# The psychotherapeutic relationship during the early phases of reorganization of the Self in stroke patients: emotions and defence mechanisms


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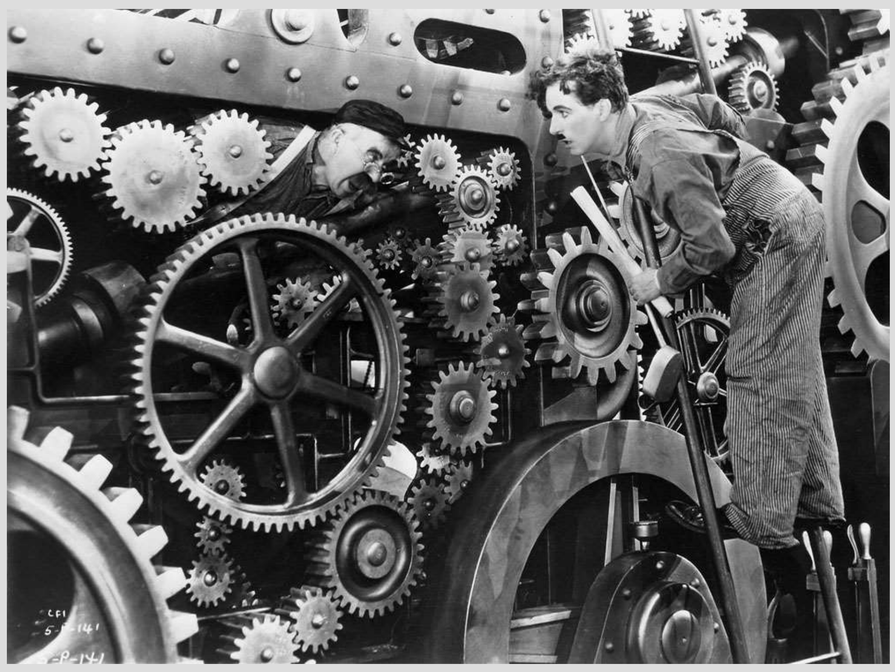
The individual Self can be viewed as a complex configuration of biological, psychological and social variables. The formation of the individual Self proceeds on the basis of primordial nuclei of aggregation until, in most individuals, a sufficiently cohesive structure is achieved by adulthood. The Self is in a state of dynamic equilibrium. Constant modifications – of both a conscious and unconscious nature – are necessary in order to maintain overall stability and a good level of psychosocial adaptation, even where existential continuity is given as desired. Defence mechanisms enter into play continually and unconsciously in the dynamics of adaptation, influencing the emotional and cognitive domains, as well as interaction with the outside world and intrapsychic and interpersonal conflicts. Psychoanalytic concepts have found correspondences in recent findings in the field of neuroscience, illustrating how the integration of conscious and unconscious mental processes corresponds to the interaction, modulation and integration of neuronal circuits and different areas of the brain (Gallese, 2001; Kaplan-Solms and Solms, 2002; Solms and Turnbull, 2002; Davis et al., 2003; Feinberg and Keenan, 2005; Mancia, 2007; Northoff et al., 2006) and suggesting how it is possible to recover existential continuity even after cerebral lesions. The aim of this work, which takes a neuro-psychoanalytic perspective, is to demonstrate the importance, in the context an integrated approach to stroke patients and their caregivers, of the psychotherapeutic relationship from the very earliest phases of restructuring of the Self. Specifically, we will examine three cases of male stroke patients with right cerebral lesions and their caregivers. These patients present severe mental confusion with associated confabulation and disorders of perception. The premorbid characteristics of all three patients included obsessive tendencies and a probably narcissistic personality structure. The clinical intervention based on a psychodynamic approach precedes a neuropsychological assessment, which is not yet possible in this phase.

**Case 1: "No more questions!"**

The patient is a 60-year old man who has suffered a stroke (TC scan indicates severe haemorrhagic lesions in the right hemisphere and hypertensive leuco-encephalopathy). He is an Italian literature teacher who lives alone and was alone at home when the stroke occurred. He has suffered in the past from an phobic-obsessive neurosis, which was partially cured by a course of psychoanalytic psychotherapy concluded around ten years ago. He was left, however, with a fear of illness and an associated distrust of doctors. The patient probably did not treat his hypertension for several years prior to the stroke. He has a positive recollection of the psychotherapy and his psychotherapist, as emerges at an early stage of his self-account, and this facilitates the therapeutic relationship.

On admission to the rehabilitation clinic, two weeks after the stroke, he is immediately brought to my attention for a psychological and pharmacological treatment of severe behavioural disorder (agitation), insomnia, confusion and confabulation.

