1
Depression

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Ms. A

Introduction

Ms. A is a 60-year-old woman, divorced housewife, and living with her daughter in her 30s, her son-in-law, and two grandsons (5 and 10 years old). Her eldest son and her youngest daughter, both in their 30s, live separately from her.

History of Present Illness

Ms. A met her ex-husband in the city; he is a distant relative, 10 years her senior, working as restaurant staff. They were married in her early 20s after a courtship of 1 year. Her first two pregnancies were planned, whereas the third pregnancy was unplanned but wanted. There were no immediate postpartum depressive episodes. She found that her ex-husband became aloof after the birth of their children; he supported the family financially but did not attend to his wife or their children, including the puerperal periods. He spent most of his time playing with birds (keeping birds as pets), gambling, and horse racing after work. There was no physical violence, but there was verbal aggression.

Ms. A's mood deteriorated from the age of 26; she had frequent crying spells. Ms. A found it hard to cope with the care of three children on her own because there was no local relative or friend to support her. She feared any stepmother might maltreat her daughters if she divorced and her husband remarried. Ms. A feared that her own experience of being brought up may have been reenacted. She had decided to leave her husband when her elder daughter reached the age of 18.

Ms. A's low mood was associated with initial and middle insomnia, fatigue, and fleeting suicidal ideas of jumping onto rail tracks but there were no suicidal attempts. Her major hope was from caring and obedient children when they were small. At times, she experienced free-floating anxiety, dyspepsia, chest tightness, and shortness of breath. She visited a general practitioner. She was prescribed a hypnotic, which was useful only for the initial period.

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Early in her 40s, when her elder daughter reached the age of 18, she decided to divorce, and she was awarded custody of her younger daughter'. Ms. A could not afford raising her, and eventually, her younger daughter lived with ex-husband while the other 2 children lived apart from her and from each other (one married and one living with a partner). Ms. A rented a room on her own and worked as a server. Ms. A was expecting her mood to improve on leaving her husband, but it did not. Ms. A was feeling guilty about leaving her youngest daughter (aged 12). This was not described excessive guilt. She was unable to work after a wrist injury, which she suffered while on duty, because she could not lift loads.

Her general practitioner referred ger and she has been known to psychiatric services since she was 42 years old (in 1998). She was diagnosed with dysthymia and was prescribed Deanxit, trazodone, and promethazine. Her sleep had improved only slightly.

Ms. A lived with elder daughter's family in the last 10 years since her daughter became pregnant. She claimed that she had a good relationship with her daughter. Her mood improved when she started to look after her grandsons, but she never reached complete remission. She was later referred to the family medicine clinic in 2009. She had defaulted follow-up in 2014 because she felt that the contact was not useful.

In the past 2 years, her mood deteriorated because her daughter was annoyed by what she considered to be an overinvolvement in childcare. For example, Ms. A repeatedly asked her daughter not to punish her children. She asked her daughter to prevent the children from making mistakes rather than letting them have a try. Ms. A also blamed her daughter for failing to correct the children when they did not follow Ms. A's commands.

Ms. A's mood deteriorated again. She developed crying spells, insomnia with poor sleep, and fatigue. She lacked daytime engagement. Her memory and concentration worsened; for example, she would forget to turn off the stove at times. She would ask "Why was it not me?" when watching news on fatal car accidents. Four months before admission, Ms. A expressed her intention to return to live alone in her hometown the following year. Her daughter responded, "you can go anytime you like." She was distressed by this response and developed fleeting suicidal ideas of dying by burning charcoal. However, she did not purchase charcoal when she saw it at a supermarket.

She was referred from the "positive ageing center" to the family medicine clinic. She had tried escitalopram 5 mg nightly when she waited for psychiatric reactivation. Her sleep remained poor with frequent dreams and sleep-talking. She also complained of constipation and dry eyes. She went to the emergency department under clinical advice in view of suicidal ideas and was admitted to a psychiatric unit.

Family History

Her youngest daughter suffered from depression.

