COUNSELLING / PSYCHOTHERAPY
AND
OLDER PEOPLE
IN
MEDICAL SETTINGS

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Abstract

This study explores the nature of the need for counselling/psychotherapy for older people who suffer a debilitating physical injury or illness. This topic is investigated within a medical setting where the emphasis is on physical rehabilitation. The relevance of this inquiry is highlighted by the paucity of literature about the individual impact of such an event and the need for counselling/psychotherapy in these situations.

Theories, on the ageing process, the body, and the self, are used to develop an analysis of the material. The suitability of a research method is considered, with particular reference to inquiring into a contemporary phenomenon within a real-life context. A case study approach (Yin 1994) utilising narrative analysis (Riessman 1993) and metaphor (Lacan 1968) was the method chosen to conduct the study.

In the data, presented in the form of interviews and cases, there is a sense of each person grappling with a new experience of self. Through analysis of the data, emergent themes termed "encounters" were developed which reveal the need for counselling/psychotherapy in these situations. These "encounters" show the shock of a disabling illness and the reality of the patient's fears of incapacity and death. A complexity of losses are also identified, some of which engender feelings of anxiety, helplessness and isolation.

The study includes illustrations of how the creative and imaginative use of metaphors can help people explore new meanings and openings to re-establish a sense of purpose and meaning in life and hope for the future. Other ways of working are introduced and suggested, for instance, guided imagery and visualisation, and the use of meditation.

Some areas indicated for future research include the role of group work with older people in medical settings and the role of counselling/psychotherapy with regard to relatives, carers and staff. Implications for future counselling/psychotherapy training are also provided.
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Chapter 1: Introduction

"Patients bring more than just their bodies and diseases" (Baker et al 1996 : 173).

The doctorate arose out of an initial interest into the nature of the emotional/psychological effects upon a person when they are 60 years and older and they are faced with a disabling physical illness or injury, that will become chronic. By becoming chronic the physical illness or injury will be persistent and never ending and as such, it will, to some extent or another, impact upon a person’s future life.

From these remits and focal points of interest the research question became formulated thus: “what may be the nature of the need, if any, for counselling/psychotherapy for older people who suffer a debilitating physical illness or injury?” This inquiry will be explored with a medical setting and, central to the research, will be the inclusion of verbatim interviews and summarised counselling sessions to see what people say; to find out what sorts of issues people talk about when they are faced with this situation.

To begin with, some reasons as to why this particular topic merits attention are introduced. Then the theoretical issues raised within the research question are outlined followed by an introduction to the remainder of the study.

In support of the research question posed by the study it was found, when compiling a literature review, that there is a confirmed gap in this field. The gap is not so much in terms of the knowledge of what can happen physically, nor in terms of an awareness
that some emotional distress may accompany a physically debilitating illness. The gap is in knowing what older people speak of when this happens to them; what sorts of emotive issues arise for them at this time.

According to Lantican et al (1994) the literature on psychotherapy with physically disabled people in general is relatively minimal. Guthrie (1996) reports that most work involving psychological interventions for chronic illness have focused mainly on counselling about the management of illnesses such as the more traditional 'psychosomatic disorders’ ulcerative colitis, peptic ulcer, asthma and diabetes. According to Guthrie (1996), people suffering with chronic physical disorders are the least investigated due to the fact that the most physically ill are, for reasons unknown, in the main excluded from studies.

Lincoln et al (2003) identify that the lack of data may also be to do with the fact, that hardly any studies have considered the use of psychological interventions for the treatment of depression following such events as strokes. Mann et al (1993) report that primary care studies of depression in older people are sparse, furthermore they add, that although depression in older people can be interlinked with a physical illness, there are some difficulties in detecting its presence in that it may be masked by physical symptoms associated with the illness (Mann et al 1993). Rogers et al (1986) conclude that the incidence of emotional/psychological problems such as depression and suicide among people with severe physical disabilities, although believed to be high, is not known (Rogers et al 1986).
It is observed by Parry et al (1996: 11) that any research into psychotherapeutic interventions with older people tends to focus on "one shot interventions for particular diagnostic groups (e.g. behavioural therapy for a clinically diagnosed mental health illness)", and not with older people with chronic conditions. It is also concluded by some, that much research with older adults is conducted in contrived situations such as within university departments, with groups of patients selected for their fit with an investigation, or with elite groups that have perhaps lacked cultural, social and clinical diversity (McLeod 1993, Niederehe 1996, Parry and Richardson 1996, Sadavoy 1994). Having introduced some reasons for conducting the research now to briefly examine the key issues raised within the research question: "what may be the nature of the need, if any, for counselling/psychotherapy for older people who suffer a debilitating physical illness or injury?"

Firstly then, some defining factors of the ageing process and old age will be discussed to give some insight into this process and concept. Next some definitions of the physical illnesses or injuries that can occur, are offered, with an introduction to the place of the body in subjectivity as it is the body that bears the injury. This is followed by some of the consequences of a debilitating physical illness or injury, which is considered both in terms of the immediate impact such as hospitalisation, and the more long term effect such as psychological and emotional distress. Issues about what is the "self"; what is the nature of "being"; are introduced next since some theories as to what constitutes us as a person; what shapes our values and beliefs may be helpful in understanding the impact that a bodily physical trauma has upon the person. The chapter finally concludes, with some comments, drawn both from the literature, and briefly from the researcher's own experience, on the issues around
counselling/psychotherapy with regard to older people and, in particular, those suffering from physically debilitating illnesses.

The ageing process and old age

O'Leary (1996: 1-20) considers the principal dimensions of old age to be chronological and biological and along with these dimensions she includes sexual, psychological, social and spiritual dimensions as also being factors of the ageing process. Chronologically ageing is part of life and, within Western society a person becomes defined as an “older adult” or an “elderly person” at the age of 65 years (Christ and Hohloch 1988, Stuart-Hamilton 1994, Terry 1997). According to O'Leary (1996) This period of one’s life can span 30 years or more.

From a biological viewpoint Weller (1989: 25) gives the following intrinsic definition of the ageing process as being “the structural changes that take place in time that are not caused by accident or disease.” Following this succinct definition the following four criteria expand on this definition and are now widely accepted as a descriptive biological perspective of ageing (Strehler 1990):

1. Ageing is universal, in that it occurs in all members of the population (unlike disease).
2. Ageing is progressive, a continuous process
3. Ageing is intrinsic to the organism
4. Ageing is degenerative (as opposed to development or ‘maturational’ changes.

(cited by Bond 1990: 19-20)

According to Featherstone and Wernick (1995: 30-31), although the biological processes of aging, old age, and ultimately death cannot be avoided, “the meanings which we give to these processes and the evaluations we make of people as they grow physically older are social constructions.” These social constructions are
predominantly “long-held associations between old age and illness, disability, disengagement and decline.” Comfort (1989 : 25) believes that these social constructions of ageing can result in people being “prescribed to be unintelligent, unemployable, crazy and asexual” when they enter this age.

According to Biggs (1993), a particular form of oppression termed ageism can emerge from these social constructions. Ageism, contend Featherstone and Wernick (1995), can “operate through the dominance of images of dependency which take away the adult status and personhood of the elderly.” Featherstone and Hepworth (1991, cited by Featherstone and Wernick (1995 : 7) state that “the bodily betrayals of old age can ... result in a stigmatising process which has been referred to as the ‘mask of ageing’, pointing to the inability of the body to adequately represent the inner self.”

The following is a description of what it means and feels like to be old:

“The fear of that final enemy of the old, senile decay,...
The fear of loss of beauty, attractiveness,...
The fear of falling status, public status and private status
The general fear of physical disability, mental decline and illness
and for the dependence they bring with them...
The fear of loss of mobility, ...of being confined indoors, and
of the consequent loss of choice of places to go, things to do...
The fear of the loss of home, having to live with other people,
or in an institute.” (Laslett 1989 : 14)

On the other hand Pincus (1981) draws our attention to a more positive side to being an older person highlighting that many people start new careers, take on responsibilities of families, go off on travels and holidays, and write books. For example, Mary Wesley the novelist began writing at the age of 70. Michelangelo, sculptor, painter, architect and poet was 71 when he was appointed chief architect of
St Peter’s in Rome and during the next eighteen years until he died at 89, he engineered the main body of the church and frescoed the walls of the Pauline Chapel. Louie Dingwall, a grandmother and the trainer of many winning racehorses was 79 when she announced her intention of applying for a licence to ride in women’s races.

"Age is a relative matter. If you continue to work and to absorb the beauty of the world about you, you find that age does not necessarily mean getting old”. Pablo Casals, master cellist and humanitarian. Aged 90.” (Pincus 1981 : 92)

However, regardless of age, to consider the significance of physical trauma for anyone, in general terms, it is relevant here to think about Kestenbaum’s (1982 : 33) notion that “the phenomenon of illness is not simply a matter of one’s physical condition … it is ontological, affecting our very image of ourselves — our being — and our circumstance — our world.” What is being implied here is that illness does not just have a physical local affect i.e. on our body but can have far deeper meanings for us, encompassing perhaps O’Leary’s (1996) earlier stated dimensions of ageing which she identified as; sexual, psychological, social and spiritual. Mayou (1997 : 24), too notes, that with illness “severity is not an objective concept; it must be considered in the light of the meaning to the patient.” To consider what meaning illness has to the patient, must include some of the ways in which physical illness/injuries can change the body.

**Physical illnesses and injuries**

The specific ways in which people can be wounded by physical illnesses and injuries can be defined in many ways but, whatever forms they take, they will inevitably involve the removal, alteration or failure of any body part, internally or externally
(Weller 1989). For instance, cardiovascular related problems, strokes, musculoskeletal conditions such as arthritis, diabetes and many other metabolic disorders, respiratory complaints such as emphysema, and neurological conditions like Parkinsons disease can all cause functional impairment and thus be debilitating (Frank and Elliott 2000, Mayou 1997).

There are then many physical illnesses and injuries, as touched upon above, any of which can impact on the health of older people and initially lead to admission to hospital before becoming chronic conditions. There are two issues here, first the initial impact of the physical illness or injury upon the person and all that entails around the surrender of one's autonomy or personal freedom and the surrender of one's integrity or wholeness by, for instance, being admitted to hospital. Second, there is the long-term aftermath of a physical illness or injury if, after the acute phase, it then becomes a chronic condition. Next we briefly consider what is the physical in terms of what is the place of the human body in subjectivity as it is the body that bears the injury; that is the site of the wound.

**The body**

Harre (1991) and Lawler (1991), are among those who propose that we are embodied beings, and, whilst not suggesting a return to Cartesian duality, do ponder upon the question of the place of the body in philosophies of the mind. This is borne out by the following comment where it is proposed that:
"In moving away from the early medicalized situating of psychoanalysis into a theory of mind and clinical practice, the mind has taken supremacy. In the interpersonal, intrapsychic play of our lives, the mind has taken not just the lead role but all the supporting cast leaving the body as a kind of prompt when the lead actors lose their lines." (Orbach 2003: 6)

Deep ontological questions are raised by Harre (1991: 18-19) when he asks “are human bodies just things?” Pile (1996: 184-185), too reflects on the question of whether human bodies are just things when he states that “the body is never merely a passive surface, a leaky container of visceral fluids, a collection of orifices, limbs, feelings, organs, and so on.” in his exploration of the ‘psychoanalysis of space’ and the body, determines that the body is one place or site “for the intensifying articulation of power, desire and disgust, of the individual, the social and the spatial” and that the body “is open to multiple writings and readings.”

Biggs (1993: 36) proposes that the body is “a means of assessing identity” and, as such, is political by being instrumental in “constructing idealized images that contribute to the physical and social world order,” it can as well “disadvantage people who do not conform to the ideal image either by appearance or disability.” Harre (1991: 12) agrees that the body is the necessary, but material, site of personhood, and as such “appears as a nexus of a complicated web of social obligations and interpersonal meanings from which each and every one of us draws the significance we assign to our bodies and their parts.”

Issues are raised about embodiment when disease strikes and how people may experience bodily malfunctions:
“One and the same person has to present themselves in action and talk as one who subscribes to, and indeed actually embodies, the local social norms of health in what they do, while at the same time they must be seen to live within the constraints set by their physical defect.”

(Harre 1991: 179)

Here there is a tension identified where a person might attempt to live “the local social norms of health” whilst at the same time trying to tussle with the constraints set by a physical disability. The following describes a personal experience (Jackson 1990) of a physical and emotional collapse:

“My bodily crack-up provoked me to take on a critical reassessment of my traditional bodily relations and masculine identity. My body reasserted its claims for a fuller representation in my existence by disrupting the illusion of my coherent, unified, rational intellect and shredding it into small fragments.” (cited by Hearn 1995: 105)

Platzer (1987: 126) raises issues about the occurrence of this, and terms it “depersonalisation”, when “someone no longer feels as though they are themselves” and regards their body as a foreign object. Thus, from this, the body cannot be regarded as just “a thing” a passive object, leaky container an array of limbs, organs etc., but a place as, Harre (1991) suggests, of personhood with multiple meanings and characteristics attached both to it, and the space it occupies, producing ever more meanings and characteristics as it experiences changes. Next to look at some of the potential impacts of a physical trauma.

The impact

One of the first impacts of a physical trauma, aside from the actual event itself, may mean that the patient has to face going into hospital which can be a harrowing experience (Heatherington 1964):
"When the patient goes into hospital for the first time he has to make a sudden adjustment to a new kind of life. He has to fit in with a new timetable involving a modified sleeping schedule, he may have to adjust to a strange diet, and he has to get used to sharing a dormitory with complete strangers. He may see strange and frightening apparatus being wheeled about on trolleys; he may experience real pain or discomfort for the first time in his life. He may also meet death or disfigurement at close quarters for the first time. He may have to submit to the authority of nurses, some young enough to be his daughters, and will have to submit to the dictates of doctors, many of whom may be his own age or younger. The patient may not know all that is expected of him in the hospital ward."

(cited by Nichols 1993: 69)

Although written by Heatherington in 1964, perhaps much of this applies today, where hospital admission can be experienced as traumatic in the sense that your familiar world is severely disrupted and replaced by a new and strange world.

Together with this complete disruption to a person’s world there is the ordeal of the whole thing; the event that precipitated hospitalisation and the actuality of hospitalisation itself. It is also acknowledged that at a time like this the ability to absorb information may be severely affected causing yet more distress:

"People who are dazed and frightened with the impact of unexpected entry into hospital, people who are very tense and inhibited during a consultation, people shaken by the disappointment of a medical failure … other factors may also influence a person’s capacity to take in information … the illness itself may cause deficits, for example there is intellectual deterioration accompanying uraemia, and injuries to the head will often produce confusion and amnesia … certain drugs take the edge of people’s intellectual abilities."

(Nichols 1993: 70-71)

As well as the having to cope with going into hospital and taking in information, Pellegrino (1982: 158), writes that illness in any shape or form upsets lifestyle and “the ill person becomes .. - a patient - a person bearing a burden of distress, pain, or anxiety; a person set apart; a person wounded in specific ways.” Rybarczyk et al (1992: 127-128), hold that chronic illness is unlike acute illness in that it requires continual psychological changes as the illness progresses and “the patient must cope
with a litany of stressors including disability, pain, a changing body image, loss of independence, social stigma, and uncertainty about the future.”

Butler et al (1995 : 44) document that “depression is the most common emotional disorder of late life...(and can) interfere with the patient’s happiness and sense of well-being, complicate the treatment of coexisting medical conditions, and increase the risk of death by suicide.” So, the impact of a physical trauma may well compound the presence of depression and will mean that a person will also have to face certain issues of loss, and its reactive process of grief (Lichtenberg and MacNeill 2000). Grief is usually associated with the reaction of loss, of the loss of someone close through death, but as Archer (1999 : 1), identifies “a broadly similar reaction can occur when a close relationship is ended through separation, or when a person is forced to give up some aspect of life that was important.” Jongbloed (1994) and Parkes (1986) also associate grief as the reaction to a sense of loss of, or damage to, the self. Next issues about what is the “self”; what is the nature of “being”; are introduced as some theories as to what constitutes us as a person; what shapes our values and beliefs may be helpful in understanding the impact that a bodily physical trauma has upon the person.

The “self”

Platzer (1987 : 126) refers to the onset of a process of depersonalisation where the person “no longer feels as though they are themselves”; a process which can be triggered by a change in body image. Grzesiak (1994) asserts, that following survival
from a physical injury or illness a person is different than before their ordeal; a change has taken place to their “self”.

Ontological theories about what is the nature of the “self” have been deliberated upon by philosophers since the time of Aristotle. Essentially, ontological issues are to do with the nature of what it is “to be”; what it is to be a “person”; what is the nature of “self”. Various attempts have been made throughout the ages to describe what makes; what constitutes an “individual”, a “person” or a “self”. Shotter (1984: ix intro.) refers to these investigations as attempts to “research into what it is to be a human being, (a) research into our “whatness”.” Samuels (1993: 4) writes that the history of philosophy has its basis in the development and structure of the human being “who enters the world as an object amongst other objects” and who then becomes a knowing subject, who is later on dominated by the language and social relations.”

Chessick (1993: 255-256) cites the ideas of Heidegger who took issue with the notion of subjectivity and argued that “a human is not a subject or essence that can be isolated and studied like an object under a microscope, but is always in activity” Heidegger introduced his concept of Dasein in attempting to answer the question “what is specific and unique about the being of humans?”. Dasein has characteristics – it has possible ways to be which Heidegger referred to as Existentials: which are

“(1) “The essence of Dasein lies in its existence” – humans cannot avoid their encounter with the world, whereas objects can because they can simply reside in space alongside each other. Cultural practices determine meanings and values, and the background that we are born into shapes our thoughts and beliefs; (2) “At-homeness” – we always dwell somewhere specifically in the world; (3) “Concern” – humans are always absorbed in something that matters to them; (4) “Worldhood” – to all of us a world around us appears always.”

(Chessick 1993: 256)
Although Heidegger does not specifically refer to bodily being indirectly, he seems to take account of embodiment by his concept that a human always dwells somewhere; is always in activity and is always absorbed in something that matters to them. According to Krueger (1990: 255) “the body and its evolving mental representations are the foundation of a sense of self.” Shontz (1990: 160) in his discussion on body image and physical disability holds that “when body image is disturbed, the Self is disturbed...when the Self is disturbed, the body image suffers to some extent as well.”

Pellegrino (1982: 159) makes reference to this disturbance of body image and the consequent disturbance to the self when he writes about the limitations of the ageing body. This is where the ontological crisis of physical illness, confronts us with the loss of many freedoms; “the freedoms we ordinarily associate with being able to act as a fully human person.” Biggs (1993: 38) adds more weight to the notion that any project of self must include consideration of the body when he writes that the limitation of the body “is not simply a matter of the ‘body letting us down’ in a mechanical sense”, but “self-presentation and self-expression” are radically affected too. Accordingly, bodily being and any concepts or projects of self are inextricably interdependent of each other. Kestenbaum (1982) suggests that when the body lets us down the resultant conflict between aims to preserve existing achievement and the engagement in the creation of new meaning can be a trigger factor for psychological distress. Psychological and emotional distress are issues that concern the practice of counselling/psychotherapy which is briefly reviewed as follows.
Counselling/psychotherapy

Both Langer (1994) and Lantican (1994), contend, as identified above, that when an individual acquires a physical impairment to their function they can experience a disruption in their self-concept and their body image and can be at risk of developing emotional and psychological problems. Counselling/psychotherapy is a treatment that may benefit some people in these circumstances, therefore a definition from the viewpoint of an older person who was in therapy may be helpful at this point:

“I think our relationship helped me to somewhat identify my identity and perhaps has caused me to see it in more reality. I don’t know if it has changed of late, or if I have seen it in a different light. I believe one is responsible for one’s own life, but a word here and a thought there can make a difference that one is unaware of at the time. I can’t say how you have influenced me, but it must have been good because I look forward to seeing you – and still do. I have muddled through my life more or less on instinct and hope I still can but it is a comfort to know you are there in case my instinct fails... I seem to be quite a different person than I was – and my desire is to be the best I can of whatever I am and believe you may be able to help me along that line. I dislike the way so many people get old and I hope you can help me to do a better job of it.”

(Morgan 2001 : 80)

Morgan (2001) felt that this was a very good summary of what therapy can be, regardless of the age of the person. In a review of the variety of therapies employed to treat people using mental health services it is identified that, in particular, older people, and also people of any age with a chronic illness or a physical disability are under-represented with regard to receiving psychological therapies (Burwood et al 1999, Parry and Richardson 1996, Pelligrino 1982). Easton (1995 : 18) states that the provision of psychological therapies for people over the age of 65 continues to be inadequate and according to him the major factor for this inadequacy “is that many
health professionals continue to believe that the elderly cannot benefit from psychological therapy."

Reynolds (1997) records that a number of studies have revealed that there is a high prevalence of depression among individuals who are medically hospitalised. According to Rybarczyk (1992), there is a growing feeling among health care professionals that psychological therapies should be accessible and provided as part of the holistic care of chronically ill patients. Parry et al (1996 : 8) urge that “the psychotherapeutic needs of the physically ill should be taken into account.” Yet, continues Rybarczyk (1992) only a few people have proposed specific therapeutic ways in which it is possible to work with this unique population and, that even when primary care providers are prepared to refer older patients they will more than likely experience difficulty in finding a suitable resource. Lasoski (1986 cited by Stanley and Averill 1999 : 516-517) suggests that this can be linked to many factors including a lack of interest in this area of work due to:

“...despite evidence to the contrary there has been a tendency to believe that older adults are “set in their ways” and resistant to change. Elderly clients may trigger clinicians’ own concerns about aging ... working with the elderly has not been considered glamorous work, and therapists may be concerned about their own perceived low professional status if they specialize in this population.”

(Stanley and Averill 1999 : 516-517)

It was issues such as this that have led to this doctorate being written, and from the researcher’s own experience in this field. Having worked within the NHS for 20 years as a registered general nurse in care of older people, then as a ward
sister/manager in the same field but in rehabilitation the researcher has prior knowledge of some issues that will be raised in this paper, and this prior knowledge has implications for choice of methodology which is discussed later. During this period there was a growing awareness by staff of the evident distress experienced by some patients and their relatives, and also of the less obvious emotional responses such as despair that some people silently suffered.

From this the researcher was given the opportunity to set up a counselling/psychotherapy service for older people who were either inpatients or outpatients of rehabilitation services which has now been operational for about 10 years. However, from the researcher’s own knowledge these services seem to be few and far between for older people who experience a change in physical function due to illness/injury and find themselves within a medical/rehabilitation setting from where they are discharged either back home or to alternative accommodation.

There is the urge to carry out more research into the feelings of older people, their fears, their needs and their worries including the role that emotional factors can play in the rehabilitation process, noting such things such as, if depression is overlooked or treated routinely and counselling/psychotherapy is not available or offered important issues for care planning may be missed altogether (Bracey 1996, Eweka 1994, McLeod 1993, Parry and Richardson 1996, Sadavoy 1994).

In conclusion, then, the pertinent features of the research question have been introduced. Beginning with the concept of ageing and old age where O’Leary (1996) considers the principal dimensions of ageing to be chronological and biological.
Under this umbrella she proposes that the other principal factors that need consideration during the ageing process are sexual, psychological, social and spiritual.

Laslett (1989) writes about old age in terms of the fear it presents through many issues of loss, including the fear of loss of falling status, physical decline, loss of mobility, etc. and all the things that accompany these losses. Comfort (1989), sees old age as a social construct with mainly negative labelling and stereotyping. Pincus (1981) highlights some celebrities who idealise a more positive view of old age.

Kestenbaum (1982), although not specifically talking about old age, reflects on the phenomenon of illness in that it is not simply a matter of one’s physical condition but should be taken account of in the wider sense of our being, that is ontologically, where it affects our very image of ourselves – our being. The specific ways in which people are physically wounded are variously defined but, whatever form they take, they will inevitably involve the removal, alteration or failure of any body part, internally or externally (Weller 1989). Thus carrying many implications about how our self image is affected when we are physically injured.

Then ontological questions are raised about the place of the body where, for instance, Pile (1996), reflects on the question of whether human bodies are just things when he states that “the body is never merely a passive surface, a leaky container of visceral fluids, a collection of orifices, limbs, feelings, organs, and so on.” Pile (1996: 184-185) in his exploration of the ‘psychoanalysis of space’ and the body, determines that the body is one place or site “for the intensifying articulation of power, desire and disgust, of the individual, the social and the spatial”. He further suggests that the body “is open to multiple writings and readings”.”
Multiple writings and readings may be what Biggs (1993) refers when he proposes that the body is a means of assessing identity. Both Harre (1991) and Lawler (1991) hold that we are embodied beings, and “that the body is the necessary, but material site of personhood.” However, Orbach (2003) argues that “in the interpersonal, intrapsychic play of our lives, the mind has taken not just the lead role but all the supporting cast.”

Mayou (1997: 24) writes that with illness “severity is not an objective concept; it must be considered in the light of the meaning to the patient.” One of the meanings is that admission to hospital must be faced where a sudden adjustment has to be made to a new kind of life. Then there is the meaning that illness in any shape or form brings distress, pain or anxiety and can, on becoming a chronic illness, mean that the person must also cope with a changing body image, the loss of independence, social stigma and face an uncertain future (Pellegrino 1982, Rybarczyk et al 1992).

These psychological and emotional issues are a response to many losses, for example, one’s freedom to live in the way that one did live prior to the injury or illness. This is where possibly grief and mourning may be experienced, and although grief is more usually associated with the loss of someone close through death a broadly similar reaction can occur when a person is forced to give up some aspect of life that was important (Archer 1999).

It is also identified that losses suffered in the aftermath of any physical debilitating injury or illness, as well as meaning a loss of ability or physical function, can relate to
a sense of a loss of, or damage to, the “self” (Jongbloed 1994, Parkes 1986). In this light the terms “loss” and “damage” equate to the fact that following their survival from an ordeal a person is different than before they had their illness or injury; a change has taken place to their “self” (Grzesiak 1994). Some ontological theories were then introduced as to the nature of our “whatness”; the nature of our “self” and how any notions of self are interdependent upon bodily being.

Finally, even though it is identified that there is a link between bereavement, separation and loss that can manifest itself with reactions of stress it is felt that the occurrence of depression in ordinary medical care and for older inpatients is underestimated and, even if detected, frequently untreated (Archer 1991, Mayou 1997, Walker and Katona 1997).

A report by the NHS Psychotherapy Services published in 1996, where in a review of the variety of therapies employed to treat people using mental health services highlighted that in particular older people with chronic illness and physical disabilities are under-represented with regard to receiving psychological therapies (Parry and Richardson 1996). There is a growing feeling among health care professionals that psychological therapies should be accessible and provided as part of the holistic care of the chronically and physically ill patients (Parry et al 1996, Rybarczyk 1992).

Having introduced and defined the research question in theoretical terms Chapter two explores, expands upon, and discusses in greater depth these salient issues which will help to inform the findings of the study. Chapter three contains a review of literature relevant to the research question. Chapter four details the search for a suitable
method to carry out the research and then rationalises the approach chosen. Chapter five presents the data, the ensuing analysis and then the findings. Finally Chapter six presents the conclusions and implications of the study.
Chapter 2: Theoretical Issues

The theoretical issues introduced in Chapter one drawn from the research question, “what may be the nature of the need, if any, for counselling/psychotherapy for older people who suffer a debilitating physical illness or injury?”, are now discussed in further detail. The rationale for discussing these salient theoretical issues at this point in the study is given later in the methodology chapter.

Firstly there is a discussion about the ageing process and old age looking at the concepts of ageing, including some stereotypical views and images. Next, theories about the body are considered, as physical illnesses and injuries are, by their very nature, bodily events, and as Harre (1991) and Lawler (1991) state we are embodied beings. Then, the chapter moves on to a discussion on the various concepts of the “self” as both Jongbloed (1994) and (Parkes (1986) propose that losses suffered in the aftermath of any physical debilitating injury or illness, as well as meaning a loss of ability or physical function, can also relate to a sense of a loss of, or damage to, the “self”.

Finally, the impact of physical illness/injury is examined in terms of the psychological and emotional reactions to issues of loss and damage. Katona (1994 : 46) identifies that physical illness is “a major factor both in precipitating and in maintaining depression in old age” and it is clear that depression in old age is common, under detected, under treated and disabling and the onset of physical illness at this age is pinpointed as a prime trigger for the onset of depression.
The ageing process and old age

O'Leary (1996) considers the principal dimensions of old age to be chronological, biological, sexual, psychological, social and spiritual. She further contends that it is essential to view these dimensions of ageing in a holistic fashion in that the status of each dimension is interdependent on all the others. Ageing is part of life and, in chronological terms within Western society a person becomes defined as an "older adult" or an "elderly person" at the age of 65 years (Christ and Hohloch 1988, Stuart-Hamilton 1994, Terry 1997).

O'Leary (1996) identifies that this period of one's life can span 30 years or more. Howie (1991) questions if there are generation differences within that age range as, for instance, there would be of people between the age of 25 years, and 60 years, and highlights that nowhere else in the life-span does a single stage so inadequately fit all those within it. Also it is the case that admission into a surgical unit at age 65 years or over means one is referred to as a surgical patient, if, however one is admitted to an elderly care unit (or as is still sometimes heard, a geriatric unit), where the age range could be 65 years to over 100 years one is referred to as an "elderly" patient (Howie 1991, Resnick 1998).

From a biological viewpoint, Weller (1989 : 25) gives the following intrinsic definition of ageing: "the structural changes that take place in time that are not caused by accident or disease". The following four criteria proposed by Strehler (1990), have been widely accepted as a descriptive biological perspective of ageing:
1. Ageing is *universal*, in that it occurs in all members of the population (unlike disease).
2. Ageing is *progressive*, a continuous process.
3. Ageing is *intrinsic* to the organism.
4. Ageing is *degenerative* (as opposed to developmental or ‘maturational’ changes). (cited by Bond 1990 :19-20)

In attempting to define the ageing process, Stevens (1990 : 225) contends that much literature on the psychology of being older “has the pessimistic ring of Jacques’ description in As You Like It (Act II, Scene vii):

Last scene of all,
That ends this strange eventful history,
Is second childishness, and mere oblivion,
Sans teeth, sans eyes, sans taste, sans everything

Machin (1992 : 83) writes that old age may be accompanied by a decline in physical and/or mental health with perhaps transient illnesses and the possible onset of chronic conditions. With these changes there “may be many adjustments to changed body image and physical functioning.”

Briggs (1990, cited by Bond 1990 : 61) records that although somewhat minor consequences of ageing are practically inescapable, such as impairment of hearing and vision, wrinkling of the skin and greying of the hair, not all is gloom in that, “although 20 percent of the population over 80 suffer from mental impairment, this means that 80 per cent do not.” Indeed, Coleman (1990, cited by Bond 1990 : 70) writes that “many studies have stressed the strengths that remain in elderly people’s memory and learning and memory ability.”

However, it is identified that when an individual acquires a physical impairment to their function they can experience with its onset, a disruption in their self-concept and their body image and because of this, it is identified, that they can be at risk of
developing depression or, at the very least, emotional upsets (Langer 1994, Lantican 1994, Loong et al 1995).

“Older adults...are likely to suffer from a complexity of physical weaknesses, limitations, and diseases that challenge lifelong capacities and overall self-reliance. Particularly in a culture that prizes independence and self-control far more than cooperation and responsible group membership, old age’s deteriorations - whether normative or disease-related - threaten the balance between controlling and being controlled that lies at the core of a lifelong sense of self.” (Kivnick and Kavka 1999: 119)

Featherstone and Wernick (1995: 1) refer to the fact that as we go through life we, more often than not, “become accredited persons who are accorded adult status” but they suggest that in later life there is the threat of the “loss of this status through the bodily decline we usually, often confusingly, refer to as aging.” They feel that this emphasis on the symptoms of bodily decline including the collection of empirical data such as state of health, weight, diet and so on in later life has resulted in gerontology and the sociology of aging being “data rich and theory poor.” This perspective is reflected in the words of a farmer’s wife quoted by Blythe (1979, cited by Machin 1992: 81) where “‘old age was once a privilege but it has now become a condition’.”

Hockey et al (1995), discuss how the ageing body can, in some societies send out meanings and messages about a person’s social status. Hazan (1980, cited by Hockey and James 1995: 144) says that “elderly people are denied personhood through effectively obliterating their life history and social identity, and reducing them to their physical and mental disabilities.” Often the physical needs of the body can end up by being the defining factor of the social identity of an older person as follows:

“Images of aging represent bodies which become increasingly fixed and inflexible as they move towards the end of the life course in terms of the range of cultural messages they are allowed to depict. ... for those who
are in deep old age, who are weak, frail or disabled, the body is not only a masking device which conceals and distorts the self which others interact with, in addition the lack of mobility and functioning capacity may make the body seem like a prison.” (Featherstone and Wernick 1995: 11)

In Western society Hockey and James (1995: 141) argue that “appearance has now come to signify “the self” and “an old, fat or disfigured body implies an undesirable self and a correspondingly reduced social status.” Biggs (1993: 36-37) in writing about older people contends that they “may become categorized, assessed or disenfranchised simply because of their bodily appearance. He proposes that there are

“Two special factors that affect personal expression and understanding in ways more pressing that at earlier periods: (i) the body becomes less able; and (ii) time begins to run out.” (Biggs 1993: 35)

Biggs (1993: 36) contends that our body is used “as a tool to effect the environment” and “one has’ rather than ‘is’ one’s body.” This becomes a more poignant supposition when something goes awry with one’s body, for instance, if it becomes less able. This is when Dittman-Kohli (1990, cited by Biggs 1993: 36) suggest that “the boundaries of possibility become increasingly circumscribed as ‘the world within reach’ diminishes and with it external sources of reward and satisfaction.”

Machin (1992: 82) writes that it is in this area, when the body becomes less able that there can be an ambivalent attitude towards old age where society is often passive in promoting the integrity of the ageing experience because “the policy of care, often remains located in meeting physiological needs and, makes no progress in the less visible areas of psychological and spiritual need.”
Where, for the most part it is assumed that because the body is old there is an expectation on the part of society that this must produce behaviour as an old self the “William” stories by Richmal Crompton cast aside some of the negative stereotypical views of what is an old self. Hepworth (1996) in his article on the “William” stories draws out vivid examples of the writer’s capacity to engender positive images of old age which is based on her stories about a young boy called William and his encounters with older people.

Hepworth, (1996 : 423-441) writes that Crompton manages to create a rapport between boyhood and old age where a conspiracy is developed “against the sentimental attitude of the mature adult towards both older women (and men) and children.” Hepworth describes this as “the public triumph of private self consciousness over prescriptive social categorisation.” The concept of “prescriptive social categorisation” applies to the notion of “ageing” and ageism.

Ageism is about the powerful perceptions and leading stereotypes that pervade society and so inform views that are held about old age (O’Leary 1996) and these views can and do vary from society to society. Within Western society Scrutton (1989) details some unhelpful myths about old age drawn from Dixon and Gregory (1987, cited by O’Leary 1996 : 37) which serve to lessen and weaken the social status of older people and support ageist attitudes:

- the myth of chronology – that elderly people are a homogeneous group by virtue of their age alone, i.e. once a person’s age reaches an arbitrary number of years they automatically become old and part of the group ‘the elderly’;
the myth of ill health – that old age automatically involves physical deterioration and that illness in old age is part of normal ageing, not the result of disease processes;

the myth of mental deterioration – that elderly people automatically lose their mental faculties, slow down and become ‘senile’;

the myth of inflexible personality – that personality changes with age to become more intolerant, inflexible and conservative;

the myth of misery – that elderly people are unhappy because they are old;

the myth of rejection and isolation – that society rejects its elderly people and is uncaring towards them, and that elderly people accepting this prefer to ‘disengage’ from life;

the myth of unproductivity and dependence – that elderly people are not productive members of society because they are not engaged in paid employment and are inevitably dependent upon others.

There are also positive myths about old age which can be as equally damaging as these negative myths, for instance the myth that old age is a time of peace and tranquillity. This ‘myth of the golden years’, according to Shura (1974, cited by O’Leary 1996: 38) “overlooks the reality that old age is a time of substantial stresses, especially those related to poverty, illness and isolation.”

These myths and observations illustrate how ageism is present within the fabric of our society and can be socially constructed. Ageism means that some of the population hold a certain image or conception about the ageing process and older people and quick classifications are made which are prejudicial and stereotypical (Butler 1975).

“Ageism allows those of us who are younger to see old people as ‘different’. We subtly cease to identify with them as human beings, which enables us to feel more comfortable about our neglect and dislike of them...Ageism is a thinly disguise attempt to avoid the personal reality of human ageing and death.”

(cited by Orbach 1996: 6)
People can also hold personal prejudices about the elderly such as:

"I know a 60-year-old Englishwoman who has just married a 45-year-old man. My reaction was: He needs a mother; God only knows what she wants. I would not have given the matter a thought had the woman been 45, the man 60." (Puner 1974 : 16)

Another anecdote tells how preconceptions are rife and potentially damaging:

"A 76-year-old man was brought into hospital ... completely disorientated. After a while ... he appeared rational. But he kept insisting that now he was ready to go home, his mother would drive over to pick him up. The doctors decided to keep him in hospital a few weeks longer, to see if his mental state would improve. One day his mother of 95 did drive over from a town a hundred miles away accompanied by her 97 year old sister, to take their little boy home." (Puner 1974 : 116).

From such notions as these Comfort (1989 : 25) says that “you are ‘created’ old by society ... but this honour is negative” he concedes, explaining this in terms of people, who are deemed to be elderly by society, can be “prescribed to be unintelligent, unemployable, crazy and asexual” when they enter this age. Hepworth (1996 : 423-441) identifies the inclination in Western culture to infantilisation practices towards older people, that is to treat them as if they are dependent children.

This is indicated by this description of how the needs of the physical body can be used by carers to define the social body of the older person (Hockey 1990):

"The frail residents of a residential home – seen as impaired in body and mind – were socially distinguished from fitter residents through different kinds of naming practices. Those who became incontinent, unable to walk without support, or perceptibly ‘confused’ in their minds’ will find themselves moved downstairs to what staff refer to as the ‘frail’ corridor.” (cited by Hockey and James 1995 : 141)

There is the sense of how this view of a person from the outside is a very negative view:
There may come a time when other people say, ‘poor so-and-so, she isn’t herself any more’...one may be tempted to agree but that would be to stick to a narrow definition of self.” (Orbach 1996 : 27)

Even if dementia is present we need to respect the sufferer equally for what they once were, what they still are and, what they may become:

“The old lady in the geriatric ward, who droops in her chair, pulls faces mutters to herself and wets her knickers, has very likely forgotten who she is, but that does not mean that she is not.” (Orbach 1996 : 27)

Although written sometime ago Norman (1987 : 4) raises points that perhaps are still salient now and apply to the perpetuation of negative stereotyping of the aged. She notes that terms such as “senile” are openly derogatory and holds that “still worse is the common use of ‘geriatric’ as a noun to describe a frail old person” instead of its correct use which is as a branch of medicine concerned with older people and their illnesses. She compounds this incorrect use of the word by stating that “we do not call a woman who has just had a hysterectomy ‘an obstetric’ or a sick child ‘a paediatric’. She further points out that this type of term and newer terms such as “wrinkly” associated with ageing, as they become part of the language go towards constructing negative meanings to the ageing process. This, she adds, also works in the other direction in that the social construction or image of “being old” gets inside the individual and this is how they then see themselves. For example:

“Call a man old ... often enough and he becomes old ... he may even, because it is expected of him, give in to weakness he never felt before and assume the shuffling gait of an old man.” (Puner 1974 : 38)

According to Aiken (1989, cited by Stuart-Hamilton 1994) as we grow older self-image and stereotypical views of old age are self-reinforcing and can be detrimental to health by causing a decline in our self-image. This implies that many older people are inclined to be inward-looking and, thus conclude that all older people are like
themselves inducing a personal lowering of self-worth and regard. O’Leary (1996: 19) cites a study by Spitz (1988), where it was found that “if human beings did not get significant recognition from others their spines literally shrivelled and they became increasingly withdrawn from relationships.” This is an example of the interdependency of each dimension, in that if, in old age, we become invisible to others (Machin 1992) by being marginalized within society due to the lessening of contact and recognition by others this can have a physical/emotional effect.

The implications is that human beings, regardless of age, need (an)other or others to help maintain the principal dimensions of ontological existence, as in chronological, biological, sexual, psychological, social or spiritual modes of being. The above illustrates how the impact of an event in one dimension; the social dimension, can have a domino effect on the other dimensions; the physical and the mental.

In conclusion then the concept of ageing is chronological, biological and socially constructed with a tendency to foster prejudices and attitudes, often negative. It could be held that these attitudes foster negative feelings about ageing for the individual where real fear and anxieties such as “the fear of loss of beauty, attractiveness … the fear of falling status, public status and private status” may be made harder to bear. (Laslett 1989: 14)

If one survives a major event there will, in all probability, be some permanent changes to one’s body, (Bernstein 1990, Shontz 1990) and there are many ways in which a person’s body can be different to how it was before they were struck by their physical illness or trauma and it is these aspects of bodily being that are explored next.
The body

Nietzsche proposes that:

"Philosophy has succeeded, not without a struggle, in freeing itself from its obsession with the soul, only to find itself landed with something more mysterious and captivating: the fact of Man's bodiliness." (cited by Harre 1991 :11)

Long (1970, cited by Lawler 1991 : 56) writes that "we are human to the extent that we have a physical appearance like that of other humans...to be a human person is also to have a living bod.". We are embodied beings state Harre (1991), and Lawler (1991), and there are those who, whilst not suggesting a return to Cartesian duality, do ponder upon the question of what is the body, and where is the place of the body in philosophies of the mind.

Burwood et al (1999) and Pelligrino (1982) also question the place of the body in the matter of subjectivity where it seems the mind holds centre stage and the body can be a neglected entity. According to Burwood et al (1999), traditionally much philosophical theory is focused onto the mind and as such, scant attention has been paid as to what is the place of the body in subjectivity and this, they write, stems from Aristotle through to Descartes where the supposition was that the mental is fundamentally distinct in nature from the physical.

Harre (1991 : 18-19) raises ontological issues when he poses the question: "'are human bodies just things'." Burwood et al (1999 : 8) suggest that many philosophers "write as if it is obvious what the human body is" even though there is continual puzzlement over the nature of the mind. Yet, Campbell (1964 : 374) writes "it is common ground that selves, as we know them in experience, in some sense have (or
perhaps are) bodies as well as minds. Turner (1984) offers the following definition of the body:

"The body, as a unique material entity, plays an indispensable role in the two ways in which human beings have a sense of identity. Our sense of ourselves as particular individuals is based in part on our sense of the continuous spatio-temporal trajectories of our bodies through which we are located in the material world. But our social identities, the kind of persons we take ourselves and others to be from time to time, are also closely bound up with the kinds of body we believe we have."

(cited by Harre 1991: 14)

Turner holds that in the former meaning of this definition of embodiment we experience our corporality as personally ruled, whilst in the latter meaning we experience it to be largely socially ruled.