*First encounter in the patient's room:* I introduce myself and begin somewhat routinely and distractedly to ask the customary questions in order to assess the patient's general psychological state, also with a view to initiating psycho-pharmaceutical treatment. Instantly, the patient reacts extremely angrily: "Enough questions! … You only ask them so as to show who's in charge … I could never stand authoritarian types or competition!" I am not irritated by the patient's reaction. On the contrary, he arouses appreciation and understanding in me, and I try to communicate this to him. I adopt a more attentive approach to our exchange, explaining the reasons for my presence at a pace that is more closely tailored to his own. There is an immediate improvement in the quality of the relationship. Very gradually, the positive therapeutic relationship allows the patient to accept the questions and the indications that draw him back towards real time and space, and he also succeeds in establishing good relationships with the other staff involved in his neuropsychological evaluations and his rehabilitation therapy. The psychotherapeutic relationship will continue after discharge.

The narration of this patient's story was facilitated by the account given to me by one of his old friends, now a widow with one daughter. She and the patient had had a romantic relationship in the past. For the entire duration of the patient's stay in the clinic, I meet with this lady once a week for an hour in an outpatient facility.

*At our first session, the lady tells me*: "He is always very angry with me. It's as though we're still in the past. In fact, when we were a couple we had a very quarrelsome relationship. He always demanded too much of me … and so it came to an end. But we remained good friends. Now our friends tell me he's saying that when he leaves the clinic, he's coming to live with me … but that's not possible!" She recounts this with an air of embarrassment and an attitude that suggest a regression on her part to a phase of their previous romantic relationship. We talk about it and this helps her to test reality in this regard. Now she can decide how much emotional and material assistance she is willing to provide together with the other friends, and she will also support the patient with respect to choices and decisions to be made following discharge.

*Aspects of transference in the relationship that are suggestive of an authoritarian female figure (it will later emerge that the patient's mother was experienced as such) are immediately evident. The patient uses projection in order to liberate himself of negated aspects of his current condition of distress and disability. Anger is the emotion that first surfaces, especially when his defences are penetrated and reality testing is imposed prematurely and in a manner that results in him being left alone. Moreover, the initial anger and hostility are triggered by the situation of excessive dependence induced by the illness, which tyrannically controls and conditions the patient and the people close to him. The aggressiveness expressed towards the psychotherapist should be interpreted as a request for contact and understanding. The patient's friend, who initially only asks questions about the illness and expected recovery time, also exhibits distress – initially denied – with respect to her excessive emotional involvement in the relationship. In fact, she is very angry about her friend's behaviour towards her, as though they were still romantically involved. She accuses him of having a bad character, as if he had not suffered a stroke. The sessions with this lady, which also continued after the patient's discharge, helped her to adjust her degree of emotional involvement and at the same time to remain emotionally attached to her friend.*

**Case 2: "Where's my daughter?"**

The patient is a 70-year-old man who has suffered a stroke (TC scan indicates a right parieto-occipital haemorrhage). He is admitted to the clinic one month after the event and is referred to me for pharmaceutical and psychological treatment for confusion, confabulation, and a perception disorder (visual hallucinations) that coincides with poor eyesight. His premorbid history (obtained from his daughter) indicates that he was a nervous, hyperactive man with obsessive tendencies. He had – and still has - a severe stutter. He was never diagnosed with narcolepsy, but he routinely fell asleep during the day as soon as he concluded an activity. He is a successful goldsmith and loves his work. Although he is not separated from his wife (who suffers from depression), he is romantically involved with another woman.

The patient's caregiver is his only daughter, who is aged around 40. She shares the same occupation as her father and carries it out with the same passion. She has a life partner, but she shares her workshop and retail shop with her father, and the two spend the entire working day together. Like her father, she is nervous, obsessive and has a stutter. And she says that she, too, has the same tendency to fall asleep when she relaxes. She is at pains to emphasise both her many similarities with her father and the way that she supports him in all respects. When she visits her father, they literally clutch on to one another. She has a significant need to control her father's environment and the different aspects of his rehabilitation therapy. In the therapeutic relationship, I feel the need to adopt an extremely cautious approach with her so as not to appear too intrusive.

*First encounter in the patient's room*. I introduce myself and ask the patient how he is. He responds fearfully: "Terrible. I'm very worried … I keep calling on that phone. You see it?" He points to his right, where there is nothing. "I'm waiting for my daughter. She's not answering. Something must have happened to her, otherwise she'd be here already." I reply that I am sorry he is so worried, that I think I understand what he's feeling, but that I have just spoken to his daughter on the phone (as I have – to confirm an appointment with her) and that she is on her way right now, that she will drop in to see him and then meet with me in order talk about him and how he is. "But are you sure?" he asks anxiously. When I reply with a resolute affirmative, he sighs with relief and relaxes. Calmly and slowly I tell him that the telephone he was pointing to is not there, however, that maybe he often calls the nurses who come when he needs them, and that sometimes when somebody is very confused they can have unpleasant daydreams. But he is here to get better, I tell him, we can help him and nobody is going to take him away from his daughter or take her away from him. He is calmer now and I leave the room telling him I'll be back to see him later.