Personal History

Ms. A was born in her hometown and was the second of four siblings. Her parents sold her to another family when she was 1 year old. This was attributed to poverty. She was illiterate. The "mother" in the "owning" family often scolded her and instructed her to care for the other "siblings." There is no history of physical abuse. The "father" looked after her and allowed her to leave the family at 20 years of age. Ms. A then migrated illegally to the city. She was a nonsmoker and nondrinker. She had no history of substance abuse or a forensic record.

Past Medical History

Ms. A had no significant medical problems (menopause at 50 years old).

Premorbid Personality
Ms. A described herself as rigid with absolute beliefs about what "right and wrong" are. She adopted avoidance as a coping mechanism.

Mental State Examination
Ms. A appeared not sophisticated but was tidy and established good contact with staff. She was dysthymic with appropriate affect. Her speech was coherent and relevant, with normal tempo and soft voice. She had difficulties in articulating her worries and frustrations. She was preoccupied with her daughter's negative responses. She thought of leaving her daughter as an escape from stress. Somatic complaints were present. She had no active suicidal ideas or psychotic features. Her insight was partial: She actively sought help for mood, sleep, and memory problems.

Physical examination and investigations were unremarkable.

Impression
The impression was that Ms. A suffered from depression of moderate severity with somatic complaints, related to relationship problems with daughters, over a background of dysthymia, and prominent sleep disturbance.

Management

The treatment involved medication (mirtazapine and clonazepam for mood and insomnia); referral to psychologist for cognitive behavioral therapy (CBT) for depression and insomnia and referral to occupational therapist for daytime engagement and cognitive assessment.

Progress
Ms. A's mood improved quickly after admission. Mirtazapine was titrated to 30 mg nightly. Clonazepam 0.5 mg nightly was also given. Pregabalin was added for restless leg syndrome related to mirtazapine and clonazepam. Ms. A had a good response to mirtazapine and refused to switch to an alternative antidepressant. She enjoyed when her family visited her. Sleep improved from 3 to 5 hours per night with structured routine, good sleep hygiene, and medication.

Ms. A wanted to live in her hometown for a short while and wait there for a singleton public housing unit to become available. Ms. A felt that living separately would prevent any conflict developing with her daughter. She was encouraged to develop leisure activities and participate in social gatherings. During discussion on postdischarge life, she often claimed sleep was still suboptimal and requested further hospital stay.

After the first discharge from hospital, Ms. A had repeated admissions for suicidal thoughts when she was feeling that she was being abandoned by her family. She still had insomnia with poor sleep hygiene. She continued to lack any daytime engagement, and this was more so when grandchildren grew up and did not need much of her care.

Consultation

JM thanked the doctor for the full presentation, but in view of the limited information available for Ms. A's early life history, he asked the doctor to clarify if there were any more data about this important period in her life. The doctor responded that Ms. A was reluctant to talk about that period in her life. Ms. A remembered "repeated scolding" but denied any abuse—physical or sexual. Ms. A spent most of that time looking after the young "siblings" of that family. JM invited the doctor to give some

more information about this woman's experience of living with this family, such as "what was it like being adopted?" The doctor clarified that her state was not one of adoption; she was expected to work for the family in return for meals and shelter. Later, the doctor explained that Ms. A had described her experience as a form of emotional "torture" and had explained that the "mother" treated her as a maid and not as a family member.

JM asked if this was slavery and the doctor responded that Ms. A perceived it this way. She further perceived that she lacked parental care and that her childhood was deprived. JM inquired if she was educated, and the doctor replied that she was not allowed to go to school, and the family did not spend any money on her education. JM asked about her status as a worker and if from the age of 1 she was an unpaid worker for this family and if the deprivation of education was common at that time in such villages in her home area. The doctor responded that she was an unpaid worker and the absence of education was common in many poor families at that time in similar villages.