Harre (1991: 19) writes of ‘metaphysical ownership’ to describe the relationship between a person and his or her body. Because one actually owns a body, lives in it and experiences it all at the same time one’s body is not just another ‘thing’; “amongst the conditions for being the very person I am is the fact that I am embodied in just this body.” The body in this sense gives us an image, an internal self portrait, in other words we have a body image which Pruzinsky et al (1990: 337-338) describe as where “we have many percepts, thoughts, and feelings about our body – its overall appearance, specific features or parts, age, ethnicity, strength, body functions, sexuality, etc.”

Merleau-Ponty (cited by Warnock 1992: 83) considers that "connection of the world with ourselves through our bodies is what gives meaning to the world". The “meaning”, or, the “significance” of the world “enters through our body because it is with our bodies, our hands or our limbs or our tools, that we will intervene in the
Warnock proposes that Merleau-Ponty’s idea is that consciousness exists in each individual’s body and, therefore, consciousness is not exclusive because it is tempered with each individual’s own preconceptions, fears and desires. As Harre (1991 : 3) declares “we must come to see our bodies, their states, functions and uses, as complex clusters of cultural constructions.”

As already stated, there do seem to be two contexts in which embodiment can be said to be; that is in corporeal terms and in social terms. In corporeal terms Campbell (1970) offers the following definition:

“Provided you know who you are, it is easy to say what your body is: it is what the undertakers bury when they bury you. It is your head, trunk, and limbs. It is the collection of cells consisting of your skin and all the cells inside it. It is the assemblage of flesh, bones, and organs which the anatomist anatomizes. It is the mass of matter whose weight is your weight.” (cited by Burwood et al 1999 : 8)

This implies that the body is an animated corpse “an assemblage of flesh, bones and organs”; merely an object consisting of anatomical parts (Burwood et al 1999 : 8-9).

In more social terms, an explanation by Sartre (1960, cited in Lawler 1991 : 57) is that “the body is both a being-for-itself (a thing) and a being-for-others (an instrument of and for social interaction).” These notions are further elaborated upon by stating that the body, particularly in illness, cannot be simply seen in purely abstract and philosophical terms but that it “also has personal (interpersonal and intrapersonal), social, sexual, biological, historical and existential dimensions among others.” (Lawler 1991 : 59).
Lawler discusses how the body and social life interact. She takes account of physical differences and writes that Kern (1975, cited by Lawler 1991:71) proposes that the body is central in determining the advent of our social life. An example Kern gives of this is that “a beautiful woman generally leads a vastly different life from a plain one.” In this context, Kern (1975), Lawler (1991) and Harre (1991) all express how there can be vast differences in how social life can be experienced according to one’s particular physical form. For example, they discuss such issues as gender, height and size, and how some aspects of physical appearance cannot be changed but how some can be altered such as hair colour and body shape to some extent. For example Kupfermann (1979) writes:

“In my teens, as an aspiring starlet and model, I was initiated into the sacred world of the ‘beauty-culture’, and I observed my body almost objectively in a detached fashion, as it was moulded into an object of glamour. I was daily pummelled, pushed, tonged and tweezed, and certainly by today’s liberated standards I was a sex-object, a dolly, who, passive, allowed herself to be primed and painted like a blank canvas every day by a team of technicians. At this point my only ‘body awareness’ was of my body’s boundary; of shape and line, of light and shade; of creating magical auras with hair and gloss ....” (cited by Lawler 1991: 94)

Kupfermann describes how she observed her own body in an almost objective and detached way as it was moulded into an object of glamour. This process also takes place in illness where the body becomes an object to be examined and treated (Gadow 1982, Lawler 1991). Lawler in her book writes about the problem of the body within nursing. She discusses, amongst other things, the body in illness and how nurses manage care both for themselves and their patients in what can be only described as sometimes harrowing situations. Here is part of an interview she conducted with a nurse which reflects this:
I. I guess I’m thinking ‘what a terrible mess’, ‘what a disfigurement’, or ‘what a terrible position to be in’ – for the person to have to have this done ... - faecal fistulas, radiation-type situations which can be terrible. That’s the sort of thing which I think ‘how awful to land up like this. Wouldn’t it be awful to be this person’

R. So you would identify with the person?

I. I think that’s what I do ... I think that’s how I cope. I think I do do that ... Sometimes it’s mixed with anger if I think it’s been somebody’s fault, neglect, or –

R. Botched?

I. Botched, yes. And I get a strong angry feeling, which I try and hide. Nothing can be done (surgically or medically to repair the damage). It’s too late.

R. Do you hide your own emotions when you have to do things which are truly dreadful?

I. Yes, I think I do. When they’re physical things like that. ...Yes, I do hold myself very much in check with physical things ... I fully subscribe to the fact that you hide the horribleness of it from the patient.

(Lawler 1991 : 175-176)

Gadow (1982 : 86), raises these issues with regard to the relationship between the self and the body particularly when illness strikes in that “the body that a patient experiences and that which a practitioner treats are seldom the same.” She continues that this can have a dehumanising effect for both parties in that “for the person in pain, the body may be an excruciating immediacy (and) for the clinician, the same
body may be an object to be examined, or—more abstractly—a problem to be solved.” This raises the issue about how practitioners and patients handle their own emotional confrontation with physical disability.

To return to the relationship between the body and the self the following sets out a dialectic progression including at one point a dualistic stage:

1. Primary immediacy: the lived body
2. Disrupted immediacy: the object body
3. Cultivated immediacy: the harmony of lived body and object body
4. Aesthetic immediacy: the subject body, exemplified in aging and illness. (Gadow 1982: 86)

Gadow describes the first dialectic level between self and body, primary immediacy, as being the stage at which the body is experienced as an aspect of the self and, as such, body and self are unified; there is no distinction between them. Gadow (1982: 88) proposes that at this level there is

“Within the experience of the lived body, two kinds of differentiation: (1) the distinction between affecting and being affected, agency and vulnerability; (2) the differences among the given ways in which the world is both affected and experienced by the lived body.”

At the second level, described as disrupted immediacy, “the agency/vulnerability distinction” becomes an internal distinction. Gadow (1982: 88) holds that it is at this level where

“The immediacy of that primary being-in-the-world is ruptured by incapacity, the experience of being unable to act as desired or to escape being acted upon in ways that are not desired. Immediacy in short, is shattered by constraint. The lived body becomes conscious of ineptness, weakness, pain—phenomena arising from within itself and thus giving rise to the internal distinction between that part (the self) which gives to the phenomenon the meaning “constraint” and that part (the body) which is felt to be the origin or site of the phenomenon experienced as constraint.”
Gadow contends that it is when things go awry and rupture the harmonious unity of self and body that the self then experiences that part of itself, which is the object body (that has gone awry i.e. in illness or injury) as an internalised encumbrance or burden.

The body can go awry in many ways as physical illnesses and injuries will involve the removal, alteration or failure of any body parts, internally or externally (Weller 1989). Christ and Hohloch (1988) write that the differences in a person’s body could be in the loss of part of the body such as a limb, a breast or an eye, or a paralysis and disfigurement of some area of the body such as facial disfigurement following a stoke or shingles. Oedematous limbs (an excess of fluid in the tissues) could be present from a reduction in the performance of the heart, as could an increase in breathlessness due to heart and lung failure.

Some of these physical differences are more readily visible than others such as a missing limb whereas increased breathlessness, or the loss of a breast for instance may not be so apparent. Other physical changes that also are not so visible or apparent initially are, loss of, or difficulty with, speech, sensory losses such as hearing, sight, and taste. People may also now have to contend with catheters to collect urine directly from their bladder, or deal with a stoma, (an opening on the outside of the body) created following bowel or bladder surgery, to allow collection of either urine or faeces into an external bag (Christ and Hohloch 1988).

Cardiovascular related problems, strokes, musclo-skeletal conditions such as arthritis, diabetes and other metabolic disorders, respiratory complaints such as emphysema, and neurological conditions such as Parkinsons Disease can all cause the body to go
awry (Mayou 1997, Frank and Elliott 2000). Physical injuries can also occur as the result of an accident, an attack on the person, or a fall, (which may or may not be related to an underlying physical illness, i.e. fall following a stroke, a fall due to loss of bone density or a fall unrelated to an illness). Alterations in body image are as follows:

"Disease involving a loss of body function, such as stroke, paraplegia, quadriplegia, coronary heart disease, and bowel or bladder incontinence, and diseases involving disfiguring skin lesions or the feeling of 'rotting away' as in cancer or gangrene, can all cause changes in body image. Rape or violent physical assault can disturb the feeling of being secure in one's own body. Changes in body image involving sexual attractiveness or sexual identity, such as surgery or trauma involving the genitals or breasts and tubal ligation, hysterectomy, or vasectomy, can be especially difficult for the patient to deal with. Intrusive therapeutic or diagnostic procedures, such as insertion of a nasogastric tube, bladder catheterization, administration of intravenous fluids, ... can also threaten a patient's body image." (Weller, 1989 : 122)

All of these traumatic events have personal ramifications for the individual, and there is the concern, referred to earlier, about how they and the practitioner working with them, handle such events. Lawler (1991 : 164) in her study on the problem of the body and nursing enquired whether nurses, who have considerable experience in dealing with people's bodies when they are ill, had ever encountered patients who objectify a part of their body that had become diseased "for example by calling their diseased foot the foot, instead of my foot." One nurse responded:

"I didn't take any notice of that ... because they're probably trying to dissociate it from the body aren't they. If they're calling it the instead of mine. They don't want it as theirs, they don't want that part of them."
Gadow (1982), insists that this is when the body, as part of the self, is experienced as a burden or hindrance to some other aspect of the self.

Lynd (1994: 399) writes about body image and how it is, in part, a social phenomenon. With regard to this she discusses the fear of bodily dismemberment and the “desire for integrity of all parts of the body” expressing that “the loss of the sense of integrity of one’s body and of intimacy with it results in a sense of depersonalization, loss of one’s own identity, which is a symptom of mental disease.”

In her writing of body dysmorphic disorder Parker (2003) discusses body dislike as a condition which can be extraordinarily pervasive and damaging to the sufferer. Freud (1923) refers to the ego as being foremost a bodily ego and that:

“the ego ‘may be regarded as a mental project of the surface of the body ultimately deriving from bodily sensations, chiefly those springing from the surface of the body’.” (cited by Parker 2003: 455-456)

In this sense Freud holds that mind and body are inextricably woven together and Parker (2003: 456) writes that this association of mind and body is evidenced by such sensations as the “intensely corporeal experience of shame”. Parker refers to the corporeal (bodily) experience of shame where the body is subjected to ‘something’ that is then imparted to the mind which then takes issue with that ‘something’.

Gadow (1982: 92) gives an example of this where the self can experience the “existential object body” (which is still a part of itself) in the case where one would have to use an arm in order to lift one’s own paralysed leg. Gadow relates this as being an “encounter of the self with the limits of its freedom; the body is not only object but obstacle.” Parker (2003) above, appears to say that when this happens it relates to a distinct association between mind and body, however, Gadow (1982) sees
this as a level of disrupted immediacy where self and body are distinct from, and opposed to, one another; a return to dualism in some sense.

Gadow (1982: 93) writes that the overall negative view of illness and aging is, to some extent, linked to the insistence upon the importance of the object body where "the body is seen as increasingly an obstacle to the self, to the point of appearing no longer passively resistant but actively hostile. Regarding the body in this way, as only object body, we are confined to the alternatives of the body as instrument or oppressor. Therefore, with its increasing "failure" to respond to the self in aging and illness, it is inevitably felt as oppressor. It demeans and humiliates the self, refusing to perform basic functions reliably. It dictates prohibitions and destroys possibilities."

Lawler (1991: 59) draws attention to the fact that it is often only when we encounter a medical dilemma that we are "brought face-to-face with corporeality as part of the human condition". According to Lawler (1991: 58) philosophy in general "reflects a dominant interest in mind as opposed to body ... almost as if the philosophers did not know what to do with the object body."

At the next level, cultivated immediacy, Gadow (1982: 96) holds that although self and body remain distinct from each other a reciprocal enabling process takes place by, for example, the acquisition of new skills to redress limitations that have arisen during the disrupted immediacy level and, this period is referred to as "the process of mastery" of the body by the self.
At the final level, aesthetic immediacy, Gadow (1982 : 92-95) examines the “body as subject in illness and aging” seeing this level as the completion of the dialectic progression which occurs in aging and illness:

“The body in illness and aging insists, not that the aims of the self be surrendered, but that its own reality, complexity, and values be supported. The acceptance of that insistence as valid is the recognition of the subject body. That is, when the body is experienced as subject, it is considered a part of the self with the same intrinsically valid claims as any other part of the self (emotional, intellectual, etc.) The subject body is not the body as substratum and precondition of the self, nor is it sheer material for expression of the self: it is part of the self. It is, in other words, capable of those activities that distinguish a self from an object. It can formulate and enact aims, purposes, value, meaning. Its aims may, of course, seem opaque to other parts of the self, but that is the nature of complex selves. The values of the emotional self are often opaque to the intellect, whereas the projects posed by the intellect may not be immediately accessible to the emotions. ... The subject body is, dialectically, an advance over the object body, because mastery and submission are no longer involved.”

At this final level the body is neither the object body undertaking the plans of the self nor just an instrument in those plans, but becomes subject body capable of formulating plans. Different kinds of subjectivity can hinge upon the expressive possibilities of the body. Therefore, in illness and aging the body establishes itself in the foreground; “the body is in pain, suffers a disability, or malfunction, that no longer makes it the willing instrument of the self” (Pellegrino 1982 : 158).

Finally, Gadow (1982 : 94-95) holds that the body has a dialectic relationship with the self, of which it is a part, and in this sense, the body, is able to express symbols and meanings some of which, Gadow contends, may seem obscure to other aspects of the self. Taking note of “the “unfamiliar language” of the body’s own expressions of symbols of meanings and values, can, suggests Gadow, lead to the regard of these meanings and values “as being as worthy of consideration as the values
communicated by any other part of the self” and “different kinds of subjectivity rest on the expressive possibilities of bodies.

These symbols and meanings expressed by the body to the self are personal and in many ways private but within the medical world the expressions of the body are public. Harre (1991: 3) raises the issue of the acquisition of language in relationship to “the body”; “the body and its parts and functions are looked at in the light of their use both as signifiers, systems of signs and as blank surfaces on which significance is ‘inscribed.’” For example, Rawlinson (1982: 70) in discussing medicine’s discourse contends that:

“Medical discourse seems to take the body as a thing for observation and technological manipulation...(an) object in the world available to the scientific gaze. Medicine reads the text of the body in order to discover something about a particular patient’s history and prognosis.”

Rawlinson (1982: 83) also argues that “insofar as medicine speaks a purely scientific language concerning itself only with observable and measurable physical findings, its discourse is inadequate to its own practice...this language recognizes the body only as a physical object.” Regarding this Langer (1994: 182) proposes that

“Physical losses are not the only ones sustained by a patient who becomes acutely or progressively disabled; the losses involving definitions of self and personhood are often critical to adjustment...Patients who, in medical terms, are in “no acute distress” may yet be suffering. Suffering may result from internal psychic conflicts involving sense of self, self-esteem, altered ability to fulfil expectations, negative perceptions of self or others regarding disability....”

Essentially, then within medical discourse the body is purely a physical object and although the person may not be in “acute distress” the ego, as the mental project of the body, (as referred to by Freud earlier), epitomises the distress of the body. In this
sense then Jongbloed (1994) and Parkes (1986) specify that there is a sense of damage
to, or loss of self experienced in the aftermath of a physical debilitating trauma. It is
further identified that among the immediate effects of any physical debilitating injury
or illness are the issues of loss and adaptation (Brearley and Birchley 1994, Grzesiak
1994). The terms “loss” and “damage” equate to the fact that following their survival
from an ordeal a person is different than before they had their illness or injury; a
change has taken place to their “self” (Grzesiak 1994).

Mayou (1997: 24) considers that with regard to physical traumas “severity is not an
objective concept; it must be considered in the light of the meaning to the patient”.
To consider the meaning to the patient it was felt relevant to examine some notions of
the concept of the “self”. This is because, as previously stated, “the phenomenon of
illness is not simply a matter of one’s physical condition ... it is ontological, affecting
our very image of ourselves – our being – and our circumstance – our world”. A
universal characteristic of most theories of the self is the fact that we are embodied

The “self”

Effectively, ontological issues are to do with the nature of what is it “to be” what it is
to be a “person”, what is the nature of “self” (Friedman 1994). It is said that losses
suffered in the aftermath of any physical debilitating injury or illness as well as
meaning a loss of ability or physical function, can relate to a sense of a loss of, or
damage to, the self (Jongbloed 1994, Parkes 1986). The terms "loss" and "damage"
equate to the fact that following their survival from an ordeal a person is different than
before they had their illness or injury: a change has taken place to their "self" (Grzesiak 1994). In order to look at the implications of these theories around loss and damage to the "self" for the practice of counselling/psychotherapy for older people it is proposed to firstly explore some notions of what is meant by the concept of "self" which also implies what is the nature of "being".

Various attempts have been made throughout the ages to describe what makes; indeed what constitutes an "individual" or a "person" or a "self." Shotter (1984: ix intro) refers to these investigations as attempts to "research into what it is to be a human being, (to) research into our 'whatness'. Young-Eisendrath (1997) in her paper concedes how difficult it is to say anything sound and consistent about the self although she does, however, have a working theory on the topic which is presented later.

Aristotle (384-322 B.C.), the Greek philosopher was one of the first to attempt to define the nature of our "whatness"; what it is to be a human being. Aristotle declared that there are several senses in which a thing may be said to 'be':

"In one sense the 'being' meant is 'what a thing is' or a 'this', and in another sense it means a quality or quantity or one of the other things that are predicated as these are. While 'being' has all these senses, obviously that which 'is' primarily is the 'what', which indicates the substance of the thing." (cited by Shotter 1984:ix intro).

Aristotle made a distinction between the physical and the non-physical aspects of what the substance of a human being is, and “one central concept of non-physical existence was soul”. The actual meaning of this concept “soul” was never exact in early thought being often referred to as “the core of the non-physical or psychic, that part which is essential and unique in mental functioning” (Gergen 1971: 5).
There was much speculation on the nature of the “soul” by Aristotle and his contemporaries, and Aristotle “took the soul to be the structure and functioning of the body itself...the “form” of the living body. Since one cannot have the form without the body which has that form, the soul cannot exist disembodied” (Shaffer 1968: 2). The basic distinction that Aristotle expounded between the physical and the non-physical attributes of human functioning continued to prevail, with Christianity intervening to dictate the most marked distinction between soul and body in that “when the physical body died, its tenant, the soul, “the immortal soul...may dwell in a heavenly or hellish afterlife” (Shaffer 1968: 3). Shaffer adds that “the term most commonly used, in the present day, in place of “soul” is the word “mind”.

Some 2000 years later Descartes further elaborated upon Aristotle’s fundamental theory on the physical and non-physical aspects of human functioning (Gergen 1971). Descartes, a French philosopher in the seventeenth century had much to say about the relationship between body and mind and, it was the reasoning underlying his celebrated dictum “I think, therefore I am” that challenged thinkers for centuries to come: As Descartes (1642) elucidates:

“I am only a thinking and not an extended being, and since on the other hand I have a distinct idea of a body in so far as it is only an extended being which does not think, it is certain that this " I " (that is to say, my soul, by virtue of which I am which I am) is entirely (and truly) distinct from my body and that it can (be or) exist without it.” (cited by Ross 1986: 19)

Descartes “looks into himself - he appeals to introspection” by this he assumes that “the best way to find out what the mind is, is to look into his own self” (Brook and Stainton 2000: 109). Descartes heralded the birth of a subject, a human being, where
logic and reason emanated from within a mind that is essentially complete within itself; with the notion that the body is purely a nonthinking extended apparatus that can be treated scientifically and mechanically. Descartes’ theory was that “a human being is compounded of two separate entities – a mind and a body, a ghost and a machine” (Passmore 1968 : 446). Gatens (1996 : 109) observes that Spinoza succinctly sums up Descartes’s mechanistic view of a human being in his explanation of the distinction between life and death where he proposes that:

“The body of a living man differs from that of a dead man just as does a watch or other automation ... when it is wound up ... from the same watch or other machine when it is broken.”

This completely mechanistic notion of the body Gatens (1996 : 109) contends “has led to insoluble problems at the level of accounting for that strange hybrid which is human being.” For according to Descartes all that exists does so under one or the other of two fundamentally different substances, mind and matter. In this sense then the “human being” hence divided within itself “is composed of a mind, complete within itself whose essence is to think and a determined body whose essence is to be a non-thinking extended apparatus.

According to May (1993 : 70) Descartes taught that “the objective world of physical nature and the body (which could be measured and weighed) was radically different from the subjective world of man’s mind and ‘inner experience’.” This theory is still evident now where the focus of treatment and care is on the somatic or physical part of a person. For instance, the body is the focus of attention of many disciplines such as physiology, pathology, chiropractice and medicine and these disciplines often take a scientific objective view of the body (Lawler 1991).
This idea raises two points, firstly there is the question of “how two substances with utterly distinct natures can be connected” (Hamlyn 1987: 143). Then, secondly, Ross argues that implicit in this view is the fact that “no ‘meeting of minds’ is possible as a Cartesian mind is “complete in itself; it learns all it needs to know about itself from itself” (Ross 1986: 22). It is this reality of the thinking “I” that confirms the existence of the thinker and, “this notion of I, the thinking, knowing, cognizing entity became one direct predecessor of the concept of self in psychology” (Gergen 1971: 6). Because of these questions about the nature of our minds, introspection according to Brook and Stainton (2000: 105) “turned out to be not a good method for uncovering the nature of the mind” and so began a shift in how subjectivity was viewed.

Logan (1987: 18-22) writes that in the late 18th Century there was a shift away from "the dominance of self as subject" to the emergence of "the self as object." This trend continued into the nineteenth century where, Logan (1987: 22) holds there was "an increasing awareness of self as prime object of its own interest": the self became the object of study and there was a drive for increasing self awareness. Then through further shifts the development of the concept of the "self" as a subject that could competently relate to the world came about through the rise of Rationalism and Empiricism. The "self" was a competent detached ' I ' able to reason, know and choose (Logan 1987: 19-20). Then came the self of the modern world, and it was during this period suggests Logan that a concern with 'personality' as it is understood today began to emerge the focus continues Logan had begun to make an historic shift from 'how do I (subject) reason about and observe the world?', to 'how does the world
make me (object) feel?, and 'what has experience made of me?' and in this sense the self had clearly become the object of interest and self awareness (Logan 1987 : 21).

William James towards the end of the 19th Century proposed that the study of feelings or images as experienced by the person could be "termed the self as known" in short the object pronoun me, whereas an investigation as to why and how does one thought lead to another within an individual could thus be viewed as "self as knower" or in brief form, the subject pronoun I" (Gergen 1971 : 16). James suggested the use of the words "Me and I for the empirical person and the judging thought" in this way he considered:

"The global self as simultaneously Me and I... they were discriminated Aspects of the same entity, a discrimination between pure experience (I), and the contents of that experience (Me)...each cannot exist without the other; the Self is simultaneously Me and I...the Self as Known or Me is in the broadest sense everything that a man can call his." (cited by Burns 1981 : 6-7)

James further claims that the self as known (the me), is comprised of subselves i.e. spiritual, material, social and physical and by so doing "considered the self not as a unitary but as a multifaceted phenomenon" with "rivalry and conflict of the different selves" (cited by Hermans et al 1993 : 33).

James’ notion of the concept of different subselves was taken up more recently by modern and post-modern philosophers, but in between times, his ideas on the notion of the all knowing 'self' led to the establishment of psychological experimentation with its focus on cognition, behaviour and perception and, women and men became both subjects and objects: both acting on and being acted upon (Potter et al 1987 : 100). This occurred with the creation of laboratories for the study of human
behaviour around the close of the nineteenth century and also Freud's discovery "that a great deal of human mental activity is not open to introspection (is unconscious, in one of the meanings of the word 'unconscious')" (Brook and Stainton 2000:105).

A rigorous behaviourist stance was also adopted with its emphasis on the scientific study of only those areas of behaviour which were observable and measurable and "anything to do with 'mind' or mental events such as purpose, expectations, thoughts and sensation had to be banished from the lexicon of psychology" (Burns 1981:10). According to Burns (1981:10) one of the shortcomings of behaviourism, was that its "rigid dogma placed self-concept study under considerable pressure... (in that) major concerns of individuals such as hopes, expectations, beliefs, thoughts,... were ruled out of order."

This became an untenable situation and it eventually became the concern of humanistic psychologists "to do justice to people's conscious experience of themselves and their role in directing their own lives" (Stevens 1990:419). Humanistic theories, although diverse, basically appear to hold the same fundamental belief in the self-directing, all knowing capabilities of the individual, Rogers, a humanistic psychologist, holds that "man lives essentially in his own personal and subjective world" (cited by Burns 1981:37); "each person is a whole" (Stevens 1990:420). Potter and Wetherell (1987:100) describe humanistic theories as searching processes: "to establish (the) true self, (and) as a quest for self-fulfilment and self-actualization". Greene and Thomas (1990:840) outline these humanistic characteristics thus:
"First a conscious awareness of existence; second, a capacity to reflect on conscious experience; and third, an ability to use this awareness to make sense of the world, to direct personal action and to achieve personal growth."

Eventually, however, humanism itself became the target of critiques where it was seen as firstly, "over-emphasizing the responsibility of human beings for their own circumstances and life changes" (Strawbridge 1996: 620-621) and secondly, because of its focus on the inner subjective world of the individual where there is "insufficient concern with social context" (Stevens 1990: 463).

Philosophers like Martin Heidegger (1889-1976, cited by Krell 1993: 234) had different ideas on the notion of the "self" and in his approach he decentralises the "self" from the concept of dominance and states that it is not man that decides "whether and how beings appear, whether and how God and the gods or history and nature come forward into the clearing of Being, come to presence and depart." In decentralising the "self" from a position of dominance Heidegger argues, we are human subjects only because we are caught up with the cultures and practices in the world: we are amongst it all from the start (Dreyfus 1987 cited by Koch 1995, Eagleton 1983). So began a concern with social context and its role in subjectivity and with this ideas were taken up around the role of language in determining subjectivity.

For postmodernists such as Jacques Lacan (1901-81, cited by Sarup 1993: 130) there is no division between self and society and he contends that we become social with the acquisition of language and it is language, therefore, that establishes us as a subject. According to Lacan "the autonomous subject has been dispersed into a range
of plural, polymorphous subject-positions inscribed within language" and in place of a unified and stable being or consciousness we get a multifaceted and disintegrating play of selves" (Sarup 1993 : 53). Gergen (1971 : 40) asserts, for example, that

"Social interaction does much to furnish the basic repertoire of concepts used by the person to understand himself and to guide his conduct... still largely unanswered, however, is the question of specialized identity... how does each individual come to view himself in a particular and specialized way - a way that sets him apart from others?... an entire culture may draw from the same basic repertoire of concepts in understanding self; however, each person draws from this basic pool in a unique way."

It is with the acquisition of language Merleau-Ponty (cited by Warnock 1992 : 86) insists that shows that the "significances" of the world are not only for the consciousness of one individual alone but for the consciousness of one individual amongst others..."to understand one's relation to the world, then, means, among other things, to understand one's relation to other people."

According to Harre (1994 : 40) this is evident in that "socially constructed differences between people are usually expressed symbolically and registered in language." For example, people are categorized by their bodily characteristics where we use corporeal bipolar attributes as descriptions, such as tall or short, men or woman, attractive or unattractive and so on. Harre adds that "the poles of these constructed oppositions tend to become evaluatively loaded in very complicated ways."

These complicated ways are reflected in postmodern thoughts that "there is not 'one' self waiting to be discovered or uncovered but a multitude of selves found in the different kinds of linguistic practices articulated now, in the past, historically and cross-culturally" (Potter et al 1987 :102). Burr (1995 : 40) asserts that each self may be "particular to and produced by certain relationships ... or social situations."
Gergen (1971: 19) argues for this multifaceted, at times, complicated view of the self by quoting the way in which former President Lyndon Johnson described himself “as a free man, an American, a United States Senator, a Democrat, a liberal, a conservative, a Texan, a taxpayer, a rancher, and not as young as I used to be nor as old as I expect to be.” Here, President Johnson uses a number of unrelated different concepts to describe himself, and, suggests Gergen, it is clear that not all of these various concepts are equally relevant at the same time, meaning that at certain times one concept of self will be more relevant or important than another concept of self.

To understand this concept of one’s relation to the world and to other people, much is owed to the philosopher Husserl (cited by Friedman 1994) and others following his footsteps. For it is Husserl who goes beyond Descartes’ cogito by proposing that the “I think” cannot be separated from that which is thought. It was this idea that led Merleau-Ponty, (cited by Burwood et al (1999), a phenomenologist, to assert that a human being is first and foremost an embodied subject. Friedman (1994: 70) writes that it was Husserl who “replaces the detached subject and independent object of older philosophy by a field of knowing in which the phenomena are accented as pure phenomena without questioning their independent existence.” Contrary to the Cartesian simplistic dualism of the mind and the body Merleau-Ponty insists that the body does in fact have its own mode of existence and is itself a subject (Burwood et al 1999: 170-171).

William James (cited by Gergen 1971: 6), theorised about these ideas at the turn of the twentieth century, (which as stated earlier were later returned to), and he linked
the concept of self-experience to his notions about the bodily self. James argued “that a person experiences, as his own material possession not only his body, but also his home, his family, and the physical objects with which he surrounds himself … (an) awareness of his reputation or his identity in the eyes of others.”

Young-Eisendrath theorises on an approach to the self which is essentially post-modern in that “one begins to experience directly the impermanent and fluid nature of Self (what Buddhists call the no-self) in which one feels essentially connected to others, not only to human beings but to all sentient beings.” She identifies four characteristics that she proposes seem to be universal in human selves everywhere:

“The first of these is coherence, the integration of complex and diverse subjective experiences into the unity of body-being. Coherence is that sense of being embodied in this body and held into its boundaries and influences…the second universal characteristic of self is continuity, the memories and beliefs that permit one to experience the self as ‘going on being’…the third characteristic of the human self is the attribute of agency or efficacy, the experience of being the author of one’s own actions, of being an agent in the world…the final characteristic of the archetype of self is affective relational patterns that are the ubiquitous features of human relationships arising from the interdependence of persons in the process of growing selves.”

(Young-Eisendrath 1997 : 162-163)

As Taylor (1989, cited in Young-Eisendrath 1997 : 163), has put it “one is a self only among other selves. A self can never be described without reference to those who surround it.” Turner (1995, cited in Bernstein 1990 : 138), states that “any project of the self must be a project of the body” and when bodily damage causes a transformation to one’s appearance, there is not only the fact that one has to deal with the fact that “most people are…eager to segregate the maimed and unsightly” but that the individual has to try to construct “a “new self”, an altered image that still affords
some bearable level of self-esteem, in spite of the way the public reacts.”  Lastly, in this chapter the impact of a debilitating physical illness or injury is examined.

**The impact**

Harre (1991 : 174) writes that “according to the *OED*, a disease is ‘a condition of the body or some part or organ of the body, in which its functions are disturbed or deranged’. This is essentially the medical concept of ‘disease’. The lay concept of ‘illness’ is much more complex.”

Illness upsets lifestyle and “the ill person becomes .. – a patient – a person bearing a burden of distress, pain, or anxiety; a person set apart; a person wounded in specific ways” (Pellegrino 1982 : 158). The physical illnesses and injuries that can lead to an older person being admitted to hospital can also come on top of other issues that the person may have been coping with at home. The other issues the person may have been coping with, according to Featherstone and Wernick (1995), can be part of the ageing process, and entail some degree of decline, which could include, increasing sensory deprivation, such as loss of hearing and vision, a decrease in mobility, increasing isolation, and the psychological effects of these losses.

So along with these issues there is illness which (Rawlinson (1982 : 77):

“Generally results in a surrender of one’s autonomy and integrity of person out of necessity or in the hope that this surrender will be in the end useful in the effort to recover those capacities which the illness obstructs and threatens. This surrender makes one vulnerable and leaves one at the mercy of others in significant ways.”
Following an episode of physical illness or injury then, and depending to what extent they recover, some people will be faced with a long term chronic disability or condition which will impact on their future lifestyle to a greater or lesser degree (Biggs 1993, Reynolds 1997). There are two issues here, firstly the initial impact of the physical illness or injury upon the person and, secondly, the aftermath of a chronic physical condition upon the person.

From this it can be surmised that some illnesses and traumas occur out of the blue and accordingly precipitate an emergency admission to hospital as, for example, a stroke, a heart attack, a fall, a road accident or an injury sustained following an attack on the person. Alternatively, admission may be more planned as in the case of the exacerbation and complication of an existing illness, such as, diabetes, or for a newly diagnosed illness, such as cancer, Parkinson's disease or rheumatoid arthritis, or because of a deterioration in a progressive neurological disease such as multiple sclerosis or motor neurone disease. As well as all these medical conditions precipitating admission, people can be admitted to hospital for surgical procedures such as for an amputation of a limb, or for repair of a broken limb following an accident or for surgery for a diseased organ or part of the body (Resnick 1998, Rybarczyk 1992).

These then are some of the instances that can necessitate a person's admission into hospital during the acute phase of their illness or trauma. There is also the fact that admission to hospital can be a traumatic event in itself as described earlier where it is highlighted that it is traumatic, in the sense that your known world is disrupted and is in turn replaced by an unknown and a seemingly quite different unfamiliar world.
There is also the fact that this traumatic experience can impair the person’s ability to absorb information when they are admitted to hospital:

“...A relative in a fraught state, people who are dazed and frightened with the impact of unexpected entry into hospital, people who are very tense and inhibited during a consultation, people shaken by the disappointment of a medical failure ... other factors may also influence a person’s capacity to take in information ... the illness itself may cause deficits, for example there is intellectual deterioration accompanying uraemia, and injuries to the head will often produce confusion and amnesia ... certain drugs take the edge of people’s intellectual abilities.”

(Nichols 1993 : 70-71)

Clearly from this it seems that whatever physical illness or injury precipitates an admission to hospital, which in itself can be traumatic, needs to be viewed as a major event in a person’s life (Brorsson et al 1998, Mayou 1997, Rawlinson 1982). It is during this time of acute illness, where it can often be a matter of life or death and there are only two outcomes; death or survival (Grzesiak 1994). When a person has passed the acute phase of their illness or trauma and they have survived, this is when, in all probability they will be discharged from the general hospital.

Once it is decided to discharge an older person from the general hospital they may either return home, or go into a nursing home or a rest home (for which there are different admission criteria), or into an elderly care rehabilitation unit (Terry 1997). These options, any one of which, depending upon the individual, may be equally traumatic and have far-reaching consequences, some of which are discussed later. In order to consider some of these effects upon an older person it is relevant at this point to consider the course of action taken when physical illness or injury is experienced.

It is within this context of illness when the acute phase of the illness or injury has passed that admission to an elderly care rehabilitation unit/hospital can take place. So
a person arrives on the rehabilitation area following some kind of trauma or illness which has involved a disruption of physical function, to some degree or another to some part of the body (Mayer 1991, Young 1996). Alongside this there is the ongoing process of ageing with which to contend, with all its inherent issues as indicated earlier. In this state then, a person will have survived their ordeal, but somehow they will be different than before they had their illness or injury in that they are neither dead from it nor are they cured from it (Grzesiak 1994: 247).

It is hoped, that admission to a rehabilitation unit as well as offering some degree of rehabilitation, will also give some breathing space so that a person can take stock of their situation. From the researcher's own experience of working with older people within rehabilitation units; assessment and information gathering about the person takes place on their arrival. This process is ongoing throughout the patient's stay. Doctors assess and carry out a clinical overview of the patient, which they record in the medical notes. Nursing staff, physiotherapists and occupational therapists record their information and assessments in another set of notes; the patient's rehabilitation team notes.

Other disciplines to whom the patient may be referred, such as speech and language therapists and dieticians also record their assessments both in the medical notes and the rehabilitation team notes. Some of these disciplines also keep their own separate notes. Lichtenberg and MacNeill (2000: 112) suggest that clinicians should conduct assessments “with an eye toward understanding multiple systems that are impaired in a single individual.” Machin (1992) suggests that whether understanding multiple systems always includes consideration of a patient’s emotional state is possibly
debatable given that in all likelihood the focus is on the biomedical model with its technical emphasis on physiological needs and care.

This multidisciplinary approach indicates the complexity of interacting issues that need to be considered when planning the care of this population. Broadly speaking, then, the gathering of multidisciplinary data takes account of the patient's demographic details, their medical status, their physical status, and their social details. Arising from this multidisciplinary assessment, "patient problem lists" are compiled by staff and each "problem" is given a number which is then written more fully as a patient plan/problem. The patient plan/problem has both short term and long term goals set with a plan of action as to how these goals will be achieved.

In this rehabilitation environment the focus is on the provision of practical physical help to counteract the loss of physical function that the patient has experienced (Rusin 1990, Gitlin 1998). For example, patients go to the gym and a physical mobility programme is set up, walking aids are provided and exercises are tailored for the patient. Washing and dressing difficulties are also addressed by nursing staff and therapists who document care plans and work with patients in these areas.

The extent to which a patient responds to their physiotherapy programme dictates the amount of involvement that they will have with a physical rehabilitation programme. Some people progress and are able to fully engage in these programmes, but if a patient is unable to walk again, or engage in this type of rehabilitation for whatever reason, their formal physiotherapy sessions are either curtailed to a maintenance level or they cease altogether. Morris (1998), recognises that the process and progress of
physical rehabilitation is important, but also recognises, for example in stroke rehabilitation, that the psychological adjustment to the disability is not always a consideration when measuring functional progress.

In these instances practical devices and equipment can be provided such as wheelchairs, and other aids, such as splints (to maintain the position of a limb), special eating implements and pressure relieving items such as special mattresses. Those who have great difficulty in standing or who are unable to stand are wrapped in slings, hoisted into the air and re-positioned from bed to wheelchair to toilet.

Alongside the organisation of this practical help a discharge check list is also part of the patient’s rehabilitation team notes. If the plan is to discharge a person back home or to a rest home or to a nursing home, a referral is made to the appropriate agency in this instance, social services, who liaise with the staff, the patient and the patient’s family regarding the patient’s practical/physical needs. Information is also provided to the patient and their family about care packages at home, or alternative accommodation in rest or nursing homes, and the financial arrangements for these things.

The help and level of advice given, particularly if the person is moving into either residential or nursing home care, depends on whether the patient will be self-funding. If they are not self-funding, meaning they do not have sufficient funds to pay for their care, social workers have to work out the financial arrangements. If they are self-funding, relatives may be provided with a booklet listing this kind of accommodation and they have to arrange both this, and the finances for a home, themselves.
Sometimes it can be the case that people become too ill or their medical needs become too complex for them to be discharged from hospital, then in this case they either return to the general hospital for treatment, or become eligible for inpatient care, and, in that case they eventually die in hospital.

These brief insights from the researcher’s own experience in this field, highlight the complexity of concerns that can face both older patients in hospital and their relatives/carers. There is a hint at this stage, of what might be the nature of some of the emotional distress and mental anguish that may be experienced in these circumstances. There are then many issues facing both patients and their relatives encompassing “the experiences of becoming ill or injured, being hospitalised and, possibly, disabled or disfigured” all of which can be very distressing (Nichols 1993: 46).

Physical trauma and its post-acute management for older adults is an intensely complex issue involving a multi-disciplinary team approach. The physical trauma, alone can have a devastating effect upon the person, whether it is, as previously discussed, immediately visible (amputation), or not so immediately evident (speech loss), or indeed hidden depending on which area of the body is traumatised (colostomy).

Therefore, whether it is a fractured limb, a paralysed part of the body, or an amputation, it is the body that is treated and tended in rehabilitation areas where the aim is on functional improvement, and as identified sometimes psychological reactions to physical trauma are not acknowledged for one reason or another. “In the
in-patient setting, these goals (rehabilitation goals) are often defined in terms of narrow domains of functional capacity (ambulation, range of motion, muscle strength, etc.) (Glass et al 2000: 172). For instance, Spitzer (1987) claims:

"That indices can be designed so that clinicians can score the quality of life or health status after observing or examining a patient even without eliciting information from the patient about how he or she feels at a given point in time." (cited by Baker et al 1996: 173)

Van den Berg describes how the everyday world is transformed for a person when illness is experienced, and then how new concerns can arise as a result of this transformation. Van den Berg describes such transformations and concerns as:

"Changes in the experience of time and space; changes in the body (from instrument to problem); constriction of the "horizon of my existence"; the patient as "stranger"; the experience of "being-in-bed" not as a sleeping person but as an ill person; the meaning of "visitors" in a sickroom; the ethics of hope; the "remoteness" of the well and the "closeness" of the physician to the ill."

(cited by Kestenbaum 1982: 23)

Here it needs to be noted that there is also a distinction to be noted between the onset of physical disabilities. Those physical disabilities brought about by a traumatic event, i.e. amputation, stroke, myocardial infarction, will have a sudden effect and the reaction of shock will possibly be more immediate. Whereas, in a gradually deteriorating condition such as multiple sclerosis, arthritis, diabetes, Parkinsons disease, the course of the illness can be gradual and insidious and shock may not be experienced in the same way. Shock may have a more "narrow psychic focus" when a life-threatening or end-stage illness such as cancer is present (Antonak and Livneh 1995: 1100). Others have identified psychosocial reactions to the onset of physical
disability as, “shock, anxiety, denial, depression, internalized anger, externalized 
hostility, acknowledgement, and adjustment” (Livneh and Antonak 1991 : 300).

As previously stated, Kestenbaum, although not specifically talking about old age,
generalises, that these factors should be considered when illness strikes when stating 
that:

“The assault of illness on humanity is not simply physical, it is 
ontological, affecting our very image of ourselves – our being – 
and our circumstance – our world. Illness is a transformation of our being-in-the-world, but not only that; it is an attack upon it, a deformation of it, because it threatens our integrity. This integrity includes that of self and body and that of self and world. With the loss of these forms of integrity we lose our freedom.”

(Kestenbaum 1982 : 33)

There are many illnesses that impact on the physical health of older people that can 
lead to admission to hospital. Some of these physical illness/injuries can 
consequently result in some degree of functional impairment that impinges on future 
lifestyle (Bowling et al 1994, Steinhagen-Thiessen et al 1993). It is not only the 
functional physical impairment that impinges on future lifestyle and is considered a 
loss, it is also the loss of our integrity that needs to be considered.

