides also described the residents and their bodies in another manner consistent with TMT tenets. On several occasions one aide mentioned that she would prefer to see pictures of the residents when they were young and productive rather than just when they were old. This aide also enjoyed working with rehabilitation residents who “got better” rather than “geriatrics” that didn’t go home. This aide wanted to work with bodies that were “ a source of life” and “productive” (Goldenberg et al., 2006) and “got better” rather then bodies that were dying and hopeless. This aide did not feel hopeless working with “rehab” patients. When the residents’ bodies did not appear to be a source of vitality and life, creating unconscious death anxiety, the aides wanted to create some hope for their own future by denying the inevitability of death.

Aides frequently emphasized physical, mental or emotional frailties when describing negative interactions with residents. Of particular note was the absence of the residents’ perspectives from these descriptions. The voices of residents were missing. Instead, when the aides seemed anxious, they imposed their personal beliefs projected into the residents. It appeared that the residents’ views did not matter; only the aides’ perspectives did. According to TMT, the aides’ expressing their beliefs appeared to be self-esteem raising experiences or attempts to change their fear-related anxiety into an

assertion of the aides' own positive feelings and beliefs, e.g. the superiority of being still young.

Managing Feelings

As noted earlier, the focus for the SNF and the aides in this study was on providing safe care and the performance of tasks, not on the interpersonal conflicts that arose in providing this care in this setting. This study indicated that the overwhelming feelings that emerged within aides during their daily work negatively impacted their interactions and behaviors with residents. Developing strategies to acknowledge and manage these feelings seems essential to improving the workplace environment for aides and the care they provide.

Exploring the origin and intensity of these aroused feelings and subsequent negative behaviors in a larger sample would be a helpful first step toward developing strategies for their management. Holmes (2009) noted that a human's brain "should be thought of as three different brains" (p. 76). The most primitive are the reptilian and mammalian brains. The third brain is the cerebral cortex, the center of thinking and reasoning where the ego lies. Holmes reported that the third brain can easily become overwhelmed by feelings originating in the two primitive brains. These primitive brains contain instincts related to survival and self-preservation. This researcher proposes that just being in the presence of nursing home residents could cause someone to have feelings that seemed to emerge from the more primitive brains. In an observational study of the elderly, McKenzie- Smith (1992) reported her feelings of hopelessness and helplessness in her role as observer of the emotional life of the elderly.

Solomon (2003) offered another explanation for the origin of these feelings. He proposed that when our unconscious belief systems are threatened, we have the option of converting to the other's belief system. However, he stressed that "we are prone to lash out at anyone who threatens our sense of self-worth or the beliefs upon which our self-worth is based" (p. 461). In the situation being studied, it would be unlikely for an aide to embrace these failing bodies. It would seem that aides are more likely to panic and lash out when residents threaten their anxiety reducing concepts. According to Solomon (2003), the first line of defense against an opposing other is to derogate them. This premise supports that when interactions with residents created overwhelming anxiety in the aides, they were compelled to manage this anxiety even if the consequences were detrimental to the residents. One way to do this was to separate from the residents with a corporeal statement. After separating, aides were then able to take an anxiety-managing action such as berating, yelling at, or neglecting residents..

Being compelled to manage overwhelming negative feelings, the aides used harsh tactics that were antithetical to the care residents expected, and the aides were expected to provide. These behaviors indicate the aides felt omnipotent and controlling toward the residents. Klein (1946) believed that omnipotent thinking was hallucinatory gratification and the denial of persecution and frustration (p.102). The object was split into a good and a bad object. The bad object could then be projected and harshly criticized. Using Klein's position, one can understand why the aides could derogate and control a resident at one moment and provide compassionate care at another.

Feelings evoked in the aides by the residents influenced which objects the aides projected onto residents and revealed the variability of aides' responses to residents. This

variability indicated transference of feelings from the aides' life experiences. For example, one aide spent "hours" with a resident who made the aide feel good, but also refused to call a family member of a resident the aide didn't "even want to look at." On examination, aides' harsh remarks to and about residents were all due to conflict. Each aide's individual concept of what or how a resident should respond was in some way challenged by the residents' response to the aide. The feelings generated in the aide from this conflict seemed to then guide the aide's response. Each aide's ability to tolerate negative feelings appeared to effect how the aide managed the conflict.

Aides' hostile, inappropriate and irrational actions were often infused with primary process focused and concrete thinking attempts at managing their overwhelming feelings. The aides' descriptions of negative interactions with residents often revealed their inabilities to tolerate frustrating feelings, as indicated by their inappropriate responses. There was a lack of mental representation that, according to Spotnitz (2004), was due to a defense system that warded off intolerable affects "threatening impulses and painful reality" (p. 39). The aides were unable to use secondary process or thoughtful language that would have been beneficial for aides and residents alike. According to Bion (1962), such inability to utilize secondary process language is a failure to tolerate frustration for a long enough period of time to change the original raw beta element or "thing in itself" (p. 8) into an alpha element that could be used for the creation of "thoughts by a thinker" (Bion, 1959). When not converted to alpha elements due to lack of tolerance, raw beta elements are then projected into the object. This process, projective identification, indicated that split-off parts of the aides' personalities then became a part of the residents' personalities. Residents' as bad objects could then be denigrated by the

aides. The aides' harsh remarks lacked "thoughts by a thinker" and tolerance of their targets, very old and incapacitated residents.