*Encounter with patient's daughter.* After about half an hour, I meet with the patient's daughter in an outpatient office. "I dropped in to see my father. He was a little anxious. He told me he had been waiting for me and that he was worried about our work and about the workshop. This time he didn't talk about the threatening people he sees in the room, but he said that sometimes, maybe, he dreams about bad people." During the exchange I have the impression that she talks compulsively in order to reduce her anxiety and that she is not really listening to what I say, whatever I say. Her most frequent assertion is that she believes her father "needs more to do, he can't be left idle. I'll bring him something to do." It seems to me that although she feels she can have a positive relationship with me, she is very reluctant to accept my role as mediator between herself and the other staff, towards whom she expresses unrelenting distrust.

*I established a positive dialogue with the patient and the patient's daughter over the course of regular encounters, but despite my efforts to mediate with the other staff, her father's stay in the clinic is suspended because she is unable to tolerate a difference of opinion and accept the clinic's proposals for the overall rehabilitation programme. The staff probably did not fully realise the extent to which both the father and daughter are dependent on their symbiotic relationship and therefore colluded in thwarting the daughter's efforts to control his environment. The intense unconscious fear on the part of both the father and the daughter of losing their extremely close relationship, and the terror that one of them falling ill might force them to live separately – a prospect that both, for the moment, seem entirely unable to contemplate. The premature endeavours to introduce distance between the two and to separate them were experienced by both father and daughter as additional abandonments on top of those already threatened by the illness.*

**Case 3: "There's a piece missing!"**

The patient is a 75-year-old man who has suffered a stroke (TC scan indicates a right striato-capsular lesion). He presents with confusion, confabulation, agitation and a disturbed sleep-wake rhythm. He has numerous neurovegetative reactions, including orthostatic hypotension. The caregiver is his wife, who is of approximately the same age and appears very anxious. She describes her husband as a very hard worker, who is still the authoritarian head and focal point of a mainly family-run business. Her description also includes characteristics and habits that suggest obsessive tendencies. The patient is said to be very generous to his family and to be considered by everyone to be an important point of reference who is now terribly missed by all.

*One of the first encounters in the patient's room*. I enter his room and see that he is pointing towards the opposite wall and whispering something. I ask him if he can explain the problem more clearly to me and in a way that I can understand. Looking straight ahead he says "See there!", pointing towards some electric sockets under the television. He then exclaims anxiously: "There's a piece missing! There's a piece missing!". I ask him to describe more clearly to me what he sees, and he does so correctly, but continues to repeat that "There's a piece missing!". I tell him that he is in a hospital room so that he can receive treatment and that this will be his room for a while. Together we name the objects that he sees around him and the furniture in the room. I leave and have *a brief conversation with his wife*, who had not been present in the room but had been waiting in the corridor in front of the nurses' station. She says with great anxiety and worry, "I'm afraid this is not the right place for him, that he won't be cared for enough, especially at night" (although the nurses are always on hand). I reply that her concern is understandable, that she feels that her husband needs a lot of care and that she herself would like to be there all the time, especially at night when people's fears tend to increase. We arrange our appointments and I leave her a telephone number where I can be contacted.

*After about ten minutes, I return to the patient's room*. I have the impression that he does not recall having seen me before. I remind him and he replies: "Yes, I think so. We met when I was coming down here to school." I leave him and return again later the same morning. I ask him how he is and whether he recalls meeting me before. He smiles and says "No, but all friends here, all friends and I feel better." I confirm that his face is more relaxed now and that he has a more lucid and less sleepy demeanour. "Yes, that's right … yesterday morning I was strange" (he is probably referring to our previous encounters that same morning). He then looks at me with interest and says: "No, I don't think I know you." I ask him if he has any questions he would like to ask me and he replies "No, not for the moment … but I will later. First I have to formulate one clearly," and he calmly prepares to go down to the gym with the therapist who has just arrived to pick him up.

*Similar to the previous cases, this case also shows how intense emotions and primitive defence mechanisms (in this case splitting and projection) play a role early on as shared mental processes in the patient and the caregiver. Also in the case described here, even if the patient does not remember the psychotherapist's intervention, he can still preserve the effects of the intervention via implicit channels that modify the narration of the Self.*

## *Conclusions*

The examination of these stroke patients reveals the disorganization of their Self. The patient's defence mechanisms tend to be primitive, while regressive phenomena, frequently unconsciously, involve caregivers. On the one hand, these phenomena evince the severe dysfunctions resulting from the lesion; on the other, they should be considered as impulses towards a new adaptation. The intense negative emotional states characterised by fear, anger and abandonment anxiety are associated with persecutory states that cannot immediately be rationalised either by the patients or by their caregiver. Denial often influences reality monitoring. These phenomena, if they are not recognised, can negatively influence a patient's potential recovery and the psycho-social reorganization of the Self of patients and caregivers.
The caregivers are all women who are emotional - albeit not always conscious – participants in shared mental processes related to the restructuring of the Self. The three cases show how both introjective processes facilitated by the therapeutic relationship and implicit memory channels can be used to foster the restructuring of the Self of both patients and caregiver. The relationship itself, even in the earliest encounters, rich as it is with emotions and transference projections, can be used to restore continuity and meanings that unify the biological, emotional and cognitive dimensions. In the initial phases, the rehabilitation schedule and the psychotherapeutic setting must be carefully adapted and tailored to the needs of patients and their caregiver.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