The notion of loss is often linked to theories of grief where this relates to “the 
objective situation of an individual who has recently experienced the loss of someone 
significant through that person's death” (Stroebe et al 1987 : 7). Grief is the term 
applied to the emotional response and reaction experienced by individuals when they 
have lost someone significant through death (Parkes 1986). So, generally the 
notions of loss and grief are applied following a bereavement in terms of the death of 
a person. Hindmarch (1993) offers this definition of bereavement:
“Bereavement has come to mean the loss by death of someone close, although it originally referred to the marauding practices of bands of 'reavers' many centuries ago, raiding the livestock of neighbouring clans. Thus to be bereaved implies being robbed or deprived of something or someone of value, so that one is necessarily poorer for the loss. Bereavement is what happens. Grief is what one feels in reaction to the bereavement. Mourning is what one does to express grief.”

(cited by Adams et al 1998 : 147)

According to Leder (1984, cited by Williams et al 1996 : 39) “grief ... is an example of emotional pain which is inseparable from its ‘gut churning, nauseating experience’, whilst physical pain bears within it a ‘component of displeasure, and often anxiety, sadness and anger that are fully emotional’.”

Parkes (1986 : 60) writes about people having "pangs of grief" where an episode of "severe anxiety and psychological pain" is experienced and that this can arise in connection with the death of someone, for example when the "lost" person is strongly missed or when something happens to bring this loss to mind. It is also identified that feelings of loss can be experienced through "failure, removal or alteration of body parts, whether internal or external; or an alteration in physical, psychological or social functioning" (Adams et al 1998 : 147).

Parkes (1986 : 204-205) identifies that amputees experience a painful pining for things that they can no longer do as the lost limb is a constant reminder of this, and he also identifies that they suffer feelings of a loss of self and feel mutilated by a part of their body being taken away. Referring to this sense of a loss of self Jongbloed (1994) relates that this also refers to the after effects of a stroke where changes in the body, he contends, can themselves impair a person's sense of self. Bosely (1998 : 2) identifies that the public find it hard to take the “physical reality of the deteriorating
body” thus adding to the impetus of a person’s loss of their sense of self. Moos and Davis: (1977 : 10-11) describe the meaning of a debilitating chronic disability:

“Preparing for an uncertain future in which significant losses are threatened. The loss of sight, of speech,...of a limb, or a breast by surgery, or of life itself, are all losses which must be acknowledged and mourned. Ironically, new medical procedures which raise hope for patients with previously incurable illnesses may make this task more difficult patients must prepare for permanent loss of function... the anxiety and apprehension of not knowing the outcome of an illness, the sense of alienation and isolation, and the feelings of inadequacy and resentment in the face of difficult demands.”

As stated earlier older people are also at risk of being separated from loved ones and losing their homes. So in addition to the permanent losses referred to by Moos and Davis they also face these other permanent losses which can cause much the same feelings. The feelings around the losses of illness suggests Parkes (1986 : 209), are akin to those felt by people who lose their homes as revealed in a study carried out by Fried concerning a re-housing project. In this study it was found that people expressed their feelings in terms of personal mutilation in that many felt as if a part of themselves had been lost or ripped out or left behind when they were re-housed. Although not a physical loss in the way that an amputation is, Parkes (1986 : 209-210) holds that this reaction to the loss of a home is a psychological mutilation and as such is subjectively every bit as real as the mutilation suffered by amputees.

Mutilation can, by these descriptions, be taken to mean that one can be maimed or impaired not only in the physical sense by the loss of, or a decline in function of a body part but also in the psychological sense by powerful feelings. It is further identified that it is not uncommon, in the event of a physical illness or injury, for individuals to experience the loss of expectations and the loss of hope (Mayou 1997).
It is also identified that this can cause damage or impairment to the self, or even a sense of loss of self, as Grinberg (1964, cited by Parkes 1986:116) contends "the pain of grief, like physical pain, is the experience of damage to the self". Brorsson et al and Lubrosky offer the following descriptions and theories about what happens to a person's sense of self or identity when a trauma of some sort or another is experienced:

"The person becomes the condition he or she has; a retarded, a diabetic, a paraplegic or an amputee. In the metonymic reduction the individuality tends to disappear and the humaneness weakens. One single attribute is allowed to define the identity."

(Brorsson et al 1998:80)

"In disability the body is switched from a silent background for the self to the foreground as an externalised object of constant awareness. The basis of one's identity is switched from achievements and social identities to that of inabilities of the body. The impairments become a master identity overshadowing all other identities."

(Lubrosky 1995:1450)

These statements substantiate the view that when a physical trauma or disorder strikes it is the "affected" part of the body that becomes the focus of attention and this can result in a loss of identity for the individual. According to Rusin (1990) and Gitlin (1998) this focus of attention can be perceived to take place both by those who care for, and help the person who has experienced this event, and, writes Biggs (1993:36-37) by society as a whole where people may be "categorised, assessed or disenfranchised because of their bodily appearance."

According to Phillips (1996:202) research indicates, for example, that "people with facial disfigurements are very aware of their deformities and other people's reaction
to them...this awareness of being obviously deviant in a negative way profoundly shapes their self-concept and self-esteem, which may be quite low.” Phillips adds that people with disfigurements “often try to fade into the background...they struggle to maintain self-esteem and achieve acceptance by others...(even) cut off their relationships with the world and go into a closet existence.”

Other specific losses that may be experienced following a traumatic event may not be so evident as a physical disability. Identified issues include the loss of an acceptable body image (internally or externally), loss of libido, loss of skills, loss of job, loss of social standing, loss of independence and choice, loss of self-esteem and identity, and loss of contact and potential changes in relationships with family and friends can also be experienced (Brearley and Birchley 1994, Evans et al 1994, Lantican 1994, O’Leary 1996). Also if a person is unable to return home, this then entails the loss of material items such as home and possessions (Thompson 1989). There is also the loss of independence which can be associated with the loss of youth where:

“The general fear of physical disability, mental decline and illness ... and for the dependence they bring with them ... the fear of loss of mobility, ... of being confined indoors, and of the consequent loss of choice of places to go, things to do ... the fear of the loss of home, having to live with other people, or in an institution.”

(Laslett 1989 : 14)

Clearly, there can be an accumulation of losses and the resultant imposition of these losses are damage and change to a person both during, and in the aftermath of a physically debilitating injury or illness. These losses and ensuing damages, and, or changes, appear to fall into three areas, firstly there are the physical losses which relate to differences in bodily appearance and performance which can be external and internal.
Secondly, there are the losses arising from an alteration in physical, psychological or social functioning, and thirdly there are material losses such as the loss of one’s home and possessions, which can also cause change and damage to a person but in a different way. All these issues of loss can produce some psychological/emotional reactions.

Livneh and Antonak (1991) and, Antonak and Livneh (1995) have provided information on psychosocial reactions to the onset of physical disability identifying them as, “shock, anxiety, denial, depression, internalized anger, externalized hostility, acknowledgement, and adjustment.” Phillips (1996 : 202) writes that “the visibly damaged often feel a profound sense of shame and vulnerability to exposure, devaluation, and rejection...they may feel deeply defective and not quite human.”

In the first place, as already described, a hospital is effectively a separate entity on its own, a world within a world, with its own vocabulary and concepts. Nichols (1993) depicts the fact that psychological and emotional distress more often than not accompanies serious illness and injuries, and can add to the difficulties of being in a hospital.

People are, in effect, in the middle of a traumatic experience, which on its own is suffice to contend with, let alone the fact that this traumatic experience as well as being “socially and physically threatening, is often alien in character, and involves separation from the home and supportive network of family and friends” (Nichols 1993 : 96-97). However, in spite of all this, it seems that in many medical settings
"There is neither permission nor encouragement to show or communicate psychological distress, ... in fact. Often, the emphasis ... is on staff not seeing, or denying, the psychological impact of serious illness, injury and hospitalization. ... the patients are encouraged by the general atmosphere to hide their feelings. Effectively, they are left alone to deal with their psychological reactions to illness unless they have some kind of breakdown.”

(Nichols 1993 : 47)

The aim of this chapter has been to delineate the salient theoretical issues within the research question: "what may be the nature of the need, if any, for counselling/ psychotherapy for an older person who suffers a debilitating physical illness or injury?" The ageing process and old age revealed that ageing is chronologically, biologically and socially constructed with a tendency to foster negative prejudices and attitudes. This produces negative feelings about ageing for the individual which is accompanied by real fear and anxieties. The body, particularly in illness, as part of the self, can be experienced as a burden or hindrance to some aspect of the self.

The implications for the self is that following survival a person is different; a change has taken place to their "self". The impact is a change in body, from instrument to problem, bringing with it a constriction of the horizon of one’s existence. It is not uncommon in the event of physical illness for people to experience loss of expectations and loss of hope together with many other losses including an acceptable body image, loss of libido, loss of independence and choice all of which can result in feelings of being deeply defective and not quite human. Next, chapter three presents a review of the literature relevant to the research question.
Chapter 3: Literature review

The theoretical issues raised within the research question “what may be the nature of the need, if any, for counselling/psychotherapy for an older person who suffers a debilitating physical illness or injury?” were pivotal in guiding the literature review. The physical trauma suffered in most instances will lead to the person being different in some way in that they will now have to endure a chronic debilitating condition that will impact on their function and ability which in turn will affect and change their lifestyle to some extent (Moos and Davis 1977).

A search of the literature at this stage has not revealed any entries under either the heading "Counselling /psychotherapy and physical disability and old age" or the heading "Elderly rehabilitation/hospital and counselling/psychotherapy.” Indeed a research report by Woolfe et al (1997) of Keele University draws attention to the lack of data on counselling/psychotherapy and old age (Woolfe et al 1997 : 189-194).

There are a few American studies carried out on psychotherapy and physical disability and or psychotherapy in rehabilitation areas. Although these are not specific to older people, two, in particular, offer theories on working with people with physical disabilities (Grzesiak et al 1994 : 240-250, Langer 1994 : 181-194). Sadavoy (1994) a Canadian, offers a relevant paper on using integrative psychotherapy for work with elderly people (Sadavoy, 1994 pp.19-26).
Rybarczyk et al (1992 : 127-140) discuss cognitive-behavioural psychotherapy with the chronically ill elderly outlining treatment issues which include the practicalities involved in working with patients in hospital settings. These researchers also note the paucity of literature in this field and record their awareness of how underserved this population is regarding psychotherapy treatments.

A research update by Niederehe (1996) on psychotherapeutic techniques with depressed older adults in America concludes that there is evidence for the use of various psychotherapeutic treatments in late-life depression. However, he states that most of the research with older people has used sample groups that have lacked "social, cultural, and clinical diversity". In this respect both Niederehe (1996 : 66-78) and Sadavoy (1994 : 19-26) acknowledge that most of the data regarding therapeutic interventions with older people has emerged from elitist studies involving "well" older people who are middle-class, well-educated, self-selected and independent.

Others have identified that possibly one of the reasons for the dearth of research involving older people and psychotherapy is the reluctance of therapists to work with this population (Orbach 1994, Silverman 1994). Orbach (1994 : 224), a private practitioner considers why therapists are resistant to taking on older patients and suggests that this may be due to stereotyping which can categorise older people as being unproductive and "less deserving of our time".

There is an increasing call for research into counselling /psychotherapy with older people in general, not just those who have been admitted into mental health areas, but

"The older we get the more we become different from one another – biologically, socially, and psychologically. Psychotherapy is very useful for older persons, but it must be tailored to the particular place our patient lies within the clinical spectrum from health to fragility".

Admission to hospital itself can be distressing and the treatment carried out can also have a major impact on a person's mental and emotional state (Mayou 1997). Nichols (1993: 6) writes:

"No matter how well-intentioned doctors and nurses might be, when they practise with the view that medicine is primarily to do with physical treatment and where they maintain the distant, impersonal, medical style of relating which depersonalises people into 'patients', then the psychological needs of seriously ill people will neither be properly recognized and valued, nor be properly met".

During rehabilitation the emphasis is placed on providing help with the dysfunctional part of a person's body with the aim to either enabling this part to regain some of its ability or to apply treatment or give care directly to it, but it is suggested that this preoccupation may eclipse other forms of meaning for the patient and deny opportunities for a deeper level of engagement (Bracey 1996). It is contended that attention should be paid to the role that emotional factors can play in the rehabilitation process (Bracey 1996, Parry et al 1996), and that there should be psychological therapies offered within the NHS to complement physical treatments (Parry and Richardson 1996).
There is, however, a quantity of literature on the subject of strokes both in this country and the United States, some of which is concerned with the incidence of depression and mental trauma in those who have suffered a stroke and also the inherent difficulties in assessing and diagnosing this fact in these patients. Some of the literature also identifies that very little research has been carried out into what psychological, psychosocial, and psycho-educational needs stroke sufferers and their carers/relatives may have (Castillo et al 1993, House 1987, Johnson et al 1997, Rusin 1990, Sembi et al 1998).

Other studies have reported on the fact that within stroke rehabilitation areas emotional well being is often not considered and even if it is noted that a patient is having difficulty coming to terms with a stroke nothing is done about it. One reason suggested for this was the fact that "there is no-one with sufficient/suitable skills to deal with these needs" (Turner et al 1994: 59, Wade et al 1987). It is also contended that as well as stroke victims, the psychotherapeutic needs of the chronically ill older person and people with physical disabilities are not being taken into account (Parry and Richardson 1996). It is held that this may be due in part to the fact that staff, as a defence mechanism against their own anxieties, focus on a patient's physical problems as they themselves are particularly vulnerable to "unconscious anxieties associated with death and destruction because their work involves close contact with damaged and dying patients" (Terry 1997: 101).

Members of staff have also identified their own reasons for this under-representation of psychotherapeutic support for older adults with disabilities and chronic illness. These reasons are, that priority is given to medical issues, that there is no one with
sufficient/suitable skills to handle these needs, and that someone who is not involved in the everyday care of patients is better able to provide this help (Caris-Verhallen et al 1999, Turner et al 1994).

Bowling et al (1994) report that remarkably very little has been published regarding how older adults deal with chronic illness, and in turn how it affects their lives. It has been reported that there is a prevalence of depression among older adults, and the importance of recognising and treating depression and, or, anxiety in this population has been identified (Katona and Katona 1996, Mann et al 1993, Mayou 1997). O’Leary cites a study by Spitz, where it was found that “if human beings did not get significant recognition from others their spines literally shrivelled and they became increasingly withdrawn from relationships” (O’Leary 1996 : 19).

It is also suggested that medically ill older patients who have depression use more health care resources and do not progress as well as their non-depressed counter-parts (Katona 1994). Yet, it seems that this is not a subject that has been explored in the care of older adults who find themselves in rehabilitation settings in the aftermath of a physical trauma, facing perhaps, a long term chronic condition which will have a major influence on their future lifestyle (Rybarczyk et al 1992, Walker and Katona 1997, Woolfe and Biggs 1997).

According to Rybarczyk et al (1992) and Walker and Katona (1997) there have been no studies up to this time evaluating any psychological interventions with elderly people with physical illnesses and disabilities. Rybarczyk et al (1992) state that a
large percentage of older adults must experience at least one chronic medical illness
and, chronic illness, unlike an acute illness, requires psychological adjustment.

Grzesiak (1994: 243) quotes Rusk, who, he states, is considered by many to be the
father of rehabilitation medicine, in that Rusk believed that around one-half of
physically disabled adults would need some psychological input to enable them to
reasonably cope. Therefore any nursing care of older people should not just include a
pre-occupation with the disability itself but should also include an account of other
factors including psychological and emotional issues (Bracey 1996, Heath, 2000).

Eweka (1994: 297) feels that counselling for older people in medical settings should
be encouraged for those “elderly clients who are already under medical attention”.
However, she then adds that there are a vast number of older people who are outside
of this setting and poses the question of “who should take care of them, since we
cannot assume that they are past care or need no care”.

Cohen (1984) begins his paper by arguing the case for a psychotherapy service for the
elderly. He argues this in the light that people are living longer, and he questions
whether therapy with older people is very dissimilar to that carried out with younger
people. He describes a resistance to the provision of therapy for the older age group
which he sees as being tied to a misunderstanding about older people in general. For,
instance, that due to the ageing process would not generally respond to therapy
perhaps because of ingrained beliefs of the inflexible nature of old age. Lasoski
(1986), suggests that this can be due to many factors including a lack of interest in this
area of work due to:
"A tendency to attribute symptoms in the elderly to the irreversible aging process and concerns that the problems of the elderly are too complex to treat. Even if older clients improve, there may be a tendency to believe that the effort may not be as valuable for older adults since they have fewer years during which to benefit from treatment. ...despite evidence to the contrary there has been a tendency to believe that older adults are “set in their ways” and resistant to change. Elderly clients may trigger clinicians’ own concerns about aging ... working with the elderly has not been considered glamorous work, and therapists may be concerned about their own perceived low professional status if they specialize in this population."

(cited by Stanley Averill 1999: 516-517)

A paper by Hildebrand (1982) explores brief psychotherapy with older patients and illustrates this with case material. She, like Cohen (cited by Hildebrand 1982: 19) remonstrates with Freud’s view that “near or above the fifties, the elasticity of mental processes, on which the treatment depends, is as a rule lacking – old people are no longer educable”. She holds that brief psychotherapy for older people is a sound option because they “do not have the time to hang about contemplating their navals, they want to get on with things” (Hildebrand 1982: 22). She also discusses gender differences that are prevalent during older life and highlights some interesting concepts concerning changes in culturally structured role patterns. Hildebrand does also discuss some difficulties with the therapeutic relationship and explains some problems with transference and counter-transference encountered between the younger therapist and the older patient.

Lantz (1995) describe an existential approach with older adults which focuses on the nature of meanings and potential meanings in the client’s life. They, like Hildebrand, highlight the relationship between client and therapist and how important this relationship is as the therapist is more than likely to always be younger. They include
three case studies to illustrate the middle stage of treatment, which helps the older person identify and then make use of meanings and meaning potentials in a way to alleviate problems, and symptoms that they encounter.

Both Lagana (1995) and Neeman (1995) investigate the under-utilisation of counselling services by older people. Lagana’s concern was investigated by the results of an empirical study involving questionnaires sent out to retired professors. The drawbacks produced by the study included the use of a lengthy questionnaire, which deterred some professors from responding. They were still unable to identify further those at risk from psychological problems in order to streamline and target a service, and this was possibly due in some part to their selection of an elite section of the population. Neeman (1995) research was focused on two areas, firstly what prevents older people seeking treatment for mental health problems, and secondly she explores the idea of therapy empowering people. She identifies prohibiting factors to seeking counselling amongst which is the cost and the stigmatisation of such services.

Cadby (1996) also explores the notion of powerlessness in older people particularly with regard to moving into residential care settings. She investigates the usefulness of a counselling service in this area. Incorporated into her research are case studies illustrating and evaluating an existential approach. Although Cadby recognises the limitations of her research because of the small number of participants, she does conclude that people in these environments should be entitled to access to a counselling service as it can install feelings of self-esteem and self-worth.
Sadavoy (1994) compares three psychotherapeutic approaches used in brief and long-term therapy for older people particularly for depression and bereavement. He evaluates the effectiveness of each particular approach and concludes that the results of brief therapy appear to be optimistic. Although, he states there is a difficulty in evaluating the long-term effect. Sadavoy does, however, urge further research on the effectiveness of therapy, particularly with inpatients and institutionalised older people.

Another American paper by Weissman (1994) also studies the effectiveness of psychotherapy as an inpatient alternative as well as a supplement to medication for the treatment of depression for older people. Weissman’s results indicate that psychotherapy could be a suitable intervention, and she urges more research in this field particularly where medication for elderly people may not be a suitable or feasible method of treatment.

According to Lyon (1996: 61-65), often physical bodily illnesses lead to depression, feelings of worthlessness, over-sensitivity and low self-esteem all of which are frequently sanitised via medicalisation of treatment with SSRI drugs such as Prozac. Lyon adds that in psychology and psychiatry today “an increasing range of forms of behaviour or experience have been given the status of independent illness entities – frequently through their inclusion within the expanding boundaries of existing illness categories such as depression – and therefore regarded as treatable with newly available medications”. Lyon whilst no denying the effectiveness of these drugs questions if this way encompasses, and here she quotes (Kleinman and Kleinman 1991), “the question of the ontology of suffering” or as she herself adds “the question of a changing sense of the self in illness”.

As identified there is limited literature on work with people with physical disabilities and with older people not diagnosed with a specific mental health illness. It is also shown that there is a reluctance of therapists to work in these areas even though it is established that medically ill older people with depression use more health resources. In order to explore these issues Chapter four considers the method to be employed to conduct the research, and details how this method was eventually chosen to explore what may be the nature of the need, if any, for counselling/psychotherapy in a medical setting for older people who suffer a debilitating physical illness or injury.
Chapter 4: Methodology and Method

This is a research study to explore the question “what may be the nature of the need, if any, for counselling/psychotherapy for older people who suffer a debilitating physical illness or injury?” To investigate this topic within a medical setting verbatim accounts and summarised counselling sessions of individuals who find themselves in this dilemma, will form the basis of this study. The search for an appropriate methodology to carry out this research is argued through and discussed, followed by the details of how it was to be conducted.

The search for a way in which to conduct this inquiry and to do justice to these accounts led initially to the consideration of a method of qualitative inquiry which Henwood and Pidgeon refer to as Strand III and which they offer as one of their three strands of qualitative inquiry entitled “discursive and reflexive”. They term this strand of inquiry as constructivism with the methodological principles of interpretative analysis (highlighting deconstruction of texts) and, within this research paradigm the method and the example of discourse analysis is highlighted with particular reference to Potter and Wetherell’s (1987) approach to discourse analysis (Henwood and Pidgeon cited by Henwood 1998 : 32).

Potter and Wetherell (1987, cited by Gill 1998 : 143) elaborate an approach to discourse analysis where one of the aims “is to identify the functions or activities of talk and texts and to explore how they are performed”. According to Potter and
Wetherell (1987: 184) discourse analysis means regarding talk, conversation and written text as research issues in their own right. They add that this research methodology “takes a social perspective which focuses on the role of discourse in interaction and sense making rather than being concerned with, for example, abstract questions of semantics, text coherence or aesthetics.

Potter and Wetherell (1987: 32) outline some of the roots of discourse analysis and note the similarity between discourse analysis and ethnomethodology in that “people use their language to do things: to order and request, persuade and accuse”. Although there is this similarity between the two methods, Hollway (1989: 19) suggests that ethnomethodology’s “concept of ‘natural language’ depends on the assumption that the text speaks of itself and argues that it does so on the basis of shared meanings between speaker/writer, researcher and reader.” Hollway continues to explain that this notion of a shared knowledge base “assumes a unitary society which spawns common meanings” and as such this approach works fairly adequately to illustrate the success of communication. Yet, adds Hollway, this approach has its shortcomings, in that namely it “camouflages the enormous variability of meanings”. Potter and Wetherell (1987: 35), agree with Hollway on this point by acknowledging that the variability of meanings within texts is incorporated into social research by being “managed through analytic strategies of restriction, categorization and selective reading.

Restriction means constraints such as those offered by, for example, questionnaires, and focused directional interviews where the researcher is seeking coherent relevant responses to meet the research question or the hypothesis (Potter and Wetherell 1987). Categorisation can depend upon “the generation of categories which can be reliably
coded and imposed over the data for the purposes of hypothesis testing" (Potter and Wetherell 1987: 41). It is also suggested by, for example, Wilder (1986, cited by Potter and Wetherell 1987: 118) that “categorisation, per se, propels the individual down the road to bias”. Lastly, selective reading means just that; the researcher although acknowledging variability in accounts would use the data “to simply buttress the favoured analytic story” (Potter and Wetherell 1987: 42). They also hold that the use of these strategies can in fact inadvertently act as “management strategies for suppressing variability” (Potter and Wetherell 1987: 39).

Because a discourse analyst does not expect that “an individual’s discourse will be consistent and coherent” doing discourse analysis would not involve the use of the above strategies of camouflaging the immense range of different meanings in accounts. This is why context and variability are important features to the discourse analyst where work is conducted on extended sequences of talk to take account of these two features whereby the:

“Focus is exclusively on discourse itself: how it is constructed, its functions, and the consequences which arise from different discursive organization...” (Potter and Wetherell 1987: 178-179)

Therefore detailing how discourse analysis is rooted firmly in the language, and as such shows that any possibility of self concept or subjectivity is purely dependent on the linguistic practices we use (Potter and Wetherell 1994). After consideration of this methodology of discourse analysis it was decided to eventually abandon this route because of its reflections on the place of subjectivity argued as follows.
Parker (1992 : 81), ponders upon the issue of how account is taken of subjectivity within this methodology and poses the question “how do we describe the person as ‘discourse user’?”. Burr (1995), Henwood (1996) and Hollway (1989) also question the place of subjectivity within the methodology of discourse analysis. They hold that where discourse analysis is concerned exclusively with the function and consequences of discourse this is where there is a point of fracture around the use of discourse analysis being used to provide an account of subjective experience. For instance, Burr argues that Potter and Wetherell (1987) have clearly little to say about the experience of subjectivity (Burr 1995). Hollway raises the issue that if the question of “why did these people do that”, is asked, in connection with this approach to discourse analysis, Potter and Wetherell would state that:

“The researcher should bracket off the whole issue of the quality of accounts as accurate or inaccurate descriptions of mental states”.  
(cited by Hollway 1989 : 33)

and that:

“The descriptive accuracy of discourse and its adequacy as a map or chart of private, subjective, mental experience is the non-issue”.  
(Potter and Wetherell 1987 : 178-179)

The search for a way in which to conduct this inquiry and to do justice to the subjective accounts that form the basis of this research led to the consideration of the case study approach as advocated by Yin (1994). This is reasoned through below with details of the five components of this type of research design. Also, along with the discussion to use Yin’s structure for the research design there is the rationale for the decision to depart from Yin’s fifth component which deals with analysing the data.
The type of research that involves the study of a number of cases together in order to inquire into a phenomenon, which is the object of the study, is described by Yin (1994: 21) as a “multiple-case study”. This approach can be useful for this type of study as Patton (1990: 54) highlights:

“Case studies ... become particularly useful where one needs to understand some special people, particular problem, or unique situation in great depth, and where one can identify cases rich in information”.

This is a key element in making the choice of a case study strategy to conduct this research, as the area of study concerns attempting to understand a particular group of people with a particular dilemma. The particular people in question are older people with a particular dilemma in that they have suffered a debilitating physical illness or injury. So, precisely, as the literature review in the previous chapter indicates, this is a neglected area of study where surprisingly very little has been published about how, in particular, older people cope with a chronic debilitating illness and how such an illness affects their lives (Bowling et al 1994).

Another key element in the choice for case study approach is that it is an empirical inquiry strategy that

- investigates a contemporary phenomenon within its real-life context, especially when
- the boundaries between phenomenon and context are not clearly evident

(Yin 1994:13)
Yin (1994: 13) advocates the use of a case study approach if the contextual conditions are deemed pertinent to your phenomenon of study and to divorce them from each other would be difficult as they “are not distinguishable in real-life situations”. In this study the actual question to be explored is, “what may be the nature of the need, if any, for counselling/psychotherapy?” and, the real-life context in which this question is embedded is, that this is with regard to older people who suffer a debilitating physical illness or injury. So to divorce the real-life context in which the phenomenon of study is situated would detract from its coherence and sense-making. This is the rationale for the earlier inclusion and coverage of the theoretical issues raised within the research question which are the real-life context within which the phenomenon is situated. The issues, which are the real-life context, within the research question are the ageing process and old age, the body, the self and the impact of the physical illness or injury.

The case study approach also advocates that the field in which the study takes place depends upon the researcher having an understanding, or a theory, of the topic of study (Yin 1994). In this case the researcher cannot avoid a degree of prior understanding of the topic of study, as it is the field in which she works. Also in line with case study approach some of the theoretical topics related to the object of the study have been introduced in the opening chapters as well as in this chapter (Yin 1994)
This strategy of theoretical development, which is indicative of prior knowledge, is a strategy favoured by case study approach, and this is why this is another key element in the choice of this approach over, related qualitative strategies such as grounded theory and ethnography, which as identified by Yin (1994) typically avoid specifying any theoretical stances at the outset of a study.

Yin (1994 : 19-20) identifies five components of a research design that is, in other words, an action plan:

For getting from here to there, where here may be defined as the initial (question) to be answered, and there is some set of conclusions (answers) about these questions.

1. a study's question(s),
2. its propositions, if any,
3. its unit(s) of analysis,
4. the logic linking the data to the propositions, and
5. the criteria for interpreting the findings

1. A study's question:

According to Yin (1994) “there may be exploratory case studies, descriptive case studies or explanatory case studies” and he advocates that “what” questions are best suited to an exploratory study. The exploratory case study approach is the one that will be best suited to investigate the research question: “what may be the nature of the need, if any, for counselling/psychotherapy for older people who suffer a debilitating physical illness or injury?”
2. Its propositions, if any:

When the topic of the research is undertaken as an exploration, instead of propositions the design needs to state "(a) what is to be explored, (b) the purpose of the exploration, and (c) the criteria by which the exploration will be judged successful" (Yin 1994: 29).

(a) what is to be explored:

- According to Nichols (1993: 47) within a medical setting:

"There is neither permission nor encouragement to show or communicate psychological distress, ... in fact. Often, the emphasis ... is on staff not seeing, or denying, the psychological impact of serious illness, injury and hospitalization. ... the patients are encouraged by the general atmosphere to hide their feelings. Effectively, they are left alone to deal with their psychological reactions to illness unless they have some kind of breakdown".

This statement perhaps indicates the need to explore the fact that if people are given the time and opportunity to talk, and be listened to, will clearly distressful emotional/psychological issues be expressed, but as well will less obvious distressful issues also be expressed. The identification of these issues, will in turn, by analysis it is hoped, reveal their nature which in turn will reveal the nature of the need for counselling/psychotherapy in this situation. According to Rogers et al (1986) the presence of psychological distress in people who suffer a chronic physical illness although believed to be high, is not known. Mann et al (1993), agree that although depression in older people can be interlinked with a physical illness there are some difficulties in detecting its presence in that it may be masked by physical symptoms associated with the illness.
(b) the purpose of the exploration:

- is to add to the sparse literature and knowledge, as identified by the literature review, about the nature of the need, if any, for counselling/psychotherapy in medical/rehabilitation settings for older people who suffer a debilitating physical illness or injury. This is both, in the identification of the nature of emotional/psychological issues that may arise for people at this time and perhaps to illustrate the potential role of counselling/psychotherapy within medical/rehabilitation settings for older people.

According to Lantican et al (1994) the literature on psychotherapy with physically disabled people in general is relatively minimal. Whilst Mann et al (1993) report that primary care studies of depression in older people are also sparse. Guthrie (1996), identifies that people suffering with chronic physical disorders are the least investigated due to the fact that the most physically ill are, for reasons unknown, in the main excluded from studies.

(c) the criteria by which the exploration will be judged successful:

Firstly, to reiterate some notions about the impact of a debilitating physical illness or injury:

Langer (1994 : 182) proposes that

"Physical losses are not the only ones sustained by a patient who becomes acutely or progressively disabled; the losses involving definitions of self and personhood are often critical to adjustment...Patients who, in medical terms, are in "no acute distress" may yet be suffering. Suffering may result from internal psychic conflicts involving sense of self, self-esteem, altered ability to fulfill expectations, negative perceptions of self or others regarding disability..."."
- The criteria by which the exploration will be judged successful will be if the nature of the need for counselling/psychotherapy for older people is, a) revealed from within the data itself, the verbatim interviews and summarised counselling sessions, via interpretations offered that interplay with the theoretical issues which, as identified earlier are, the ageing process and old age, the body, the self and the impact of a debilitating physical illness or injury and, c) that it may add to the theoretical and knowledge base in the provision of counselling/psychotherapy for older people in medical/rehabilitation settings. The use of counselling/psychotherapy will be evidenced by summarised counselling sessions following the interviews and, in the interview and counselling session in the appendix.

3. Its unit of analysis

- Yin (1994: 22) states that “as a general guide, the definition of the unit of analysis (and therefore of the case) is related to the way the initial research question(s) (has) been defined”. A reminder of the research question “what may be the nature of the need, if any, for counselling/psychotherapy for older people who suffer a debilitating physical illness or injury?” prompts how the terms within the whole question were earlier defined. Because as stated earlier the case study approach promotes the cover of real-life contextual conditions “believing that they might be highly pertinent to your phenomenon of study”, rather than divorcing them (Yin 1994: 13).

A unit of analysis needs to be established to enable the study to be focused on the collection of relevant data which will help to answer the research question. The verbatim information given by people when they were invited to speak to the
researcher will be the unit of analysis. The unit of analysis defined as such is crucial to understanding how the case study then relates and contributes to a wider body of knowledge (Yin 1994). The wider body of knowledge to which it is hoped this case study will relate and contribute is to counselling/psychotherapy with older people within medical/rehabilitation settings.

Yin (1994 : 25) writes that "the fourth and fifth components have been the least well developed in case studies".

4. Linking data to propositions (as previously identified exploratory case studies instead of stating propositions state a purpose) (Yin 1994), and this component has been covered above under 2b) where the purpose of the exploration is explained.

5. Criteria for interpreting the findings

According to Yin (1994 : 102) there is not detailed guidance on this component of the research design stating that "the analysis of case study evidence is one of the least developed ...aspects of doing case studies". Whilst agreeing with the application of one of his general strategies, that of relying on "theoretical propositions about causal relations – answers to “how” and “why” questions – (in that they) can be very useful in guiding case study analysis in this manner" (Yin 1994 : 104). For example, there are causal relations to theoretical propositions about the aging process about how and why an older person may, for instance, feel unworthy and useless.
Other aspects of Yin’s strategies for data analysis where he writes that the “concern of the case study analysis ... is with the overall pattern of results and the degree to which a pattern matches the predicted one” (Yin 1994 : 108) seem, in one sense, to hark back to the discussion at the beginning of this chapter. This is where Hollway (1989) and Potter and Wetherell (1987 : 35) argue the shortcomings of some social research analytical methods that can camouflage an enormous variability of meanings within texts by managing them through analytic strategies of restriction, categorization and selective reading”.

To return to the fifth component then, the criteria for interpreting the findings, after some reflection it was decided that Yin’s general strategy of following the theoretical propositions and the literature review that inform the direction of the study, is relevant. However because of the identified problematic issues, as discussed above, with his specific analytic strategies it was decided to depart from Yin at this point, and consider the use of a qualitative method of analysing the data that would open up ideas of subjectivity. The method decided upon is derived in part from the work of Riessman (1993) who writes on narrative analysis and, also draws on the theories of Lacan, who studied the work of Husserl and Heidegger (cited by Sarup 1993). The appropriateness of using this methodology for analysing the data is argued through as follows.

Riessman’s (1993 : 3-4) concern is with the narrative “respondents narrativize particular experiences in their lives” and she adds that:

“Respondents (if not interrupted with standardized questions) will hold the floor for lengthy turns and sometimes organize replies into long stories ... precisely because they are essentially meaning-
making structures, narratives must be preserved, not fractured, by investigators, who must respect respondents’ ways of constructing meaning and analyse how it is accomplished”.

In discussing how to look at analysing a story Riessman (1993 : 5) quotes Bruner (1990) who holds that with narrative analysis “there is no one method” and has to do with “how protagonists interpret things”. Riessman (1993 : 61) herself writes that

“Ultimately, of course, the features of an informant’s narrative account an investigator chooses to write about are linked to the evolving research question, theoretical/epistemological positions the investigator values, and, more often than not, her personal biography”.

These notions seem to be reflected in the following thoughts that Riessman (1993 : 57) quotes from Heidegger who declares that:

“As I scrutinize transcripts, features of the discourse often “jump out,” stimulated by prior theoretical interests and “fore-structures” of interpretation (Heidegger, 1927/1962)”.

Riessman’s (1993 : 70) notion on the approach to narrative analysis that holds with the researcher respecting respondents’ ways of constructing meaning and then choosing features of an informant’s narrative account to write about which are “linked to the evolving research question, theoretical/epistemological positions the investigator values, and, more often than not, her person biography” resonates with her notion that “narrative analysis can be combined with other forms of qualitative analysis” though she argues that this is not an easy task as “combining methods forces investigators to confront troublesome philosophical issues and to educate readers about them”.
From the interviews the reasoning is to attempt to locate the nature of the need for counselling/psychotherapy by interplay with the theoretical issues discussed earlier. A reminder that these theoretical issues are, the ageing process and old age, the body, the self and the impact of the trauma. The actual method, the way of doing this is detailed later. Before this, some “troublesome” philosophical issues are struggled with to introduce the theories of Lacan which will be the driving force of the method of analysis.

Parker (1992 : 104) holds that “psychoanalytic and therapeutic discourses thread their way through culture, capturing people in a variety of subject positions and providing models of the individual. This thought that psychoanalytic discourses can establish subject positions and provide some discussion as to what it is to be a person within the discourse led to an exploration of Lacan, a postmodern psychoanalyst, whose version of subjectivity according to Pile (1996 : 134) “has to be understood spatially, two places determine subjectivity, language and the unconscious”.

According to Burr (1995 : 40) we may have a number of “selves”, and he suggests that each self may be “particular to and produced by certain relationships ... or social situations”.

Others quote that:

“The methods of conceptualizing the self involved in different linguistic practices have vital consequences for the positioning of people in society; they are not neutral or without impact, they produce senses of the self which may be negative, destructive, oppressive, as well as senses which might change and liberate (Coward, 1984; Henriques et al., Parker, forthcoming; Williamson, 1978).” (cited by Potter and Wetherell 1987 : 104)
These ideas of the discourse user and the senses of the self alluded to here could possibly be explored using psychoanalytic ideas about discourse particularly as the activity of counselling/psychotherapy is defined as being about the therapeutic use of self within a relationship (Tschudin 1992). Langer (1994: 181-182) writes about the loss of aspects of oneself incurred when disability is present, and contends that one of the aims of psychotherapy may be to help preserve the sense of self. Young (1989, cited in Riessman 1993: 3) states that “embodying the self in stories can occur in settings where the self is being disembodied, such as medical examinations”. Bury (1982, Riessman 1990, and Williams 1984) hold that when the trauma of chronic illness occurs individuals reconstruct “a coherent self in narratives”.

To arrive at some Lacanian perspectives on subjectivity the concept of “person”/“self” in post-modern psychoanalytical terms is traced historically, from ancient philosophical ideas about subjectivity to post-phenomenological psychoanalytical theories that enlarge on the theory of language and subjectivity.

Shotter (1984: ix intro, cited by Samuels 1993: 4) succinctly refers to these investigations on subjectivity as attempts to “research into what it is to be a human being, (to) research into our ‘whatness’ “and he proposes that, in a nut shell

“The history of philosophy is determined by the development and structure of the human being, who enters the world as an object amongst other objects who then becomes a knowing subject, who is later dominated by language and social relations”.
Postmodernists such as Lacan (1901-1981, cited by Sarup 1993 : 6) also see no division between the “self” and society and contend that we become social with the acquisition of language and it is language, therefore, that establishes us as a subject. It is now widely contended that the autonomous humanistic subject has been “dispersed into a range of plural, polymorphous subject-positions inscribed within language”. (Sarup 1993 : 130)

It would be useful at this juncture to consider how the study of language has developed to take account of this theory of disintegrating and multifaceted play of selves, and the many forms of subject-positions. Beginning with Husserl’s phenomenological method, where, for example, difficulties have been raised in applying this methodology to the study of language to investigate subjective accounts and narratives. This difficulty is expressed by Eagleton (1983) and Harland (1993) who both take up stances around the position (or non position) of language within the interiority aspect of Husserl’s phenomenological approach.

Eagleton 1983 : 60) identifies the fact that there is very little place for language in Husserl’s approach in that:

“Husserl speaks of a purely private or internal sphere of experience; but such a sphere is in fact, a fiction, since all experience involves language and language is ineradicably social. To claim that I am having a wholly private experience is meaningless: I would not be able to have an experience in the first place unless it took place in terms of some language within which I could identify it”.

Harland (1993 : 67) contends that although Husserl views language as aiding the disclosure of forms of thought he “rarely sees the forms of language as actually
determining the forms of thought”. Harland (1993: 69) continues that because Husserl focuses “ultimately upon the thinking and perceiving of a single mind, he views language also in terms of a single mind – the utterer’s mind”. Heidegger turns this idea of language being purely a convenient way of fixing meanings from within an interval private experience on its head.

In contrast to this notion of private interiority of experience Heidegger “meditates on what it feels like to be alive” (cited by Eagleton 1983: 62). According to Eagleton (1983: 58) Heidegger’s concern is with how the subject had come “to be” and what is feels like to “be” a human being, which is at odds with Husserlian phenomenology where the “subject was to be seen as the source and origin of all meaning (and) it was not really itself part of the world since it brought that world to be in the first place”.

Central to Heidegger’s work is the meaning of “Being” with an emphasis on the ontological foundations of what it is “to be”. In this, Heidegger proposed that it is “in speech the speakers have their presencing” thus opening up the issue of subjectivity and language (cited by Krell 1993: 406). Parker (1992: 104), as previously stated, maintains that psychoanalytic discourses intermash through culture and capture people “in a variety of subject positions and (provide) models of the individual”.

Frosh (1987, cited by Hollway 1989: 82) maintains that Lacanian notions concerning subjectivity also show that the human subject:

“Is constructed in and through language. This does not imply that there is any particular pre-existent subjectivity which learns to express itself in the words made available to it by language, but rather that the initially ‘absent’ subject becomes concrete through its positioning in a meaning-system which is ontologically prior to it and more extensive than it. The subject, the pronominal ‘I’, is created through an order
that originates outside it, in the flux of inter-subjective relationships that surround it and elect it to a place in their midst. Because of this, we are possessed and 'spoken' by language we do not own ourselves, but are constructed according to possibilities offered us by words”.

For Lacan then, it is when we acquire language that conscious subjectivity is produced and it is a constant changing process each time we step into language (Urwin 1984). It is this view of Lacan's, where he stresses that it is the acquisition of language that produces conscious subjectivity, and, that conscious subjectivity is a constant changing process each time we step into language that implies a certain dynamism to the idea of subjectivity. As such, then this notion adds vitality to the concept of conscious subjectivity and one of the ways in which accession to language does this is “... because language is founded on a system of oppositions such as 'I/you' and 'self/other', and it is this, adds Burr that makes "the sense of being a person in one's own right" (Burr 1995: 156).

This in some way relates to Lacan's notion of the "Other". For Lacan "language is the site of desire" and his work focuses on the human subject as defined by linguistic and social pressures (Bowie 1991: 83). Lacan sees no separation between self and society "human beings become social with the appropriation of language ... society inhabits each individual" (Sarup 1993: 6). Eagleton (1983: 174) refers to Lacan's thoughts on the language and the 'Other'

“Language always pre-exists us: it is always already 'in place', waiting to assign us our places within it. It is ready and waiting for us rather as our parents are; and we shall never wholly dominate it or subdue it to our own ends, just as we shall never be able entirely to shake off the dominant role which our parents play in our constitution. Language, the unconscious, the parents, the symbolic order: these terms in Lacan are not exactly
synonymous, but they are intimately allied. They are sometimes spoken of by him as the 'Other'—as that which like language is always anterior to us and will always escape us, that which brought us into being as subjects in the first place but which always outruns our grasp”.