When criticizing residents, aides were resistant to considering the perspectives of the residents because the aides were trying to manage and reduce their anxiety. Without consideration for the residents, the aides could easily attack. When death anxiety is prevalent, the defense of the worldview and the self-esteem generated by the expression is most important. Aides disliked the residents who were antagonistic, and felt helpless with the helpless or hopeless residents. The aides used self-esteem creating statements to reduce these feelings and their unconscious death anxiety. In the example previously described, the aide's self-esteem was buffered by derogation of the resident as the aide defended why she refused to look at him or provide the service she was obligated to perform. Aides' self-esteem raising opinions were stated with little information about what the residents might have thought or felt about the interactions. Information was not necessary because the goal of the response by the aide was to buffer her anxiety.

The primitive feelings aroused by residents' failing bodies and minds were frustrating and intolerable for an extensive period of time and added to the inherent anxiety of the environment. During this project, the researcher proposed that aides needed to pay more attention to these feelings and tolerate them for the time necessary to develop language that would describe them. Bion (1962) posited that thinking was an emotional experience that needed to be understood first before thinking could develop into thoughtful language. If the emotional experience was not understood, then the possibility of less than thoughtful or primary process-focused thinking would prevail. The aides did

not have the time, knowledge or place to develop an understanding of these levels of interactions with residents.

Aides' inability to tolerate frustration was evident in their negative responses to residents. Such behavior indicated that they were impulsively discharging negative feelings in an attempt to mitigate their anxiety rather than tolerating the negative feelings. I found myself frustrated that the aides were self-absorbed and not considerate of this dependent nearly helpless population of residents. At times, I attempted, through reflective questions, to engage aides in having new thoughts about residents. On other occasions I attempted to educate them about what a resident might be feeling during these difficult times. These attempts appeared to be premature for the aides and frustrating for me.

Shephard (2009) reported a conversation with Sponitz in which he said that when we are with hopeless people, our feelings are so primitive and hostile that we are terrified and will do almost anything to get rid of those patients as "sooner or later we feel the patient ought to be put out of his misery"(p. 10). Shepherd (2009) elaborated that in these intolerable situations, caretakers ought to "tolerate the hopelessness and murderous feelings" (p. 11). The aides did not indicate any attempts to tolerate their feelings. However, it appeared that their goal was to control or buffer these intolerable feelings by trying to engage in action to fix, change, derogate or get rid of the source of the emotional problem. If the aides had tolerated the frustration, they would have had time to develop "thoughts by a thinker" and curiosity about why residents were talking or behaving in a manner that caused such negative feelings.

The aides' preoccupation with managing their feelings interfered with their ability to listen to residents. This preoccupation effected aides' expression of thoughtful communication. Carveth (2002) noted that "the language of communication involves the capacity to consider thoughtfully what another person is saying" (p. 39). Aides also lacked the "emotional vocabulary" (Carveth, 2002, p. 39) to communicate in thoughtful language.

Aides' view of the residents' behavior was that residents were deliberately being frustrating, infuriating and manipulating. Thus, the aides felt attacked by the residents and made no attempt to understand or resolve the issues residents raised. Simultaneously, aides seemed to sense the hopelessness of residents' situations and their helplessness in resolving it. Meadow (1976) wrote that when a person has been injured (emotionally), a system of tension reduction is mobilized. She emphasized that if the cause of injury was deemed to be another person, then that "aggression will be turned outward" (p. 48) in an effort to reduce tension. The aides seemed to mimic Meadows' explanation when they thought the residents caused their negative feelings. The resident was the problem and was attacked.

Many statements the aides made about residents were shockingly aggressive. Freud (1915) believed that the unconscious did not know its own death but took joy in the murder of an enemy. Both TMT and Freud's framework have relevance to the aides' responses to residents when overwhelmed with negative feelings. Aides acted out their negative feelings by yelling, avoiding call lights, and ignoring services the residents needed. Aides were at the level of frustration and anger that they treated residents as though they were inhumane foreign objects. It is important to point out that each aide's

method of managing feelings seemed to follow a personal pattern that emerged from each aide's life experiences.

Identification/Self-revelations

Aides' identification with residents and self-revelations suggest the aides had personal biases in their responses to residents. The identifications were positive and negative and often conflicted with their expressed opinions of residents. What was noteworthy was the aides' identification with residents whose behaviors were expressions of the living. Aides' conscious minds seemed to identify with only those residents who could take some action on their own behalf, even if the aides found this action irritating. Identification with the living, rather than the dead, was the theme.

In regard to another group of residents who were more appealing and accepting of their life in the SNF, aides had different feelings from those about residents who raised disgust, anger, and anxiety about death. Aides explicitly reported that they themselves could not be like residents who accepted life in the SNF although they enjoyed caring for them. This researcher proposes that the aides are unable to identify with the "accepting of life in the SNF residents" because, to the aides, this meant accepting death. Freud's (1915) theory that the unconscious could not identify with its own death supports the aides' identification with residents fighting to live. However, Klein (1946) thought the unconscious could recognize threats to its life, which created a death anxiety. This researcher proposes that the aides' inability to identify with the "accepting of life in the SNF residents" residents indicates a conscious decision because " identification requires the perception in the mind's object field….of a representation that can be viewed as part

of the self" (Spotnitz,1976, p.58). The aides could not view accepting death as part of themselves. A person can be dead, but it can never be known (Bion, 1970).

Aides' self-revelations were often antagonistic and revealed in personal stories, for example, when describing aggressive interactions with residents. These self-revelations support Freud's theory of repetition compulsion. Freud (1920) postulated a repetition compulsion was when a person tried to master the feelings originating from a trauma in the past, most often at a very early age. A conflict needed to be resolved. Each aide revealed a repetitive pattern of personal stories or vignettes, activated when intense negative feelings dominated their emotions. This behavior seemed to represent attempts to manage feelings as well as change the original trauma. According to Soldz (1981), "the hostile person cannot accept others as they are but must try and make them what he believes they should be" (p. 241). Aides often described residents solely by how they believed the resident should be behaving. Having beliefs about how residents should respond allowed aides to become aggressive when residents failed to meet these expectations.