JM asked the doctor to clarify what Ms. A's perception of growing up would be. Would she see herself as having a similar life experience as the other children in her "bought-in" family? Did the other children receive education? The doctor responded that she would see herself as disadvantaged because the other children did receive education. Ms. A. often "grumbled" that her biological siblings received better care that she did. She knew who her biological family was. JM said, so she was aware that she was not the child of the family in which she had been sold. Yes, because she was in contact with her biological siblings. JM asked about her understanding of why she was sold and not any of the other children. Ms. A. did not have a clear idea of why that was the case. She attributed the sale to poverty and to the fact that her elder biological sibling was needed to look after the other children because the parents had to work to sustain the family.

JM summarized the predicament of Ms. A as that of someone whose life was far from ideal but not unique in that cultural setting. She lived with her daughter's family (not unusual in that culture), she had been divorced (not uncommon in today's city—or elsewhere), she remained in contact with her children, and she was unable to work (5 years from retirement age). Her situation could not completely explain her depression. Not many women in her situation suffer from recurrent depressive illnesses and gain hospital admissions because of suicidal ideation. One needs to look deeper and further to gain a genuine understanding of her depression. Another important feature of her condition is that Ms. A improves rather quickly after admission to hospital. She improves before any medication has time to cause a lift in mood.

JM inquired what the doctor's understanding of why Ms. A responds in this way to her predicament. The doctor replied that she has no role in her daughter's family. She did have a role when she was bringing up her children and her grandchildren; since she lost her job, she lost not only a role but also the social contact and she felt lonelier. JM replied that she had to contend not only with the *absence* of a role and of connections but also with the *loss* of them (role and connections) and that she was becoming more isolated and without a purpose in life. JM asked if her connections were related to her "feeling useful?" The doctor said yes.

JM noted that it seems that when she lived with her daughter, she was fulfilling a number of functions; she was useful and in return she had connections and a purpose in life. With the loss of these functions and connections, she not only feels redundant and isolated, but she is without a useful role and without meaningful connections. JM asked if she has any other connections, such as with friends. She is friendly with some neighbors with whom she plays cards sometimes, but this activity "bores" her at present and so, she does not seek their company as much. JM then stated so, she does not have any friends. The doctor replied, none at all. JM then said, and is this the reason why she is dreaming of returning to her hometown? Is she hoping that she will find some connection there? The doctor agreed with this. JM noted that her predicament is depressive; she has not managed the

present transition in her life in a creative way and asked if she could have stayed with her daughter if she had managed the situation there more positively. The doctor said that it is common for grandmothers to stay with one of their children's families in that culture, and it would be possible for her to do so (live with her daughter). JM asked if the aspect of Ms. A's behavior that was making their living together difficult or untenable was known. The doctor said that she wanted her daughter to follow Ms. A's style of bringing up children. JM summarized then she was not respectful of her daughter's and her son-in-law's views on how they should bring up their children. She was critical of them. She would not accept the different way that they had decided to bring up their children.

JM responded that it is not only a matter of her beliefs about upbringing of children but it is also the matter of her actions. Ms. A insisted on criticizing and on influencing her daughter's family so that their family would be brought up in Ms. A's way. He then asked if she was aware that her intervention was going to influence the relationship with her daughter negatively. The doctor said that she knew of the effect that her behavior was having, but she insisted that hers was the right way. JM noted that although Ms. A's main need was one of being connected, her behavior was putting that connection in danger and asked if she was clear that her behavior was working against her own needs and that for the sake of doing things in the way that she believed was right she was endangering her relationship with her daughter? The doctor replied that she was aware. JM then responded, so she was consciously prepared to sacrifice her relationship with her daughter for the sake of struggling to do things in the way that she thought was right.