Levinas cited by Hand 1989 : 149). it seems, sums up this idea of the language, the social and the notion that we are not interior beings but beings out in the world amongst it all:

“The act of expression makes it impossible to remain within oneself or keep one’s thought for oneself and so reveals the inadequacy of the subject’s position in which the ego has a given world at its disposal. . . . the subject who speaks does not situate the world in relation to himself; not situate himself purely and simply at the heart of his own spectacle, . . . instead he is situated in relation to the Other”.

Levinas questions the stability of the ego, and most certainly implies the death of the myth that we are a unified whole. Therefore, we can never restore the ego to its former impeccable state, because we simply cannot return to something that never existed. He also says that we as subject are in turn subject to the Other. Lacan describes the Other as “the locus in which is constituted the I who speaks (with) him who hears” (Muller and Richardson 1982 : 138). The Other as previously stated can be taken to mean, the language; the unconscious; the parents; the symbolic order.

According to Bowie (1991 : 82) when Lacan refers to the unconscious as being the discourse of the Other:

“He is hinting at a kinship, . . . between the structure of language and the structure of the subject: both are articulations of difference, neither has a centre; both involve endless displacement; neither has a point of plenitude or stasis”.


Lacan (1968 : 241) is particularly concerned with “the discourse of the unconscious” and it is the unconscious that is, according to Lacan “structured like a language” (cited by Eagleton 1983 : 168-169), and it is that, to which Lacan alludes to when he speaks of the unconscious “as a ‘sliding of the signified beneath the signifier’, (which produces) a constant fading and evaporation of meaning.

According to Lemaire, the Lacanian analyst “does not attend to the content of this discourse itself, but to the rents in it, the ‘formation of the unconscious’ which establish a new content: that of the motivations of the unconscious” (Lemaire, 1977 : 216). Lacan believes that “the unconscious is structured in the most radical way like a language” (cited by Muller and Richardson 1982 : 2). Sarup (1993 : 2) writes that Lacan’s notions of linguistics are rooted in Saussure a pioneer in the field of linguistics and who is ascribed with differentiating between the signifier (the sound or the written image), and the signified (the concept or the meaning). Simply explained as in “the sound image made by the word ‘apple’ is the signifier, and the concept of an apple is the signified”.

Lacan questions the notion that the parts that combine to make the sign (sentence) are fixed and interdependent. He, in fact, changes Saussure’s algorithm to “make it S/s (Signifier over signified). The bar separating the two symbols stresses the cleavage between them” (Sarup 1992 : 47). Lemaire (1977) writes about the significance that Lacan places on the line in the Saussurian algorithm when he stresses that “in language, the line symbolizes the mind’s detours in search of meaning; in psychoanalysis, it symbolizes the repression of the signified in other words it symbolizes the repression of the meaning.
In this way Lacan gives more importance to the Signifier maintaining that “the signifier has an active, colonising power over the signified implying that the signified does ‘slip beneath’ the signifier and successfully resists our attempts to locate and delimit it” (Sarup 1992: 47). For example the two signifiers “men” and “women” each positioned above separate doors can indicate the same signified (mean the same thing); a toilet; but there is no denying that each signifier (each word) has its own chain of signifieds (concepts, meanings) to which society, culture and life have contributed.

Lemaire (1977: 136) writes that for Lacan “the unconscious is a second structure. It is interpolated on the basis of the nodal points in the patient’s discourse”. Sarup (1992: 52) explains that nodal points provide “a vantage point from which everything that happens in a given discourse can be situated both retroactively and prospectively. In this sense according to Lacan language “can be used metaphorically ‘to signify something quite other than what it says, and it is this ‘metaphoric aspect of language (that) allows it to point the word to something beyond its literal meaning and referent’. Thus implying a struggle with the inexpressible.

This notion of the inexpressible is further explored by Bowie where he firstly identifies “the obdurate and impersonal systemic force” of language stressing a rather rigid view, but secondly assigning “the pluralizing semantic power” of metaphor in language as a power available in the speech of each individual. Bowie (1991: 65-66) describes this both rigid and fluid view of metaphor thus:
“The metaphor of the ‘signifying chain’ proves to be particularly versatile. It has a suitable penal and correctional air: the chain is what limits the speaker’s freedom, and the concatenation of its links speaks of a rigid causal order in which he is powerless to intervene. Yet the chain is also mobile, sinuous and able to loop back upon itself; any one of its links can provide a point of attachment to other chains”.

This shift to the view that humans are housed in the language begs the question of how we can speak of ourselves, or for that matter how can we speak of anything, when all we have are these signifying chains upon which to draw, and these chains in turn refer to other chains and so on. Lacan’s view is that:

“Analysts must relate directly with the unconscious and this means that they must be practitioners of the language of the unconscious – that of poetry, puns, internal rhymes. In word play causal links dissolve and associations abound”. (cited by Sarup 1993 : 7)

Killick (1994 : 3-5) a writer believes that people with dementia portray examples of how poetical language can be and the following are features from the speeches of two people with dementia that he recorded to illustrate this fact:

“It’s so foolish getting in a knot, or grieving about getting in a knot, I want to get to the point where it’s a case of a matter of course, after all, what is this lump if you can’t make sense of it?”.

“It’s a different country here. I don’t like it, and they don’t speak the language properly either. I’m suffering from monkey-puzzle. The monkey-puzzle is this place. The puzzle is; how to cope with monkeys?”.

Lacan’s idea of how analysts could be practitioners of the language of the unconscious drew on Freud’s concepts of condensation and displacement, both detailed as being essential functioning elements of unconscious processes. Lacan took the notion of condensation and compared it to his own notion of metaphor, where one word comes in place of another (Benvenuto and Kennedy 1986 : 120). As Hollway (1989 : 52) writes, “the psychoanalytic concept of condensation refers to just
the same notion - containing (condensing) many meanings in one idea or image” For Lacan displacement “the unconscious process whereby something of significance in an idea is detached and passed on to another image” is the same notion as metonymy Bowie (1991 : 132) likens this process to a railway system in that “metonymy keeps desire on the rails, ... always pressing ahead to the next destination, but metaphor supplies a limitless profusion of junctions, loops and branch-lines”. Having discussed and methodology to conduct the study next the actual method of exploration is outlined.

Method

The method of exploration into the research question “what may be the nature of the need, if any, for counselling/psychotherapy for older people who suffer a debilitating physical illness or injury” is derived in part from Riessman’s narrative approach and, in part from Lacan’s (1968 : 241) interest with “the discourse of the unconscious” and his theory that the unconscious is “structured like a language” (cited by Eagleton 1983 : 168). Riessman (1993 : 52) “takes account of structural properties (frames, stanzas, parts) (and) key metaphors”. Hollway (1989 : 51-52) discusses Lacan’s theory of metaphor and argues that:

“Metaphor refers to the way that many meanings can be contained in one image...metaphor and condensation both refer to “the compression of multiple meanings into a single image”

Benvenuto and Kennedy (1986 : 106-107) states that Lacan holds that:

“It is through the articulation of a discourse that meaning is acquired, one has to follow both the usual structure of language, and the way that one metaphor leads to another – the ‘metaphorical interplay’”. 
Central to the study are, a) the verbatim accounts and, b) the presentation of summarised counselling sessions. Throughout the study the researcher has borne in mind the ethical considerations that Pitts (1998: 20-21) states needs to be taken into account when undertaking health research which involves participants. She emphasises that people in these situations are especially vulnerable as they may undergoing treatment, and may also be the recipients of bad news. Given these issues, Pitts (1998) stresses that anyone conducting research in this area has a special responsibility to ensure that individual's rights are respected and that we, as researchers, "do no harm".

Interviews were conducted with patients who are in rehabilitation areas following an acute episode of a physical illness, disorder or injury. Potential participants from two rehabilitation areas were sought by randomly having their names, which were from the total population at the time, withdrawn from a hat. Usually people are aged 65 years and over are admitted to these areas, however, there are occasions when someone in their late fifties or early sixties can be admitted, for example, admitted straight from their home via their GP, so they were also included if randomly selected and wished to participate (Patton 1990).

Excluded from the study were those patients who have already been referred for counselling, those deemed too frail or too ill to participate, those unable to speak at all, those who could not speak English and those with a diagnosis of dementia. This is in accordance with the NHS Trust Ethics Committee's guidelines where the research was conducted. The researcher acknowledges that it is inevitable that
patients were at different stages of their hospital stay and that they were in the rehabilitation areas for different reasons. Once the above criteria was met and participants were agreeable ten audio taped interviews were conducted in a conversational style to hear how people talked of themselves and what issues arose for them in this situation.

Patients who wished to participate in the study were given an oral explanation of the proposed research project and a written information letter. In the information letter it was explained that pseudonyms would be used and all identifiable information would be changed. Because of the personal nature of the research there were ethical considerations in that what “emerges for the informant may be painful and distressing, and it is the responsibility of the researcher to do everything possible to ensure the well-being of the person” (McLeod 1994 : 167). In this context if participants found some issues arose during the interviews that required further support, if they so desired, further counselling sessions were offered with the researcher, and with their agreement this would be part of the research. However, if anyone wished counselling and no further participation or wished to withdraw from the study at any time their wishes were upheld. Also if someone wished for counselling with another counsellor this facility was also available. Part of the research also includes in the appendix one of the interviews with the researcher’s interventions, and a more detailed account of a series of counselling sessions with one of the participants.

The case study will be constructed in layers with the first layer consisting of the ten verbatim interviews. The second layer will be the summarised counselling sessions of those participants who progress from the initial interview into counselling. The third
layer is an analysis of key metaphoric texts generated by the interviews and selected according to Riessman's approach to narrative analysis that holds with the researcher respecting respondents' ways of constructing meaning and then choosing features of an informant's narrative account to write about which are "linked to the evolving research question, theoretical/epistemological positions the investigator values, and, more often than not, her person biography" (Riessman 1993: 70). The features or texts chosen will relate to Lacan's (1968: 241) interest with "the discourse of the unconscious" and his theory that the unconscious is "structured like a language" (cited by Eagleton 1983: 168).

During the interviews the aim was to allow people to talk of what they will at this time, so conversations were carried out in a way to specifically invite the telling of this without imposing too much of the interviewer's motivation upon the conversation. To do this it was felt people needed firstly to be put at ease, following this the opening question was around asking if the person could tell the researcher a bit about perhaps what had happened to bring them into hospital, and then moved on to enquire how things were going for them.

Following this opening the researcher attempted to allow the conversation to run in the direction that the person wished it to run, with the researcher's interventions as minimal as possible, and then only with the intention of supporting the person's line of conversation, by not asking leading questions but by reflecting back emotional content. This goes against typically medically orientated "interviews" which consist mainly of asking a series of questions that generally force the respondent to organize their experiences into predetermined categories (Strickland 1994).
In a sense then the conversations were, as far as possible, without boundaries. The researcher acknowledges that this is very unstructured but what was required was to just generate a conversation led by the patient. As Riessman (1993: 57) quotes:

“In settings where the telling of long stories is not expected, such as medical interviews, patients often have to fight for the floor to tell one”.

To set out the vast amount of raw data, generated by the interviews, in a style that would offer ease of readability prompted the researcher to use Riessman’s approach, whereby the core of a person’s story is displayed in his or her own words. Riessman (1993: 44) employs this approach because she proposes that it offers an ideal realization of the text, in that it:

“Excludes interactions between teller and listener, false starts, pauses, discourse markers, nonlexical expressions, and other features of spoken language”.

Others, for example, McLeod and Lynch (2000: 397) have also employed this method of omitting the therapist’s interactions to enable the client’s story to be more easily followed. According to Hermans et al (1993: 57), the deletion of all interpunctuation is a way of letting the person speak from their own world “as freely as possible”.

Riessman (1993: 45) is guided by the work of James Gee (1985, 1986, 1991) on the poetic features of language, and as such her approach includes arranging the text in stanza form which “is a series of lines on a single topic that have a parallel structure and sound as if they go together”. McLeod and Lynch (2000: 392) have also used this method by presenting a person’s account “through a series of interpretative
accounts intended to allow the reader to form as much as possible of their own judgement of the meaning of the text”. They also display the text in poetic form “to allow the rhythm and sense of what was said to be more apparent”.

The second layer of the research consists of presentations of subsequent counselling sessions of those participants who wanted further support. These counselling sessions were not tape recorded as the researcher felt this would be too intrusive so summarised presentations of these subsequent sessions are included. It is acknowledged that tape recording and note taking during a session can be intrusive and may produce dynamics of their own. Therefore, the researcher has attempted to offer a summary of the sessions from handwritten notes. Patton (1990 : 347-358) contends that handwritten notes after the event can take the form of brief scripts of conversation of a few lines interspersed by short written descriptions of what was said, considered, or debated in the time between

Finally, the third layer is a presentation and an analysis, of the offered from some key metaphoric texts selected from the interview data that contain, according to the researcher, key metaphors relating to the theoretical perspectives set out in the study, an example of which is given below following a reminder of the method.

Riessman (1993 : 52), in her work focuses on such concepts as “key metaphors ..., key words, (and) how substantive themes get developed through these, and other linguistic choices”. Riessman’s analysis of these stretches of talk includes examining its organizing metaphors and framing these stretches as narratives. Metaphors are also a key element in Lacan’s view of linguistic choices in that for him language,
"can be used metaphorically 'to signify something quite other than what it says' (and it is this) metaphoric aspect of language (that) allows it to point the word to something beyond its literal meaning and referent" (cited by Sarup 1992: 52). Lacan's notion is that "analysts must relate directly with the unconscious and this means that they must be practitioners of the language of the unconscious - that of poetry, puns, internal rhymes" (cited by Sarup 1993: 7). Lacan expresses that the function of the analyst "is not only to listen ..., but also to hear - where hearing (as opposed to listening) implicates the hearer in the utterance of the speaker" (cited by Forrester 1990: 145).

It is Riessman's notions of setting out the data in stanza and Lacan's notions of metaphor as described in full earlier and above and here succinctly stated, that the study relies upon for its interpretative strategy: Hollway (1989: 51-52) writes that:

"Metaphor refers to the way that many meanings can be contained in one image...metaphor and condensation both refer to 'the compression of multiple meanings into a single image'."

An example of an analysis of a key metaphoric text would be as follows:

"it's been a great shock to my system
I'm not dead in one sense
but bits of me are"  (Terry)

The text draws the reader's interest to Terry's personal viewpoint by the use of "I" and "me". Frosh (1987) maintains that Lacanian notions concerning subjectivity also show that the human subject:

"Is constructed in and through language. This does not imply that there is any particular pre-existent subjectivity which learns to express itself in the words made available to it by language, but rather that the initially 'absent' subject becomes concrete through its positioning
in a meaning-system which is ontologically prior to it and more extensive than it. The subject, the pronominal ' I ', is created through an order that originates outside it, in the flux of inter-subjective relationships that surround it and elect it to a place in their midst. Because of this, we are possessed and 'spoken' by language we do not own ourselves, but are constructed according to possibilities offered us by words".

(cited by Hollway 1989 : 82)

Thus Terry confirms that it is his personal story provided by the pronominal ' I ' that straightway carries with it, as Frosh (1987, cited by Hollway 1989 : 82) declares, “the flux of inter-subjective relationships that surround it and elect it to a place in their midst”.

The text is narrative in that it deals with a change in Terry’s situation from, it seems being fully alive, to now having to contend with the fact that some bits of him are now dead. The metaphoric phrase “it’s been a great shock to my system” indicate the blow that has been struck to Terry’s system; system meaning his organism; his body; his self. Terry says “my system” which brings into sharp focus not only an encounter with his bodily being, but his “system”. The shock, the blow as well as being a bodily blow has been a great shock to his system; possibly a tragedy in the form of a disruption to Terry’s organism, his way of being in the world metaphorically he is encountering a self in transition. Also what of the dead bits of him is this how Terry now thinks of himself a person with dead bits; dead bits of body, and “the great shock” of having to live with both live bits and dead bits all as part of his body. These are metaphorical markers of a sense of powerlessness descending upon him and all the private and public inferences this has for a man.
The other key metaphoric phrase "I’m not dead in one sense" is pivotal to a sense of grappling with a new experience of self. Yes it does mark the fact that "dead" the signifier, signifies lifelessness and unresponsiveness, yet Terry has qualified "dead" by adding that "he is not dead in one sense" metaphorically pointing to something about himself being that is alive and responsive. Plus the one remaining "sense" could be the acumen to help deal with this traumatic event and make some "sense" of it. Lacan describes the way in which the person is confronted by the unconscious which he stresses is striving to express what is really forbidden to the speaking subject and that:

“This inevitably creates tensions and splits in the subject, who continues to be de-centred, lacking fading. On the one hand he tries to speak and on the other he is faced by the impossibility of doing so. It is out of these tensions, which the subject relives...that the subject comes into being". (Benvenuto and Kennedy (1986 :181-182)

Interpretation of Terry’s metaphoric text show a projection of some images, on the one hand, of the consequences of this damage to the self, and on the other hand, there are images that could indicate some self restorative images. In that as Lacan, cited above, suggests, there is the possibility and the impossibility of speaking and it is “out of these tensions, which the subject relives...that the subject comes into being”. This is an example of taking a key metaphoric text and offering an analysis of it, but the full analysis of such texts is detailed in the next chapter, including how themes were developed and the way in which such metaphoric texts relate to the theoretical issues delineated earlier. This is now fully explored using the ten interviews.
Chapter 5: Data, analysis and findings

To address the research question which asks - "what may be the nature of the need, if any, for counselling/psychotherapy for older people who suffer a debilitating physical illness or injury?" - at this point it would be helpful for the reader to have some insight into the environment and the atmosphere in which patients find themselves as this environment does have implications for the delivery and practice of a counselling/psychotherapy service. This insight is drawn mainly from the researcher's own experience of more than 25 years in such an environment.

As detailed in chapter two, medical/rehabilitation settings for physical illness or injuries can be very much focused into dealing with the physical bodily aspects of the trauma and as such there is often very little space for emotional psychological aspects. The idea is for as quick a turn around as possible, fast track rehabilitation following the acute stage of a physical trauma is what is intended, however in reality this is not always the case. People are individuals and sometimes as previously stated the physical 'mending' of an injured part of the body is not always feasible, therefore, people may spend longer in the unit whilst their future is deliberated upon.

In these units the counselling/psychotherapy service, if there is one, can find itself being fitted around a multitude of other things, including ward routines, meal times, treatment times (i.e. wound dressings, catheter care, blood collections, etc. etc.), drug rounds, physiotherapy, occupational therapy, tea rounds, domestic rounds, doctors rounds, visiting times, case conferences, maintenance work, and so on.
Account also needs to be taken of the fact that people are ill and perhaps tired, therefore, the times of sessions vary from a few minutes to an hour or more depending upon how the person is feeling. There is also the issue of where people want or are able to be seen, for instance, at times the person may be having a day in bed, or if the weather is good they might like to go outside. All of these factors need to be considered in the light of confidentiality and the depth and quality of the rapport that can be established. Rybarczyk et al (1992 : 127-140) are among the few to actually consider these practical barriers to participation in therapy along with some practical concerns that need to be dealt with before therapy can proceed.

As discussed in the previous chapter the interviews were conducted starting with an invitation for the interviewee to tell their story of what brought them into hospital and what things had arisen for them at this time. Interviews were intended to be as unstructured as possible, therefore, there was no time limit as such and endings occurred as naturally as possible, sometimes mealtimes, or other ward related routines dictated the ending, or it just seemed the time to conclude, as would happen in a normal conversation.

This is, as previously stated, quite contrary to what usually happens in medical settings “where the telling of long stories is not expected, (and) patients often have to fight for the floor to tell one” (Riessman 1993 : 57). This is one of the rationales for including the ten interviews and the ten summarised case studies to allow the hearing of people’s stories.
Each person’s interview is presented in their own words set out by the researcher into segments of accounts to allow the reader to interpret as they may. Immediately, following this summarised case studies are presented of all of those who wished to progress into counselling sessions. Then finally some themes will be drawn out from the interviews and analysed as per the methodology discussed in the previous chapter.

Some participants wished the researcher to include a medical definition of their condition in order to better inform readers. Most people professed to not knowing much about the condition from which they suffered and one or two people identified that they would appreciate more information.

**Transference and countertransference issues**

Here it is of value to define the processes of transference and countertransference that occur during counselling/psychotherapy sessions. According to Kernberg (1958, cited by Newton et al 1999 : 21), “the terms *transference* and *countertransference* have been used more broadly to refer to all of the patient’s and therapist’s emotional reactions toward one another, whether based in reality or in neurotic needs”. As it is reported that Menninger allegedly said that countertransference is dangerous only when it is forgotten about (quoted by Slakter 1987 cited in Newton et al 1999 : 22). Therefore, it is countertransference issues, that is my reactions to each person are briefly discussed at the end of each summarised counselling session.
Interviews and counselling sessions

1. Interview with Terry

I was working in the laundry
repairing the washing machine
and while I was working I had a stroke*
fell down
and lost control of my movements
found I couldn’t get up
I was thrashing about on the floor calling for help

I had had though I was unaware of it
several indications of something going wrong
but I was entirely unaware of it
because as far as I was aware
I had good health

When I think about it now my first indications were
if I had a snag or a problem
I couldn’t actually get hold of them
I couldn’t solve them as well as I used to
there were no clear thoughts
it was like I just couldn’t
I just couldn’t take a straight path to solving a problem

The feeling of the stroke was like I was falling over
there was a big sheet of water went across my eyes
and I thought to myself at the time
I think I’m having a stroke
I think I’m dying
if this is death it’s not so bad as I thought it was

To put it together now requires single mindedness
the thought of how you put it together organize it
that’s what goes to pieces.
you imagine a blood clot going across your brain

Maybe I’ve been lucky
my brain hasn’t been damaged
the memory part whatever has been saved

All in all though
it’s been a great shock to my system
I’m not dead in one sense
but bits of me are
There's one thing I would mention
I'm suffering from a fear of going to sleep
it had been such a blow
that I am really afraid of going to sleep
because I may not wake up again

What I need is a mental boost
I don't have anyone to support me
nobody really understands what it feels like
to have your life changed so much
I get really down
there isn't really anyone to talk to about my fears

In retrospect it would have been actually
in lots of ways
better if I had died
because prior to my stroke I was a very active fellow

I've lost a lot of things
my freedom of course
my freedom
you're bound by something
by your mind by your body

Parts of your body are so strong
you could stand on your head
but you can't stand on your head
doesn't matter what you do
you can be as strong and determined as you like
but you can't
because you'll stand up
and your brains will make you fall over

They've told me in a nutshell
I won't recover much use in this arm and leg
they don't come to take me to the gym anymore
I suppose that's telling me something

The bottom line is I need to walk again
it's really one of the great necessities
because if you can't
that's it really
I’m constantly thinking that I must motivate
to get myself out of this chair and walking
because when I leave here what will happen
am I going to get enough help at home
this is one of the reasons why
I shall have to move out of my house
because I can’t actually get out of it without walking

I try and talk to someone
to find someone with something in common
I’ve only found one or two

I do what any normal red blooded bloke will do
excepting that I can’t walk
I mean I will occasionally attempt to flirt with one of the nurses
not in any serious way but just
I can be hurt the same as anybody else

I don’t really know what it means
this stroke
I mean in terms of
of whether
or how difficult it would be for instance
to ever be in a relationship

Besides, what woman would look twice at me now
I mean I’m disfigured
for ages I didn’t want to look at myself
I still don’t want to

God is this my life
sometimes I sit here in this chair
and it comes over me in waves

I’ve got my girls
but I can’t talk to them about
well certain things
you know they wouldn’t understand

I remember having a beautiful day
it was with my youngest
we went out on our bikes
out into the forest
took some beans and stuff
and cooked up a meal
it was such a beautiful day
When I was divorced
I lost 2 stone in weight
because I'd been hurt
it still depresses me now

The thing that gets me is when I see people
people who get ahead in leaps and bounds
I get jealous
why can't I do that
why can't I be like that
I ask myself why? why? why?

I take a deep breath
and I think
Oh! my god
this is hard going
you know it will never end
am I always
well yes
am I always going to be like this
maybe yes maybe no

Then you start to maybe
feel a little bit of fear again
and you feel a bit helpless
I do feel frightened
then maybe frightened
and not too sure

* stroke – The onset is sudden in cerebral haemorrhage and cerebral embolism because the interruption of blood flow happens quickly. Its effects are noticed almost immediately. Sudden death rarely occurs as a result of stroke. There are usually neurological symptoms related to the site of ischaemia: for example, if the left side of the brain is affected, the paralysis of the face, arm and leg will be present on the opposite or right side. Speech disturbances also are related to the area of brain cell damage ...pain may be present in affected limbs and often persists. The patient may experience difficulty controlling his emotions. (Weller 1989 : 892)

A summary of counselling sessions with Terry:

On the first meeting Terry's conversation was centred very much about being in hospital, how long he had been in hospital, and the fact that his physiotherapy sessions he felt had dwindled. He wondered whether he would be improving very much more. Terry's stroke had affected his left side quite severely, he was in fact that
very morning to be, in his words “measured for my coffin on wheels”. He was to be measured up for his own wheelchair, which he had been told would now be a permanent fixture in his life. He said that he felt very much now like “damaged goods”. Terry seemed to think that there was some doubt as to whether he would ever be able to walk again. He began to question things about his future wondering if he would ever return home. He had also tried to find other people to talk to and he said he was finding it increasingly difficult to deal with the situation “I mean I have these feelings of ..., it’s too difficult to even think that this is it” “that this is my life in one of these” (Terry then slapped the side of the wheelchair).

Subsequent sessions with Terry took place either outside or inside in his ward, which was a 6-bedded area. Sometimes other people were present, patients, visitors or staff moving about. During these periods Terry seemed to fluctuate between being quite high-spirited calling out to, and having a banter with the staff, or he was in his own words “depressed” and “fed-up”. Terry preferred to be outside in the grounds, weather permitting, and during these periods he would take an interest in things such as the shape of trees and how a particular scene presented itself to him. This was possibly due to his artistic background that he talked over at times. Terry mentioned about one of his, as he called it now “lost pastimes” where if he had the time he used to like going out for a walk with a sketch pad. He declared that he was no Rembrandt but that he used to enjoy the walk and the “excitement” of “sussing out” something or some scene to sketch and then perhaps later he would attempt to paint a picture.
In between times Terry experienced the death of Gordon, who had been a patient in the same 6 bedded ward as himself, and this had a significant impact on him, bringing out issues of his own mortality. There were issues about death and dying and the fact that bits of him were already dead.

His daughters visited, one more so than the other and he said he looked forward to their visits. He later told me that he was worried about one of his daughters, Merielie, the one that did not visit that often. She took drugs and he was very concerned about her health. She had been sleeping rough for periods of her life and she had had, he said, as far as he knew two abortions. She had managed to get in to see him and he just wished he could help her. He said he worried himself sick over her.

Terry’s speech seemed a little more unclear during this period and saliva dribbled from his mouth. He also became more and more frustrated that his left hand would not move. He now had his “own” wheelchair and a rest had been attached to it for his left arm and hand. “It’s so bloody heavy” he would say about his arm, and “do you know I just feel I could pick up that glass but of course when I try I can’t, it’s bloody useless, I’d be better off without it”. If I passed through the ward sometimes Terry would be sitting slumped in his wheelchair either dozing, other times he would be found in the corridor attempting to propel himself along, saying at these times how he needed to just be able to set something in motion for himself.

Terry became quite upset as to not feeling like a man anymore and was distraught about his appearance. He also talked about his relationship with his wife who had divorced him about 7 years ago. He said that he had threatened her saying it was the
last straw, “I put my hands around her neck because I was so frustrated and angry”.
Terry said that he had got to this pitch with her because she constantly left him to go
and visit her son. He said she used to go off sometimes for days at a time. He
explained that they had both been previously married and that they both had children
from their first marriages. He had two girls and Mary had a son from her previous
marriage.

Terry explained that his first wife had died in a road accident when his two girls were
very young. Terry expressed tremendous feelings of guilt over this as he said he had
been driving the car. “I can see Christine’s face, and now on top of all this, christ”,
“I’ve tried to rid myself of it, you know, lay it to rest”. “I thought I had been lucky
with this stroke, that my brain hadn’t been damaged, but ... but now I’m not so sure,
it’s all still in here”. (Terry taps his head).

Terry said he began to drink heavily to try and forget and had eventually gone to AA
(alcoholics anonymous) as he realised he had a problem with drink. He feels that all
this had an affect on his daughters although they were very young at the time. After
this happened Terry said he devoted himself to them but he feels that what happened
has had an influence on what has happened to Merielle.

Later Terry began to wonder if he could take up his art work in some way. He
surprised me on the next session by pulling out a sketch pad that his daughter had
brought in and he had “sussed out” that the weight of his left arm anchored the pad
enabling him to draw. The nursing staff also took an interest and encouraged Terry to
draw and sketch, and one member of staff also had an interest in art. We also explored the idea of discussing paintings perhaps with others in a group.

As Terry's stay in hospital stretched longer he eventually had to face the trauma of giving up his home with all the ensuing issues that this brought him about what does his future hold. He expressed feelings of great apprehension as to where he would end up.

Counselling sessions with Terry are written in more detail in Appendix one

2. Interview with Jeremy

I've been in here now for just over two weeks
I had a problem with my catheter
and also my muscles

My muscles had contracted even more so
and, and so it was thought
that I should come in here to have it sorted out

The trauma of coming into hospital
I don't think has helped me emotionally

My life was turned upside down 4 months ago
I had to leave my home
I've been in a nursing home since then
yeah, I was put into a nursing home
because I've got ms (multiple sclerosis)*

It feels like
like
I've been put on the moon
yeah

I was living at home
then gradually the disease
it bears down on all you touch
everything you touch really
My wife
she noticed I suppose
it was affecting the children
as much as it was affecting her
so she felt that
that I would benefit from
being in a nursing home situation

So that’s where I am really
in a home
it only took one phone call
that’s all
to the social worker
and I was gone the next day
it was as quick as that
it was virtually within a day
they said they had a bed
that was it really

It’s been very difficult for me
I felt unwanted
and really not needed any more
and that
I can tell you
is such a feeling
sometimes it seems to flood me

There’s a lot of people
all in the same boat
some in much worse conditions
than I am
where the disease
the disease has attacked
their vocal cords
they can’t speak

Whereas I
I can still talk
I can still move
albeit in
in a very limited way
though truthfully
I am
I am virtually paralysed
from the neck down
it’s hard
it’s hard being encased in this body
The first month I was there
(in the nursing home)
three people died
it was the last straw
everyone there
they all seem so much older
than me

No-one can really help you
you’re trapped inside
inside your own body

They come yeah they come
and they do
they do what they have to
and that’s it really

You’re like a piece of meat
to be seen to
I know it’s not their fault
but you feel just like the next package
yeah
the next to be dealt with

Just watching them struggle
it’s a nightmare
watching them
watching them dress me
I’m deadweight
and all I get is the pain

Some you try and talk to
some are really nice
but some
well they don’t want to know

I feel yeah I feel
that’s it I’m here
I’m sat in total isolation
I’m alone

I feel like an empty shell
does anyone see me
no-one hears me
it’s like
it’s like screaming into the dark
So there I am laid out and there I'll stay really

I felt this morning if only
if only I could look towards the future
sometimes I look backwards
where I've been

It's been the change of location and the feelings I have
as I say people dying
dying around me
it seems to bring me into real life

A bit of a shock really
maybe in some ways
it will be difficult to
you know
face going back.

* Multiple sclerosis (MS). Typically the symptoms ... are weakness, incoordination, paraesthesias, speech disturbances, and visual disturbances, ... the course of MS is usually prolonged with remissions and relapses over a period of many years. Stress due to trauma, infection, overexertion, surgery, and emotional upset can aggravate the condition and precipitate a flare-up of symptoms ... therapeutic measures include medications to diminish muscle spasticity; measures to overcome urinary retention, speech therapy and physical therapy to maintain muscle tone and avoid orthopaedic deformities. (Weller 1989 : 610)

A summary of counselling sessions with Jeremy

Jeremy is in hospital, he explains, to have a few things sorted out that have gone awry for him at the nursing home where he now lives. He explained that the G.P. who attended him in the nursing home had arranged for him to be admitted. After two sessions, Jeremy is transferred back to the nursing home where further sessions are continued. He found the whole experience of coming into hospital quite difficult to contend with in that he feels "the trauma of coming into hospital" has not helped him emotionally. Jeremy speaks about how his life was turned upside down 4 months ago
when he had to leave his home and be "put" into a nursing home. He now feels this is a further disruption for him, but the upshot of multiple sclerosis Jeremy says is that "when you’ve got a disease like mine you are never free you’re forever trapped" "you spiral into yourself there is no escape". Jeremy says he is virtually paralysed from the neck down.

During another session Jeremy said "I feel I’m in a box, life is passing me by". He felt that no-one, unless, they were in the same boat as him could possibly understand what he was going through.

Jeremy, at other times, would talk over when he was playing Irish music in pubs, weddings and “dos”, he had played the guitar and flute. He had also played guitar in a pop group and talked about “the gigs” they had attended.

There were times when Jeremy found the separation from his wife and children unbearable and he would ask “how can I deal with this feeling” “there is no way out of it, it’s on top of me I can hardly stand it, I can’t get away from it”. He tried to make the best of any social contact that he had with his wife and children, but he said he had always had great difficulty in expressing or demonstrating any emotions, prior to and since his illness.

With difficulty he talked over how, as a father, before the MS “kicked in” he had wished to be closer to his children, but had found it hard to connect with them. He felt his wife was slipping away from him, as her visits were less frequent. He felt extremely distressed by this, plus the fact that this also included his children as they
were still quite young and the reliance was on his wife to bring them with her to visit him. He thought that if he did not connect with them they would gradually slip away from him.

Jeremy had been a university lecturer in philosophy and often would debate “a philosophical point” on ontological issues as he put it. Sessions were usually not too long as the disease process was starting to affect Jeremy’s vocal chords, although the speech therapist suggested it was beneficial for him to continue to try to continue to strengthen his voice or, at least, to maintain what he had.

However, Jeremy came up with a compromise where he would listen to a philosophical reading and if he was able to he would discuss. He often brought philosophical issues to bear on how he was feeling and the situation he now found himself in. Sometimes he was keen to know what was going on in the world, “the world outside my world”, at other times Jeremy was as he put it “in deep despair”. Sometimes Jeremy said he dreamt about being able move although he said they were very strange dreams.

Jeremy sometimes could spend longer talking than other times due to the strain on his vocal chords. When he was experiencing difficulties he would operate his music system via a Possum*. Jeremy would make comments about the Possum such as “it’s so slow, but unlike me, in the end it gets there”.

On the times when he played his music, via the Possum, he would often, in between listening, return to discussions about music about which he was very knowledgeable.
This Jeremy said had been a wonderful period in his life, and he talked about the different venues he had played and many of the things that happened when they were “on the road”. He harked back to the topic of music frequently, and had photographs of the other members of the group on the wall in his room.

Jeremy was always to be found in his room, he was, in his own words “completely dependent on the staff”, explaining that he was here in his room until perhaps lunch time when someone would come to take him to the dining room. He said breakfast was always in his room, but lunch time was the time he was potentially able to mix with other people but he said “I don’t want to fall into the trap”. The “trap” meant for Jeremy becoming what he called “institutionalised”, and one of the ways in which he thought this may happen was at the lunch table.

He explained that he sits with three other people around a table and because of his condition he needs to be fed. He finds this whole experience embarrassing and incredibly difficult to deal with, he said both for himself and he also thought that whoever was feeding him may also find it difficult, depending he said on how sensitive they were to this particular situation. Some staff are distracted he said, “they don’t appear to concentrate on what they are about”, but he went on to say that it was not just the feeding, but the fact that he was fed before the others had their meal and, more to the point he was moved back to his room when he had been fed. Whereas he thought it might be a missed opportunity to talk to someone.
Jeremy was very worried about his relationship with his wife and his children who were young teenagers. He felt that the gap was widening between them. He talked over some aspects of his marriage saying that the MS had destroyed any vestige of closeness with his wife, “when you have to see to the shitty end of someone ... but it doesn’t mean you’re dead”. Jeremy talked about missing his love from his wife in both the physical and emotional sense, he felt he was wasting away not just with the disease but with the lack of contact with her. He increasing spoke about how he had had difficulties in expressing love for his wife even when he was able, but now he wanted some closeness. He was very concerned his wife would cease to visit and as well as not seeing her, he would not see his children.

He also expressed some distress over his lack of contact with friends he had had previously, saying that people very rarely visited, he added that they used to visit him at home where everything was set up for him. Jeremy thought that one of the reasons for lack of visitors was the fact that the location of the nursing home was too distant for people to travel. This being the only home “that would accept someone like me”. He explained that social services had installed all the equipment needed for him to be at home, but in the end his wife had been unable to cope.

Jeremy touched on some of his childhood and how his relationship with his father had been very stilted, saying that he had never been able to talk to his father. He said that his father had been a perfectionist and he felt he had been the one his father had picked on “nothing was ever good enough”. His sister, he felt, had been loved by his father, she was “the angel”. Even he said his mother took a back seat to Fiona (his sister), where father was concerned. One thing he said he did get right though he felt
in his father’s eyes was the fact that he eventually became a university lecturer. He thought that his father probably was secretly pleased with him “but he would never show it”.

Jeremy was either in his wheelchair or laying on his bed. He would have some physiotherapy to his limbs to try to maintain the muscle tone he had and to prevent further deterioration. He was distressed that his body was becoming increasingly contracted “the disease if it doesn’t get you one way, it’s cruel, it gets you another way”. When Jeremy talked about certain things tears would spring to his eyes, but there was the sense that he tried his utmost to prevent them falling. (When paralysis is present from the neck down there is no way that one can oneself, for instance, wipe away tears or blow one’s own nose).

Jeremy thought that the nursing home tried to provide activities, but for him he said they were not to his liking. Possibly, he thought, this might be due to the fact that many or, in fact, he said it seemed that most of the other residents were older people, and when he had gone along to anything a lot of people seemed to sleep through things, so he had given up going. He said that some of the activities seemed childish and he was not taxed intellectually at all, but he recognised the difficulty that the nursing home had in that to try to please everyone would be an impossible task. He told of a trip out in the mini bus but was disappointed that when they reached their destination they were unable to leave the confines of the bus “we could only sit in silence and look out at the sea, I was desperate to feel the air”.

Jeremy had met one other chap who was even younger than him who was a resident in the home. The problem being, Jeremy said, was that “Paul is on total bed rest and has been for the last year owing to some problems with one of his legs and his back”. Jeremy said that Paul had told him he had asked to have his leg amputated because of how deformed it was, and this was causing great difficulty with him being able to sit in a wheelchair, he had, therefore, weighed up the options of either staying in bed for the remainder of his life, or amputation so that he could fit into a wheelchair. However, Paul was depressed because of the long wait. Jeremy would have to wait for someone to take him to see Paul and then wait for someone to collect him from Paul’s room.

Jeremy continued to be interested in music and expressed a desire to be involved in some way in education, and was at great pains he said “to remain philosophical about life”. His wife continued to visit albeit less frequently and she did bring their children with her. Jeremy sometimes returned to talk about his relationship with his father, and how life at home had been so very unhappy for him especially with regard to his relationship with his father.

*Possum - patient-operated selector mechanism; a machine that can be operated with a very slight degree of pressure, or suction, using the mouth, if no other muscle movement is possible. It may transmit messages from alighted panel or be adapted for typing, telephoning, or working certain machinery (Weller 1989 : 746).

*My thoughts*

The changes in roles that Jeremy has been forced to accept from being, a husband, father and breadwinner to now being virtually stuck in one place, the shrinkage of his world is clearly evident. How could I relate to Jeremy. My own personal feelings were one’s of sadness for Jeremy and the position in which he now found himself.
There was also the fear and anxiety that what if I was to suffer such a fate how would
I or, how could I, handle the situation. I felt humbled at times by the bravery that
Jeremy displayed in the face of his illness and does this detract from me being able to
be present to him on an equal footing as one human being to another human being.

Given all these tough hardships Jeremy’s sense of humour shone through and one of
the sources of laughter was that I reminded him of the “hippy” period of the 1960’s.
We would laugh about this together plus one or two of the other little anecdotes that
he would regale me with, and any yarns that I acquired between our meetings would
also serve to make us laugh.

We talked about all the changes in his life, his fear of being alone, his anger over the
cruel blow that life had struck him, and his sadness about not being physically
touched in the sense of a loving relationship. Things became more difficult when
Jeremy had problems with his voice as the illness began to rob him of even this.

In exploring ways that would lessen the impact of the disease process which had the
effect of making Jeremy spiral into himself and feel “boxed up”. One way would be
for him to leave his room on occasions to become “unboxed” and engage in
conversation with other people and to continue to take an interest in philosophical
matters. This was achieved by him choosing some topic or word and then it would be
written on the board on his wall, staff were encouraged to come and view the topic of
the week and discuss it with him. Sometimes this became a source of great
amusement between Jeremy and certain members of staff. Another way to be
“unboxed” was that Jeremy realised he was still very much an educator in that he was able to invite students to come and interview him.

He felt life was passing him by and was keenly feeling the separation from his wife and children, and was concerned that his wife’s visits were becoming less frequent. He expressed difficulty in demonstrating any emotions towards his children prior to, and, since his illness. It was suggested that he start by taking a keen interest in what they had been doing and listen to them and also that they could start a living diary of their activities for him.

Jeremy fluctuated between good days and bad days. He had managed to contact some musicians he knew and they started to visit him and on occasions they brought their instruments.

3. Interview with Evelyn

Sometimes I wonder why I’m here
because actually
I feel all right
then
I found out it’s the medicine and stuff that’s keeping me all right

But I’ve got a knee
which I inherited
my mother had a knee like it
it’s swollen and difficult walking
I don’t think there’s too much wrong with me
other than this bad knee
Though my nerves are a bit bad
I do suffer with my nerves
and I think that's due to my father
he was an alcoholic
he fought it all his life
but
yeah, in the end he had to give into it
and when he did
oh god
life was a bit difficult
'cause he got a bit nasty
there were some very bleak times
I can still remember
and that's why my nerves are affected

So I'm not very fond of drink myself
and I've never had a cup of tea in my life
I can't stand the smell of it
I don't know why
it's an unusual thing
but my mother
she loved a cup of tea
and she used to say
look I've poured you one out
but I remember saying no mother
but she couldn't understand it

Mother had a difficult time
she was a lovely lady
and I had a lovely sister too
she was only half a sister
I don't know how we managed that
but she had a different father than me

Mother was a very patient woman
and she was very intelligent
I didn't know anything about her people
because I came along a bit late you see
I had two sisters
and they were almost grown up when I arrived
so she must have been getting on mustn't she

Kate well
she was born under the sign of Scorpio
and she didn't seem to fit into the family at all
and I didn't see much of her but my other half a sister
she was very good to me
and she loved me very much
If I think a bit deeply
I look out into the night sky and there are
there are other things whirling about in it
And I wonder if they’re inhabited or if we go
after so called death
if we go there
or where do we go that’s what frightens me
because I know that we still are what we were

Yes, we still are what we were
because my mother said she would come back
and she’d only been gone two hours and she was back
and I looked at her and I said
Oh not now mother I’ve been through so much

I want to tell you this
because I’ve kept it
right deep
deep inside
you see
I’d had to poison her
she had cancer
and I wasn’t going to let her suffer
so I hastened her death
which is a very difficult thing to do
but she wasn’t dead
she was back again you see
to reassure me I suppose
but it was a very hard thing to do
I couldn’t bear her suffering
but I’ve suffered ever since
I’ve been tormented over it

Summary of counselling sessions with Evelyn

Evelyn said she had felt very confused and lost by coming into hospital. First she said
she had been in the big hospital and then they moved her here; “of course my
hearing’s not so good, so I don’t always hear what they’re saying to me”. She also
said that some of them “they talk so fast too, I can’t pick up on what they tell me”.
Evelyn is still not sure why she is in hospital, other than her knee is bad and she cannot walk that well at the moment, “they said I fell down”. Evelyn remembers this now but “why oh why” she wonders does she have to stay here.