Aides described identifying with residents whose regressed behavior was much like that of very young children. McKenzie-Smith (1992) noted that a nursing home resident often "sounded like a very young child who was trying to communicate" (P.364). She acknowledged that very much of residents' care, such as wearing diapers and being fed and ambulated, is like the care a child needs. Residents need care and understanding similar to what is needed by children. However, most children eventually become productive and valued while elderly nursing home residents may continue to degenerate and fail. Some of the residents' childlike behaviors reminded the aides of their

own children. The contradiction was that the residents were not going to get better and become productive as the aides hoped their own children would. When the residents did not respond to the aides' nurturing care, the aides felt like failures as parents to the residents. The aides' responses to feeling like failures were to criticize the residents.

The aides' repetitions, along with unconscious identifications, indicated they lacked knowledge and understanding of their own feelings. At these moments, aides reverted to their individual defenses. They showed no curiosity about their own behaviors or residents' behaviors when their unconscious feelings activated the repetition compulsion. Bion (1962) noted that just loving or just hating another person was adverse to the development of curiosity, which is the means to knowledge. According to Bion a person needs to tolerate frustration, a key factor in the development of curiosity. If a person becomes curious about a feeling, the feeling could be tolerated longer and knowledge about the feeling could emerge.

Listening

The interventions of this study, aides listening to residents and discussing their listening interactions in supervised group sessions, resulted in a dramatic reduction in conflict between aides and residents. There were changes in the dynamics between the aides and the residents, and an increased curiosity about residents' lives. Discussions about the listening interactions differed significantly from discussions prior to these interventions. In the earlier discussions, aides rarely mentioned the residents' perspectives of the interactions. Residents' voices were missing. With listening, the aide/resident interactions became a "two-way-street", as described by one aide. A sense of reciprocity is evident in one aides remark "we get something back."

Listening allowed for recognition by residents and aides that the others were similar (Greenberg et al, 1990) as they were both living human beings. Residents were not just “a series of tasks to be completed’ in the work day, and aides weren’t just “things” that provided care. There appeared to be a mutually significant recognition that evolved into meaningful relationships. Bernstein (1986) noted that a person being listened to “felt better, reassured, had very positive feelings for the therapist” (p. 64). The positive feelings appeared to be reciprocal for both residents and aides. The negative uncanny feelings that the aides seemed to respond to when providing direct care to the residents did not dominate the interactions when the aides described listening to the residents. Listening was about living. At a minimum level, the aides’ unconscious conflict about the dying residents was mitigated. At a maximum level, the residents were perceived as just like the aides and conscious conflict was decreased. When the aides’ unconscious death anxiety became overwhelming it created a resistance to listening to the residents. Death anxiety had disturbed the aides’ cognitive processes but when the residents were perceived to be more like the aides, the aides’ anxiety and resistance to listening to the residents diminished.

As residents described their lives before and in the SNF, the aides began to identify with the residents’ life experiences. They called the residents friends. The aides began to understand what life was like for residents in the SNF and became advocates for them. To the aides, residents became like them and their worldviews were similar.

By listening, the aides progressed from a paranoid-schizoid position where objects are split to a more mature position of seeing the residents as whole objects, both good and bad. Klein, Bion, Winnicott and other psychoanalytic writers described the

paranoid-schizoid position as one where part objects were split off into good and bad objects from which persecutory and omnipotent thinking originated. When whole objects were recognized, the depressive stage of development occurred. According to Klein (1946), in the depressive position there was a better synthesis of internal and external realities. The other was recognized as a separate person different than one's self. A similar occurrence happened after aides began listening to residents. They described residents as whole people with faults and sadness but also with wishes and desires. One aide said, "X can drive us crazy but when you hear her story, something changes." When the residents were seen as similar to the aides, residents were viewed as people with good and bad qualities.

All of the aides used terms such as "its cool" or "neat" when expressing feelings about listening to the residents' stories. Aides used these same terms when residents showed explicit positive interest in meeting with the aides. Maldonato (1987) wrote that "the message requires a recipient of the unconscious towards which it can be directed…[and the] necessity of being recognized by the object, which occurs in the transference" (p. 380). As aides became recipients of the residents' messages, transference developed and residents were recognized as human, just like the aides. Being recognized as humans allowed the residents to transfer positive feelings from objects in the residents' early lives onto the aides. The positive feelings were mutual as the aides were equally able to identify the residents with early positive objects in their lives. One of the tenets of modern psychoanalysis is that "being with a person exactly like oneself -- a twin image-- strengthens a child, makes him feel recognized, understood,

liked…equivalent to being loved”(Spotnitz, 1988). A twinship developed as aides loved hearing residents’ stories and residents loved that aides were listening to their stories.

Freud (1915) held that hate and loathing by humans developed because they knew so little of each other. Bion (1962) supposed that if humans just loved or just hated another person, they would not be curious and no new knowledge could be developed. He assumed that curiosity could not develop unless one initially became curious about one’s own feelings. People needed to be curious about why they loved or hated another person. Prior to listening to the residents, aides appeared to either love or hate them. After developing a relationship through listening, the aides became curious about the residents.