JM inquired how the doctor made sense that Ms. A sacrificed the most important thing in her life for the sake of doing things in the way that she thought (she felt) was right and what the point of conflict with her daughter about the bringing up of grandchildren was. And more, what was the nature of the conflict between her and her daughter? Ms. A's daughter felt that her mother was overprotective. Ms. A believed that her daughter should correct her children's errors, while her daughter believed that she should allow her children to experience the consequences of their mistakes. JM asked if there was a way of helping Ms. A to maintain the connection with her daughter by changing her behavior in relation to the grandchildren and if there was a way of helping her understand that her beliefs about the values of bringing up the grandchildren are connected with her own experience as a child. Ms. A feels strongly that the children's needs should be addressed in an immediate way, whereas her daughter was prepared to hold back. Can Ms. A's current behavior toward the grandchildren be linked to her own early childhood experiences? The doctor noted that when she was a child, Ms. A was aware that her needs were not addressed and only demands were placed on her.

JM responded that her own privation as a child remained a powerful force for her current behavior toward her grandchildren. It was emotionally impossible for her to allow what she perceived to be some privation in her own grandchildren. The meaning she gave to the current situation was a replication of her own privation as a child. Analytically it is important to see how she had not overcome the trauma of her early privation and that it was these feelings that were driving her (even to her own cost) to rush to meet the grandchildren's needs immediately. In this way Ms. A was attempting to overcompensate for her own privation, and this feeling was so powerful that living with her daughter had become impossible.

In view of this understanding, if Ms. A were to be receptive to analytical therapy, what would you set as the objective of therapy? Therapy would be directed toward resolving the feelings arising from her early painful experiences. JM concurred; she needs to mourn and grieve the deprived childhood that she had. After the mourning is complete, she will be more likely to be able to separate her own childhood experiences from the present experiences of her grandchildren. For example, her relationship with her daughter will be a lot better if she allowed her daughter to bring up her children in a way that her daughter thought right, instead of seeing that as a repetition of her own privation. She

will be in a better position to allow her daughter to be the authority over her own children. She will be able to see that her grandchildren, being brought up in her daughter's way, are not being deprived in the same way that she had been when she was a child.

JM asked if there any chance that she may live with her daughter again. It was clear that her daughter will welcome her back. JM responded that there is a hope that if she resolves this mourning that she will be able to live with her daughter and have a life in which her need to be connected is more likely to be satisfied than it is presently. This change will address one of the main reasons for her depression. Once she has resolved that grief, she is more likely to see the separateness of her own experience from the experience of her grandchildren and she will be able to have a more contemporary life experience with her daughter. Ms. A is likely to feel that her grandchildren, being raised in the way that her daughter and her husband wish, is not a repetition of her own deprivation and that her grandchildren are having a pretty good life. Feeling like this, will make it easier for her to take a grandparenting role, which is secondary to that of her daughter. She will be a grandmother helping her daughter instead of going against her. This will enable her to adopt the new role of "the helpful grandmother" and will remove one source of frustration and conflict in the new extended family situation.

JM noted that because her depression has a large element that is reactive to the situation, an improved life situation is likely to improve the feelings of depression. It is fortunate that the relationship with her daughter is not irrevocably broken down and it is conditional. "Mum, if you respect my way of bringing up my children, I will welcome you to live with my family." So the line of therapy could be two-pronged: one line is to help her accept, mourn, and complete the grief about her own childhood experience and the second to point to the direction that she can strengthen the connection with her daughter (instead of threatening it with antagonism) and in this way remove one of the main sources of her depression.

JM noted that another aspect of her life is her need to develop other relationships not related to her eldest daughter and her family. She needs to have her own adult and separate connections and sources of support. If she remains with the only connection of that with her daughter and her family, this is likely to create serious difficulties. There is a high risk that she will become overbearing and overdemanding. There will need to be a separate focus on why her relationships with her own peers have not gone well. Relationships with her peers are a whole new chapter. My guess is that she breaks the relationships with her peers before they have any chance of becoming genuinely supportive. It seems that she does not have the patience to negotiate the relationships with her peers so that they become mutually supportive. Ms. A's approach is good in the beginning of a relationship, but she seems to break it at the initial stage without working at developing the relationship with her peers. She misses the opportunity of advancing the superficial relationship to make it a more substantial one. The doctor agreed to work with her in moving through her previous experience and on developing new relationships with her family and with her peers.