Evelyn talked over the fact she used to have a strong faith but it was the threat of purgatory that scared her. She said “they drummed and drummed it into you, yes purgatory, its like hell and they could leave you there for ever if they wanted to”. She said they were wicked to do that to make someone that frightened and she said she still could not stop thinking about it. Indeed, she said she had turned to religion when she had left home in the belief that it would help her but she felt that religion had also let her down.

Evelyn said her nerves were bad and being in hospital did not help. She was wondering how long she would be in hospital and what was going to happen to her especially now that she could not walk that well. Evelyn said she did not have anything to with her neighbours where she lived as “all the old ones have gone now” all the new ones she said seemed so different always busy here and there.

Evelyn developed shingles* during her time in the hospital, and this proved to be very painful indeed and she eventually lost her sight in one eye due to this. The shingles became a great source of pain and this was very hard to bear at times. Evelyn wondered if the shingles was sent as a punishment for what she had done to her mother. Evelyn felt quite unwell for sometime following the episode of shingles and she found it incredibly hard to bear the trauma of losing the sight in her right eye.
Throughout this time she continued, when she felt up to it, to want to have “a talk”. At times this was done outside where Evelyn felt that the fresh air and sunshine were of benefit to her painful nerves. It was on one of these occasions that Evelyn talked about her father and how his drinking had made him such a “nasty piece of work”. He beat her with his belt to work harder and harder, his cruelty extended to such things as making her sit at the back of the room away from the fire even when she was soaking wet from being outside collecting wood for the fire. For Evelyn it was the fact that “he never included me in the circle” and she added “I was always left outside it”.

She said “we used to dread him coming home from drinking none of us would speak unless he wanted us to for fear of him losing his temper, oh he was so wicked”. She described how she would try and make herself so small so he would not see her, “I used to curl up under the table into as tiny a ball as I could hoping he wouldn’t find me” but she said he nearly always found her.

She said “see the others (two other half sisters) they weren’t his, mother told me I was, and I was the youngest, and mother would say don’t upset him when he wants you that’s why because you’re his” Evelyn said she thought that if she went willingly with her father at these times her mother would be spared from any beatings from him.

Sometimes Evelyn said she thought or she wanted to believe that her father truly cared for her as he would pick her up and cuddle her, but she said however much she wished that were true, at the bottom of her heart she knew it was not and that at the
end of the day it was his own feelings that he was satisfying. She said it was at times when this happened that she almost kidded herself into believing that father loved her and wanted her inside the circle.

Shortly after father died Evelyn’s mother started to become ill and Evelyn nursed her and tended to her for 3 years. At first Evelyn said that her mother just became unwell and gradually seemed to get more tired and unable to do things. It was not for sometime that she saw pads that her mother had been using on her breasts to soak up “the mess” that Evelyn suggested they see the doctor. But Evelyn said that her mother did not want to see the doctor as she thought that the sores on her breasts were to do with when she was milking the cows and they had caused these “places” where they had pushed up against her.

However, Evelyn said that eventually she persuaded her mother to have the doctor and it was diagnosed that she had fungating breast cancer. Evelyn nursed her mother at home but she said “there were times when I couldn’t stand the sight nor smell of it, I’d have to run out and be sick, see, it was like a lot of horrible fungus growing on her”. Evelyn said that was why she had had to do what she did. At this point Evelyn said “I knew you’d understand and not think me mad, you know when someone clicks with you.”.

Evelyn did not talk anymore about her father until the time when someone had been to see her about leaving the hospital and leaving her to perhaps consider living in a residential home. She wanted to talk this over and was worried that she would be put somewhere without being asked whether it was what she wanted. She was so anxious
about what life would be like living with other people as she had not lived with anyone since she had left home. Evelyn said only two people have loved her that was mother and one of my half-sisters so she had spent a long time alone. She said that what her father had done to her had spoiled her for anyone. She said she still sometimes thought that purgatory was waiting for her.

Evelyn continued to be plagued with pain from the shingles.

*shingles (herpes zoster) is a local manifestation of reactivation of infection of the varicella zoster virus, the causative agent of chickenpox, characterized by a vesicular rash in the area of distribution of a sensory nerve. It is common in adults and the elderly ... pain of segmental distribution occurs before the appearance of the rash, which evolves from macules to papules, vesicles and then pustules in the same way as chickenpox but is more dense. Herpes zoster affecting the eye causes severe conjunctivities and possible ulceration and scarring of the cornea (Weller 1989 : 436)

*My thoughts*

Evelyn aroused all kinds of feelings within me. She was a very tiny lady and seemed a very dear person who had experienced a tremendous amount of grief in her life. Where Evelyn’s father had never let her be inside the circle I wanted Evelyn to be encircled to feel wanted and cherished not to be that little person curled up in a ball hiding under the table. I wanted to help her, to rescue her from purgatory. Also I was aware of my lack of knowledge of ‘purgatory’ in the religious sense to which Evelyn referred. The absence of love and the isolation revealed in Evelyn’s life stirred feelings of my own early life and I felt a connection with her on this level. Evelyn’s isolation had been further compounded by the episodes of shingles that she suffered. She reported great sadness at how lonely and isolated she felt her life had been for the most part.
My presence with Evelyn I felt was mainly supportive and listening. Evelyn said she found it comforting to have been able to share all these calamitous events in her life as if by doing that they become more bearable. She was distressed that purgatory might be waiting for her however she came to realise that she had borne such a weight of things in this life that her slate was now clean.

Evelyn and I continued to work together as she prepared to leave hospital and go to a residential home. She was able to take control of decision making regarding the area and the type of home she thought would be suitable and she is currently living quite contentedly in a large home where many activities are on offer.

4. Interview with John

I've had a lot of involvement with hospitals
I was a funeral director
yeah, for 28 years

People say funerals are dealing with death
but it's not
it's dealing with the living
you help the living
the living relatives.
I suppose most people think about the body
but it is about the living
the living

I feel now that I am living
but a living death

I've got worse
its suddenly taken a turn for the worse
the Parkinsons
I feel very trapped inside
I'm here to give my wife a break
to see if there’s anything else they can do for me

They’ve tried things when I was under 65
they did this test
and it was fantastic
it was half morphine in this pump
they put on me
and after about 10 minutes I was able to run up and down the corridor
fantastic
it’s only short term
you have it pumped into you
then you lose it
it lasts about an hour
then of course 65 loomed up

This is the first time in this place
I’ve done it before the under 65
but I’m 65 now
yeah
I belong to the old age people now
I don’t feel 65
I think it’s unfair they take it at 65
say Oh well he’s 65 now
string him along a bit

When I first had it, the Parkinsons
I went to the Parkinsons Society
well there was Parkinsons and Multiple Sclerosis and things like that
there was an old boy there
he said how long have you had Parkinsons
so I told him about 12 years then
he said oh well, I’ll tell you one thing
you get a damn sight worse as you get older
I said, thank you very much
he told the truth which is
well the best thing to do I suppose

When you get a terminal illness like this
you know damn well you’re not going to get well
you try and kid yourself that you are
but you know that you’re not

It’s affected my private life
my wife’s very caring and very understanding but
it’s like playing golf
I can’t do that any more
When you sit
and things go round in your mind
it's difficult
I never get to talk about things
you sit and things go round in your mind

You go and sit down for lunch or breakfast
breakfast this morning was at half past eight
I spoke three words between then and now
I find that you are talking to a person
then you realise that he doesn’t understand what you’re saying
he can’t talk
he’s had a stroke or something

I feel as if I’m getting old
I’m now 65 and to the Authorities
I’m past it
sort of useless
it’s like my opinions and views don’t count
I am 65 I don’t feel 65
it made me really annoyed reading in the paper
old man in his sixties

Much as they try to do for you
when it boils down to it
you’re on your own
you’re on your own in it

I never thought I’d end up like this
well you don’t do you
sometimes the shaking
it’s that bad
it’s frightening
I can’t even eat
can’t take a drink
well only through a straw
some they look at you
you just want to be
yeah at times like that
you wish the floor would open up

Summary of counselling sessions with John

John explains that he is in hospital for respite care. He comes in for 2 weeks every so
often to give his wife Irene a break from caring for him. “I hate this disease its ruined
my life it takes everything away from you”. John talks about his illness, he has Parkinsons disease,* how it feels like a living death saying that “I would sooner be dead it just erodes bits of your life”. John explains that he got the Parkinsons about 5 years ago then a couple of weeks ago he found he could not stand as his toes “went stiff”. Thankfully, John hopes that this has now passed and it was just a blip as he can now stand, albeit unsteadily and walk a short distance; he uses a stick to keep balanced. The trouble John says with Parkinsons is that “sometimes you freeze and you can’t for love nor money get going” John said his wife wanted to walk him down the road again but John said “I can’t face it I feel like a silly old man”.

John is getting terrible irritation on his arms and he says its driving him insane. He clutches at the skin where he can get at it at the top of his arms, the remainder is covered with dressings and tubigrip. He feels he is suffering like this because he must have done something wrong. The irritation continues to be a source of great discomfort to John for the next few days. He told me that they were sending him up to the skin clinic at the general hospital to try and find out what was wrong. Following this John is prescribed medication and an ointment which thankfully soothed the condition. He remained in hospital for a further couple of weeks.

During this time John talked about his working life as a funeral director and that he saw it not so much as working with the dead but working with the living, the relatives. “I felt I was doing something really useful but now with this rotten illness I’ve lost everything”. Even though he had been retired for some years John had played an active part in his local community centre helping his wife out with things such as
luncheon clubs and jumble sales. He also used to like a game of darts at the local pub, but John said the Parkinsons “it affects everything, your private life all of it”.

John did talk over his marriage to Irene saying that they had got married late in life but both for the first time. John thought at one time he had been destined to be on his own but that meeting Irene had been such a wonderful event in his life. However he was very saddened by how things had turned out and the fact that there were no children that Irene could now call on to help her look after him. John discussed the fact that he did not really like coming in for the respite care, “my wife and I love each other and just want to be together, but she has bad knees and I realise she needs a rest”. John did touch on how much he misses Irene when they are parted saying they have always been a very close couple, but he said that the Parkinsons has even destroyed something of that.

Unfortunately the irritation on John’s arms returned at internals to plague him with a vengeance and the skin specialist prescribed some different oral medication which he was hoping would seem ease the discomfort of it.

John talked especially about the embarrassment he felt due to the visible signs of the Parkinsons disease, also how distressed he is about the constant scratching he has to do to relieve the skin irritation. Also he said “It’s things like having a drink, what normal people do all time, but see look, when the shaking starts there’s no way” John said he felt acute embarrassment about eating and drinking in public, as he put it, “I have to use a straw when its really bad and eating well that’s another nightmare, the
food can end up on the floor” John went on to say that “not to have control of your body is just so degrading” John says he has lost quite an amount of weight.

Another issue that bothers John is that he feels sometimes that the staff know more about his needs than he does himself. “I keep telling them I’m constipated but they say I’m not” “It’s so bloody awful feeling so dependent on others” But he added “it must be just as hard for them, they get some tricky customers to deal with”.

John found the whole idea of being with others who all seemed to be so much older than him difficult to deal with. He was unable to find anyone to have a conversation with as they either could not speak or could not hear what he was saying. John said that being able to talk was one of the only things left for him and even that was virtually impossible at times to do.

John talked about his mother and father saying he was 12 when his mother died; she died of TB and he had been in the room with her coughing up blood which he had found very distressing. He and his father became “good pals” after the death of mother. going off to football matches and the theatre together. John had been with his father when he died, saying he missed him so much as he had been both mum and dad to him. John talked about his childhood in Scotland, telling about cycling and walking. Also he talked over his work in a foundry before becoming a funeral director, and how some people saw it as a low status job, but he did not, he had enjoyed that time.
John said that he now has to take a slower path through life. He did think that the trouble was that people do think “that I’m a trifle mad”, because, John thought with his speech, “it’s like the rest of me it can freeze”.

*Parkinsons disease – Usually appears gradually and progresses slowly. At first the victim may be troubled by mild tremors of the hands and nodding of the head. He may notice that his movements are somewhat slower and more difficult then usual. Then loss of mobility in the face produces the characteristic masklike facies. As the disease advances, the tremors increase and may involve the whole body, although generally they are not apparent with intentional movements. The muscles become stiffer, making movement increasingly difficult. The gait becomes shuffling and festinating. The back tends to become bent forward in a stooped position. Parkinsons disease does not affect the mental capacity. (Weller 1989 : 696)

My thoughts

At the onset on working with John I found it quite difficult to deal with the Parkinsons Disease in that it got in the way of being with him. It was very intrusive, making its mark felt most of the time, and this is how it feels for John. He is never free of it, only when he falls asleep. In his words the Parkinsons has taken everything away. The issues that I experienced in dealing with it were ones of frustration at the slowness of John’s speech and then I felt guilty about having these feelings. If I found it difficult to sit and be with him how did others respond to him.

Therapeutic interventions with John were perhaps just the fact that someone could listen to him and be with him. Parkinsons had inflicted him with tremors which were increasing in severity his voice also was weakened and like his body there are times when it just freezes. He was keen to converse as he said that being able to talk was one of the only things left for him although at times it was difficult. Therefore, he was encouraged to come along to join a group called pot luck that we were running, which was in the main focused on communication using drama, poetry and literature.
5. Interview with George

I can’t explain the falls
all I know is I’d be doing something and
then
boom
George would hit the deck
like the air force planes
crash landed in the hospital

I spent most of the war in the Army
I had wanted to be in the Air Force
but there it wasn’t to be
who knows
I might not have spent
spent time in one of the camps

I was captured and spent time in a prisoner of war camp
the Japanese, well some of the things that happened
it’s something you never forget
you can’t obliterate
it’s in your mind
stuck there
the pain of it stays

In fact my knee, which I had to have replaced
was a direct problem of my treatment
and incidentally that didn’t work the first time
and they did it again
and it took me three or four months to get over it

Then I had my wife’s ill health to contend with
she had terminal cancer
then developed alzheimers
I told my doctor
that she didn’t want to go into a hospice
and I said I would look after her
which I did for about three years
then my health went

I went into hospital
“G” for geriatrics
which has now become care of the elderly
my wife was still alive then
I didn’t really know what was wrong with me
apparently I had angina
which I knew nothing about
I never knew I had it
and since then
I’ve been in a number of “Gs” at the hospital
My general health has deteriorated
and I’ve had falls
so here I am crash landed in this hospital
my legs they wont carry me

My experience has been
well of course I think it all depends on the individual
let me illustrate what I mean
at the present moment I’ve three or four nurses
they look after me in turn
but they way they do it
some it’s a delight to ask to do something
others are rather brusque
you must do this
you must do that

I think to myself
what have I become

During the cold war
I had complete control of certain areas
for instance I could evacuate all the hospitals
and other departments
I had authority over the area
I never had pretensions that I was better than anybody else

Now well now I feel very apprehensive
I try to suppress any bad feelings I have
I say to myself you mustn’t get paranoid or anything
take things and do as you are told
you know it’s bad feelings
what’s going to happen to me

I try to get on with people
but there are times
when I think people are doing the wrong thing
And I have to bite my tongue
I try to take things in my stride and do as I’m told

I would like to present myself as looking like George
that’s my own private ego
I have no knowledge of what the programme is
there’s no thought of me being in the programme or organizing it
I just go along with whatever they say
and say “certainly”
I don’t profess to having full knowledge of certain things
but it would be nice to know why you’re doing certain things
it would be nice to be told you’re doing this because
that does this or that does that
they’ve got a job to do
and perhaps it’s because the next patient that comes in
wouldn’t understand what they were talking about
even if they tried to tell them
so they have to treat somebody like myself
I hate to say this
who understands what’s happening
the same as people who stare at you
and don’t know what’s happening

It’s like the other day
the chappie in the next room
he had a fall
well my first instinct is to press the bell
and make certain everybody knows it’s urgent
not only do I press the bell but I shout
and in fairness
they said to me thanks very much for doing that
we kind of worked together you know
and how can I say it
I enjoyed that

I would love to be taken to the gym
and somebody say to me
we do this for that and that for this
but I’m not entitled to it
and I accept that’s the way it’s done
I’m not complaining
but for my own piece of mind you know
I do like to be more involved

I lost my wife 3 years ago after 47 years together
it’s very lonely
But I got myself a big television with Sky and Cable
I’m an avid sports fan
I live in a block of flats with a warden
they can’t pick us up now
they’ve gone under new regulations
that if we fall
they call an ambulance
they just come in and see to you
examine you for fractures and things
the last time I didn’t want to go into hospital
but they said we think you should so here I am
**Summary of sessions with George**

George after four sessions went to live in a residential home, so the remaining sessions took place there. In sessions, which took place, in the hospital before he left George discussed in more detail his past medical history, describing in detail the things that had befallen him and how after this series of events there was a marked, albeit, slow decline in his ability to do what he used to do.

He again raised his thoughts on what was the programme of rehabilitation he thought he was part of but, at the same time, feeling that “there’s no thought of me being in the programme or organizing it”, but quietly accepted that was how things were, in that he was treated the same way “as those poor souls who stare at you and don’t really know what’s going on”. George expressed how difficult it was for him this state of affairs where all his life he had tried to be helpful and become involved in whatever he was a part of.

George did talk a little about his time in the Army, particularly about being a prisoner of war, and how some things at the present time in his life brought back his memories of being a prisoner of war. “I know, of course, it’s nothing like that, how I am feeling at the present time about my lack of freedom, of course it can’t compare to that time in any shape or form, but somehow I do feel so restricted now”. George’s feelings of being restricted did not just apply to his physical ability to not move as he used to do, but also applied to his “having to bite his tongue” and do as he is told.

George touched on some of his experiences in the prisoner of war camp saying he felt still so tormented about some of the images of that time. “I still see the bodies
hanging, hanging from trees, or makeshift rails they put up, some had been flayed alive can you imagine what hell they went through, your skin stripped from you while you are still alive, those screams they will live with me forever, those souls, I fear, are in my head”.

Sometimes George said, he was also in fear of the nightmares he suffered periodically and this made him reluctant to go to sleep at times. He said it was times like that when he really missed his wife, Grace, because she would cuddle up to him and they would love each other and he said that helped so much, “but now, all there is is an empty space beside me there is no place for my feelings to go”.

George had nursed his wife for three years and as well as the terminal cancer she had developed Alzheimer’s disease and he had experienced a very traumatic time when she died. He had gone to see the doctor and in passing had said, “pity about the old fashioned gas ovens” and he also had said “can you give me something to hasten me on”. These comments he said he made, not jokingly, but a way of expressing how he felt at the time. George then literally found himself almost overnight in a mental health centre where he was admitted for electric treatment. He had been very distressed over this and still was “it’s in my notes, perhaps that’s held against me”. He said he felt that some bits of his memory had been wiped out, it was a terrible experience.

George explained that he had coped with his restless nights in one way when he was at home by watching Sky and Cable television for the sports coverage as he was able to watch the programmes all night long if necessary. Whereas now George is put into
bed when staff come around to him and this is where some nights he finds himself in his own words “quite tormented by my thoughts” and unable to sleep much at all.

George said he played the piano and said he would have been a musician but that he had twin sisters and money did not go far. He also said that going into the army had really put the tin hat on any plans he might have had about been able to earn his living from playing the piano. His twin sisters had died a few years previously within months of each other he recalled.

George had been told that it would be very difficult for him to return home and that he would have to think about going to live in a residential home, he decided that this was probably the only realistic option open to him. He reached this decision after a trial period at home where he again fell and this time, unfortunately, injured his hand. George had a son who lived in Canada, but the distance would make it impossible for George’s son and his family to be able to offer any support at all. George explained that his son had gone to work in Canada and once there had met a Canadian girl and set up home there with her. George and Grace had been to visit them a number of times over the years and they maintained contact by telephone each week.

George’s move into a rest home happened quite quickly, this is largely due to the fact that there are many more rest homes than there are nursing homes. He left the unit almost the next day of knowing about the vacancy, going to the home he had chosen because of its location. George had wanted to be near where he had lived in a block of flats as he had a friend that lived there. This move proved to be very traumatic for George because strangers had to go to his flat and clear out his belongings of which
he could only select only a few to take to the rest home. George was visibly quite upset over having to dispose of certain possessions and cried during the first session at the home “I’m not robust, I’m not up it” he remained very shaken about the whole experience.

George seemed to be becoming increasingly unhappy and withdrawn at the rest home. He objected to his room being locked as soon as he was up, as the home, he said seemed to insist that everyone should go and sit in the dayroom. George was to be found sitting in the same chair and told me that this was now where he was to sit. The chair had its back to the window and faced into the small lounge area. George found it quite soul destroying having to face the same three ladies every day saying that it was not that he bore them any bad feeling but they were quite frail and often asleep. George himself appeared visibly smaller and frailer.

*My Thoughts*

George was a very smart gentleman and told me he would try right to the end to maintain his appearance. I felt drawn to comment on his smart appearance, and perhaps this was in some restorative to his diminished sense of self. There is a sense of self in the continuity of our body, because that is how we are known to others by our embodiment. Also how we clothe, adorn and decorate our bodies silently speaks for us. By the same token any weakness in the body also makes its mark on both our self and on other/s.

It was the lack of control that George was experiencing over his life that struck a poignant chord with me, in that here was a gentlemen who had been to war, had
orchestrated his own life until now. I let myself try to imagine the feeling of a diminished sense of self that George was experiencing where there was no thought of him being in the programme or organising it. It raised my fears and anxieties about ageing and death coming ever closer and brought it home to me that my life is now more limited than it was due to my ageing.

Therapeutic interventions with George meant recognising that he had a coping strategy for some things i.e. at home watching television from bed if he could not sleep. But in hospital George expresses a lack of control over many things so it was questioned as to how he could take back some control of his life i.e. over when he goes to bed. Interventions were of a supportive nature when George had to move to a rest home. However, as he was not happy in the home he went into with encouragement he took control of his life and after a lengthy period he eventually moved to another home where he is extremely happy.

6. Interview with Hazel

The fall
I had a fall
and it was onto flat ground
if it had been at a different level
perhaps I could have got up
but you can’t get up
you see that’s been my trouble for 2 or 3 years

Since this has happened I’ve felt different
as somebody said
it’s your confidence that goes
because I mean like now
I mean I can’t get up and get away from this if I wanted to
I’m stuck that’s the kind of thing
when they shut the door I’ve no way to get out
I pray literally
I pray hard
I say to God give me the strength to bear this through the night
I pray an awful lot

My mother prayed a lot
she lived the life of a saint
when she was dying
she couldn’t speak
but she had written on a piece of paper
God is love don’t weep for me
and when I hear that....

I’m claustrophobic
there’s only one young man here who knows what it is
but he says he’s never had anyone to deal with before
I’ve had it since I was a little girl
only during the War it sort of had to go I suppose
you were looking after hundreds of air women
then it all came back

I have read that what happens during your earlier life
can sometimes re-appear
it wasn’t a stupid sort of book
it was a big thick book
it was a beautiful book
I just happened to open it at a page where the brain was in a big circle
and it said that what goes into your brain as a baby stays there
and I suppose now when the brain is older it’s full
and it won’t take anymore
it’s got to the end of using the brain
I’ve read things like that
as sometimes you can help other people know what they are talking about
it said you can because that is really true
you can memorise it and it’s there to pass on
you’ve got to get onto other people’s wave length
I was terrified to get in the ambulance
I couldn’t lay flat
I was thinking about my husband when he was ill
I said I would stay with him
but a young doctor
I think she was a graduate or something said
there’s no need we’ll look after him
but they let him fall out of bed
I was jolly mad when that happened
because I was fit and well
and I’d offered to sit all night with him
because all he wanted was Hazel
he was calling out all the time he wanted me
and I would have been there for him
he died during the night

It brought it all back to me coming in here
well you see you’re not in control of yourself
that’s why I want to get back home

The biggest thing has been having to ask people to take you here and there
in the morning they say where do you want to be taken

Also I leak a bit here
I managed to get my dirty pants into the laundry basket
and it just comes on
I can’t stop it
my water just goes a bit a bit
so I have to ring and say I’ve been dripping
I was able to raise my bottom and wash there
it sounds stupid but I was pleased that I could do that

But I never thought I’d come to this
not being able to move
not being able to jump up and do what I want
I can’t go home until I can walk

The other thing is
most of them have had these strokes and things
and they’re in desperate condition of all kinds
I think there’s only about one that’s a bit compus mentus like myself
if as much as me
because I am quite with it
I have this fear
if I do fall
and I can’t get up

I went into a nursing home for 2 nights
I didn’t want to go
but my doctor put me there
he said he wouldn’t take responsibility for me unless I went

I do feel so alone at times
I’ve only got one child
she says I’m an old misery

I was in the infirmary as a child
my mother had to leave me there
I cried
but I tried not to make a fuss
I was always not wanting to put anything onto anyone else
I am the person I was when I was born
My faith has gone away a bit
I was going to give in

I was going to give up
whether or not my faith is going to be strong enough to get me over the barrier
I get low points

You see there are people
I don’t like people being sharp with me
or getting at me
it doesn’t do me any good
and it doesn’t cost them anything not to be sharp

Well when I said to one of the girls
please don’t draw the curtains
she looked up and said
why?
just like that
I mean if she’d said
oh why my dear
that would have made it better
as if she’d understood
but when somebody just says
why?
as much as if to say what the heck’s wrong with you

I try to be helpful and sociable
but they may only remember me as that crabby old lady
because I’ve been so miserable here
because there is this feeling of isolation
you feel so abandoned
Summary of counselling sessions with Hazel

Hazel talked about her leg still being a problem “look its so swollen, I’ve never had a leg like that before, I have to be truthful, I don’t like the look of it at all”. Hazel was very concerned about what was going to happen continually wondering if the swelling would go down and would she ever get back on her leg again and so walk again. She said “I once said to Eric I hope my legs never get swollen like you see older ladies legs, now look at mine” Hazel is quite tearful over this.

Hazel talks about being taken to the dayroom and not really wanting to go there mentioning that if she is lucky she will get sat next to someone sensible. She said “the trouble is they haven’t got the time to keep moving you, once you’re there you’re there you’re stuck”. Hazel expressed her concerned over this issue of feeling stuck because of the claustrophobic feelings she had experienced on and off throughout her life. She could not bear to have door to her room in the hospital closed at night and if it happened that it was closed she said the agonies she felt were so severe and frightening.

Hazel recalled that her mother was a deeply religious woman with a very strong faith. Hazel said “I do pray to god to help me, my mother was a devout Christian, I only hope that my faith will be strong enough”. She said she had had to deal with a lot of things including her husband Eric’s death and how traumatic that had been where she had wanted to stay with him but they had said there was no need. Eric had died after
Hazel had gone home after being told this, and she bitterly regrets that she was not by his side when he died.

Hazel talks of her daughter Clare, and that Clare thinks Hazel is an old misery, Hazel finds this very hurtful. Clare was born to Hazel late in life and Hazel said she had made sure that Clare was not subjected to a deeply religious upbringing that she herself had had to endure. She said “mother used to make me go on my knees constantly to thank the lord and sing his praises, she would do it with me and we would stay there for sometimes quite long periods”. Hazel said sometimes that she had wanted to “pass water” very urgently and her mother insisted that she hold it in for as long as possible and if necessary Hazel was to relieve herself on the floor, so that their communication with the lord was not interrupted. Hazel had hated this. Hazel said she had not inflicted that on her daughter although she herself had a faith. Hazel said that Clare had gone back home (she lived a distance from Hazel), and in one sense Hazel was glad that she had returned home “you expect daughters to be helpful and caring but she’s not”.

Hazel talked over books she had read and again remarked that “what gets put into your brain as a baby and when you are growing up stays there” and she added “perhaps as you get older the brain gets fuller and wont take any more” Hazel continued “although I’m in the world in two senses, one sense is this (touches her head), not so sure about the other sense – oh! I know I was a whole woman, or I used to be, when my husband used to say you’re the best – I never took much notice”. Hazel went on to say that she liked a woman to look like a woman adding that she
used to like to put on her make-up and wear a corset “it would give you a bit of shape, then you could go off down the high street”.

Hazel explored the possibilities of whether she would be able “to go off down the high street” ever again. She was beginning to think that this would just become a distant dream as she went on to explain, she had also been told, since she had been in hospital that she had a thing called scleroderma*. Hazel said they had told her it is quite a rare disorder, a bit like arthritis, but instead of the joints being affected it is all the tissues in your body that are affected. Hazel showed her hands and arms exclaiming about the lumpy appearance adding that when she couldn’t understand exactly what it all meant someone told her that “it’s the condition where you turn to stone, everything eventually goes solid”, and she added “there is no treatment whatsoever only pain relief”. Hazel said she could cope with it being over her body but it was how it affected her face that she said caused her the most distress. She said that she had been wondering for sometime why her face had appeared to be so flushed and lumpy looking; she had kept it covered with makeup, “me being vain, and wanting to cover it up and pretend it was all right”. Hazel was finding the scleroderma very hard to deal with in terms of how it was altering her appearance, which she found very frightening and what it was leading to; the turning to stone was a very distressing thought.

*scleroderma – an uncommon connective tissue disease in which both hardening of the connective tissues of many organs of the body, including the skin, heart, oesophagus, kidney and lung, and damage to the blood vessels may occur. The skin may be thickened, hard and rigid, and pigmented patches may occur.
My thoughts

Working with Hazel raised more about my own bodily being and how fragile the scales are positioned in life and with Hazel for some reason I very keenly felt my own vulnerability in growing older. Recognizing that parts of my body do not work now as they used to and that I do a certain amount of covering up to try and delay the process of ageing. Sometimes I do feel the need to try my hardest to make things better for people but working with Hazel reminded me that I cannot make things right for people. Although Hazel’s condition the scleroderma could not be made to go away I felt she was able to talk about her true feelings about this and other parts of her life, her relationship with her daughter and her religious faith and somehow ‘girdle herself up’ and go on.

Therapeutic interventions with Hazel were validating her feelings the pleasant and not so pleasant ones. Also checking her coping strategies and in a sense shoring them up, i.e. the fact that she experienced some relief in prayer. Also that it was all right to use make up to cover things up. Hazel eventually went home.

7. Interview with Sylvie

I don’t want to be a bother to anyone
and I’d sooner drop dead than suffer a lot
can you understand that

I worry about it
I get depressed
I don’t think that I believe in anything
I used to
but now
well I don’t think I’ve got any faith
I mean, to me death is that and that’s the end of it
What I think is so terrible is that they tell you everything
I mean I only asked if I was going to be alright
I suppose I wanted a gentle answer
you know, even if it's bad news there's a way of telling you

But no they said no you're not
you've got this tumour and it's growing
they said .......
it's like an octopus with tentacles
can you imagine how I feel
knowing even what is looks like inside of me

I have nightmares about it
I can't seem to get it out of my head
you know, the thought of it
its horrible like your body is being taken over by something alien

One of the staff here is very nice
she's brought me in some knitting wool
I was telling her that I used to do a lot of knitting at one time
I hope I can do some
when the thoughts aren't in my head

I feel I'm living a death now
and its worse than I ever imagined
I know that I would be better off not knowing
being oblivious to what's inside me
they could have been less detailed in what they said

Jim comes in when he can
trouble is it costs such a lot of money on the bus
so he can't come that often
it's £3.00 a day for him to come
well you multiply that by say seven
you can soon see what it runs to

Sorry I'm going on and on
I feel I want it all to run out of me
When I start I want to go on and on

Summary of counselling session with Sylvie

Sylvie said that before all this happened she had been coming in and out of hospital
regularly because her weight had been going down. She said she had had a tube going
into her stomach for the past year since she had a stroke. She explained that this was
how she had got her nourishment for the last year, saying that the stroke had affected her voice and her swallow, but she had got her movement back pretty well. She reckoned she had recovered quite well except for this tube. Sylvie said she has a terrible craving and temptation that “if I see food, I want to put it in my mouth, but I would probably die if I do that”. But then she reflected that now she was dying and was even deigned the pleasure of eating, but also reflected that what would be the point of prolonging life anyway.

She talked about when she was working saying “I worked for some nice people as part of their family doing the cooking, serving the food, I really felt accepted, me – accepted”. She said she came from Czechoslovakia and during the war often she heard people say “well they’re foreigners – people never differentiated between foreigners – we were not trusted – people were cautious around us”. Sylvie said it made life even harder, but she said how grateful she was for people taking her on in service.

She talked about her husband Steve, who she met while she was working in a large country estate. Steve, had been working on the land, and she said he had a vast knowledge of land life saying there was nothing he did not know about horses, cattle, pigs and sheep and he was, she said, very sensitive to how horses were treated. Sylvie explained this was probably due to the fact that Steve’s father had worked with horses and carts having come back from the first world war and he gone to work on a farm where the horses too had been in the war and had terrible scars. Steve had died a few years ago, and that’s when Sylvie had met Jim. She explained that Jim lived in the same block of flats and they had struck up a friendship, he had lost his wife some 20
plus years ago and had been on his own all that time. They had decided not to live together but they spent a good deal of time in each other's company, both being without children and they had found a sort of solace in one another Sylvie said.

Sylvie talked about Steve saying that although he had been a good man in lots of ways he had been a very private man, very much interested in his work on the land and the animals in his care. She felt that he did not always have that much time for her, and although she never ever told him she felt neglected that was the feeling that she most often experienced during their married life. She said that early on in their married life she had asked Steve about having children and he had told her never to bring up that subject again, and Sylvie said with some sadness that she never ever did talk about having children again. This was a great source of distress to her, the fact that she could never talk about it to her husband and secretly she pined and longed for children.

Every so often Sylvie talks about her present illness and "says she cannot get the idea of the octopus inside her mind saying "it's such a vivid image in my head". She does have days where she feels so weak and not up to much talking but during these times is still wanting the presence of someone because Jim cannot be with her all the time.

*My thoughts*

I felt very sad at times when I was with Sylvie and in some sense I took on the burden of her dying feeling heavy and not wanting to go on. At times I felt inadequate when I was with her not knowing what to say, how to respond to her. The dying and not
being able to eat in the conventional way and her view that if she could this would only prolong her life and what was the point of that. At times I found Sylvie very uncomfortable to be with and perhaps it was that she reminded me of people I have loved and lost and of my own immortality.

However, interventions with Sylvie included validating how treasured and accepted she was by families for whom she worked. Also acknowledging her distress about not having children and being with her when she talked about her illness. We worked on some guided imagery visualisation techniques to overcome the images that she had in her head. Also meditation techniques provided to be helpful to Sylvie, they were something to work on and she seemed to value being able to put her mind to this.

8. Interview with Ellie

Well I was standing in the kitchen
having a cup of coffee
before I went to my job

I only did a bit of cleaning
but it helped to give me a bit of extra money
and I enjoyed the company

All of a sudden
I felt I had to sit down
it was
it was as if all my strength had gone
you know
drained away
this arm felt a bit funny

Anyhow after a while I felt okay
and I did manage to go to my little job
anyhow that night I didn’t feel at all well
I couldn’t move my right side
It was my next door neighbour that found me like it the next morning
he’s got a key
we’re
we’re you know
friends

Anyhow the upshot of all that was he called the doctor
he didn’t come ‘til four o’clock in the afternoon
suppose they didn’t think it was urgent

Tom helped me get to the toilet
I don’t know how he managed
well when the doctor came he said
we’d better get you off to hospital
it looks like you’ve had a stroke
I thought Oh, my god ... no

Well mother had one
it was awful
she couldn’t talk
only make noises
we never know what she wanted
I remember the look on her face
it was like
like she was afraid of everything
it still haunts me
the way she looked
terrified

I’m a bit frightened that people won’t understand me
in my own head my voice
my voice
it sounds slow
heavy
then I get this yaayaayaayaa business
where I can’t stop saying it
my teeth chatter

I caught sight of myself
they’ve got a mirror in the gym
I didn’t realise how awful I look

heavy that’s how this arm and leg feel
I keep moving these fingers
if only they would grip
if only my leg would carry me
It’s the fact that where they sit me
that’s it
that’s where I stay
well they leave you in this chair (wheelchair)

I don’t really have much to say
I seem to have gone into myself
everyone seems to be sick in some way

Even when I went to the gym
people are detached from you
they’re just doing a job
you’re one in the queue

They’re not expecting me to do miracles
I feel totally stranded
as if I’ve been washed up on the beach and left there
even the tide doesn’t come in to take me back

I don’t know what Tom’s going to do
he’s been a very good friend to me
well more than that
he’s a lovely man (cries)
I’m sorry
it’s
it’s just that I don’t know what’s going to happen
there’s no-one I feel I can ask
some seem flippant about everything
if you do ask
it
it doesn’t seem important

I sit here with it all on my mind
you know
what about Tom

He says he still loves me
but how can he
I know he wouldn’t say anything
but it’s what I feel
it’s what I feel inside and outside

The stroke
the stroke it’s got me inside and outside
inside and outside
that’s how it’s affected me
that’s what it feels like
Sometimes they talk to you as if
you know as if you’re not right
I asked the time
she said it’s not time to go to bed
I didn’t ask that
it made me feel I hadn’t got my right senses.

Summary of counselling sessions with Ellie

Ellie feels that everyone seems to be arranging things for her “my daughter, these people here ... you never have a say ... no I don’t...I might like to decide something for myself”. Ellie had heard talk that she may not be able to return home and there were arrangements being made for what they call “a home visit” to see how Ellie copes for a few hours at home. Ellie was extremely concerned about this as it seemed, so someone else had said to her, a bit like going on a test with people watching you to see, for instance, how you perhaps get on and off your bed, how you put something in the microwave, and things like that. Ellie expressed that she would be devastated if she could not return home, and this is where she was worried about other people seemingly taking control of what she can and cannot be allowed to do.

Ellie was most unhappy in hospital saying she could not bear to be there she says she feels “in no-man’s land” she also said “it’s a terrible lonely feeling, I dread the dawn of each day”. Ellie expressed that some seem hard on her “one said you’ve got this left side you can do it...I thought that was cruel...I asked for a drink...she said it’s over there”. Ellie said I asked one of the staff the time and she said what do you want to know for you’re not going anywhere. It things like that Ellie said that make her feel ten times worse.
Ellie talked a little about her life telling that she had worked for a large clothing firm in her home town of London, saying it was a sweatshop and they did not earn much money. They made parachutes during the war. Ellie had lived in Clapham and it was from there that her daughter thought it would be best if she came to where she lives now to be near her. Ellie's daughter thought that Ellie would be better near her, especially after Ellie's husband left her and went off with another woman. The trouble was that Ellie had had many friends in London and she had been involved in some social activities. She said she played the piano for the Health and Beauty League and also had experience of playing the piano and violin in "pubs".

Ellie said that she didn't think of herself as being old, and found it hard to imagine that she was. She also thought in one way that it had been a mistake to leave London, because she said her daughter was always too busy, but on the other hand she would never have met Tom. Tom and Ellie are very close they live next door to each other. Eventually she confided that she and Tom had slept together, she said if her daughter knew she would be horrified that people of Ellie's age actually did that sort of thing. Ellie was very worried about her relationship with Tom, in that how would things now go between them, given, in her words that she had one half of her body that was nigh on useless to her or anyone else "I'm condemned to this sitting here, I feel so anger and bitter inside why has it happened to me". Ellie says "I'm not happy, I'm sad, I keep crying" she says she has a sleeping pill and sleeps for 2-3 hours then is wide awake.

Ellie is very worried about what is going to happen to her. Ellie said the physiotherapist has told her to live only from day to day, but she is concerned over her
future. She is worried about becoming a vegetable, she feels frightened she is becoming like her mother who also had a stroke. Ellie remembers nursing her mother for a while at home and she took a turn for the worse and Ellie managed to get her into bed then when the doctor came he took one look and said “this woman’s dead” Ellie thought how cruel. Ellie went on to say that there were eight girls adding that they’ve all gone now bar one Beryl. Ellie does not get on well with Beryl all she said was “I hope you’ve saved enough for your funeral, what a thing to say”. Ellie added that when her sister Joy died she had no-one to turn to and this was during the period that her husband left her.

Sometimes Ellie said she feels that she wants to lose control, she wants to scream and scream. Ellie says she feels frightened, she doesn’t know what is happening to her and sometimes she says she starts calling out for help “help me, help me I shout, then I start with this … I don’t know what it means … I make this noise … it’s like yaayaayaayaayaayaa”. She shows how she does this and thinks it sounds foreign, Indian or African and questions how she knows something like that. She tries to stop herself by biting on her tongue “I can’t control myself” she says and asks if she is going mad. Sometimes she feels its happening to her perhaps when she is in the dayroom, she gets a premonition that she is it going to happen her chin starts to quiver.

My thoughts

The metaphor of a steam valve came into my mind when I listened to Ellie. I visualised her as this steam valve that wants to let rip, that has let rip in the past, but currently is under instructions or duress not to. Some of the steam is trying to escape when she calls out and it’s a bit like being gagged when you can’t take control of yourself, be the maker of your own destiny. She felt she was in no-man’s land, a
foreigner – her own body has come to make her feel that way because that too is now no longer under her control. Ellie keenly felt this change in her body, and with particular regard to the issue of sexual relations with Tom which she cautiously raised with me as she asked me how this would affect that side of things. This is a subject that is very rarely raised by people and Ellie said she almost hadn’t had the courage to do so. I was glad she had as it is an important aspect of life but initially I felt put on a spot and I guess surprised because, as said, it is so rarely discussed.

Therapeutic interventions with Ellie allowed her to release some of her feelings and pent up emotions. Ways were discussed to help her take back some control of her own life and herself, even to be in control of her sleep pattern. Ellie joined a group that is run on a weekly where the emphasis is on the use of drama, poetry and literature, and through the medium of poetry and literature Ellie further explored her options. She found it enjoyable and gave her, she said, some self-confidence back which made her feel better. Ellie also eventually returned to her own home.