Prior to listening to residents when the performance of tasks was the aides’ primary focus, there was little need for being curious about the residents’ lives, Aides expressed wishes that the residents would not request anything so the aides would not have to do anything. Before the aides knew the residents, at least one aide felt that suicide was more appealing then life as a resident. That aide wondered about a resident with multiple paralyzing physical ailments. “Why does he get up…I would just lie there and die.” The residents needed to accept the aides’ care without complaints or criticisms while the aides awaited the residents’ deaths. Listening allowed the aides to focus on the residents as humans with wants, needs and desires. Meadow (1988) noted that in Freud’s (1907) interpretation of Jensen’s *Gradiva,* the female character cures the protagonist “by not confronting him with reality, and by listening to him tell the whole story” (p. 336). It appeared that listening to the residents was the cure that each participant needed.

Curiosity developed when listening became the focus. Aides began to wonder why residents got out of bed or why an Alzheimer’s resident could remember a

conversation from a week earlier. This curiosity was reciprocal as both aides and residents described wanting more information about each other's lives. Furthermore, aides became curious about the health, diagnosis and prognosis of the residents. This led to aides exploring how they could improve the residents' quality of life. Not only did residents come to life as a result of curiosity, but aides came to life as well.

My listening without judging, changing, valuing or helping allowed aides to express the many conflicts that arose in their daily work with residents. Being able to express their negative thoughts and feelings in this process cleared the way for the aides to be able to access the positive parts of their personalities (Newsome, 2009, personal communication) such as kindness, compassion and humor. These positive parts or objects in the aides' psyche had an excess of positive feelings that was used to connect and support the residents.

Implications

The outcomes of this study have significance for nursing home managers and the discipline of psychoanalysis. The findings indicated that the prevailing societal and cultural beliefs that aging and frailty have little value negatively influence the daily lives of nursing home residents and their primary caregivers, nursing home aides. This worldview appeared to affect the emotional interactions between aides and residents that were often based on managing conflict.

Implications for Nursing Homes

The institutional structure of the nursing home, driven by government regulations, fiscal and safety anxieties inherent in the care of elders and others unable to care for themselves, mandated physical care but failed to address the emotional needs of its

residents or the aides who provide this care. Aides lacked the training, understanding and support needed to emotionally care for this vulnerable population. Conflicts that appeared to be both consciously and unconsciously motivated created negative emotional interactions between residents and their primary caregivers, nursing home aides. Left to their own devices, aides used universal defenses from their own past life experiences such as belittling, avoiding, derogating, and yelling to manage the overwhelming feelings that were natural and unconsciously motivated in working with, for the most part, hopeless and helpless population. In the midst of current nursing home policies and procedures, aides and residents were trying to avoid or discharge these feelings with limited success.

Both Modern Psychoanalysis and TMT provide possible explanations for the derogatory behavior. Modern psychoanalytic concepts and techniques of receptive listening and group supervision provided a potential solution to this denigrating behavior. In this study bi-monthly facilitated group meetings provided a safe place for the aides to express their thoughts and feelings in language without being judged, changed, valued or helped. The residents, aides, and other staff could all benefit if training and supervision were consistently available as components of an implementation plan for receptive listening. Group members would be able to process ideas with one another and become aware of how their feelings and actions affected interactions with residents. This awareness would allow aides to become curious about their interactions and in the long run, provide better service and care for residents, as well as better communication with residents and staff.

An important finding was the influence that transference and countertransference feelings had on the interactions between aides and residents. Lifelong experiences seemed to play an important role in how and why aides and residents responded to each other. A greater understanding and use of these natural phenomena's could greatly enhance communications between all members of the nursing home community.

Creating time and space for aides to temporarily disengage from their tasks and listen to residents is the second key element to the success of this approach. The benefits of incorporating a regularly facilitated group for aides and a scheduled weekly time for aides to listen to residents could be an improved quality of life for residents and an improved workplace environment for aides and other staff. Another potential benefit could be increased curiosity and more resident-focused care including activities initiated and directed by the aides. An increased understanding about residents' behaviors could lead to a potential decrease in the use of medications and behavioral interventions to subdue residents. Supportive sessions with the aides over time could have the potential to create less conflict between aides and residents; aides and aides; and aides and other staff. As conflict lessens, the need for aides to separate from the nursing home itself would lessen. The financial implications of improved quality of residents' lives, decreased staff turnover, a healthier work environment, and less use of medications and behavioral interventions for the nursing homes and the federal governmental agencies that support them would be substantial.

Implications for Psychoanalysis

The results of this study can enrich the discipline of psychoanalysis. TMT theorists believe they have found a method to empirically establish that unconscious

death anxiety (out of conscious awareness) has an effect on determining conscious cognitive processing. TMT empirical research studies, over 200 to date, support the basic psychoanalytic concept that the unconscious controls much of human experiential communications in conscious cognitive processing (Gilhooley, 2008).

The qualitative data from this study supported what is evident in both TMT and psychoanalytic literature, i.e. that conflict is at the root of most negative interactions. Freud originally believed that there was conflict between the ego and libido. Later he added aggression as an instinct that competed with libido. This meant another conflict had to be managed. TMT asserts that humans have an existential conflict that needs to be managed in order to thrive in their self-conscious world. The evidence from this study indicates that the aides had conflicts both conscious and unconscious about life and death which they managed in ways consistent with their own personalities and experiences.

TMT research indicates that, when unconscious anxieties are challenged conflict arises, and the ego responds in a manner that buffers those unconscious anxieties. Since the unconscious only knows life (Freud, 1915) or the preservation of life, being with SNF residents is a threat to the unconscious life of the aides and creates conflict. Aides are confronted with the conscious reality that they are going to die one day. Just working with residents in the SNF environment created an unconscious death anxiety (out of focal awareness) that TMT finds so problematic. When any additional emotional response was created by aides' interaction with the residents, they responded with corporeal adjectives to separate dying residents from living aides. The aides' reactions indicates when unconscious anxieties are challenged the unconscious responds in a manner that attempts to reduce those anxieties..