JM then noted that it seems that her difficulty in proceeding in the mourning process is reflected in her reluctance to even contemplate her early life experience. She needs to be shown that it is possible with a professional's presence and sympathetic understanding to undertake this painful mourning process. Her chances of moving on will improve if she completes this mourning process and accepts that the past was past and is not being repeated in the present. This has been an interesting case; thanks for presenting it so well.

Scientific Literature

This case is of particular interest because it highlights the long-term impact of child selling. This is, of course, an abusive practice that was common in several countries during times of famine or other social privation. Children are also sold for sexual exploitation, prostitution, or for organ

transplantation for a financial reward to, usually, the father. Most commonly the sold children are females. Surprisingly there is no scientific literature easily accessible on this issue. One can find the case of the sold child in the literature of Child Abuse and Neglect.

The other focus for this case is one of the "loss of role" and loss of connections in the later stages of life. References to "retirement" in more general terms (not only from gainful employment) are cited in relation to other cases in this work.

Mrs. Z

Introduction

Mrs. Z is a 56-year-old unemployed woman, living alone in her elder brother's public housing unit.

History of Present Illness

Mrs. Z began to complain of low mood in the last 2 to 3 years. She also realized that she was never happy throughout her life. She had on-and-off crying spells. She slept poorly. She had intense anticipatory fear when she knew that her brother would be returning to the city. She had fleeting suicidal ideation from time to time, but there were never actual attempts or related preparation. She sought help from general practitioner and was later referred to psychiatric outpatient department.

Personal History

Mrs. Z was born in the city. She has two older brothers and one younger sister, with each sibling was born 2 years after the previous one. She reported that she was treated badly by her father and elder brothers since childhood. She was often blamed and scolded by them for being "stupid," while her mother turned a blind eye toward such treatment. She had always been a submissive child to her young sister and to her father and elder brothers, hoping that she would be scolded less frequently. She tended not to express her feelings to others. She stopped studying after the first year of secondary education and started working. She recalled that she never had plans to study further or get married because her father kept telling her that she should stay at home to care for her parents. During this time, her siblings moved out of the family home one by one after having their own families; Mrs. Z continued to live with her parents.

Mrs. Z's mother died 10 years ago (2007) from breast cancer, and her father died of a heart attack 6–7 years ago (2011). Although she put much effort in taking care of her parents when they became ill during their final years, she never received any gratitude from her father until the last moments of his life. Yet, she continued to take care of her parents and never considered abandoning them.

After her parents died, her younger sister moved back to live with her because she was having marital problems and was in the process of divorcing. After several years, her younger sister remarried and her husband moved in to live with them. As it was inconvenient to live with her brother-in-law, she moved to her second elder brother's home 3 years ago. Her second elder brother's family had already emigrated, and they returned to visit the city several times a year. She described that whenever her second elder brother returned to the city that he criticized her daily for being useless and told her to go to die so that she would not be a burden to this world, although she would prepare meals for her brother's family when they were in the city. Her brother's wife and children seemed not to notice the criticism at all. Mrs. Z stopped working 5 or 6 years ago (2012).

Past Psychiatric History

Mrs. Z is new to psychiatry; she has no history of violence or suicide attempt. There is no family history of mental illness.

Past Medical History

Mrs. Z suffered from bilateral knee pain and was diagnosed with osteoarthritis. She had operations on her knees (bilateral knee replacement carried out in a private hospital in 2013), but the pain persisted, making it difficult for her to walk normally. Mrs. Z also suffers from hypertension, hypercholesterolemia, and allergic rhinitis; there is no known drug allergy.

Mental State Examination
Mrs. Z is an obese lady walking slowly with a stick; she is neat and tidy, wearing a surgical mask, calm and settled; she made fair eye contact and showed no psychomotor disturbances. Mrs. Z's mood was low and her affect congruent. There were no psychotic symptoms, and she denied any active suicidal ideas; she was orientated to time, place, and person. Mrs. Z. had good insight.