9. Interview with Clive

I try to be philosophical
it’s very hard for me
to be sitting here
to be honest
I think to myself
why don’t they just give me a gun
and I’ll shoot myself

I’ve always been able to brace myself
you know, against things
somehow deal with whatever
but my god
this
this is something else
I really can't deal with it
in any shape or form
I can't get my head round it

My brain's telling me one thing
yeah, that I can walk, I can move my fingers,
I can talk properly
but I can't
it's like being stuck in mud

Let alone the shock of coming in here
well that's enough for anyone of my age
everyone else looks so much older
it's a shock to the system

The thought that I could live another
20 plus years like this
that's what they've said
that having a stroke doesn't necessarily mean that you will die from it

It's dead wood
they may as well cut it off
Christ, I'd be better without it ... ...

You get told where you can and can't go
what's happened
why get treated that way
it's the way you're told
it's a bloody nightmare

I feel so changed
I had no inkling what a stroke could do

I've been used to being on the move
never anchored down
What the bloody hell am I going to do

There's Ray he's, well he's my partner
we've been together for almost 16 years now
even that's hard for me to talk about
I mean I haven't told anyone here
but I get the feeling they've got an inkling
that's what's hard
you know I miss him
you know what I mean
yes he visits but I worry
I worry if he'll stick with me
Summary of sessions with Clive

Clive says he sits in the wheelchair all day and the cushion is hard. “What sort of life is this?” he says “I didn’t ask for this to happen”. He had been up and about before he had the stroke and now he has been told that it’s doubtful he will walk again “there’s nothing more they can do”. It says it was an absolute blow “I felt floored, what can I do – I’m just wasting time sitting here”. Clive talked about how frustrated, mad even that he is, that he can’t do things. He thought he was going to slide into depression. “I’ve always been able to brace myself against things”. He tries not to get angry, not to think too much.

Clive says he used to do a bit of fishing and gardening but doubts whether he will ever be able to do those things again. He says that is how he met Ray his partner. It was through fishing and we got friendly, that was 16 years ago. Clive said he was married for a few years but always thought something was wrong, not with his wife but with him. He says he stuck it out but was never comfortable with the relationship. He had a son, but he has not seen him since he took up with Ray. Clive says he can understand how his son must have felt and that he doesn’t blame him for not wanting to stay in touch.

Clive is finding it so difficult being in the rehabilitation unit. To him many of the other patients seem so much older and quite a few of them are deaf so he has found it hard to converse with anyone. Clive said he had no idea of what a stroke was. He had heard about people having them but “you never think about these things until it
happens to you”. He says he finds that he keeps dropping off to sleep “like the rest of them in here... I suppose it’s boredom”

There is talk of him having an electric wheelchair and he views this in two ways, on the one hand it will be good and give him some independence, but on the other hand it means it’s permanent; the way he is permanently going to be like this.

Ray and Clive have got a ground floor flat so there is a possibility that he could return home. This hinges a good deal on whether Ray is prepared to help Clive. Clive worries about the physical aspects of his care and whether he wants to put Ray in this position. There are also issues around the fact that Clive also has reservations about this. Then he wonders what choice he has in that if he doesn’t return home the only other alternative would probably be a care home.

My thoughts
How could I relate to Clive in the face of his illness, his despair and his grief over his losses. I cannot imagine him living in a care home, he just looks far too young to be in this position. The stroke has taken him completely by surprise and has had an impact on so many areas of his life. He is worried about his relationship with Ray and that this has now changed from one of a couple in a loving sexual relationship to what Clive now sees as an unequal relationship. The loss of this is emotionally painful for Clive.

Therapeutic interventions with Clive gave him space to talk over his issues and to make the decision to talk things over with Ray. Also to explore if there are any other
ways in which he can keep his interests going in fishing and gardening. Clive finds he
gets so angry inside and on exploration with him a form of relief is to be outside in the
fresh air. So he arranges this himself with the staff.

10. Interview with Pam

I've always had varicose veins
osteoarthritis
ulcers and then
a little while ago
I got this new bed
my friend's
my old bed was
you know a bit ropey
got this new bed
and then I fell out of the blessed thing
and that was what caused this
ummmmm
broken
whatsaname
broken talius bone
that's in my foot
I've also got arthritis in my knee
I've got osteoporosis

I hate being like I am
it's like being trapped
I want to get out

Ulcers
I've had ulcers
since twenty odd
although it was nasty
you can get out with ulcers you know

I was managing on my crutches
but it's the steps and stairs you see
and feeding my cats
that's a problem
but I made sure I fed them
it's a real blow
I worked you know
I worked nearly all me life
until I took retirement
I did nursing when I was a kid
but I had to pack it up
‘cos even though in those days it was
it was hard
see they had long wards and they nagged you
in the end I had to pack it up ‘cos me legs
you know
they went bad

Then I did typing
but I got fed up with that
typing that was
in London
2 years I did that
then I went to P.W.C.
that’s a factory in Midbank
that’s quite a distance
I used to ride me bike over there
so I’ve always been active
that’s why it’s hard
really hard

So as I say I’ve been attending hospital
since I was twenty odd for veins
course it gradually got worse as I got older
and that was it
you know
but it’s hard

I’ve been here for over a month now
because I was in the other hospital
for a week
I got taken there when I broke this see
(arm)

Well as I say I was managing not too bad you know
then I got a flare up of arthritis
and my sister lives in Yorkshire
and I phoned her
and I said to her
I can’t manage
she said
you don’t get like that very often
Anyway she came down
‘cos she’s got this driving job all up and down motorways
anyway she came down
and well the upshot was the district nurse
she recommended a care home
but they didn’t have any vacancies
so I got this one in Marksbury
and that’s where I went
and I put my cats away
and I was there
I wouldn’t like to sell up and go there
they’ve got this big flight of stairs
and I can’t get on a chair lift
can’t see why I can’t have one at home

You see the district nurse from the surgery came to do my ulcer
that was on the Monday
and then god it happened
I heard it crack
yeah me bloomin’ arm bone crack
and I thought
I’m sure that’s gone
you see they haven’t had the training like these staff nurses have had
anyway she went to drag me up ‘cos I wanted to get off the loo
That’s when it happened

I went down the hospital Tuesday
to see about my ulcers
I saw Fay
she’s the nurse that sees to ulcers
and I said to her I’m sure this is gone
anyway she’s very efficient
she’s a very nice person and she’s a cap person
anyway she got a sling for it
and she said we’ll get that x-rayed for you
and of course got it x-rayed it was broke
I’ll never go to that care home again
and it was quite expensive
I didn’t like it there

Too many potatoes there
you know
all sat slouched in their chairs with no expressions
but people have sold their home to go there ‘cos they’ve got nowhere to go
old people
ughhh
I couldn’t stick it
And then my teacher friend came up
and she said it's like an attic you know
it was awful
of course me legs were up like balloons
yeah
so after they x-rayed my arm
and they found that
they took me to accident and emergency
of course they need the beds there

So the next day they plastered it for me
and I was there a few days
and then they got me a bed here
it's a blasted nuisance
I've had to pay eighty odd pounds to have my cats put away
'cos I've not got people to look after them
damn nuisance
I know there's people worse off
but I live on my own

Through choice I wouldn't want to go in anywhere and live
I like living on my own
because you can please yourself

I feel frustrated
there's not really anybody to talk to
a couple of people in the ward have had strokes
I try not to get too down
but some things get to you
some of the staff are kind
'cept them that's a bit abrupt
but I can shut them out
some of these old people could be upset
but I suppose most of them are a bit deaf
and they can't hear very well

I worry about home
my home affairs
but you see if I give her half
well I shall have to find somewhere
somewhere rented or something
it's my sister
they were ready a month ago
she had it all signed up
yeah they came down from Scotland
yeah somebody said to me if I sign the power of attorney
see I don't know a lot about this
I could be homeless
I can’t stay here ‘cos they need the beds
I wouldn’t like to stay here you know
partly ‘cos one of ‘em in particular she can be very abrupt
I try to let it go in one ear and out the other

I tell you what I don’t want to live ‘til I’m old
looking round here I couldn’t stand it
no … no …. I couldn’t
it’s already bad enough
‘cos I don’t think I’ve got a hand really in what happens to me
it’s like I’ve lost me
you know what I mean

I tell you there’s one thing I don’t agree with here
see all my family have gone off quick
nobody lives in my family for long
my dad died
he had lung cancer he never retired
my brother had a brain tumour he was only 28
my auntie had cancer she was only 60
I tell you what I did notice
a person died here last night
I think they should have a side ward
perhaps they haven’t got anywhere
I don’t know
five o’clock yesterday morning she was hallucinating
the people who came to see her were nice

I used to think things out
but as I say
I seem to have lost me somewhere
this whole thing that’s happened to me has been an absolute pest
to be honest I just hated it
where I can’t walk
only with crutches
see they were going to take this off
this leg
that was last year
and I said no
I couldn’t cope with that
I’ve noticed men in here
they’ve had theirs off
I try not to think about things
Summary of sessions with Pam

Pam had received the news that her right leg (the one they wanted to take off last year) had become very infected through the presence of the ulcers there. During the next week she said that a quick decision was going to have to be made about her leg, because it had become gangrenous and if left the gangrene would travel rapidly up her leg and attack the rest of her body in time. Pam talked through her dilemma and came to the decision that she would not have her leg amputated. The ensuing days saw a deterioration in Pam with the smell from the gangrene pervading the ward. So a decision was made to move Pam to a side ward where she continued to want to talk sometimes wanting to know what was going on in the world outside, sometimes she talked over her life and then sometimes she talked about her life ending.

My thoughts

Pam readily chatted when we first met but gradually as the gangrene took its toll on her body she became more still. I was appreciative of the times when Pam's ability to chatter was there but also I was able to be with Pam when she was in a more reflective mood talking over past times and also about her death. It was a difficult ending as the smell of the gangrene became all pervasive and even the hardened of us to nursing fought to remain dignified in the face of it. Pam's courage and at times fear of her death humbled me and saddened me but her strength inspired me.
The analysis

As discussed previously, the analysis will be conducted in accordance with Yin’s (1994) case study approach, whereby the research question and the stated purpose enable the study to be very focused. The study’s question; “what may be the nature of the need, if any, for counselling/psychotherapy for older people who suffer a debilitating physical illness or injury?” encompasses the purpose of the study which is to explore “what may be the nature of the need, if any, for counselling/psychotherapy?” The purpose in collecting the data was to explore what may be the nature of such a need by seeing what emerged from the interplay between the data and the theoretical perspectives set out earlier (Yin 1994).

The criteria available to increase construct validity is the use of multiple sources of evidence this then is the rationale for including the ten participants, in order to supply the multiple sources. With regard to internal validity, Yin specifies that this is not necessary for exploratory studies (Yin 1994), however for external validity for exploratory studies Yin quotes (Herriott & Firestone 1983), who specify that “the evidence from multiple cases is often considered more compelling, and the overall study is therefore regarded as being more robust” (cited by Yin 1994 : 45). Yin (1994), also proposes that the use of multiple-case studies may have the effect of providing compelling support for the outcome of the investigation. The final test is the reliability of the case study meaning that the research is capable of being replicated i.e. it could be conducted by another researcher also, “if two or more cases are shown to support the same theory, replication may be claimed” (Yin 1994 : 31).
Yin (1994), states that one of the general analytic strategies for an exploratory case study is to allow the theoretical orientation set out in the first part of the research to guide the case study analysis. This general strategy needs to be conducted with another mode of analysis, and Yin (1994) signals the use of a dominant mode of analysis called pattern-matching as a possibility for exploratory case studies. However, as Yin (1994: 35) specifies that internal validity is not a concern for exploratory case studies therefore, cause and effect per se is not the issue. With cause and effect being a component of pattern-matching there does seem to be potentially some tension in this area of case study analysis, as discussed earlier, and it is this aspect of the case study approach that Yin identifies as being problematic in that it is one of the least well developed components of the approach.

To return to the fifth component, the criteria for interpreting the findings, after some reflection it was decided that Yin’s general strategy of following the theoretical propositions and the literature review that inform the direction of the study, is relevant. However because of the identified problematic issues, as referred to above, with his specific analytic strategies it was decided to depart from Yin at this point, and consider the use of a qualitative method of analysing the data that would open up ideas of subjectivity.

Taking Riessman’s (1993: 70) approach to narrative analysis that holds with respecting respondents’ ways of constructing meaning, and, then attempting to formulate a method on how to analyse the data to somehow accomplish this, resonates with her notion that “narrative analysis can be combined with other forms of
qualitative analysis” though she argues that this is not an easy task as “combining methods forces investigators to confront troublesome philosophical issues”.

The method eventually decided upon was derived in part from the work of Riessman (1993) who writes on narrative analysis and, also draws on the theories of Lacan, who studied the work of Husserl and Heidegger (Sarup 1993). Which is an attempt to incorporate an analysis of key metaphoric texts drawn from within the participants own accounts, which are in turn set out according to Riessman (1993). Rennie et al (1992 : 244) hold that in “giving the participant control over the content is consonant with an inductive, theory-generative strategy” which resonates with aspects of the exploratory case study strategy as discussed above.

Accordingly, Lacan holds that analysts must be specialists in the art of the unconscious, thus indicating that the function of the analyst “is not only to listen …, but also to hear – where hearing (as opposed to listening) implicates the hearer in the utterance of the speaker” (cited by Forrester 1990 : 145). These notions of Lacan’s will be applied to the verbatim data that has been offered to the reader from which subsequently an interpretation is offered. Rennie et al (1993 : 244) talk of “moments of metaphoric expressiveness” as a way of conducting analysis within the narrative paradigm to guide the emergence of themes.

These “moments of metaphoric expressiveness” or key metaphoric texts conceivably to do with what may be the nature of the need for psychotherapeutic help, have emerged from the text with continuous engagement and interplay between the data and the theoretical perspectives discussed earlier within the study. Three themes
emerged for the researcher from the reading and rereading of the interviews and they are identified as: a) encounters with bodily being, b) encounters with self in transition, and c) encounters with O/others. An overall theme has also emerged that represents a struggle where people are “grappling with a new experience of self”.

**Encounters with bodily being**

The following key metaphoric texts relate to how a person experiences an encounter with their body when it is traumatised and damaged in some way.

“It’s hard being encased in this body” (Jeremy)

“It hate being like I am
it's like being trapped” (Pam)

Here it is important to recap important aspects of the method (fully described in the previous chapter), that is now to be applied in the quest to offer the reader a reading of some of the texts from the interviews that may, or may not, illuminate what may be the nature of the need for counselling /psychotherapy. Riessman (1993 : 52), in her work focuses on such concepts as “key metaphors ..., key words, (and) how substantive themes get developed through these, and other linguistic choices”. Levin (1999 : 127) takes the word ‘metaphor’ and suggests that to think about the Greek etymological hints preserved within it i.e. that metaphors serve to “carry forward our experience”, is a useful reference point.

Benvenuto and Kennedy (1986 : 221), describes how Lacan modified Jakobson’s terms of metaphor and metonymy to describe how a discourse can develop along two different semantic lines:
“In any discourse, both metaphoric and metonymic poles will be present...metaphor is related to similarity and to selection – ‘A section between alternatives implies the possibility of substituting one for another...selection and substitution are two faces of the same operation’...he linked metonymy to the connection of word-to-word”.

Lacan linked metaphor and metonymy to Freud’s concepts of condensation and displacement, which are essential modes of functioning of the unconscious:

“Lacan described condensation as the ‘superimposition of signifiers’ and compared it to his notion of metaphor, where one word comes in place of another...displacement (metonymy): one idea’s emphasis, interest, or intensity may be detached from it and passed on to other ideas, which were originally of little intensity, but which are related to the first idea by a chain of associations”.

(Benvenuto and Kennedy 1986 : 120-121)

Bowie (1991 : 132) likens this process to a railway system where, for instance “metonymy keeps desire on the rails, and always pressing ahead to the next destination, but metaphor supplies a limitless profusion of junctions, loops and branch-lines”. For Lacan:

“In metonymy an original splitting is represented, whereby the order of language replaces the subject’s lack of being...(but) it is in the game of the passage from one signifier to another in metaphor – where one word substitutes for another word (where)...the interplay of metaphors is a major means of encountering unspeakable truth...”.

(cited by Benvenuto and Kennedy 1986 : 118-119)

So, it seems that for Lacan, the subject uses the language “as a system common to other subjects...(and) one must not then think, that speech masks one’s thoughts” as “the interplay of metaphors is a major means of encountering unspeakable truth” (cited by Benvenuto and Kennedy 1986 : 117-119). Hence, Lacan’s notion is that “analysts must relate directly with the unconscious and this means that they must be
practitioners of the language of the unconscious – that of poetry, puns, internal rhymes” (cited by Sarup 1993: 7).

Both texts from Jeremy and Pam are narrative in the fact that they give the reader an order of speech, a hint of a story about a change in circumstances from being not as they were previously to how they are now.

“It’s hard being encased in this body” (Jeremy)

“I hate being like I am
it’s like being trapped” (Pam)

It is the metaphors “encased” and “trapped” that develop the theme of an encounter with body. These metaphors are powerfully descriptive as to the strength in one sense of one’s own body. The body that has always encased us and trapped us by the very nature of its being our vehicle for being and moving about in the world now, as evidenced by the use of such metaphors the body has become a prison. Jeremy objectifies his body, by referring to it as “this body”

I’ve been used to being on the move
never anchored down before (Clive)

I feel totally stranded (Ellie)

I’m stuck that’s the kind of thing
when they shut the door I’ve no way out (Hazel)

Clive, Ellie and Hazel too use metaphors that bring them into sharp face to face contact with the fragility of their bodies. Clive uses “anchored” as a metaphoric expression for how he feels now his body cannot free him. Ellie’s “stranded” and Hazel’s “stuck” also are ways of metaphorically expressing a sharp encounter with one’s body.
All these terms "encased", "trapped", "anchored", "stranded" and "stuck" are metaphoric expressions of being cut off, marooned, left high and dry, and produce feelings of ensnarement. Lacan proposes that metaphors can be ways of signifying something quite different to what is being said. Using language is an action; a movement perhaps the very act of expressing feelings of, for example, being cut off, being marooned can be a freeing experience from being bodily bound.

Heidegger contends that

Bodily being does not mean that the soul is burdened by a hulk we call the body ... We do not 'have' a body; rather, we 'are' bodily.

(cited in Levin 1999: 124)

Levin adds that for Heidegger "these reflections draw him into thoughtful contact with bodily feeling, with sense and sensibility", and that for Heidegger "every feeling is an embodiment attuned in this or that way, a mood that embodies in this or that way" (Levin 1999: 124). Heidegger proposes we do not 'have' a body, but rather we 'are' "bodily"; here Plugge succinctly offers two viewpoints which reflect the ongoing debate over what is the "body". Plugge (1970: 294) underlines the age old and continuing debate over the physical body and over what he determines is the live bodiness of man and states that the physical body, as defined by classical physiologists and biologists is:

"A morphologically determined and regulated substrate, in which the stimulus outcome in the reflex arc is described as the effect of a physically defined stimulus. But even where the stimulus outcome is recognized as a finally determined reaction, the stimulus is defined not in its significance but in its physical characteristics. The consequence is to isolate the organism from everything it meets with in the world".

This definition can be applied to emphasize that often in the treatment of physical trauma "the stimulus outcome is recognized as a finally determined reaction" i.e. a
loss of physical function as a result of a stroke could be a paralysed limb; thus "the stimulus is defined not in its significance but in its physical characteristics". This non-recognition of the significance of the "finally determined reaction"; but recognition of "its physical characteristics" is perhaps evidenced, where, for instance, "in the in-patient setting, these goals (rehabilitation goals) are often defined in terms of narrow domains of functional capacity (ambulation, range of motion, muscle strength, etc.)" (Glass et al 2000: 172). For instance, Spitzer (1987) claims:

"That indices can be designed so that clinicians can score the quality of life or health status after observing or examining a patient even without eliciting information from the patient about how he or she feels at a given point in time". (cited by Baker et al 1996 : 173)

Morris (1998), also identifies that the process and progress of physical rehabilitation is important, but also recognises, for example in stroke rehabilitation, that the psychological adjustment to the disability is not always a consideration when measuring functional progress. Thus this is the understanding of bodily being in a purely physical sense. The suggestion here is that perhaps more attention should be paid to the metaphoric expressions used by patients to describe how they feel; how they feel "trapped", "anchored" and "stuck" etc.

The above notions about the psychological adjustment to disability not always being considered are in some sense caught in George's text where he says

"I would love to be taken to the gym
and somebody say to me
we do this for that and that for this
but I'm not entitled to it"  

(George)

George has been told that he, physically, will progress no further therefore his visits to the gym have been stopped. In one sense this is understandable because this is
perceiving George essentially in his purely physical bodily form for the purposes of rehabilitation. However, the gym, or gymnasium is the signifier; the word, what it signifies; the meaning, is keep fit, exercise and movement which does not have to have solely physical connotations if looked at metaphorically. One can exercise one's mind and use speech as a means of movements and even explore the possibility of dialogue with our body in a different way which is what Plugge suggests.

Plugge (1970 : 294) reflects upon an alternative view of bodily being which he determines as being bodily live:

"Everything that is bodily live is, as something never completed but ever newly arising, to be understood as a phenomenon crucially determined by the given situation and its meaning, changing from one to another form personal and yet belonging to the world... all that is bodily live actualizes itself, through continuous self-transformation, within the situation...the bodily live arises in situations in which an egoic live body indissolubly united with my world and with all the other are born in ever new engagements and to ever new forms".

The suggestion here is for a 'lived' bodily being that is forever finding itself re-determined by the inscription of new meanings. This notion could be said to be captured by this thought of Heidegger's:

""Wood" is an old name for forest. In the wood are paths that mostly wind along until they end quite suddenly in an impenetrable thicket. They are called "woodpaths."
Each goes its peculiar way, but in the same forest. Often it seems as though one were identical to another. Yet it only seems so.
Woodcutters and foresters are familiar with these paths. They know what it means to be on a woodpath". (cited by Krell 1994: 34)

Krell (1994 : 34) writes that the image grasped from this is one "that combines the linearity of the way with the flexure of renewed inquiry". Therefore to hear people express how they have been affected by their traumatic bodily experiences, entails in
this sense hearing the continuing narrative; the linearity, with the curvature; the “renewed inquiry” the unconscious breaking through at the curve.

To offer an interpretation of this “renewed inquiry” Lacan holds that analysts must be specialists in the art of the unconscious, thus indicating that the function of the analyst “is not only to listen ..., but also to hear – where hearing (as opposed to listening) implicates the hearer in the utterance of the speaker” (cited by Forrester 1990: 145). In this sense Lacan points clearly to the art of not only listening but also to what he suggests is the deeper art of hearing what is said; hearing in this sense he implies is where the listener hears beyond what is said, to what is not being said, in other words the unconscious; that which seeps through via metaphor, puns and poetical linguistic turns. Lacan also in this statement connects the hearer to the utterance of the speaker; in other words how the utterance is interpreted by the hearer; thus indicating that the interpretation depends greatly upon the hearer’s knowledge, culture and so on.

“you’re bound by something
by your mind by your body” (Terry)

you’re trapped inside
inside your own body” (Jeremy)

“It’s the fact that where they sit me
that’s it
that’s where I stay
well they leave you in this chair” (wheelchair) (Ellie)

“I feel very trapped inside” (John)

“I never thought I’d come to this
not being able to move
not being able to jump up and do what I want” (Hazel)

Part of Lacan’s theory of language is that we all have to personify ourselves with, and through, the use of language (cited by Sarup 1993). Therefore, to personify, or
identify ourselves in this way of talking means we are directly referring to the effect that our bodily state has had upon us, either directly, as in where Jeremy says:

"you're trapped inside
inside your own body"

or indirectly, where Ellie says:

"It's the fact that where they sit me
that's it
that's where I stay
well they leave you in this chair" (wheelchair)

Both Jeremy and Ellie express acknowledgement of the body as a mutual embodiment and presentation, which in a sense stamps its authority upon their way of being; upon their way of being in the world. This is what Merleau-Ponty (1962: 82) alludes to when he writes about one's body being integral to human existence:

"The body is the vehicle of being in the world, and having a body is, for a living creature, to be involved in a definite environment, to identity oneself with certain projects and to be continually committed to them".

It is an acknowledgment of the body as a vehicle; the mode of transport in the physical sense for our being in world. By the same token, by our physical presence within the space that our body takes up at any given time, there is the essence of the person within that space. However, when the vehicle of being in the world, the body suffers a blow to its physical prowess there is a sense of exposure to the sheer weightiness of its influence upon our way of being.

"heavy that's how this arm and leg feel
I keep moving these fingers
if only they would grip
if only my leg would carry me" (Ellie)

These metaphorical expressions are related to a direct feeling of "boundness" of being immobilized to some extent or another by one's own body. Even to the point of being
“encased” within, and therefore “trapped” by, one’s own body thus becoming completely submissive to it which in turn may make us feel vulnerable. One’s physical freedom of movement in space has been severely curtailed and even stopped, which could have implications for the essence of who we are within that space. Metaphorically, trepidation of the “renewed inquiry” is brought into sharp focus by way of the wider implications of the loss of freedom of physical movement which greatly affects one’s volition; the exercise of one’s will.

Schopenhauer (1964) takes “the will” of self, or of ego as being the force that effects and produces spontaneous movement. Husserl describes the body as being:

“An organ of the will, the one and only Object which, for the will of my pure Ego, is moveable immediately and spontaneously and is a means for producing a mediate spontaneous movement in other things, in, e.g., things struck by my immediately spontaneously moved hand, grasped by it, lifted, etc”. (cited by Welton 1999 : 29)

Husserl uses the term “organ of the will” for his description of the body implying that the body is a tool for, or instrument of the will. Whereas Schopenhauer (1964 : 122), in his portrayal of the will/body declares:

“If every action of my body is the manifestation of an act of will in which my will itself in general, and as a whole, thus my character, expresses itself under given motives, manifestation of the will must be the inevitable condition and presupposition of every action...Thus the body itself must be manifestation of the will, and it must be related to my will as a whole, that is, to my intelligible character, whose phenomenal appearance in time is my empirical character, as the particular action of the body is related to the particular act of the will. The whole body, then, must be simply my will become visible, must be my will itself, so far as this is object of perception...”.
Schopenhaur understands that for him “the whole body, then, must be simply my will become visible, must be my will itself...”, thus engaging us with the idea that there is no split between “will” and “body”.

Gadow (1982 : 88) in her theory of the dialectic levels between the self and body depicts the first dialectic level between self and body, which she terms primary immediacy, as a level of equilibrium and harmony. Primary immediacy, she declares, is the immediacy of being in the world, “of feeling able to affect one’s world and be affected by it”. This capacity to feel able to affect one’s world in this sense appears to hinge completely on one’s “bodily ableness” which is at one with the “feeling of ableness” which, according to Gadow is rooted in the “self”. She proposes that there are two kinds of differentiation within the experience of the lived body at this primary immediacy stage; the distinction between influencing and being influenced, and the distinction between agency and vulnerability.

These differentiations “are secondary to the overriding unity of the self-body in its principal focus, that of distinguishing itself from the world”. Although Gadow acknowledges that there are distinctions between influencing and being influenced and between agency and vulnerability, it is her belief that it is our bodily form that carries the main function of characterizing our being which is driven, or guided by the “feeling of ableness” which arises in the “self”.

Gadow (1982 : 88) writes about the second level, which could be where incapacity strikes the body and there is disrupted immediacy, “the agency/vulnerability distinction” becomes an internal distinction and it is at this level where:
"The immediacy of that primary being-in-the-world is ruptured by *incapacity*, the experience of being unable to act as desired or to escape being acted upon in ways that are not desired. Immediacy in short, is shattered by constraint. The lived body becomes conscious of ineptness, weakness, pain—phenomena arising from within itself and thus giving rise to the internal distinction between that part (the self) which gives to the phenomenon the meaning "constraint" and that part (the body) which is felt to be the origin or *site* of the phenomenon experienced as constraint".

In the new relationship between self and body Gadow draws parallels between her dialectic levels of self-body experience and Hegel’s description of the master-slave dialectic where, “(1) the self is experienced as free subjectivity, the body its vehicle and instrument, serving the will of the self as does the slave its master; (2) the inversion of that relation: the body rebels, refuses to function, and through the asserted independence, the former master—the self—becomes the slave” (Gadow 1982: 88-89).

Here, it seems that Gadow and Hegel mark out a definite distinction between what they term the “self” and the self’s body. Gadow talks of that part (the self), and that part (the body), and Hegel talks of the “will of the self” equating it to be master of the body which is the slave, or, conversely, when the tables are turned and the former master (the self) becomes the slave to the body.

The distinction here is that Gadow and Hegel discuss bodily disturbances indicating a failure of the body in the form of illness and disease and talk about that part (the self), and that part (the body) and how an inversion of this relationship is produced via this disturbance. Whereas Husserl and Schopenhauer take what they term “the will” of self, or of ego as being the force that effects and produces spontaneous movement, but
with no discussion of the role or “the will” of self or of ego when functional incapacity caused by illness and disease strikes.

Lawler (1991 : 59) writes that “it is in medical encounters or the experience of illness that one is often brought face-to-face with corporeality as part of the human condition” as illustrated in the following texts:

“I’ve been used to being on the move
never anchored down
what the bloody hell am I going to do”
“It’s like being stuck in mud” (Clive)

“I feel totally stranded
as if I’ve been washed up on the beach and left there
even the tide doesn’t come in to take me back” (Ellie)

There is a sense of vulnerability now that Clive and Ellie are face-to-face with their own corporeality. The notions of vulnerability may be immediate ones which reflect that during illness a person can be confronted with what (Parker 1988, cited by Lawler 1991 : 135) referred to as “the boundness of embodiment”. Lawler explains that it is at this time “that their need for assistance with privatised body functions can be both embarrassing and unprecedented in adult life” (Lawler 1991 : 135). Alongside of this a person can also undergo the start of the loss of control over their body, and this in itself can turn into a source of embarrassment:

“Also I leak a bit here
I managed to get my dirty pants into the laundry basket
and it just comes on
I can’t stop it
my water just goes a bit a bit
so I have to ring and say I’ve been dripping” (Hazel)

“Besides, what woman would look twice at me now
I mean I’m disfigured
for ages I didn’t want to look at myself
I still don’t want to” (Terry)
The capacity for embarrassment makes its appearance at around the age of 5 years, it needs an audience and it is more keenly felt if that audience is comprised of strangers (Lawler 1991). Heath (1988) claims that embarrassment has received scant attention in sociological studies, even though he proposes that it is a underlying feature of social life. He offers this definition of embarrassment:

"Embarrassment lies at the heart of the social organization of day-to-day conduct. It provides a personal constraint on the behaviour of the individual in society and a public response to actions and activities considered problematic or untoward. Embarrassment and its potential plays an important part of sustaining the individual’s commitment to social organization, values and convention. It permeates everyday life and our dealings with others. It informs ordinary conduct and bounds the individual’s behaviour in areas of social life that formal and institutionalised constraints do not reach".


Both Hazel’s and Terry’s words hint at embarrassment about their situations and themselves metaphorically implying the personal constraints on their behaviour in society (both micro – hospital, and macro – outside). Both of them making inferences about the public response to actions and activities considered problematic or untoward.

For Hazel this is about the issue of “leaking” and “dirty pants”; about the embarrassment of her private bodily functions now being part of the public arena – “smell too is an occasion for embarrassment” Terry perceives his bodily being as the obstruction; the obstacle to how he wishes to be in the world – “embodiment opens up the possibility of being looked at, in person, so to say” (Harre 1991 : 165). His thoughts are around whether an(other), a woman, could even bear to look at him and also there is the issue of him looking at his-self. Embarrassment records Harre “can trouble people – indeed it can become destructive and even pathological” (Harre 1991 : 145).
Denzin (1987 : 287-288) discusses the phenomenology of the emotionally divided self, or the belle ame (beautiful soul) “a self that is torn apart internally, a self that feels emptiness and nothing...the emotionally divided self is a disembodied self”.

The emotionally divided self continually experiences “a cluster of emotional experiences, including anger, wrath, envy, jealousy, and fear, directed towards the other, or the ‘They-selves’ of the everyday world” (Denzin (1987 : 287). The belle ame is a schizoid personality: and poses the fundamental existential question of “What am I in my being?” but along with this question:

“He fears the loss of the very void he discovers he is. His relationship to being-in-the-world and to being-with-others can very aptly be characterized as the “splitting of the ego” (the self) -into many possible “parts”...which is described by R.D. Laing as the opposition of an “inner-self system” to a “false-self system”...the “disembodied” and the “embodied” self’. (Lacan 1968 : 290-291)

“My brain’s telling me one thing
yeah, that I can walk, I can move my fingers,
I can talk properly
but I can’t
it’s like being stuck in mud” (Clive)

“I think to myself
what have I become” (George)

“What am I in my being” both Clive and George seem to be grappling with this fundamental existential question.

On the other hand, if one is in good bodily health the usual association of metaphors with this are generally powerful and influential ones where the question of “What am I in my being” seems explicitly simple and imponderable. Because this is related predominantly related to youth, fitness, health and beauty as any media output, such as television, newspaper, journal or magazine will confirm. This reinforcement of the
meaning of physical beauty and health in western culture is prevalent (Van Deusen 1997). Crawford (1980) attests that:

"Health is increasingly linked with ‘feeling good’ and ‘looking great’, a notion of true ‘well-being’ which rests on the idea of ‘balance’ or ‘harmony’ between body, soul, mind and emotion, as well as satisfactory relationships with other people and society as a whole".


Somewhat, suggestive of the fact that one can only achieve a ‘healthy’ harmonious state of body, soul, mind and emotion and so attain agreeable relationships with others and society if one ‘feels good’ and ‘looks great’. “Feeling good” and “looking great” are naturally subjective individual accounts, however Lingis (1999 : 303-304) quotes Foucault whose notions of ‘feeling good’ and ‘looking great’ are one conceivably popular view of this.

“Mastery and awareness of one’s own body can be acquired only Through the effect of an investment of power in the body: gymnastics, exercises, muscle-building, nudism, glorification of the body beautiful”.

The foundations of this mastery of one’s own body are rocked somewhat as evidenced from the following pictorially descriptive texts about the experience of bodily disturbances:

“I have nightmares about it
I can’t seem to get it out of my head
you know, the thought of it its horrible
like your body is being taken over by something alien” (Sylvie)

“sometimes the shaking
it’s that bad
it’s frightening” (John)

“heavy that’s how this arm and leg feel
I keep moving these fingers
if only they would grip
if only my leg would carry me” (Ellie)
"my mother had a knee like it
it's swollen and difficult walking" (Evelyn)

"I am virtually paralysed
from the neck down" (Jeremy)

"my general health has deteriorated
and I've had falls
so here I am crash landed in this hospital
my legs they won't carry me" (George)

The above texts focus on metaphors which give different, distinctly less popular perspectives to those stated earlier. Levin (1999) takes the word 'metaphor' and suggests that to think about the Greek etymological hints preserved within it i.e. that metaphors serve to "carry forward our experience", is a useful reference point (Levin 1999: 127). The experiences alluded to above are immediate ones of physical functional curtailment of motion and movement. More far-reaching experiences metaphorically alluded to are the changes to one's self and consequently one's world, as a result of changes to one's bodily being. Harre (1991: 170-180) raises issues about embodiment when disease strikes and discusses how people experience bodily malfunctions such as when Clive speaks of:

"The thought that I could live another
20 plus years like this
that's what they've said
that having a stroke doesn't necessarily mean
that you will die from it" (Clive)

Harre in discussing chronic illness adds that:

"One and the same person has to present themselves in action and Talk as one who subscribes to, and indeed actually embodies, the local social norms of health in what they do, while at the same time they must be seen to live within the constraints set by their physical defect". (Harre 1991: 179).
Here Harre’s statement could be referring to where Clive speaks of “the thought that I could live another 20 years plus like this”: where “like this” metaphorically points to the changed body image which he now has to deal. Harre suggests that “chronic illness must not only be suffered. It must be done” (Harre 1991:180).

“...I don’t profess to having full knowledge of certain things but it would be nice to know why you’re doing certain thing it would be nice to be told you’re doing this because that does this or that does that they’ve got a job to do and perhaps it’s because the next patient that comes in wouldn’t understand what they were talking about even if they tried to tell them so they have to treat somebody like myself I hate to say this who understands what’s happening the same as people who stare at you and don’t know what’s happening.” (George)

Pile (1996:184-185) reflects on the question of whether human bodies are just things when he states that “the body is never merely a passive surface, a leaky container of visceral fluids, a collection of orifices, limbs, feelings, organs, and so on”. In his exploration of the ‘psychoanalysis of space’ and the body, Pile determines that the body is one place or site “for the intensifying articulation of power, desire and disgust, of the individual, the social and the spatial” perhaps as evidenced above where George metaphorically hints at all these things. Pile therefore surmises that the body “is open to multiple writings and readings”.

Embodied metaphoric subtexts of a dread; a fear; an uncertainty about one’s own body; about one’s own self that produce an impression of chaos and turmoil. Perhaps since previously, i.e. prior to the advent of trauma, one possessed a docile body such as described by Foucault, “a body is docile that may be subjected, used, transformed and improved” in the sense that the body was under one’s control and, if wished could
be disciplined to achieve this bodily state (Foucault 1999 : 263). There is some sense of a metaphorically rebellious body in the above expressions where there is an insistence that the body is no longer docile and pliable. By the very nature of what has happened to the body - its reversal into the no longer docile and pliable entity - causes a reaction within us which Plugge (1970 : 297) refers to as the point when “an experience of estrangement as well as one of intensified ownership” occurs:

“The intrusion of something virtually objectal into the previously merely unreflectively lived bodiness, i.e. the emergence of “heft” into the previously taken-for-granted freshness, puissance, and volition, its actualization accompanied by intensified belongingness to me and on the other hand too by the experience of its estrangement, the reciprocal intertwinedness of the characters of the one who bears and what is borne, of the egoic and the mundane”. (Plugge 1970 : 306)

Plugge (1970 : 299) writes of an intrusion into the previously taken-for-granted bodily being that had influence and will power. An intrusion that is objectal; that has “heft”; that has some substance, some weight to it, that to which he refers to as “the phenomenon of the bodily as physical”. Plugge argues that these thinglike characteristics emerge and evidence their presence in our live bodiness at certain times in our lives. For instance, appearing in fatigue and exhaustion, in internal illnesses, and even by the “nursling (who) regards his legs in the first months of life as strange and distant things, until he is able to incorporate them through feeling and kicking” (Plugge 1970 : 304). This experience of the “phenomenon of the bodily as physical” evokes strong feelings in the realisation that, for example, the damaged legs do still belong to one’s body; to one’s self; but that they are now changed and at odds with the rest of one’s body; the rest of one’s self; and as such impact upon one’s once familiar world.
The constructs of the experience of the “phenomenon of the bodily as physical”, which may include depression, feelings of worthlessness, over-sensitivity and low self esteem can be often sanitised via medicalisation of treatment with SSRI drugs such as Prozac (Lyon 1996: 61-67). As according to Lyon (1996: 64) in psychology and psychiatry today “an increasing range of forms of behaviour or experience have been given the status of independent illness entities – frequently through their inclusion within the expanding boundaries of existing illness categories such as depression – and therefore regarded as treatable with newly available medications”. Lyon (1996: 65) whilst not denying the effectiveness of these drugs, questions if this way encompasses, and here she quotes (Kleinman and Kleinman 1991), “the question of the ontology of suffering” or as she herself adds “the question of a changing sense of the self in illness”. It is this notion of a changing sense of the self in illness that is examined next.

**Encounters with self in transition**

In Levin’s (1999: 128) discourse on Heidegger’s thoughts, he suggests that “the ontological dimension of our embodiment is its (our) openness-to-being, its (our) ekstatic exposedness, its (our) receptive responsiveness and responsive receptivity to the presencing of being. Levin (1999: 135) clarifies in his own way the notion of “the ontological dimension of our embodiment” by terming it to mean:

“Our bodily felt experience of an ongoing breaching, opening and carrying-forward manifesting through appropriately disclosive hermeneutical gestures, movements, and organs of perception in relation to the ongoing (abyssal) questioning and measuring of our existence by the presencing of being”.

Perhaps during the times, i.e. when experiencing pain or pleasure, that our body is in the spotlight this is when we truly come face to face with the ontological dimension of our embodiment. The emotionally expressive bodily felt experiences are, by rupturing through, in the following expressions, clearly causing a commotion by the “questioning and measuring” of one’s existence. These bodily felt experiences are communicating themselves “by their presencing of being”; they are present in the changing way of being:

“The stroke it’s got me inside and outside
inside and outside
that’s how it’s affected me
that’s what it feels like” (Ellie)

“Lost control of my movements” (Terry)

“Since this has happened I’ve felt different
as somebody said
it’s your confidence that goes
because I mean like now
I mean I can’t get up and get away from this if I wanted to
I’m stuck that’s the kind of thing
when they shut the door I’ve no way to get out” (Hazel)

“I think to myself
what have I become” (George)

“I never thought I’d end up like this
well you don’t do you
I can’t even eat
can’t take a drink
well only through a straw” (John)

There is the essence of the bodily self unhinged cast into dark chaos “the stroke it’s got me inside and outside”. There is a sense of the self in transition, for example, where George says “I think to myself what have I become” Hazel too, expresses that “since this has happened I’ve felt different” calling into focus that they are experiencing a changing self. Expressed losses such as Terry’s “lost control of my
movements” and John’s “I can’t even eat can’t take a drink” also signal a changing self. A changing self that is associated and identified with body image; both in how the bodily image is experienced and how it is felt. For Heidegger “our self-image is not simply cognitive – it is determined by our developmental and life experiences, our place in history and culture and so on” (Chessick 1993 : 255).

Rawlinson (1982 : 76) describes how illness affects our self-image

“One falls ill, and the insistence, intransigence, and opacity of the body in illness signifies the limits of one’s ability to direct one’s own history...the ill person experiences a loss of himself”.

This indicates how interconnected our body/self image is to the way in which we interact within the world. As Heidegger reflects “our self-image is not simply cognitive – it is determined by our developmental and life experiences” and in the context of illness “the limits of one’s ability to direct one’s own history” are affected and “the ill person experiences a loss of himself”, as is the fact that “we grieve for the ill person not simply because he reports that he suffers pain...but because the pain tends to obliterate self...we experience a loss of the other to the suffering” (Rawlinson 1982 : 76).

White et al (2000 : 141) contend that if there is only concentration on the malfunctioning of the body and its parts following a stroke – “this approach often loses sight of the person as a human being” and in so doing there may be neglect to the assault on other areas of everyday life “encompassing home, work, leisure and social relationships including relationships with self and others”.
This fear about the body in disturbance or distress may point to the ontology of suffering which could have implications both of a biological and a cultural nature for the changing sense of the self in illness (Williams et al 1996). These implications, according to Csordas (1994, cited by Williams et al 1996:36) are that emotions such as fear “are most fruitfully seen as embodied existential modes of being; ones which involve an active engagement with the world and an intimate connection with both culture and self”. Thus the phenomenological experience of our bodies both in illness and health is underpinned by emotions which also supply “the ‘link’ between personal problems and broader public issues of social structure” (Williams et al 1996:36).