Bion (1957) reported that patients were not interested in the causes of their pain and did not appreciate interpretations from others as to why they felt that way. Modern psychoanalysis supports the idea that reducing conflict by joining patients' resistances is one of the keys to changing how one thinks. The therapist joins and even supports the resistance of the patient until the patient has "enough awareness and ego strength" to have a more life-enhancing and controlled behavior pattern (Spotnitz, 2004)

When the facilitator did not challenge aides' views or try to change their beliefs, aides could express their negative thoughts and feelings without being challenged, reducing the chances of conflict in the relationship. Without conflict the aides' positive aspects emerged and helped increase their self-esteem. With increased self-esteem, aides were able to listen to the residents. Creating a group process that engages but does not challenge unconscious anxieties or conflicts supports psychoanalytic theory, concepts and techniques that could be useful in non-psychoanalytic professions such as health care, education, social services, the arts, law enforcement and others.

It appeared that aides' unconscious or conscious ideas, positive or negative, motivated their behaviors toward residents. When positive ideas were activated, aides connected or bonded with the residents in life preserving-connections for residents and themselves. When negative ideas were activated, aides separated from residents, as life preserving actions for themselves. This form of separation often took the form of an attack on these stimulating, perceived threats—the residents. Although the aide's motivation was the removal of the threat, the behavior was an attempt to control the resident. From the perspective of psychoanalytic theory, aides' behaviors would not be considered negative but primary process focused attempts to manage unconscious

motivations induced by their work. Interventions with the aides should address these unconscious motivations.

Being listened to without judgment and receiving positive feedback appears to facilitate the expression of conscious and unconscious motivations. Joining (Margolis, 1994) a person's unconscious and conscious motivations can create a similar-to-me relationship and increase self-esteem and a desire to live. The aides' abilities to discuss listening to a resident increased their self-esteem, created a similar-to-me relationship and reduced the need for defensive responses to dissimilar others. Being in a similar-to-me relationship gave the aides access to their instincts (Billow, 1999) to be curious. Being curious about residents provided aides with an opportunity to have new feelings and ideas about residents that their previous reactions to death anxiety had prevented. These new thoughts, feelings and ideas were developed when aides related to the residents as living human beings like the aides. Thus listening and being listened to can lead to increased self-esteem, curiosity, and creative thinking.

Finally, it appears that TMT's empirical research (Pysczynski et al., 1999) supports modern psychoanalytic theories, concepts and techniques that emphasize the importance of joining, mirroring and reflecting rather than challenging peoples' defenses and uncovering unconscious conflict. Reducing conflict in these aides gave them more access to the positive life-enhancing parts of their personalities increased their self-esteem curiosity.

A number of researchers (Kettell, 2001; Knight, 1986; Semel, 1986) have reported psychotherapy can be a helpful intervention for the psycho-social problems of

the elderly population. In these studies, the interventions were implemented by psychotherapists.

The current study distinguishes itself from previous work in several ways. First, in this study nursing home aides rather than professionals implemented the intervention to the nursing home residents. Second, the researcher facilitated this small group of aides without valuing, judging, helping or changing the aides when they spoke about their work and the residents. Third, the aides were free to say anything, and did. Since this model used trained aides instead of professionals it is likely to be more cost effective and potentially more sustainable.

Like all studies, this one has limitations. The small convenience sample in this study limits its generalizability. Replication of the study with larger samples of residents and aides in nursing home facilities of varying sizes and purposes is needed. There is a need for further research and exploration on ways to improve the lives of nursing home residents and the function of the nursing homes themselves.

Appendix A

Examples from Aides Indicating Overwhelming Emotions

- a pain in the ass
- I got mad
- We despise each other
- I have a hard time when they die, I block
- I hate her
- makes me vomit
- It is very annoying
- I just can’t stand looking at her
- I am going to frigging die
- I see that as disrespect

- …scared the living shit out of me.
- he is just a pain in the ass
- Why get up?...just lay flat, and be done with it.
- the noise level gets to me too
- it is exhausting
- so irritating
- If you want me to say something good, forget that I don't have anything good to say

Appendix B [BEGIN EACH APPEDIX ON SEPARTATE PAGE.]

Examples from Aides Indicating Antagonism or Hostility

I mean, when I first started working with him I didn't know how to take him so I was like, you know E if you are not going to be polite and you can't respect me, you know, as a person then I can't be in here with you and I would have to tell him that if he wasn't going to be respectful and call me names that I would have to leave and I would. …I went in there today and he was being rude. You know what, E, I know you have a personality under there somewhere and I know it is not this mean old man and he bustered out this big ole grin. (1.190-196)

I got mad, she is talking about her skin and oh, look at my …. And blah, blah, blah and I said [resident] I said let them put lipids in your TPN and you won't have any skin issues,

you know and she said I don't want that and so I said then eat a cheeseburger and oh god. (1.243-246)

We despise each other. (3.37)

"I hate her because she is a dirty, dirty woman. And I do not like dirtiness…

…Her room is cluttered. She smells. She doesn't clean herself properly. Just the thought of her makes me vomit…" (3.42-45)

It is very annoying when I have her too, when you do try to help her. You can't win. (3.80-81)

I just can't stand looking at her face. (3.95)
Her dirty teeth, I think that is what makes me angry. (11.144)

…That I might become a murderer.(3.102)