"gradually the disease
it bears down on all you touch
everything you touch really" (Jeremy)

"It's affected my private life
my wife's very caring and very understanding but
it's like playing golf
I can't do that any more" (John)

The ontological dimension of our embodiment is in a sense nakedly exposed in that metaphorically there is the epitome of suffering; but suffering in different ways, as the unconscious strives to be heard in the words. What is this thing; the unconscious? Wolman’s notion is the fact because “that we haven’t had direct contact with something, and we don’t know how to find it does not necessarily mean that what is unknown to us does not exist” (Wolman 1968:6). Lacan’s notions of the unconscious are that it shows itself “in dreams, jokes, slips of the tongue, symptoms” and argues Lacan language is the condition for the unconscious, the unconscious cannot be without language:
“Like conscious discourse, the formations of the unconscious (dreams, etc) are saying something quite different from what they appear to say... At certain privileged points, such as in slips of the tongue...language seems to be torn apart. Conscious discourse is rather like those manuscripts where a first text has been rubbed out and covered by a second. In such manuscripts the first text can be glimpsed through the gaps in the second. The true speech – the unconscious – breaks through usually in a veiled and incomprehensible form”. (Sarup 1993 : 9)

This is the metaphoric ability that we humans use to convey multiple meanings and thus use them to signify something quite different from their concrete meaning (Sarup 1993).

Where, for Jeremy: “gradually the disease...it bears down on all you touch everything you touch really” its as if the disease has a great weight to it stifling everything beneath it. The words bring the metaphoric image of very little surviving beneath the heaviness of the disease, the disease itself is hard to bear both personally and in the wider social realm. John expresses how it; the disease has affected his private life saying that how caring and understanding his wife is, but adding that “it’s like playing golf I can’t do that any more” Metaphorically, for Jeremy, where the disease; where “it bears down on all you touch”, and the “it” in John’s private life may refer to sexuality and masculinity in which their self-assurance may be shaken. Connell (1987) offers his meaning of maleness in that it is:

“Not a simple thing. It involves size and shape, habits of posture and movement, particular physical skills and the lack of others, the image of one’s own body, the way it is presented to other people, and the ways they respond to it, the way it operates at work and in sexual relations. In no sense is all this a consequence of XY chromosomes, or even of the possession on which discussions of masculinity have so lovingly dwelt, the penis. The physical sense of maleness grows through a personal history of social practice, a life-history-in-society”.
(cited by Lawler 1991 : 95)
Lawler (1991: 95-96) comments that Connell's definition of maleness is focused on "force, performance and competence as is sport, such that displays of masculinity are designed to illustrate the 'natural' superiority of the male over females, or over other males". Connell also argues that "constructs of masculinity oppress women and become dysfunctional for men who do not define themselves within stereotypical masculine frameworks, or who do not possess the 'natural, physical prowess of maleness". Person (1980, cited by Lawler 1991: 99-100) believes that "for men, masculine gender 'leans' on sexuality much more than is the case for femininity or female sexuality ... to be masculine is to empower the body sexually and simultaneously to use that power to express masculinity.

Freedman (1990: 274) details how "an unique closeness exists between one's body and one's identity". She states how our corporeal self is a central part of our self-concept and identifies that fundamentally high positive correlations are found between body satisfaction and self-esteem, one being interdependent upon the other. Thus, is there an inference that things such as one's identity and one's self-esteem are demoralised, unnerved:

"I worry about it
I get depressed
I don't think that I believe in anything
I used to
but now
well I don't think I've got any faith
I mean, to me death is that and that's the end of it" (Sylvie)

"Now well now I feel very apprehensive
I try to suppress any bad feelings I have
I say to myself you mustn't get paranoid or anything
take things and do as you are told
you know it's bad feelings
what's going to happen to me" (George)

"I can't go home until I can walk" (Hazel)
One’s “corporeal self” has undergone changes so has this damaged our illusion of unity which could be that which Lacan refers to as the state:

“In which a human being is always looking forward to self-mastery, entails a constant danger of sliding back into the chaos from which he started; it hangs over the abyss of a dizzy Assent in which one can perhaps see the very essence of Anxiety ...”. (cited by Welton 1999: 218)

“Anxiety”, writes Tillich “is the existential awareness of nonbeing” (Tillich 1994: 373).

“All in all though
it’s been a great shock to my system
I’m not dead in one sense
but bits of me are” (Terry)

“god is this my life am I always going to be like this” (Terry)

Tillich (1994: 373) makes clear three types of anxiety in accordance with the three ways in which nonbeing threatens being:

“Nonbeing threatens man’s ontic self-affirmation, relatively in terms of fate, absolutely in terms of death. It threatens man’s spiritual self-affirmation, relatively in terms of emptiness, absolutely in terms of meaningfulness. It threatens man’s moral self-affirmation, relatively in terms of guilt, absolutely in terms of condemnation”.

Unconsciously, the three ways in which nonbeing threatens being and thrusts anxiety forward are intimated in the above expressions. Firstly, where nonbeing threatens man’s ontic self-affirmation in the way of the anxiety of “the irrationality, the impenetrable darkness of fate”; fate that has death ultimately at its heels.

“The thought that I could live another
20 plus years like this
that’s what they’ve said
that having a stroke doesn’t necessarily mean
that you will die from it” (Clive)
The implications for an Lacanian analysis are that “the unconscious is a second structure. It is interpolated on the basis of the nodal points in the patient’s discourse” (cited by Lemaire 1977 : 136). Nodals points provide “provide a vantage point from which everything that happens in a given discourse can be situated both retroactively and prospectively” (Sarup 1992 : 53). After every nodal point in the signifying chain “there always remains the persistence of a gap between utterance and its enunciation “you’re saying this, but what are you really telling me?” (Sarup 1992 : 90). It is Clive’s thought that he could live another 20 years “like this”; that could be the nodal point; the persistence of a gap where perhaps there is the unspeakable dread of having to live “like this”. And how can Clive’s illness be borne; what is ‘like this’?

Harre (1991 : 180) writes

“As embodied beings, even the chronically ill must act through their bodies, but as beings concerned to display their adherence to norms of propriety, chronic illness must not only be suffered. It must be done”.

Thus the chronically ill must act through their bodies maintaining modesty and decorum keeping it respectable. Yes chronic illness must not only be suffered “it must be done”. The question then arises as how can it be done whilst it is being suffered.

Secondly, the nonbeing which threatens man’s spiritual self-affirmation where there is the loss of an answer “however symbolic and indirect, to the question of the meaning of existence...” this produces the anxiety of meaninglessness.

“"It feels like I've put on the moon” (Jeremy)

“I've lost a lot of things
my freedom of course
my freedom” (Terry)
"I've been so miserable here
there is this feeling of isolation
you feel so abandoned"  (Hazel)

Thirdly, there is “the anxiety of self-rejection or condemnation.

"You're like a piece of meat to be seen to
you feel just like the next package"  (Jeremy)

Grzesiak et al (1994 : 244) believes that “acquired physical disability makes
formidable demands on the mind”. Heidegger refers to moods that occur “when one
is affect-wise at a given time, a particular disposition or state of mind” and that a
human is not a subject or essence that can be isolated and studied like an object under
a microscope, but is always in activity” (Chissick 1993 : 255-256).

**Encounters with O/other/s**

Lacan declares that we do not have a static set of characteristics and proposes his
theory of “‘the dialectic of recognition’ where we gather knowledge of what we are
‘from how others respond to us” (cited by Sarup 1993 : 12). As Bowie (1991 : 83)
highlights Lacan’s ‘Other’ “is a pliable and sometimes confusing notion” and can
mean “one member of the dialectical couple ‘Subject-Other’” and also “the limitless
field and overriding condition in which both members find themselves”.

This limitless field and overriding condition in Lacanian terms explains Sarup (1992 :
185), “can be variously defined as the Father, the Law, a place, any dialectical partner,
the signifier, or the repository of language and culture”. This ‘Other’ writes Sarup
(1992 : 105), can be “the unconscious that slides through the gaps in intentionality”.
According to Benvenuto and Kennedy (1986 : 173), Lacan considers the fundamental
ontological question, which concerns the very nature of the subject’s being, thus leads to considering “the subject’s basic dependence on the Other… the Other becomes the real witness and guarantor of the subject’s existence, as it is he who can recognize the subject. Bowie (1991 : 82) writes that “- the Other takes language as its field of action:

“Language was there from the beginning as the condition of the individual’s subjecthood, and supplies the underlying vacillatory pattern for all his adventures in being. Language may of course be construed as an abstract system, and for that purpose may be drained of its personal content. But as soon as language takes again the form of speech it reassumes its intersubjective character: It becomes a ‘third locus, the endlessly mobile space in which the Subject and its Other are made, dissolved and remade’.

The functions of speech and language are what Lacan generally referred to as the Symbolic Order, and in Lacan’s view “it is through language that the subject can represent desires and feelings, and so it is through the Symbolic Order that the subject can be represented, or constituted” (cited by Benvenuto and Kennedy 1986 : 81).

“I feel like an empty shell
does anyone see me
no-one hears me
it’s like
it’s like screaming into the dark” (Jeremy)

“does anyone see me
no-one hears me” (Jeremy)

For Lacan, the Other becomes the real witness and guarantor of the subject’s existence, as it is he who can recognize the subject (cited by Benvenuto and Kennedy 1986 : 173). Conceivably, Jeremy’s metaphoric expression seems to scream out that his very existence as a subject is threatened by, in one sense, by the non-presence of an “other” to give him any feeling of being represented as a self. To feel “like an empty shell”, to feel unseen, unheard these are powerful metaphors. The Symbolic
Order is also concerned “with the function of symbols and symbolic systems, including social and cultural symbolism” (Benvenuto and Kennedy 1986 : 81). So is Jeremy’s expression also a wider unconscious signification on our social and cultural activities and institutions with regard to how his “bodily being” influences how he is “seen” – constructed as a person in the gaze of the other.

Benvenuto and Kennedy (1986 : 172) propose that “one might be tempted to restore the ‘total’ or ‘unified’ reality of the subject by counting on the concrete reality of the body; however, they continue that:

“Lacan considered that even this can be contested, merely by reference to the body in psychotic states of disintegration; or the hysterical and hypochondriacal bodily symptoms, which follow no medical reality; or the body of the infant before it is unified in the mirror image...the body (is described) as a unity only as an image: its unity is, from the beginning of life, a function of the signifier and so its meaning – for instance as a unity it can function as an imaginary ‘coat of arms’ of the body, or as the ‘battlefield’ of conflicts in a variety of symptoms...”.

Gliedman and Roth (1980) stress that “the universal concern about how others view us, a preoccupation that endures throughout the life cycle” (cited in Shontz 1990 : 146). Shontz (1990 :146) adds that those who are visibly disfigured “always face the possibility of being shamed or publicly shown to be defective, and as a result feeling devalued...they share a special vulnerability, and can be readily viewed as blemished and not quite human”

\[
\text{some they look at you} \\
\text{you just want to be} \\
\text{yeah at times like that} \\
\text{you wish the floor would open up} \]  (John)

Lacan’s notions of the unconscious play around with the fundamental philosophical issue of ontology, “the study of ‘being’ and ‘non-being’. In addition, declare
Benenuto and Kennedy (1986: 170), “it would seem that, for Lacan, the problem of being cannot be separated from the relation of the subject to the “Other”.

This belief in our bodily form characterizing our being through the gaze of the other is upheld where both Jeremy and Ellie acknowledge entrapment and hence limitation by, and, within their bodily form. Metaphorically, by the same token their following words more deeply support the aforementioned dominant ideology that, once one’s bodily being is diminished in some way through physical illness there is the real sense of being either invisible, or that senility or a diminishment of one’s mental faculties has taken place.

“Sometimes they talk to you as if you know as if you’re not right I asked the time she said it’s not time to go to bed I didn’t ask that it made me feel I hadn’t got my right senses” (Ellie)

“I would like to present myself as looking like George that’s my own private ego I have no knowledge of what the programme is there’s no thought of me being in the programme or organizing it I just go along with whatever they say and say “certainly” (George)

In discussing the structures of the emotionally divided self Denzin (1987: 291) distinguishes that one of the structures is “Others”. He identifies that the “Other/s” like Lacan’s notions can be from “the immediate situation of the subject … or they may reside in the distant past…”. Denzin (1987: 291) further expands his theory by stating that:

“Regardless of biographical origin, the other overwhelms the subject, setting (in the eyes of the subject) standards that are impossible to attain. The subject attempts to win the approval of the other; to be a ‘good’ self in their eyes,…the subject hates the persons he imitates,
yet he complies with their perceived wishes...emotionally divided selves translate into action other people’s definition of who they are. They seem unable or unwilling to move forward in terms of their own self-definitions. The self that complies with the wishes of the other is perceived as false or inauthentic self”.

This causes a basic division in the self-system of the subject where for instance “outwardly she complies with the wishes of others...inwardly she rebels... outwardly the behaviour of her false self appears normal...yet this is a facade ...she perceives herself as living a lie...inwardly she feels intense anxiety, hatred, and fear” (in that) “she feels captured within the very skin of her body...she feels that she is a captive of the other” (Laing 1965, cited Denzin 1987 : 291).

Both Ellie and George outwardly comply with the wishes of others: inwardly they rebel... metaphorically expressing being “captive of the other”. Ellie says: “it made me feel I hadn’t got my right senses” is the danger that the other has captured her right senses. George states that “I would like to present myself as looking like George” what does this imply that he cannot do this, is George experiencing something of Pam’s anxiety:

“it’s like I’ve lost me” (Pam)

Chaos is anxiety “Anxiety strikes us at the very “core” of ourselves: it is what we feel when our existence as selves is threatened.” (May 1993 : 49). People can experience anxiety in a number of ways: “a “gnawing” within, a constriction of the chest, a general bewilderment; or they may describe it as feeling as though all the world around were dark grey or black, or as though a heavy weight were upon them, or as a feeling like the terror which a small child experiences when he realizes he is lost”. (May 1993 : 40)
On this issue Gatens (1996: 39) renders an account of what she refers to as "the primitive core of ethical concerns and judgements" for others, which at a fundamental level, for her, amounts to the recognition of another body (corporeal similarity), by oneself, which then, in turn, evokes one's concern for it. She adds that "it is this identification that makes ethics (and of course cruelty) a specifically human possibility. Thus, according to Gatens "the primitive core of ethical concerns and judgements" for others, must fundamentally rest on some form of recognition by (an) other of literally your bodily (corporeal) self or metaphorically, at least, the very essence of what is you, for there to be any concern raised by (an) other.

"does anyone see me
no-one hears me" (Jeremy)

"I would like to present myself as looking like George
that's my own private ego" (George)

"I felt unwanted and really not needed any more" (Jeremy)

"I feel as if I'm getting old
I'm now 65 and to the Authorities
I'm past it
sort of useless
it's like my opinions and views don't count
I am 65 I don't feel 65
it made me really annoyed reading in the paper
old man in his sixties" (John)

Is there an expressed desire for recognition. Lacan describes desire as "a want-to-be in the subject that is unsatisfiable either through gratification of his needs or acquiescence to his demands... man's desire is the desire of the Other" (Muller and Richardson 1982: 281). "Desire can compel the subject only through signifiers (and man is a subject only by being subject to the laws of language)" (Muller and Richardson 1982: 328). Lacan's (1968: 193) notions of desires are that:
“Man is Consciousness of self...man becomes conscious of himself at the moment when – for the ‘first’ time – he says: ‘Moi’...understanding man by comprehending his ‘origin’ is therefore to understand the origin of the Moi revealed by the Word...It is the (conscious) Desire of a being which constitutes that being as a Moi and reveals him as such by bringing him to say: ‘Je’...The human Moi, is “the desire of a Desire” – Lacan calls it “the metonymy of desire” – desire being “the revelation of a void, the presence of an absence of a reality.”... The humanity of desire is expressed by the desire for recognition (as a subject) ...”.

Goldstein (1994: 403-404) speaks of this desire

“To grasp the fullness of life, one must consider ... (an) area of human experience. I have called this the “sphere of immediacy” ...the sphere of immediacy makes unity possible between the world and ourselves, particularly in our relationship to other human beings. ...In this sphere is not only the source of all creativity, the development of friendship, love and religion, but also those possibilities for failure, sorrow and anxiety which are part of our life. While being in the sphere of immediacy may involve danger, we deliberately take this risk, since only thus can we realize ourselves fully”.

Lacan in some way also gives partial credence to this notion where he maintains that the “identification of oneself with another being is the very process by which a continuing sense of selfhood becomes possible” (cited Bowie 1991: 30-31). Lacan, although conceding in his own view that this selfhood is fictional, he nevertheless declares that these “fictions are as important as the real where subjectivity is concerned” (cited by Parker 1992: 110). Lacan, writes Dews (1987) sees these fictions to be the “constraining and illusory features of conscious self-identity...”and it is this which ties the person quite firmly to “relationships, defences and repression” (cited in Parker 1992: 110).
There is also the question of whether pain is fictional and Krell (1993 : 19) writes how Heidegger sought to uncover how the subject had come ‘to be’ and what is feels like ‘to be’ a human being:

“Man questions his own Being and that of other things in the world. He is always – in no matter how vague a way – aware of his being in the world. Heidegger called the Being of this questioner who already has some understanding of Being in general “existence” or “Dasein”.”

“Just watching them struggle
it’s a nightmare
watching them
watching them dress me
I’m deadweight
and all I get is the pain” (Jeremy)

Bendelow (1993, cited in Williams et al 1996 : 38) declares that “pain is never simply a form of physical suffering, but also encompasses emotional and affective dimensions, feelings which, in turn, are crucially linked to ‘gendered’ modes of bodily being”, in addition “in contrast to the dominant biomedical model, pain is a lived, embodied, physical and emotional experience”. Leder (1984, cited in Williams et al 1996 : 38) proposes that “pain … can be used to describe not only physical agony but emotional turmoil and spiritual suffering”.

Williams et al (1996 : 41) stress that “having one’s feelings ignored or termed irrational is analogous to having one’s perceptions invalidated.”. Hepworth (1996 : 423-441) identifies the inclination in western culture to infantilisation practices towards older people, that is to treat them as if they are dependent children.
"You get told where you can and can’t go
what’s happened
why get treated that way
it’s the way you’re told
it’s a bloody nightmare" (Clive)

"Well you see you’re not in control of yourself" (Hazel)

Denzin (1987 : 291) discusses the other or others who have power over the world of the emotionally divided self suggesting that they may be “from the immediate situation of the subject (an employer, interactional associate, family member, spouse, etc.), or they may reside in the distant past”.

Lacan (1968 : 183) speaks of the conscious cogito being “supplemented by an unconscious subject who may be the subject saying “I think” or “I am,” but never both at once, since the question of the subject’s being is posed at the level of the unconscious”. A reminder that to read the unconscious text or texts underneath the message Lacanian style would be to draw on Lacan’s idea of how analysts could be practitioners of the language of the unconscious. Where he, in turn, drew on Freud’s concepts of condensation and displacement, both detailed as being essential functioning elements of unconscious processes. Lacan took the notion of condensation and compared it to his own notion of metaphor, where one word comes in place of another (Benvenuto and Kennedy 1986 : 120).

As Hollway (1989 : 52 ) writes, “the psychoanalytic concept of condensation refers to just the same notion – containing (condensing) many meanings in one idea or image”.

For Lacan displacement “the unconscious process whereby something of significance in an idea is detached and passed on to another image” is the same notion as
metonymy. Bowie (1991: 132) likens this process to a railway system in that
“metonymy keeps desire on the rails, … always pressing ahead to the next destination,
but metaphor supplies a limitless profusion of junctions, loops and branch-lines”.

Here one interpretation of the unconscious would indicate that both Hazel and Clive
feel themselves to be less powerful and thus face difficulties in managing their own
lives and this handicap suggests Freund (1990, cited in Williams et al 1996:41),
“may, in turn, contribute to existential fear, anxiety and neurophysiological
perturbation. Serious illness, stresses Nichols (1993: 17) “so often leads to the loss
of key roles in a person’s life – occupational, social, sexual and within the family”.

These potential accumulative losses are referred to by Clive:

“‘There’s Ray he’s, well he’s my partner
we’ve been together for almost 16 years now
even that’s hard for me to talk about
I mean I haven’t told anyone here
but I get the feeling they’ve got an inkling
that’s what’s hard
you know I miss him
you know what I mean
yes he visits but I worry
I worry if he’ll stick with me” (Clive)

Levinas holds that

“The act of expression makes it impossible to remain within oneself
or keep one’s thought for oneself and so reveals the inadequacy of
the subject’s position in which the ego has a given world at its disposal.
…The subject who speaks does not situate the world in relation to him­
self, not situate himself purely and simply at the heart of his own
spectacle,…instead he is situated in relation to the Other”.
(cited by Hand 1989: 149)

“I pray literally
I pray hard
I say to God give me the strength to bear this through the night
I pray an awful lot” (Hazel)
"I was going to give up
whether or not my faith is going to be strong enough
to get me over the barrier
I get low points"  (Hazel)

Gabriel Marcel, who for a time called himself a “Christian existentialist” shared some of his existential features with Heidegger but the tone of his philosophy strikes an optimistic and hopeful tone. One of his realms of thought is being-by-participation:

“Man comes into his individual being... by communion with other men through love, hope, and faithfulness. The other man must not be a mere “It” or just “somebody”, but “Thou”, known and loved. Only through the relationship with man as “Thou” does the “I” find his freedom and fulfilment. By loving others, man transcends his own limited self. Without love, man's existence is isolated and reduced. God is the absolute “Thou” who cannot be demonstrated by rational discourse, but He is only encountered in man’s personal engagement with Him”. (Misiak et al 1973 : 78)

Hazel in expressing her relationship with her God is in some sense metaphorically conveying that she is drawing some strength from her faith – without which she may feel more isolated and reduced.

"most of them have had these strokes and things and they’re in desperate condition of all kinds
I think there’s only about one that’s a bit compus mentus like myself if as much as me
because I am quite with it”  (Hazel)

"when I was divorced
I lost 2 stone in weight
because I’d been hurt
it still depresses me now”  (Terry)

"I was captured and spent time in a prisoner of war camp
the Japanese, well some of the things that happened
it’s something you never forget
you can’t obliterate
it’s in your mind
stuck there
the pain of it stays”  (George)
"Though my nerves are a bit bad
I do suffer with my nerves
and I think that's due to my father
he was an alcoholic
he fought it all his life
but
yeah, in the end he had to give into it
and when he did
oh god
life was a bit difficult
'cause he got a bit nasty
there were some very bleak times
I can still remember
and that's why my nerves are affected" (Evelyn)

Could the above expressions relate the Lemaire's (1977 : 179) description of Lacan's notions that we form our fictional selves from being “caught up in the symbolic” where we are simply represented, obliged to translate ourselves through the intermediary of discourse and in this sense we will become lost, lured away from ourselves, and thus shape ourselves in accordance with the other’s look”. Lacan proposes “that we get knowledge of what we are from how others respond to us” we form our fictional selves and shape ourselves in accordance with the other’s look. The pain is still in George’s mind from all those years ago during his closeness with the Japanese. Evelyn suffers with her nerves, her nerves are still reeling from the affect her father had upon her many years ago. Terry’s depression is still with him from the divorce all those years previous. Hazel sees herself quite with it when she compares herself to others who are in all kinds of desperate situations.

Lacan (1968 : 164) views speech as a movement toward something, an attempt to fill the gap without which speech could not be articulated. These notions of how Lacan utilises the language and his ideas of the unconscious seem useful tools to employ when engaged in psychotherapeutic work with patients, however the difficulty
presented by his work is referred to by Benvenuto and Kennedy (1986 : 61) where it is identified that Lacan even although:

"He discussed the necessity of understanding the role of the type of language determined by the ego. Nonetheless, he was still opposed to any idea of adjustment to the social environment".

How this takes account of people with physical disabilities attempting to adjust to the social environment may be a bone of contention. Particularly when according to Sarup (1993 : 6) “for Lacan there is no separation between self and society. Human beings become social with the appropriation of language … Society inhabits each individual”.

On the other hand:

"Lacan considered that the psychoanalytic relationship was one between subjects, and so could not be reduced to a relationship between two unified, stable individuals, with easily objectifiable psychological properties. It is not easy to grasp this notion, except perhaps within an analytic relationship, where thoughts and feelings often seem to come and go in a fluid and contradictory manner”. (cited by Benvenuto and Kennedy 1986 : 62)

Perhaps this is evidenced by Ellie where she is subject to the language “yaayaayaayaayaa” which comes and goes and is out of her control. She cannot stop it coming out; she is spoken by it. Is it some form of madness as Lacan suggests in that “in madness speech no longer tries to make itself recognizable (cited in Muller et al 1982 : 100). Or perhaps it is a foreign word as Leclaire (1978 : 81) points out that “sometimes there are unknown words strangely concocted from a mixture of languages...”.

Lacan proposes that the therapist should be attending to what is not being said and what comes out between the words, and that perhaps we can only help people by hearing where their language is failing. Ellie maybe does not have the language to
speak of what is real and possibly frightening to her and uses "yaayaayaayaaya" precisely because language is limited.

From the three core themes, encounters with bodily being, encounters with self in transition, and encounters with O/other/s one general theme has been identified and that is a sense of "grappling with a new experience of self". This grappling with a new experience of self could be related in part to what Harre (1991: 178) alludes to at the end of his quote on modes of 'illness conduct' when he suggests that

"People can choose to be active or inactive in relation to some experienced bodily malfunction, perceived as a symptom. In the inactive mode there are such attitudes as ignoring the symptoms, denying their existence, or simply accepting them passively. There are at least three ways of the taking up of the active stance... one can regard the illness as potentially destructive and resist it... one might regard the symptoms as the occasion for a flight into illness as liberating... people can and do turn illnesses into occupations... they accept their bodily withdrawal from normal social duties and construct a new social world around it".

In conclusion, from the interviews and the summarised cases an overall sense of people grappling with a new experience of self and three sub-themes termed "encounters" emerged. Metaphoric texts were used to help reveal some of the issues that older people face in these circumstances. From this indications of the psychotherapeutic use of metaphor as a way of helping establish and support this new emerging self was uncovered. Conclusions and implications of these findings are discussed in the final chapter.
Chapter 6: Conclusions and implications

This last chapter reflects upon, and discusses the findings of the study, beginning with a brief review of the themes extracted from the data and the methods employed to conduct the research. The findings are discussed in terms of what is the nature of this need, in other words, what are the characteristics of this need for counselling/psychotherapy in a medical setting for older people who have suffered a debilitating physical illness or injury? Following this are the conclusions and implications that have emerged from this study.

The need for counselling/psychotherapy in a medical setting emerged from the interplay between the data (the interviews and the cases), and the theoretical perspectives. Themes developed from this, outlined in the last chapter, were used to identify the nature of the need for counselling/psychotherapy in a medical setting for older persons suffering from a debilitating physical illness or injury.

The themes were arrived at through deep engagement with the data, from which, initially, there was an overall sense of individuals, in one way or another, “grappling with a new experience of self”. This is illustrated by the following texts:

All in all though
it’s been a great shock to my system
I’m not dead in one sense
but bits of me are

My brain’s telling me one thing
yeah that I can walk, I can move my fingers
I can talk properly
but I can’t
it’s like being stuck in the mud
I caught sight of myself
they’ve got a mirror in the gym
I didn’t realise how awful I look

I hate being like I am
it’s like being trapped
I want to get out

There are implications here for the research question in that people have suffered a tragedy and are now struggling to come to terms with a changing “self”. There are issues here, for example, of not being dead in one sense but now feeling that bits of you are dead. Then your brain is saying you can move, can walk, and can talk, but the presence of one’s body makes itself felt by dictating that these are no longer simple tasks. There is the glimpse in the mirror that shows a different self with an almost unacceptable changed look. Then there is the statement about the “new” self being experienced as so different from the “old” self that it is hard to even like it.

From within this overall sense of people grappling with a new experience of self three sub-themes gradually emerged which were termed “encounters”. The first sub-theme was identified as; “encounters with bodily being” the second; “encounters with self in transition” and the third; “encounters with O/other/s”, (in Lacanian terms, referred to earlier, the “Other” can be defined as the Father, the Law, a place, or any dialectical partner). These three encounters, which were metaphorically articulated in various ways within the data, are briefly defined firstly, to establish why the method used was chosen to conduct the study, and then secondly, to show how these “encounters” answer the research question.
Firstly then, with regard to an encounter with bodily being, these references illustrate the consequences in the physical sense; “I’m stuck”, “anchored down” and “trapped” yet these terms also convey metaphorical feelings of entrapment and being fenced in by the body exerting its presence. The body too, has a way of expressing meaning as in “I’m deadweight” where the total mass of one’s body weight is used to communicate a sense of existence that metaphorically weighs one down and, by the same token, hint at powerlessness.

Secondly, an encounter with self in transition is metaphorically implied by, for example, the expression; “what have I become” which gives a sense of puzzlement about the change to ‘I’. This feeling of bewilderment is further compounded by “it’s like I’ve lost me” which alludes to a certain degree of angst and discomfort about “me” being metaphorically misplaced. Even a change in the character and quality of one’s voice, where it is conveyed that “it sounds slow, heavy”, can infer a change to one’s self.

Thirdly some instances of encounters with O/other/s where, for example, this text, “I’m now 65 and to the authorities I’m past it sort of useless” could be an implied metaphoric dialogue or relationship with various sections of society, from those who make the rules, to those who have little understanding of the ageing process and older people. Another encounter is implied from the following, “I would like to present myself as looking like George” where, metaphorically, there is a sense of wanting the opportunity to be acknowledged and recognised as one’s “self” perhaps implying, as one’s former self even though there is a new changed “physical” self. This acknowledgment and recognition from and by O/other/s could include staff, the counsellor/psychotherapist and so forth.
Having extracted the sub-themes termed "encounters", from the data, one of the initial implications for the research question is that one of the needs is for people to be heard, to be listened to, for account to be taken of their stories. To have someone hear what they are suffering, to hear about the trauma, and also to hear about them as individuals is obviously important as evidenced by the fact that people were willing to talk and then wished to continue through counselling sessions.

However, to answer the research question by offering an analysis of their stories to uncover more about the nature of the need, if any, for counselling/psychotherapy the researcher felt justified in the employment of the research methods used. Although chapter four deals in full with the methodology and method it is felt important to briefly reiterate some salient points as a reminder, in particular, of the analytic strategy used to produce and present the findings.

Yin’s (1994) case study approach provided the structure and guidance required for the study. It allowed for the fact that the researcher had prior knowledge of the field and thus promoted the establishment of theoretical perspectives from the start of the study which is indicative of such prior knowledge. Also another key element of the case study approach is that it allows for the inclusion of multiple-cases in order to spotlight a particular group of people with a particular problem. However, the case study approach according to Yin (1994) offers no definitive guidance on the criteria for interpreting the findings from the data. To do this required a method that would fit within, and be compatible with, Yin’s case study approach and this was developed as follows.
The researcher felt the data was pivotal to the study, particularly as it consisted of the
telling of stories in a setting where, as identified earlier, this is not always encouraged.
It was at this stage that another method was considered to facilitate the structure of the
interviews. After long and careful deliberation as to the most appropriate and
engaging way in which to present the interviews, it was decided that features of
Riessman’s (1993) narrative analysis could be used. Her approach was chosen both
to enable ease of readability and, also to allow her notions of the poetic features of the
language to combine with Lacan’s (1968) notion of the metaphoric aspects of the
language.

Riessman (1993 : 52) is interested in the poetic features of language and her approach
to narrative analysis “takes account of structural properties (frames, stanzas, parts)
(and) key metaphors” thus this became central to how the interviews were set out. It
was also Riessman’s notions of how substantive themes can develop and be organised
into stanzas via metaphor that led to the consideration of the theories of Lacan to aid
the analysis. Metaphors are also a key element in Lacan’s view of linguistic choices
(Sarup 1992 : 52), where the “metaphoric aspect of language allows it to point the
word to something beyond its literal meaning and referent”. Lacan (cited by Sarup
1993 : 7), holds that “analysts must relate directly with the unconscious and this
means that they must be practitioners of the language of the unconscious – that of
poetry, puns, internal rhymes”.

Lacan (cited by Forrester 1990 : 145), expresses that the function of the analyst “is
not only to listen...but also to hear – where hearing (as opposed to listening)
implicates the hearer in the utterance of the speaker”. Therefore, the hearer, the researcher, is thus implicated in the utterance of the speaker and, as such, the interpretation/analysis of the raw data is based solely on what features of it the researcher selects. Riessman (1993: 61) also states that analysis may take into account that:

“The features of an informant’s narrative account an investigator chooses to write about are linked to the evolving research question, theoretical/epistemological positions the investigator values, and, more often than not, her personal biography.”

So this too allows the researcher to link the accounts to the theoretical/epistemological perspectives that he or she chooses. So this method of analysing the data was chosen over other methods such as phenomenology which advocates the bracketing out of such personal imprints. For Lacan the metaphoric aspect of language allows language to be taken beyond its literal meaning and referent. Lacan (cited by Benvenuto and Kennedy 1986: 117-119), proposes that in this way the subject uses the language “as a system common to other subjects... (and) one must not then think, that speech masks one’s thoughts” and, adds Lacan “the interplay of metaphors is a major means of encountering unspeakable truth”. It is these aspects of Riessman and Lacan that were used to extract the sub-themes and then subsequently drawn upon to produce the analysis. Following this brief recap of the research method it is these sub-themes that are now presented and discussed to answer the research question.

In providing answers to the question the discussion focuses on two areas, firstly, on what emerged from these metaphoric encounters that tell us about the nature of the need for counselling/psychotherapy for older people in medical settings. And, then secondly, what are the implications for the practice of counselling/psychotherapy in order to be able to address these needs.
Firstly, then to discuss the sub-theme of “encounters with bodily being” (where the body itself is not made reference to directly) yet there is an acknowledgement of the presence of one’s body in a metaphorical sense it makes itself felt or known:

I hate being like I am
it’s like being trapped

I’ve been used to being on the move
Never anchored down before

I feel totally stranded

I’m stuck that’s the kind of thing
when they shut the door I’ve no way out

Extracted from the above texts these terms “trapped”, “anchored”, “stranded” and “stuck” are all metaphoric expressions of how the body has made its presence felt by imprisoning and fastening one down; curtailing movement; leaving one marooned and cornered. In Lacanian theory these could be identified as nodal points and, just to recap, nodal points are heard between signifier and signified, for example “anchored” or “stranded” being the signified (the word), and the signifier is the meaning attached to “anchored” or “stranded”. Then there is the ‘superimposition of signifiers’ this is where the notion of metaphors can be applied where one word comes in place of another word and the language can point to something quite different.

This is where it is so vital to hear what is being said, as well as establishing a strong empathic relationship with the person in order to support them better with the reframing and reconfiguring of the powerful metaphors that spring from these nodal points. The inferences here for the research question are that perhaps this is where it
may be deemed essential for the counsellor/psychotherapist to have some knowledge of physical debilitating illnesses and injuries. This is in terms of an awareness of the perceptual and cognitive changes that may be taking place due to the illness and also how the condition can affect the body i.e. contractures caused by strokes, and the mask like expression that can accompany Parkinsons disease. Also the patient's drug regime may be worthy of consideration as this too may have implications for working with a patient, for instance, some anti depressants can induce tiredness and other side-effects.

An example of some work with Jeremy is given to illustrate the involvement of some of these issues and to show how nodal points and metaphors are used when there is an encounter with one's bodily being. The following texts are just a small part of the interview conducted earlier in the study with him:

```
I am virtually paralysed
from the neck down
it's hard being encased in this body

I was living at home
then gradually the disease
it bears down on all you touch
everything you touch really

I feel yeah I feel
that's it I'm here
I'm sat in total isolation
I'm alone

I feel I'm in a box
life is passing me by
``` 

The impact of these encounters with his own bodily being are so keenly observed in Jeremy’s texts above, where he refers to the metaphoric pain of separation, loneliness and grief. Within the summarised case (in chapter 5), Jeremy talks of spiralling into
himself where there is no escape. Jeremy’s world is for the most part one room in the nursing home where he now lives after returning from hospital. Therefore, being “encased” in his body refers to his imposed confinement within four walls and to his reliance upon a wheelchair. This is where, it is important, as established by case study methodology that the phenomenon cannot be divorced from the context in which it is set. The implications for the research question are that it might be helpful for patients if the counsellor/psychotherapist has an awareness of working with people whose world has become smaller and more limited through the constraints set by their illness.

Jeremy talked about the paralysis of his body and what he now could not do, and what being “boxed up” meant to him in that he is alone in one room like being in a box. The use of nodal points and metaphor is a means of opening up some spheres of possibility for him, much like the junctures on the railway line referred to earlier and to reach this point meant returning, in some part, to things with which he used to be involved; unlocking and freeing his mind that was not “in a box”.

These issues did at times bring expressions of loss, grief and despair so the main skills used at points like this are those of clarification and reflection to enable Jeremy to talk over these losses. Then with encouragement help him explore those areas of his life that are now changed but at the same time encouraging him, to find his own metaphors, that open up possibilities of still having some involvement with things but in different ways. In all of this the very act of talking is a movement that itself can be freeing and flowing in the metaphoric sense so counteracting feelings of being “stuck”, “anchored” or “encased”. Visualisation and guided imagery are also
techniques that were helpful ways of guiding and moving thoughts which enabled Jeremy to visualise ways in which he could be "unboxed" and not be "stuck"; enabling him to be able to open the lid himself whenever he wished.

The nodal point "teacher" became instrumental in working with metaphors as to how Jeremy could open the lid from the box. As he had a past history as a teacher of philosophy it was talked over, that on occasions, he could make the choice to leave his room and engage with others. To further encourage his return to philosophical matters he eventually decided that he would have a thought, a notion or, sometimes just a word and this would then be written for him onto a write-on/wipe-off board that was obtained for his room. Meetings with staff were planned and they were encouraged to come and view the topic or word and discuss it with him also Jeremy invited one or two of the other residents to take part. Another way of lifting the lid and removing the paralysis from the "teacher" part of Jeremy meant he was able to instigate the inviting of students to come and see him, either for the purposes of interviewing him or just to talk with him. By supporting Jeremy to find new metaphors and then helping him to interpret them made him feel better and empowered him to regain some control over his life.

This is just an illustration of how encounters with bodily being brought about by disabling physical illnesses or injuries can bring about expressions like; "stuck"; "anchored" etc. Then as further shown the creative use of nodal points and metaphors can be a means of opening up a sphere of possibilities. Other ways of reading texts in this manner are borne out in the next identified theme.
The second identified theme is an “encounter with self in transition” where there is a stated and an implied (metaphoric) changing state to one’s being, to one’s self:

Since this has happened I’ve felt different
I think to myself
what have I become

I’m frightened people won’t understand me
in my own head my voice
my voice
it sounds slow
heavy
I don’t have much to say
I seem to have gone into myself

It’s like I’ve lost me

In the above texts people seem metaphorically to be confronted with a loss of their former self/selves. It is acknowledged that people with a chronic condition have to cope with a condition that is permanent and, as Hemingway (1996: 42) writes, “their sense of permanent loss has been compared to the grieving process...because of their ever-changing circumstances...as well as mourning the loss of what the person once was, the patient (has) to get used to a ‘new’ person”. It is like a crisis (Gadow 1982) when the self experiences that part of itself, which is object body (as in illness or injury) as an internalized encumbrance or burden. For example, this crisis manifests itself as fear in that you will not be understood as your voice sounds different than before a stroke was suffered. Consequently there may be a reluctance to speak and this can lead to a withdrawal from social activities and interaction.

When a person becomes ill they may feel isolated by their new identity (Moos and Davis 1977), as someone who is different from before and who is different from other people. There is bewilderment about what has happened, you have become changed or are in the process of changing and have lost yourself, lost who you used to be.
Perhaps there is the sense that one will never return to one’s “old” self and post modern implications are that there is just not one self but plural selves (Sarup 1993), so this may inform the fact that there is yet another “different” self emerging.

The notion could be that this different “new” self is exerting itself and subsequently, there is a need to support its establishment. This has implications for the research question in that Lacan has the potential to be very helpful to do this via his nodal points and metaphors. For example, where one’s voice sounds different than before, the nodal point “different” could provide the key to some of the therapy that might help this person. It has been expressed that her voice sounds “slow and heavy” and “different” than before so the more she speaks and hears it herself the less it will seem different. Therapy may involve work on an individual basis (possibly in consultation with the speech and language therapist), using poetry or literature reading or even singing to strengthen the voice and this can boost morale and give the person back some self confidence. This has implications for the research question, as already identified above, in that if there is no support and help available people may end up by retreating into themselves and withdrawing from social activities and interaction.

Therapeutic group work, which is mentioned within the study, could be beneficial in helping people avoid becoming socially isolated and lonely, as well as helping the establishment of this emerging different “new” self. There are many avenues of doing this (some of which it is hoped are fun), which the researcher did not have space to explain, but a flavour of them would be, drama, dramatic reading/listening, role play/seated acting with gestures, creative writing, haiku (a form of poetic writing),
literature/poetry, movement to music, dancing on the spot, singing, art, reminiscence, inviting others, free association.

As Taylor (1989, cited by Young-Eisendrath 1997 : 163), puts it “one is a self only among other selves. A self can never be described without reference to those who surround it”. This may have implications for counsellors/psychotherapists wishing to work with people in medical settings, both from the viewpoint of research into therapeutic group work, and from the ability of the therapist to use some of the above techniques.

Finally then, the third theme is an encounter with O/other/s this is where in metaphoric terms there is an implied dialogue or relationship with O/other/s and it is via this third encounter that further implications for the research question are discussed. According to Lacan’s theory of “the dialectic of recognition” this is where and how we gather knowledge of what we are “from how others respond to us” (cited by Sarup 1993 : 12). Phillips (1996 : 202) contends that people are very aware of their deformities and other people’s reaction to them and this awareness “profoundly shapes their self-concept and self-esteem which may be quite low (and) they “often try to fade into the background cut off their relationships with the world and go into a closet existence”.

In a medical setting there is a chance that a person may become isolated and feel virtually invisible and this could lead to a loss of identity. According to Lubrosky (1995 : 1450) this can happen when disability strikes and the basis of a person’s identity is turned from their achievements and social identities to that of the disabilities
of their body “the impairments become a master identity overshadowing all other identities”. There are issues here about the fundamental ontological question concerning the very nature of our being which, for Lacan (cited by Benvenuto 1986: 173), means that there is a basic dependence on the Other for the subject’s existence and for him “the Other becomes the real witness and guarantor of the subject’s existence”.

*Does anyone see me*
*no-one hears me*

*That’s it I’m here*
*I’m sat in total isolation*
*I’m alone*

*I would like to present myself as looking like George*

In the text above George feels that his impairment has come to define and describe him. He expresses that he would like to present himself as looking like “George”, (which may be the desire for some continuity of his previous self prior to his disability whilst at the same time incorporating his “new” self). The work of the counsellor/psychotherapist would be to support him in establishing his “new” self by perhaps the suggested ways described earlier. There are further “encounters” hinted at here, where the O/other/s, for example, could be staff so this could carry implications for further areas of research. These further areas of research could include education and training of staff with regard to, for example, communication and the ageing process.

Also in the above texts; “*does anyone see me*” and “*no-one hears me*” where it is the absence of encounters with O/other/s that is poignant and, as mentioned earlier, a person can shrivel both physically, and in the metaphoric invisible sense, when there is a lack of warm human contact. Therefore, working as a counsellor/psychotherapist
within a medical setting for older people means that there is every likelihood of being a significant Other in encounters with people with a host of different debilitating illnesses and injuries. This might have implications for this area of research as it could be suggested that in the training of counsellors/psychotherapists it may be considered desirable to have some knowledge and understanding of such illnesses and injuries and the ageing process. For instance having a stroke can have a significant impact on many areas, such as mobility, speech, vision, perception and cognitive processes and, writes Sprenkel (1999: 218), because of its sudden onset:

"A stroke provides little opportunity for the individual to prepare for its subsequent impairments...if the stroke impairs a number of functional areas, the individual is at greater risk of increased dependency and social isolation, which often contribute to feelings of depression and loneliness...elderly male patients often speak about feelings of loss and inadequacy if they experience changes in their abilities to function sexually."

From this it is clear that counselling/psychotherapy in these situations needs to take account of the fact that the work will involve people who are experiencing a complexity of issues. Issues, as discussed, brought about by sudden dramatic changes to a person’s sense of self and, where, in the grappling with a “new” experience of self there is the risk, as acknowledged earlier, of depression, loneliness and feelings of inadequacy, as for instance, in sexual matters as identified above.

Encounters with O/other/s (according the Lacan) can also have wider implications and relate to society:

Some they look at you
you just want to be
yeah at times like that
you wish the floor would open up
I feel as if I’m getting old
I’m now 65 and to the Authorities
I’m past it
sort of useless
it’s like my opinions and views don’t count

Gliedman and Roth (1980, cited by Shontz 1990: 146), stress that “the universal concern about how others view us is a preoccupation that endures throughout the life cycle”. The two texts above illustrate the fact that those who are visibly disfigured “always face the possibility of being shamed or publicly shown to be defective, and as a result feeling devalued...they share a special vulnerability, and can be readily viewed as blemished and not quite human”.

Van den Berg (cited by Kestenbaum 1982: 23), goes on to describe how the everyday world is transformed for a person when they experience illness or have a chronic condition in that there are “changes in the experience of time and space; changes in the body (from instrument to problem); (and) constriction of the ‘horizon of my existence’”. The potential impact and outcome of this type of encounter with one’s own bodily being makes one vulnerable (Rawlinson 1982), and leaves one at the mercy of others in significant ways. Here there are implications for research in the area of training and education of others as in induction of new staff in clinical settings and perhaps further a field, for example, in schools. Following this reflection and discussion about the findings of the study, the chapter concludes with some points drawn from this and the rest of the study.

The researcher believes that there is a need for counselling/psychotherapy in medical settings for older people who suffer a debilitating physical illness or injury, but also
believes that the nature of such a service is quite different to that undertaken in a more usual setting. Implications for the research question are that some account should be taken of the influence of the environment upon the delivery and practice of counselling/psychotherapy. Rybarczyk et al (1992) are among the few to take note of, and acknowledge the fact that, these practical barriers need to be considered before therapy can be undertaken. Some of these contextual issues are discussed here and are further illustrated in the attached counselling sessions in appendix two.

When working with medically ill people the environment has particular implications for the delivery and practice of a counselling/psychotherapy service, namely, that the service has to fit around a whole host of other activities such as ward routines, physiotherapy, visiting, drug rounds, treatments and so on. Also people are ill, possibly tired, they may be wheelchair dependent, or be on long term bed rest, so there are issues about how, when and where to see them as space can be at a premium. Given these issues about the environment concern needs to be given to confidentiality and the depth and quality of rapport that can be established in these circumstances perhaps where space is an issue.

From the evidence presented it may be seen as desirable for the counsellor/psychotherapist to have some insight into the environment and workings of a medical setting. There is a multitude of equipment and some knowledge of moving and handling of such may be seen as a requirement for the safety of both the therapist and the patient. For instance, there are the practicalities of handling equipment even down to knowing how to raise and lower beds and, how to manoeuvre, and fit footplates onto a wheelchair.
Recognition of the various members and their roles of the multi-disciplinary team may be viewed as essential, because advice may be needed from the physiotherapists, speech and language therapists and/or the nurses regarding some aspect of a patient’s care that may arise when they are alone with the counsellor/psychotherapist. An example of the sort of issue that may arise is that if a patient requires a drink, and their ability to swallow has been impaired due to a stroke, unthickened fluid of any kind would almost certainly cause them to choke and possibly die if the fluid reached the lungs.

An awareness of drug regimes might also be considered important as, for instance, some anti-depressants induce tiredness and fatigue. Along with this knowledge of medical terminology is essential as this will be met in the patients’ notes and in discussions with staff. There are also matters of confidentiality and ethics about working with patients and the tension between sharing information with the team. Also it is recognizing when and how to seek and access, additional help or resources for a person, which can be as diverse as the clergy or a fisherman to come in to see the patient who, for example can no longer go fishing in the usual way but may be helped in some other way to keep his interest, i.e. by talking about or helping to make flies for fishing.

In order for the counsellor/psychotherapist to better understand the meaning of the impact of a physical disability and the disease process it might be advantageous to have knowledge of the aging process, the body, the self. This familiarity with these theories gives an awareness of mobility, speech, perceptual and cognitive changes as
well as sensory impairments such as hearing and vision. This would also encourage a better understanding of such notions as ageism and stereotypical views of ageing that may be encountered in these settings.

A further implication for research is in the area of recognising and identifying those at risk of depression and emotional distress, and the support and education of both staff and family/carers around these issues. Due to such things as time constraints, pressure of work or perhaps the unwillingness or lack of knowledge to recognise or talk about psychological issues the emphasis is on not seeing, or denying the psychological impact of serious illnesses, injuries and hospitalization. Nichols (1993: 47), writes that “patients are encouraged by the general atmosphere to hide their feelings...effectively, they are left alone to deal with their psychological reactions to illness unless they have some kind of breakdown”. These factors are evidenced by such metaphoric texts as this:

\[ \text{Things go round in your mind} \\
\text{it's difficult} \\
\text{I never get to talk about things} \]

Buschmann et al (1995: 49), holds that depression can be difficult to detect and in an older person it can often be masked by somatic ailments, and it is also contended that older people “either fail to express or deny emotional affiliations...(and that) it is common for the depressed elderly to avoid verbal communication. McKenzie’s (1996: 43) personal description of physical illness illustrates this point:
"The physical impact comes first – with pain, dysfunction, broken bones and disfigurement...emotions ricochet around one’s consciousness all the time...instead of being in a situation of perceived status and choice...I became a number, a condition, a treatment plan...in short, I became depersonalised...was made homeless while a hospital in-patient, and lost many personal items...meanwhile friends disappeared, partners vanished...one has no control, no purchase or order and no rights...if one protests, one is labelled ‘difficult’...there is psychological scar tissue to carry.”

Morris (1998) identifies that the process and progress of physical rehabilitation is important, yet notes that in stroke rehabilitation the psychological adjustment to the disability is not always a consideration when measuring functional progress. This further buttresses the fact that in physical rehabilitation areas where the concern is on the functional progress of patients their psychological and emotional needs may be sidestepped. It is identified that there are many reactions to the onset of physical disability. Livneh and Antonak (1991: 300), state that “shock, anxiety, denial, depression, internalised anger, externalised hostility, acknowledgement, and adjustment” can accompany a debilitating illness. Adams and Bromley (1998: 147) state that bereavement and grief too, is experienced through “failure, removal or alteration of body parts, whether internal or external; or an alteration in physical, psychological or social functioning”. It is also established by (Parkes 1986), that people feel actual bodily pain and emotions such as grief when separated from home and relationships, and the illness may not be the only problem they are facing. This indicates that patients, as well as having to contend with the current issue, that of the physical illness or injury that brought them into hospital, may also have other issues prior to this among which could be any number of things such as addictions, phobias, depression, anxiety attacks, relationship difficulties etc.
The relative, friend, and or carer of the patient also may have issues of their own and these can include the pain and grief of separation and sometimes guilt that they will no longer be able to take care of the person, or if the person returns home, they need support as the person will be changed from how they were before. Relatives, friends and carers may also have issues of their own that have been present for many years which they have never had the opportunity to address or talk over.

Taking all the above into consideration the nature of the need for counselling/psychotherapy in this setting is one of creativity, imagination, flexibility and adaptability. Some of the ways in which this can be done have been suggested and include techniques such as guided imagery and visualisation, but it is not within the bounds of this research study to fully explore this and other concepts. The researcher can only record that her own training incorporated, and has subsequently included, client-centred therapy, elements of Freudian analysis, cognitive therapy, existentialism, phenomenology and philosophy. From this an interest was developed in the language and the philosophical notions of self and bodily being, which have, as recorded in this study, contributed to the suggested use of nodal points and metaphors as a means of helping people in the situations described.

Metaphors are a way of putting forward ideas of other ways of looking at things by increasing people's options. The use of metaphors has been illustrated as a way of widening someone's vista and opening up their opportunities, and from this Kopp and Craw (1998 : 310), write that "exploring and transforming client metaphors invites clients to use their own metaphors and creative imagination to cultivate the seeds of change and growth". Mearns and Thorne (1996 : 49-50) also suggest that "learning
to appreciate a wide range of metaphor is a very useful counsellor skill...it is just one of the ways in which the counsellor’s breadth of life experience can contribute to her understanding of the varied ‘personal languages’ of clients”

From this the implications for the research question are that the counsellor /psychotherapist is able to give people the space to talk, and as written earlier the very act of talking is a movement and freeing experience. A person can feel isolated by their new identity as someone who is different than before and is different from other people, so there is a need to support the acceptance of a new self-concept and to restore someone’s self esteem. For instance, a lady who suffered a stroke and could no longer carry out her own cooking and domestic chores was asked if she minded if staff came to her for advice on cooking and all things domestic. This can counterbalance feelings of depression, loneliness, loss and inadequacy and be beneficial to both the patient and staff. Another instance was another lady who also had suffered a stroke, but prior to this had chaired many meetings and was a public speaker, and she thus was encouraged within a group setting to undertake these roles again.

Group work is not covered within this study but it can be helpful and therapeutic in many ways, one of which, for instance, is for people to gain strength to their voices. Sometimes within an institutional setting people do not talk that much and their voices can become frailer and weaker. So various types of group activities can help restore the strength and tone of the voice and can have the added bonus of rebuilding self-confidence and establishing the new “self”. Dramatic reading or role play using gestures are good ways to work with people who can no longer stand or walk that
Japanese haiku (poetry) is another way of running a creative writing group, even if one or two people have to be the scribes for the rest of the group. Free word association is also another means of generating a discussion and encouraging creative writing.

After looking at some of the implications for the research question the following comments and suggestions by McDaniel et al (1977) are included, as is some discussion on the work of Sharman (1981, cited by O’Leary 1996). Sharman’s approach is included to add more validity to the study’s findings as some parallels could be drawn with her work and with the findings of the study.

McDaniel et al (1977), writes that because illness happens to the individual that what makes it such a lonely and self defining experience. He discusses the fact that illness is the ultimate out-of-control experience, and by invading the person often changes them permanently. Also that hospitalisation can strip the person of their identity and they can be treated as a bundle of organ systems. Counselling/psychotherapy offer an opportunity for connection, whilst not denying the singular experience of the individual, and can support the patient and family in trying to maximise the outcome, improve the quality of their life and to cope with the process.

Sherman (1981, cited by O’Leary 1996 : 84-86), offers an integrative approach that identifies, uses and enhances the natural resources of the person. This approach can be adapted to use within a medical setting where initially the importance of a person’s health and physical needs is recognised. Sherman contends “that critical and stressful material needs have first to be met before individuals can turn to their emotional
needs". It is at this point that counsellors can provide "emotional support and encouragement, as well as practical guidance" in the way of seeking information or advice. Sherman speaks of stage two where the counselling objectives are "more psychological or personal...the counsellor is called on to provide support and coping strategies in order to stabilize the self-esteem and sustain the morale and coping efforts of the client". This may be gleaned through reminiscence where the person can recall pleasant times and things they have achieved and thus acknowledge their abilities.

Sharman’s approach also incorporates the techniques of cognitive psychotherapy which can be used to enable the therapist to work with the person to identify coping skills and enhance cognitive mastery. This also deals with "changes in basic attitudes towards self and towards one’s life". The work of counselling/psychotherapy would be to work with the person so that they can take back some control over their own lives, albeit in a different way than before. It is about the choice, enabling people to have more choice, enabling people to express themselves, exploring whether they carry on down one particular track or do they take another track. Sharman’s approach acknowledges the centrality of the relationship between the client and the counsellor advocating "accurate empathy, warmth and genuineness on the part of the counsellor". Sharman also uses natural helping networks such as family, “and peers in both support and therapeutic groups”.

There are aspects of existential therapy in these approaches where the identified aim is to empower the person so that they take responsibility for their own choices and the change process. From an existential viewpoint, Brody (1999 : 91-97) writes that “the
client is seen as the “primary subject in the therapeutic encounter...with the therapist as helper/consultant/companion in the effort to the client’s life less stressed”.

To summarise, the study has drawn out themes to answer the question about “what is the nature of the need, if any, for counselling/psychotherapy in a medical setting for older adults who suffer a debilitating physical illness or injury?” The themes identified were guided by the interplay between data (the interviews and the cases), and the theoretical perspectives. It was established from these themes, that physically debilitating illnesses or injuries suffered by older people poses personal problems and issues that may be encountered in several different ways. The need for counselling/psychotherapy in medical settings for older people when they suffer such traumas was expressed in the form of encounters, encounters with bodily being, encounters with self in transition and encounters with O/other/s.

From these encounters it was established that disability can lead to dependency on others giving feelings of powerlessness and lack of control and give rise to depression or anxiety. The cumulative effect of all this can lead to feelings of uncertainty, helplessness, isolation and withdrawal (Viney 1983) which can made people more vulnerable to illness and can work against their rehabilitation and recovery. This carries implications for further research in that Lichtenberg and MacNeill (2000) hold that depression has been established as having a significant impact on functional recovery and depression among older people has been found to be an important risk factor for failure to recover following illness or injury. Other studies Clark and Smith (1998 : 74) have found that:
“Depression was associated with poor physical and social outcomes (and that) depression did little to diminish the functions gains made during rehabilitation: rather,...depression may act to degrade functional status.”

It has also been found that depression in older patients Arean et al (2001 : 94), is a common debilitating problem in that:

“Research shows that depressed older adults have deficits in coping skills – deficiencies that may impair ability to cope with the stress related to depression (and) aging...somatic therapy may not be enough to help these people in coping...psychotherapies that can be delivered in primary care settings are therefore important to develop.”

Therefore with depression being identified as a debilitating problem and also an influential risk factor in failure to respond to functional rehabilitation programmes it seems essential that the training for counsellors/psychotherapists within medical settings incorporates some knowledge of the theories raised in this study, for example, the aging process, the body, the self. This will give some awareness of the impact and outcome of such traumas thus enabling a better understanding of the meaning of a physical disability to the patient.

A counsellor/psychotherapist working in this setting will encounter issues that may not be met so frequently in a usual setting so will need the ability to absorb the shock of a disabling illness and, be prepared to face the reality of the patient’s fears of death on a daily basis. They would need to strive, in spite of the loss and pain incurred by the illness, suggests Krupnick (2002 : 921), “to help the individual re-establish a sense of purpose and meaning in life and hope for the future”. Moreover, the role of the counsellor/psychotherapist within these settings should have the potential to
increase the care for staff and carers as they too need support to be able to face the reality of patients’ fears and anxieties. Given this, it is also essential for the counsellor/psychotherapist to ensure that they have adequate supervision to enable them to be able to work in the most effective way in this situation.

Finally, some further areas for future research are the effectiveness of other therapies such as cognitive behavioural therapy for older people with debilitating physical illness or injuries in medical settings. Also further investigation is indicated into group work with older people in medical/rehabilitation settings, and, how best to provide support for relatives, friends and carers. Also raised within the study are issues around the provision of informal care for staff as well as formal support such as clinical supervision either individually or in groups. There are implications within the study for the investigation into the future training needs for counsellors/psychotherapists wishing to work both with older people and, in medical settings.
Appendix one

Interview with Jeremy with the researcher’s interventions

The researcher attempted to allow the conversation to run in the direction that Jeremy wished it to run, with the researcher’s interventions as minimal as possible, and then only with the intention of supporting his line of conversation, by not asking leading questions but by reflecting back emotional content. This goes against typically medically orientated “interviews” which consist mainly of asking a series of questions that generally force the respondent to organize their experiences into predetermined categories (Strickland 1994).

After ensuring that Jeremy was comfortable and that he was happy for the interview, as previously discussed with him, to take place, I set the tape recorder running.

C: Well Jeremy at last I’ve got organised...well as we talked before I wanted to ask you a bit about what had brought you into the unit and then perhaps a little bit about how things have been going for you...is that ok?
J: I’ve been in here for just over two weeks ...I’ve had a problem with my catheter...and also my muscles
C: Your muscles
J: Yeah...my muscles had contracted even more so...and, and so it was thought... that I should come in here to have it sorted out...the trauma of coming into hospital...I don’t think helped me emotionally
C: You think it’s upset your emotions
J: My life was turned upside down 4 months ago...I had to leave my home...I've been in there (nursing home) since then...yeah, I was put in there...because I've got ms (multiple sclerosis)*

C: That sounds as if it was a difficult time for you and you didn't have much say in it

J: It feels like...like...I've been put on the moon...yeah...I was living at home...then gradually the disease...it bears down on all you touch...everything you touch really...my wife...she noticed I suppose...it was affecting the children...as much as it was affecting her...so she felt that...that I would benefit from...being in a nursing home situation...so that's where I am really...in a home...it only took one phone call...that's all...to the social worker...and I was gone the next day...it was as quick as that...it was virtually within a day...they said they had a bed...that was it really

C: It happened very quickly then...it must have been a bit of a shock for you

J: Yeah...it's been very difficult for me...I felt unwanted...and really not needed any more...and that...I can tell you...is such a feeling...sometimes it seems to flood me..............there's a lot of people...in the same boat...some in much worse conditions...than I am...where the disease...the disease has attacked...their vocal cords...they can't speak...whereas I...I can still talk...I can still move...albeit in...in a very limited way...though truthfully...I am...I am virtually paralysed...from the neck down

C: That in itself is not easy to deal with

J: It's hard...it's hard being encased in this body
C: Yes that alone must be difficult for you let alone the move on top of everything

J: The first month I was there (in the nursing home)...three people died...it was the last straw...everyone there...they all seem so much older...than me

C: That happening must have made it even harder for you to cope

J: No-one can really help you...you're trapped inside...inside your own body

C: That must make things very tough for you in some ways

J: They come yeah they come...and they do...they do what they have to...and that's it really...you're like a piece of meat...to be seen to...I know it's not their fault but you feel just like the next package...yeah...the next to be dealt with...just watching them struggle...it's a nightmare...watching them...watching them dress me...I'm deadweight...and all I get is the pain...some you try and talk to...some are really nice...but some...well they don't want to know

C: As well as having to deal with all the personal things you've tried to talk to some but with others you've not had much luck that can't help much with how you feel

J: I feel yeah I feel...that's it I'm there...I'm sat in total isolation...I'm alone...I feel like an empty shell...does anyone see me...no-one hears me...it's like...it's like screaming into the dark...so there I am laid out and...there I'll stay really...I felt this morning if only...if only I could look towards the future...sometimes I look backwards...where I've been...it's been the change of location and the feelings I have...as I say people dying...dying around me...it seems to bring me into real life...a bit of a shock really...maybe in some ways...it will be difficult to...you know...face going back
* Multiple sclerosis (MS). Typically the symptoms ... are weakness, incoordination, parasthesias, speech disturbances, and visual disturbances, ... the course of MS is usually prolonged with remissions and relapses over a period of many years. Stress due to trauma, infection, overexertion, surgery, and emotional upset can aggravate the condition and precipitate a flare-up of symptoms. ... Therapeutic measures include medications to diminish muscle spasticity; measures to overcome urinary retention, speech therapy and physical therapy to maintain muscle tone and avoid orthopaedic deformities. (Weller 1989 : 610)
Appendix two

Counselling session with Terry

As previously stated rehabilitation units for physical trauma can be very much focused into dealing with the physical bodily aspects of the trauma and as such there is often very little space for emotional psychological aspects. In these units counselling can find itself being fitted around a multitude of other things, including ward routines, meal times, treatment times (i.e. wound dressings, catheter care, blood collections, etc. etc.), drug rounds, physiotherapy, occupational therapy, tea rounds, domestic rounds, doctors rounds, visiting times, case conferences, maintenance work, etc; in other words psychological care can be quite low on the list. (Rybarczyk et al 1992 : 127-140)

Account also needs to be taken of the fact that people are ill and perhaps tired, therefore, the times of sessions vary from a few minutes to an hour or more depending upon how the person is feeling. There is also the issue of where people want or are able to be seen, for instance, sometimes the person may be having a day in bed, or if the weather is good they might like to go outside. All of these factors need to be considered in the light of confidentiality and the depth and quality of the rapport that can be established. Rybarczyk et al (1992) are among the few to actually consider these practical barriers to participation along with some practical concerns that need to be dealt with before therapy can proceed (Rybarczyk et al 1992 : 127-140).
Kestenbaum (1982) considers that illness damages the patient's humanity and he holds that ethical imperatives should be concerned with an effort to "restore the patient's humanity". Pellegrino identifies four areas in which the humanity of the ill person is compromised:

The person's loss of freedom of action through impairment of his body; his lack of knowledge upon which to make rational choices enabling him to recover his freedom to act; his dependence upon others for recovery and hence his loss of freedom from the power of others; his increased vulnerability and the consequent threat to his self-image

cited in (Kestenbaum 1982 : 18).

Pellegrino argues that it is important for professionals to thus grasp the "existential situation" of the ill person in order to be authentic in practice. Kestenbaum (1982) holds that "metaphor may be necessary and so, too, other imaginative devices" to bring insights into illness-as-lived" (Kestenbaum 1982 : ix).

Terry is a 62 year old gentleman who was admitted to the general hospital about five months ago. After spending one month there he was transferred to the rehabilitation unit where he has now been for four months. He has recently been commenced on some anti-depressant medication, and following the interview that he gave he decided that he wished to take up the offer of counselling, and would be willing for the researcher to take some notes (as previously detailed in the research that if possible one complete therapy would be documented more fully).

My first impressions of Terry were that here was a man who had a fit looking body and looked as if he spent time outdoors as his arms, legs and face looked tanned. He was wearing a loose rounded neck white t-shirt and navy blue shorts. His round
brown eyes and round face were now not quite symmetrical as the stroke had left its mark by pulling down the left side of his face. Terry was clean shaven and had closely cropped still dark hair that lay flat to his head. His left arm and hand were resting on an attachment fitted to the wheelchair and he had his right foot on the ground and the left one was on the footrest on the wheelchair.

Terry suffered a cerebrovascular accident, a stroke, which resulted in complete paralysis of the left side on his body. His speech has been affected to some extent... in that in his own words... “my voice sounds much weaker...and sometimes I wonder if I make complete sense...my logic is not always straightforward”. Terry also becomes fatigued, so bearing these things in mind, it was arranged that the first session would take place about one week after the interview at a mutually convenient time.

Session one
The first session took place in the ward office during one afternoon with the agreement of the ward staff. Unfortunately, even though steps were taken to ensure privacy, there were two or three interruptions for various things such as files etc. needing to be collected. (C = Counsellor)

Terry talked about being in hospital, and that this was the first time he had been in this room

Terry: This place seems quite big...it seems to sprawl...but of course you don’t get to see much of it...you’re confined to your own ward for most of the time

C: Is that what happens here then...you sort of get confined to your own area
Terry: Pretty much so...they used to come and get me and take me to physio...and that gave me a break really...you know...change of scenery...a bit different...different faces

C: That sounds as if you got something from that

Terry: Yeah...I did...other than the fact I was getting physiotherapy...it was the chance to get with others... when I was at work I used to find someone to have a talk with...

C: Oh right...you mentioned that you worked in a laundry...

Terry talked over his working life in that he had worked in the building trade for a number of years and then "'course my age went against me really for carrying on with the building industry...so that's when I took the job at the laundry..." Terry talked about his job at the laundry and was pleased that he had had another man to work with who showed him the ropes. He explained that Jim had been working there for a number of years and was able to show Terry the maintenance side of the machinery. Terry then went on to say that unfortunately that's where he was when he had the stroke...

Terry: It shook me you know...I'd always thought of myself as being a fit person...yeah an absolute blow...it scared the shit out of me...you wonder what's happened...

C: It must have been as you say pretty frightening for you...

Terry: It was...I came too...my head felt like a ton weight...my whole body felt heavy...I didn't really come to until I was in hospital...I wondered what had happened...I was pretty groggy before I realised...

C: Before you realised...
Terry: Well no one really gave me a clear picture of my situation...and you...well I guess I was sort of hoping that I would...you know...get over it...just listening to bits and pieces I used to overhear them saying...but...one day when they came and dressed me...they put me in this...(Terry banged the side of the wheelchair)...in one flash...in one foul swoop...that was it...yes that was it...and this morning they came to measure me for my very own wheelchair...my coffin on wheels...I mean that says it all doesn't it...no-one's really explained things to me

C: It sounds like you feel there's not much light at the end of the tunnel at the moment and you have been left in the dark about things

Terry: Yes that's exactly how it feels...

Terry talked about how angry and bitter he felt about what had happened to him and how quickly he had been confined to a wheelchair. Terry talked over the fact that he had had tried to find other people to talk to, other patients on the ward, but discovered that there were few to have a conversation with...he also expressed that he was finding it increasingly difficult to deal with the situation of living from a wheelchair...

Terry: I mean I have these feelings of...it's too difficult to even think that this is it...that this is my life in one of these...I feel stuck

We had just started to explore what feeling stuck might mean, when a student nurse knocked the door and came in to remind Terry that they were coming around with the tea trolley and that it was important that he have a drink. We mutually agreed that this was a time to stop as Terry was feeling tired and in need of a drink..

At the end of this session I felt the strain of not always being able to quite hear what Terry was saying and had frequently to ask him to repeat things for me. I asked him if he minded and he said he did not because he felt he was doing something he was
having a conversation, and at least he said he was having a chance to talk over things, to speak to someone. I have noted that as well as a weakening of the body, many people who are institutionalised for any length of time do experience a weakening of their voices, sometimes entirely attributable to the illness they have, but often it happens anyway, because they do not have the opportunity to talk. Also it has been identified that elderly patients can be reluctant to speak due to speech impairments following a stroke (Terry 1997:102). So returning to Terry’s metaphoric expression of feeling stuck; talking is an activity; a movement; so in one sense he is becoming unstuck.

From this first session I felt I was able to listen to Terry’s anger about what had happened to him even given the difficulty sometimes to hear his voice, the constraints of the environment and in the shortest of interactions. Rowe (1991) writes about the difference between ‘listening’ and ‘hearing’:

In hearing another person we are simply waiting for that person to pause so we can talk... In listening to another person we concentrate upon what the person is saying, we think about what the person is saying... In listening, we ask about the details of the story the person is telling us, and, most important, we find out what the story means to the person telling it


It’s the undercover story; the unconscious subtext where for example Terry speaks of being measured up for his own wheelchair. Terry refers to this, this wheelchair as his “coffin on wheels” to what does this metaphorically refer. Maybe the sense that I also was unconsciously thinking of how a wheelchair could “chain” someone to it. This type of reaction could be the result of what Carl Rogers expresses as genuineness within the therapeutic relationship.
Carl Rogers talks of genuineness which is one of his core conditions for therapeutic rapport:

Genuineness means that the therapist is openly being the feelings and attitudes that are flowing within at the moment. There is a close matching, or congruence, between what is being experienced at gut level, what is present in awareness, and what is expressed to the client. (Kirschenbaum 1990 : 135).

When a person feels that he or she is, in a sense, the “acted-upon” person it is according Yalom, hard for any movement to ensure. They have, in fact, forfeited their freedom. Perhaps there is a little of this where Terry says: “in one flash...in one foul swoop...that was it...yes that was it...and this morning they came to measure me for my very own wheelchair...my coffin on wheels...I mean that says it all doesn’t it...no-one’s really explained things to me” Yalom holds that the notion of “freedom” not only needs us to, “…bear responsibility for our life choices but also posits that change requires an act of will”. (Yalom 1991 : 9).

Husserl takes what the term “the will” of self, or of ego as being the force that effects and produces spontaneous movement. Husserl describes the body as being

An organ of the will, the one and only Object which, for the will of my pure Ego, is moveable immediately and spontaneously and is a means for producing a mediate spontaneous movement in other things, in, e.g., things struck by my immediately spontaneously moved hand, grasped by it, lifted, etc.

(Welton 1999 : 29)

Husserl uses the term “organ of the will” for his description of the body implying that the body is a tool for, or instrument of the will. But he does leave room for “the will” to be visualised as a force that effects and produces spontaneous movement may be in other ways to actual bodily movement.
It was a little difficult arranging the next session as Terry was to have an appointment with the speech and language therapist to assessing his swallow. He was currently experiencing problems in swallowing and there was a high risk of him inhaling fluids and food into his lungs instead of into his alimentary tract which potentially could be lethal. At the present time all his intake was being thickened, fluids and solids, which he was not happy with. We left it that I would keep in touch with the ward to see when a good time would be for him.

Session two
It was actually almost a week later to the day but this time it was late morning when I met with Terry. Too early in the morning presents difficulties with the ward routine. Terry was having a bit of banter with the nurses who were in the room and it was good to hear some laughter. With good weather Terry suggested we go into the garden which was easily accessible from the ward. We found as quiet a spot as possible and this time I went to collect Terry's morning drink noting it required the thickener added to it.

Terry said he liked being outside and that was what he had enjoyed about his work in the building trade. He seemed keen to talk about the garden and what we could see, the layout of the shrubs and the trees that were there. I said he seemed to have an eye for nature and we chatted for awhile about the garden then Terry said "of course it's all the hidden tragedies that I feel sad about"

C: The hidden tragedies
Terry: Yeah...I used to do a bit of art work...at one time never went out without a sketch pad...lost pastime now... so it's all the hidden tragedies of things like the
pictures that I won't do... I was no Rembrandt but I used to enjoy walking and the excitement of "sussing out" something... some scene to sketch.

We spent a little time talking about various artists and techniques of painting and drawing and we talked about what might be the nature of the kind of scenes he might depict now, and whether in fact he could actually resume his artwork; whether he could recapture the lost pastime; whether he could using his "sussing out" skills to suss out something again. Following this I returned to Terry's "hidden tragedies" wondering what other things it might include.

Terry: I think... yeah... it includes things like... well the whole thing about ever being normal... you know... I feel I'm too young in one sense to be in here like this... when you look round... there's a lot of very old people... I feel angry... cheated.

At this point a nurse came for Terry as the doctor wanted to see him so this was a very short session and I supposed in some way I questioned the value of it from a counselling viewpoint. What is counselling, should I have picked up from session one where Terry ended by saying: "I mean I have these feelings of... it's too difficult to even think that this is it... that this is my life in one of these... I feel stuck"; should I at this stage pursued his feelings of feeling stuck and what is the meaning of life now for him. Also now there was the issue of Terry's "hidden tragedies" which I felt had been left hanging in the air.

From an existential viewpoint Binswanger writes about Heidegger's proposal that "man as a creature of nature is revealed in the throwness of the Dasein, its "that-it-is," is facticity..." (cited in Friedman 1994: 414). "The body... is part of facticity. It puts..."
limits on human potential, but is at the same time our gateway into the world”. (Biggs 1993 : 35). Conceivably, Terry’s body has put limits on his human potential in one way, but by the same token it is his gateway into the world. Binswanger also notes that Heidegger’s thoughts were that “man is not only mechanical necessity and organization, not merely world or in-the-world. His existence is understandable only as being-in-the-world as the projection and disclosure of world” (cited in Friedman 1994 : 413).

In this light perhaps this session was important in my gaining some understanding of Terry’s existence in that he is not only mechanical necessity and organization, not merely world or in-the-world (meaning that he is not only just a mechanical extension i.e. a person in a wheelchair and a member of the institution i.e. the ward; the hospital). Whatever he speaks of and is encouraged to speak of expands my knowledge and confounds his own knowledge of his existence as being-in-the-world as the projection and disclosure of world. Part of which metaphorically may be his excitement of “sussing out” something. Also exploring the metaphor of Terry’s “hidden tragedies”.

Session three
It was heavy rain and I found Terry sat in his wheelchair by the side of his bed. The 6 bedded ward was still quite busy with the mornings activities i.e. bed making, some domestic duties, one gentleman still in bed, who Terry told me had had a bad night and there had been a death during the night on the ward. I told Terry I would try and find somewhere for us to go out of the ward. There were one or two places I was
hoping would be available and fortunately there was a spare single room on another ward, not ideal surroundings but at least private.

He told me that he was feeling so depressed and fed-up. He had been deeply affected by the death of one of the other men in his room.

Terry: They (the staff) did their best to screen it all off...poor Gordon...he had been suffering...but you knew it was going on...no-one’s talked about it today.

We both reflected on this event and the finality of death. Terry felt it keenly and was upset saying that Gordon had been there almost the same length of time that Terry had.

Terry: It’s not only death that gives you this knot inside (he made his hand into a fist and pressed it into his body)...it’s everything else that you suddenly start to think about...everything else that’s changed.

C: Yes...I guess in thinking about Gordon’s death it brings up other things...

Terry: Well it does...for one thing...am I in a dead end here...bits of me...bits of myself are dead...I’m not sure about getting back home again...I’ve heard them talking about things and...as far as I can understand it depends on a lot of things...it gets me down.

C: You feel very stuck and a bit in the dark about things.

Terry: Well I do... it’s whether I can walk...or if not walk...if I could transfer...get from chair to bed...also the house has steps at the front...they don’t know about that yet..

C: So there’s a not knowing at the moment...an uncertainty about what’s going to happen...
Terry said he felt he was wasting time, time dragged and he felt he was not getting any where. He then went on to talk about his daughters, one, Penny, visited more than the other and he said he looked forward to their visits. He was worried about his other daughter Merielle as she took drugs and Terry was very concerned about her health. She had been sleeping rough for periods of her life and had had, as far as he was aware, two abortions. She had managed to visit him and he just wished he could help her, saying he was worried sick over her.

Although perhaps opening up the conversation for Terry to speak about other issues that death brought up did I close off Terry’s discussion about his own death. Stanley et al (1999) quote Lasoski (1986), who suggests that elderly clients may trigger clinicians’ own concerns about aging in that it brings one’s own mortality to the forefront. Boss writes that:

> Unless a human being has become aware of and acknowledged as his own all his possibilities of relating to what he encounters (whether they please him or his fellow men or not), no true self-knowledge, no authentic responsibility, is possible.

(cited in Friedman 1994 : 432)

Heidegger asserts that “one may either accept death as qualifying all one’s possibilities, or else exclude it from consideration as long as possible” (Macquarrie 1972 : 196). Maybe Heidegger’s clarification of this is where he holds that “death is in other words, the one fact of my life which is not relative but absolute, and my awareness of this gives my existence and what I do each hour an absolute quality” (May 1958 : 49).

I discussed this with my supervisor who felt a space had been made for Terry to talk about the death of Gordon and this was as important in that he was able to express his
feelings about this. The use of reflection and clarification were supportive interventions and my supervisor sees counselling as the sphere of possibilities.

Session four

Another fine day weather wise, so we are able to go outside. Terry is feeling more and more frustrated that his left hand will not move, he tries frequently to stimulate it by rubbing it with his other hand. He now had his own wheelchair and a rest had been attached to it for his left arm and hand. His speech seemed a little more unclear and slurred today and, also he had a tissue to constantly wipe away the saliva that dribbled from his mouth. He imagined his paralysed arm moving, "do you know I just feel I could pick up that glass but of course when I try I can’t…it’s bloody useless…I’d be better off without it”.

Terry became quite upset and distraught describing himself as not being a man anymore “I guess I’m just a sad old bugger now” We talked about his sadness which was part of seeing what the future held which included the fact that he would never have another woman. I asked Terry what meanings there were to having someone; to having another woman

Terry: Well I suppose I mean in the romantic way...

C: Yes I guess I see what you mean…but also there may be other ways in which to have someone

Terry: I’m not sure what you mean

C: Well I was just thinking that there are a number of ways we can have someone, it might not be in exactly the way we want but, for instance, there is the
company of someone...someone’s opinion...someone’s interest...someone’s love...I
guess those are the kinds of things that I mean

Terry: Well yes I see what you mean...I hadn’t thought of those things

Terry said that Penny (his daughter) had been in to see him and that started him
thinking about his wife (her mother). Terry said his wife had divorced him about 7
years ago. He said that he had threatened her saying it was the last straw and that he
had put his hands around her neck because he felt frustrated and angry. He had got to
this pitch with her because she constantly left him to go and visit with her son,
disappearing for days at a time. He explained that they had both been previously
married and that they both had children from their first marriage. He had two girls
and Mary had a son.

Terry explained that his first wife had died in a road accident when his two girls were
very young. “I try to put the whole thing out of my mind...but Penny looks so like
her mother that ...I get weighed down with it again”

C: What is it that you are weighed down by?

Terry: I was driving the car... I can see Christine’s face and now on top of all this,
christ, I’ve tried to rid myself of it, you know, lay it to rest...I thought I had been
lucky with this stroke...that my brain hasn’t been damaged, but...but now I’m not so
sure...it’s all still in here (Terry taps his head).

Terry said he began to drink heavily to try and forget and had eventually gone to AA
(alcoholics anonymous) as he realised he had a problem with drink. He feels that all
this had an effect on his daughters although they were young at the time. After this
Terry said he devoted himself to them but he feels that it had a bad influence on
Merielle, that they grew up with no mother.
C: It must have been awful to keep all this in your head

Terry: Yes...I've kept it bottled up

We explored the metaphor of uncorking the bottle and that when a bottle is uncorked it lets things out. Maybe in the uncorking of the bottle Terry has been able to let it go at last. O’Leary (1996) writes that “self-understanding brings an awareness of a whole range of choices” adding that “unconditional positive regard for a client’s feelings, be they positive or negative, gives them the opportunity to understand themselves as they are” (O’Leary 1996: 104). Being able to free oneself of something that has weighed heavy. When unconditional positive regard is experienced it helps people deal “with their hopelessness and to verbalize their formerly inadmissible feelings of pessimism and despair” (O’Leary 1996: 93).

Where Terry expresses earlier that he feels he now is “just a sad old bugger” are where he refers to himself as not being a man...a man in the sense of maybe how western society and culture define manhood i.e. having sexual prowess. Having a stroke can have significant impact on many areas e.g. mobility, speech, and cognitive processes, and adds Sprenkel (1999: 218), because of its sudden onset

A stroke provides little opportunity for the individual to prepare for its subsequent impairments...if the stroke impairs a number of functional areas, the individual is at greater risk of increased dependency and social isolation, which often contribute to feelings of depression and loneliness...elderly male patients often speak about feelings of loss and inadequacy if they experience changes in their abilities to function sexually

Session five

Terry seemed quite tired and exhausted today when I arrived he had not had a good night so it was arranged that he go for a rest on the bed. After he was settled on the
bed I went to say goodbye to him and check he was all right he insisted I stay for awhile. Terry started to talk about Gordon again the man who had recently died on the ward and said he wondered if it was his turn next.

Terry: When you’re laying here you do start to wonder… and sometimes I do wish it was my turn… then you start to think about all the things you could have done better…

Terry talked about his marriages and what had happened to Merielle and some regrets he had about his life.

There was a new man in the ward and he and Terry had been talking about football. Terry seemed pleased that this had happened and even talked about the bottle being uncorked and that he did feel somewhat relieved. He asked when I would be back and we made arrangements for the following few days.

Session six

I found Terry out in the garden and I fetched a chair and sat down with him. He told me he had something to show me, and from the side of his wheelchair he pulled out a sketch pad and put in on the arm rest. Lifting his left arm he used it to weigh down the pad and showed me a sketch he had started.

Terry: I thought I would try and suss something out again… Penny got this for me when I started talking to her about what I used to do… remember we talked about it…

C: Yes I do remember us talking about it

Terry and I discussed art and the various techniques and styles. I offered to bring him some paint brushes that I had for him to try out. He had “sussed out” one of the nursing care assistants, Victoria, who also had an interest in art and he had been
chatting with her. It was she who had helped him rig up the best way for him to use his sketch pad. We then wondered, if there was anyone else that might have any further ideas as to how he could do his sketching and would anyone else be interested in discussing perhaps a picture. Where could he explore and investigate the resources. Terry: I still get the illusion that I am moving my fingers...I try and focus all my energy on moving them but nothing stirs...I can only half smile...that’s what Penny says...you give me half a smile Dad.

We talked about Penny and Merielle and Terry’s friend who visits, being Terry’s outer links with the world at the moment...they bring in fresh air...and a sense of life...of movement...and maybe how important it is to share that with them...to be eager for what they bring in with them...not in the material sense...but their presence.

Terry dresses in the clothes he wore before the stroke which are either track suit bottoms or shorts (depending on the weather) and loose t-shirt tops although they bring back painful memories we also talked about the clothes being a symbol of life continuing and some kind validation that Terry still wants to be himself.

I left him that day with those thoughts and the thoughts about sketching. Also that for the next session I would bring in a picture of a painting for discussion.

Bolen (1966, cited by Brody 1999 : 104) raises the dehumanization that occurs:

When illness forces someone to relinquish control to caregivers; choice after choice is stripped away as energy and competencies decrease. If this movement is transcended in a positive way, however, it can favorably change the lives of both those affected and those around them. The therapist can encourage and empower the person afflicted by the way she “frames” the situation to the client.
O’Leary (1996 : 92) holds that “the creativity of individuals is often expressed through arts, crafts and recipes...storylines can often recall past experience...and the counsellor can use these to enable...people to confront their feelings...anger, resentment and laughter are possible emotions that can emerge”.

Follow up sessions built on Terry’s metaphor of “sussing out” he and others, some on his ward and some from other wards, had formed a small group. Of course there were times when people left and goodbyes had to be said, but links were forged and Terry said the uncorking of the bottle had changed to not bottling out.

As Terry’s stay in the rehabilitation unit stretched longer and he eventually had to face the trauma of giving up his home with all the ensuing issues that this brought him about what his future holds. He expressed feelings of great apprehension about where he would end up.
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