If they don't drive you nuts, then they can get better care because you don't mind taking care of them…. Yeah, because look at X. Like she is one of the nicest ones of all times and I will spend hours in that room getting her ready and she won't complain one single bit, you know and there is frigging X who just wants everything, he is so needy and he is so obnoxious, you know and he what he wants really isn't so hard, but he is just a pain in

the ass, you don't want to even look at him… Yeah and he wants to call [his daughter] but he can't hear and he can't talk. And I'm not going to call her.(5.377-396)

No, and I won't help X when I am with Y and I won't help her anyway because I don't like her. (3.76-77)

She's fun though to keep on track when you go in and she wants something. She'll go for the rest of the day if you let her… so it's fun to bring her back, keep bringing her back and bringing her back, I have a blast with that. It probably isn't nice but…[blocks face with arm, looking at camera] (3.476-479)

Last Thursday, last Thursday, yeah. I almost ripped her head off. I told her woman you are wicked. You are mean. I was like; you do know that if you talk nice you might get a little bit farther. But I said you are mean. (7.1092-1093)

You know who I would not be able to do this with is X. That is my own personal thing…I don't do well with her… I've heard the stories. I've heard the excuses and she is one I could not do this with. (1.202-205)

I get pissy. She makes me angry. She makes me very angry. You know, I have a handicapped son and I have bent over backwards to not be manipulated by him. You know what I mean and he does not manipulate people. He tends to do the little crippled boy thing, but that is not manipulation. She is the mistress of it and I don't like that. I

don't like being manipulated. So, I would have a hard time… Unfortunately now, my responses to her are I am very sarcastic with her and she doesn't come to me as much anymore because she knows. One day, I am terrible, but I was busy. My office has piles of stuff. I am focused. She will do things like. Scratch my back. No, no zzz leave I am busy…One day I told her to eat a cheeseburger and I got reported. So, I have to be careful. (1.207-242)

Like me and Z were in the tub room with him… I was like, "X, you are such a stud" and then she said, "Yup you are such a stud," and he was like, "You women, I hate you" and then he was fine with me, though. Like he yelled at Z like I…(8.388-390)

Like I actually have to take a deep breath before I go into the room…
…and I cannot stand that whole, "Can you get me this?" I am like oh my god; I am going to frigging die. (11.230-233)

I have two people, What about manipulating other people. I have a hard time going into [their] rooms. I don't want to believe them. You know what I mean. I don't want, I will not agree with some of the things they say. (11.311-312)

I mean when you are not dealing with her next to her. Because I am always like close the curtain and leave me alone … She is like "you got to do this" and "why didn't you do that?". It is like "X, shut up." (8.1119-1125)

When I feel like that I just grab a curtain and snap it like you see in the movies. The nurse will go in and you know, snap the curtains. That's what I do, it is like "whack"… (3.287-291)

Oh yeah, one day I am incompetent. I am like alright I am. (LAUGHING) He rings okay his bell again and I am like am I still incompetent? He is like yeah. See you later. (9.373-375)

She likes to bitch. (8.140).

I can't think of a way, I can't express, I see that as disrespect. You know, the disrespect is that we are, you know, hard working we are trying to do a good job and she is playing little games. (5.497-499)

It is probably not what she says, it is me picking up the way she feels. You know, if she is upset about something she tries to make somebody else upset. (2.341-342)

She's not functioning well…her leg hurts, her arms tingle ...she's uncomfortable…but I think I've convinced her that she's uncomfortable because she stays in bed. She needs to move. I said you are of the age where you need to keep moving in order to be able to keep moving. She just looked at me; I said lying in bed hurts! Everything hurts when you lay in bed. She looked at me, and I said you're in there with this damn curtain pulled and

you got nothing to think about but yourself of course you hurt. She just looked at me … but it's true. (6.717-723)

I used to be petrified you know she would always talk to me and I would be like, okay, I will stand those things because I didn't want her to feel bad. Now it is just like you need help. (11.179-181)

Appendix C

Examples from Aides Indicating Helplessness

You know with this new thing and the aspirations and stuff. I'd go in and tell him he needs to get up for his meals for his lunch, supper and…and he did he started getting up. Why get up? Would I have gotten up? With that sort of medical diagnosis just lay flat, and be done with it. Why get up? (2.410-413)

It is funny that something that drives me crazy when his wife comes to see him and she doesn't take her coat off. And she sits there with her arm around him with her coat on… I think it is horrible. Have they asked her to take her coat off? (3.595-599)

I don't want her to feel uncomfortable. When I feel she is feeling uncomfortable I feel uncomfortable.

BROWN: I am like xxx don't do this to me. She is like what! She is like What!
I am like don't…Wasn't breathing. She has coded on us once.
YELLOW: Twice and we had to resuscitate her.
BROWN: and her eyes were like this purply color and I was like xxx,. She is going what… (laughing). The look she gave me. She is like what… You just scared the living shit out of me. She knows. (11.520-535)

How can you, how do you relate to a person who has dementia? I don't know what is in her mind. I don't know what is going on. (8.606-607)

I think this type of work is very draining because there are so many emotions.
So much emotion involved in this work. There are so many people, so many personalities, the noise level gets to me too…especially X…Ohhh…Through all that, it is exhausting…It gets sometimes so irritating, like you just have to go somewhere. You have to go somewhere as you can't deal with it. Run down the hall…Or close my door… (8.668-678)

I have a hard time when they die. I block. (9.932)

YELLOW: Most of time I am feeling like how do I make her feel better? How to make her feel better? So my mind's racing.

BROWN: You do the same thing I do when somebody is upset it is like okay how do I fix it.

YELLOW: I don't have those skills, the knowledge or whatever to make her get better. I want to make her feel better.

BROWN: Yeah, I don't know, maybe it does and we don't see it. I don't know. We are in and out of there and don't have time to …

GREEN: That is why I make those bath salts because, you know, I think it does help these people. Because I don't make any money on them you know.

YELLOW: They are getting calming and we are getting calming.

GREEN: It makes everybody else calm.

(LAUGHING)

YELLOW: Little air fresheners in the windows.

BROWN: (LAUGHING) Calm everybody down.

YELLOW: …in every room.

(LAUGHING)

BROWN: That way you could do anything you want with them and they wouldn't even know it.

YELLOW: And we would be happy too. We'd be happy not doing anything. (8.725-740)

When she was complaining about her right leg, I said you know what, I said I can't even lie on my right side for more than 2 hours without it hurting. You have been on it for 20

days…. She just looked at me and went oh, and that was it. It was terrible. I mean.(1.328-332)

I have a hard time with X going the bathroom. Oh yeah… I am like X stand up and stop (laughing) you can actually lose it. (laughing) and she is like stop what, stop what, my butt hurts. No it doesn't just stop….And I looked at her one day and I didn't mean to say it, and do you want me to make your butt hurt. (Laughing) (9.984-990)

That's kind of why we got in this business in the first place but we don't get to do it… We don't have time to hear anybodies stories we want to keep them quiet that's why we give them drugs.(6.338-339)

GREEN: …and another thing, she does is she eats in bed. She is laying flat. Is this ok?
GREEN: If she chokes to death wouldn't we be liable? (8.305-309

PINK: xxx is going to be really hard because he can't talk very well anymore. (2.163)

That is what I like about not having my own ticket because she drives me crazy with that. (8.331-332)

Some people won't even go near him...It is hard a couple from Staff Solutions…won't come near the long hall because of him. (4.1000-1015)

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Appendix D

Examples from Aides Indicating Positive Feelings

That is strange. I sat with her last week and she told me this real cool story.(3.142).

Oh, another thing she told me she was a tomboy and so, I was too. I could relate to her. (3.439-440)

Thoughts ran and stuff and so but there are times when we really connected and I feel like you know, feeling like going to your neighbors having tea. I feel like I am having tea with a friend and I do feel that closeness with her. You know at those times. And I sense when I am not in that state feeling those things. I feel like a staff person. (laughing) and the relationship is different. So…(9.776-780)

Just to be your friend if you need somebody to talk to. (2.113)

Then she talked about that he was so heavy into sports. Um, he would go to a baseball game, come home and take his jacket off and turn the TV on and put another sports game on… so he didn’t have a lot of involvement with the family. She took care of the kids and she planned activities and he really didn’t get involved… So it sounded like my life. I related to her, you know. I told her to. Would come home and watch TV too and that sort of bonded us, you know. (10.101-110)

YELLOW: Sometimes when zzz is so animated about stuff, it is like a couple of buds sitting there at the bar. It really is and I just really like her. I really like her a lot.
GREEN: When you do like somebody, it can't help wanting to put, like put your own values on them like… (8.962-965)

I have been having a party with X. I've got the easiest one of all. It has just been awesome. Last week was a little iffy…,…We laughed and laughed and talked and sung. We sat there and sang songs. I'm not kidding you, it was a blast. We talked about all her singing that she used to do, I said how much I loved to sing and how I have a horrible voice but I love to sing. She goes sing something… …So I sang this old song. I missed a couple of words and she corrected me. She was really teaching me to stand up and do it. I was getting lessons. It was just fun. I brought her in a whole big bouquet. It was like I had given her a million dollars. She was so happy to have them. Not one negative thing she said to me…She was just so happy to be talking, so excited. So happy to talk about it. Not one negative.(11. 614-634).

No his legs start shaking. When he sees her, it is just like a little dog…. Yeah, every time he sees Z if he is standing there it goes a million miles an hour….What is up with that leg X? You are just like a little dog when you see Z and he is like (resident makes a noise) and he is so funny. Scratch him behind the ears…He's a riot. I wish we all had the same relationship with him. (4.1000-1014)

I think it is very cool, the two people who hate each other. (8.92)

and they did, they hated each other, to be able to sit down and talk to each other. I think it is cool…She hates everybody. (8.102-105)

Because I don’t have the right frame of mind so that is what I am saying, she can sense you know, whether I am genuine or not so… (9.782-783)

Appendix E

Examples from Aides Indicating Discharge of Feelings

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I don’t think I can do it. I really can’t. I can’t do it.(3.154)

She would tell it to me. I know her past history with working and how she is. I told her I did not believe it. I told her Blue is a good Aide and I totally disagree with her feelings about her and it was connected with another Aide who she is… You know, you have to say well… (3.185-188)

…look she gave me. She is like what… You just scared the living shit out of me. She knows. (11.520-535)

…that if he wasn’t going to be respectful and call me names that I would have to leave and I would.(1.190-196)

…but he is just a pain in the ass you don’t want to even look at him… (5.377-396)

Last Thursday, last Thursday, yeah. I almost ripped her head off. I told her,’ woman you are wicked. You are mean’…But I said you are mean. (7.1092-1093)

One day I told her to eat a cheeseburger and I got reported. So, I have to be careful. (1.207-242)

When I feel like that I just grab a curtain and snap it like you see in the movies. The nurse will go in and you know, snap the curtains. That's what I do, it is like "whack"... (3.287-291)

… She is like you got to do this and why didn't you do that. It is like X shut up. (8.1119-1125)

… I was like X you are such a stud and then she said yup you are such a stud and he was like you women I hate you and then he was fine with me, though. Like he yelled at Z like I… (8.388-390)

Appendix F

Training Material

How we will be with residents

Our aim when we are with residents is to create an atmosphere in which they can speak unhurriedly, or be silent, or sad, or angry, or in any state that they want to be, while we listen, with our mind in a mode of functioning that has as its goal; making the residents feel understood. We will learn a way of how to listen to residents that will embrace the resident feeling understood. We will constantly ask ourselves the question "Why did the resident say or do that?" Our responses to the residents will discount our judgments, nor criticize, help or expose our values to the residents.

Contact Function

Contact Function is used as a basis for responding to the residents. The use of contact function is meaningful only when there is a connection from genuine and caring associates.

Contact function is the way residents do or do not seek contact with the associates and how the associates respond to that contact. The importance of the contact function is that its use will be the bridge that resident uses to discover that the associates are just like them. When people are with someone just like themselves they feel free to say anything because they intuit that they will be understood.

Associates responses to residents are cued to the residents' verbal attempts to solicit some information about their characteristic preoccupations (what they talk about all the time), to satisfy their personal interest in the associates, or to convert silence or monologue into dialog through a casual question (Spotnitz 1976 , p.142). In simple

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terms: Why is the resident asking me this question, or making this statement either verbally or by action? There are two reasons residents will make contact. One, the more primitive, is flight from danger especially when their feelings are going to be exposed. The best way to handle flight from danger is for the associates to make the focus on an external object; like the associate or some outside individual. The second reason is to fulfill a need for objects (people) from the earlier period of life. If residents ask questions, then associates answer the questions as narrowly as prescribed by the patient's question. (Margolis 1994) A direct contact is concrete, "Can I relax while I talk". A simple answer to that question would be "Yes". However, depending on what the associate has been observing (for example a very anxious resident) the associate may feel that a more appropriate answer would be "Can you relax" However a vague, self-absorbed or silent contact "You don't love me" reveals the resident only thinking of himself. A response to that question might be "Do you want me to love you".

The contact function's unfolding is a gauge of the development of a dialog as compared to two parallel conversations taking place such as the resident making primitive or minimal communication and the associate responding to the contact of the patient. The more minimalistic or self-absorbed the resident's responses are the more self-absorbed he is. As personal contact with the associate becomes more frequent, it would then be appropriate for the associate to make a statement connecting what the resident has been talking about to the associate such as, "Am I like that too?" This minor interaction is important as it brings the conversation to focus on the relationship between the associate and the patient; developing and attachment or friendship that says we are like each other. (Margolis, 1994, p.206).

Techniques

***Object oriented question**:*

The Object Oriented (OOQ) question is used to protect the self-absorbed resident from having his ego (self) damaged by unwanted tension. An object oriented question is calculated to draw attention away from the person's own ego toward something or someone else. Examples of Object Oriented Questions are: What is the man's name? What was the movie about? What did you have for breakfast? Am I like that? One can easily recognize that the OOQ draws the self-absorbed person away from talking about himself, to talking about something or someone else; the man, the movie, breakfast or me, but always away from the resident.

Object Oriented Questions are almost always used with a patient who is having difficulty communicating. The patient could not be communicating for a variety of reasons but whatever the reason for not talking we always want to wait several minutes before responding and then ask an OOQ.

Joining and mirroring

In the simplest terms joining and mirroring refer to communication from the associate to the resident that we are alike. The associate agrees with what the resident has communicated (contact function). The agreement may be simple such as "Yes" or that's right" or the associate may echo the resident's statement by repeating it:

Resident: I slept poorly last night and feel tired today.

Associate: You look tired.

Or

Resident: I feel miserable.

Associate: You’re entitled to feel miserable.

The associate is agreeing with the resident in both examples. By agreeing with the resident the associate does not challenge any of the resident’s beliefs-which open the way for the resident to feel understood.

When the associate mirrors the patient the associate saying that I’m just like you:

Resident: I feel depressed.

Associate: So do I.

Or

Resident: I’m not doing well at this talking stuff.

Associate: Maybe I’m the one who’s not doing well.

Both joining and mirroring are used to help the self-absorbed resident put his thoughts and feelings into words - especially thoughts and feelings that the resident previously has not been able to say. During the initial stages of meeting with a resident only joining and mirroring statements that agree with the verbal content of the resident’s communication are to be used – always agree with the resident. When working with a patient for a long period of time associates will learn ways to join and mirror with the resident’s denied feelings and thoughts.

Reflection:

Reflection is returning to the resident a question that the resident asked the associate when the resident’s question was asked to avoid his characteristic pre-occupations.

Example:

An elderly nursing home resident had been complaining non-stop for 20 minutes (something he did during every session) about all the problems in his life without once asking for comment from the associate. The resident finally stopped complaining and there was silence. The resident then nervously asked the associate:

Resident: Are you married?

Associate: Should I be married?

Resident: Well, uh, well (silence) shouldn't they have better food in here? I'd like a nice thick steak. But I'll never get it.

In the above example the associate slightly frustrated the resident who then continued complaining about his personal problems. The slight frustration nudged the resident to begin talking about what he doesn't talk about. In latter sessions the resident began asking the associate how many residents he visited daily:

Resident: (After complaining about his problems for about 20 minutes) How many resident do you see here?

Associate: How many should I see?

Resident: (Pause) Oh, I don't know maybe 10.

Associate: Do that many need my help?

Resident: Yea, most of them do in here. But I couldn't do what you do. I couldn't listen to all their problems. I don't know how you do it?

Then in a latter session after complaining for about 10 minutes:

Resident: Do you have an office in here?

Associate: Would an office help me?

Resident: Yea. You could make some big money with the people in here. There are some people who really need help.

And during a later session:

Resident: I’ve been trying to help this woman across the hall. We talk almost every day.

Associate: You’re doing what I do.

Resident: Yea. I like the way you think. You think just like me.

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