Diagnosis
Dysthymia, which was perpetuated by poor stress coping strategies.

Consultation
The consultation was started with the request to clarify a few points of history. Mrs. Z. started earning at the age of 14–15 years. She is obese with a body mass index (BMI) of 30. Her intelligence was considered to be slightly below average. She had undertaken semi-skilled jobs. The siblings were "well off" with one sibling running their own business and a sister being a housewife.

The therapeutic contract was not clear, but it involved the use of antidepressants (on account of low mood and anxiety); the medication was not significantly helpful but had led to some "partial improvement." The improvement had been noticed to take place 3 to 4 weeks after onset of medication. The staff noticed that she demonstrated fewer crying spells, fewer temper outbursts, less self-harming-harming, and fewer ruminations but no change in interest in activities. Her sleep was normal when brother was absent but problematic when he lived with her. Mrs. Z did not complain of anhedonia and did not demonstrate any diurnal variation of mood.

The use of antidepressants was justified based on the sleep disturbance. This was questioned because the sleep disturbance was conditional on her brother's presence. The next question was, if the presence of her brother is so unsettling, why did she continue living with him? Could she not live in a place of her own?

The provisional formulation was that this was a woman who was depressed because she was being criticized by her brother, was submissive, and had been previously criticized by parents.

Mrs. Z did not see herself as the agent of her own predicament but that she was at the mercy of other people's wishes and actions. The doctor clarified that the arrangement by which she lived was not a necessary part of the culture prevailing in the city and was unfair to her as a younger sister. The doctor added that this arrangement was not the result of Mrs. Z's generosity but an expression of her being taken advantage. There was no doubt that she was being exploited. It seemed that this woman of limited ability was in an unfortunate position in which the only resort of comfort for her was to (over)eat.

In conclusion, Mrs. Z was exploited and was not in a position to take charge of her own life. She had a serious difficulty in becoming the agent of her own predicament. Therefore, the therapeutic

intervention needed was the provision of a professional (counselor or social worker) who would support her and direct her in establishing a way of living that was fairer to her and which would secure her human rights. The counselor may mediate on her behalf with key family members. Mrs. Z. could be supported to improve her physical health (she needs to lose weight because her obesity limits her ability to move and restricts her independence).

It is unlikely that analytical therapy would be appropriate for her. Mrs. Z. is more likely to respond to a continuous intervention that would have realistic (and finite) expectations for change of a pattern of a lifetime. Ambitious therapeutic objectives can only lead to failure in the patient and disappointment in the therapist. The services of occupational therapy may provide support, socialization, and a program toward some work in the final years before retirement.

One can see how her early life experience of being psychologically and emotionally abused led her to see herself as a person of lesser value and as one who is not entitled to fair treatment because she was not as able as her siblings. Mrs. Z unfortunately continued relating to her family (and possibly to others) in the same way that had been established in her family of origin from a young age.

Any change in her approach needs to be gradual and coupled with considerable amount of support and small increments of interpretations. She may be helped by comments like: "Even if you are not as able as your siblings, this does not give them the right not to respect you and certainly does not mean that exploiting you is justified." Mrs. Z could also be given opportunities to build her self-esteem by being engaged in tasks that carry a realistic chance of success, which will then be demonstrated that she (and her work) is valued. A simplistic example is she may be given a chance to carry out a job that is not too intellectually demanding and is attainable by her despite her knee disability—perhaps something like answering the phone at a center. Being useful and successful can only help to improve her self-esteem and the confirmation by colleagues and seniors may help consolidate this improvement.

Ms. B

Ms. B is a 21-year-old single unemployed woman living with her family in a public housing unit.

Presenting Condition

Ms. B was voluntarily admitted to the hospital on 21 May 2018 because of unstable emotions, following a suicidal gesture after an argument with her boyfriend.

History of Present Complaint

Ms. B has had a stormy relationship with her boyfriend ever since they started courting when they were Form 3 classmates (7 to 8 years previously). Over the years, they broke up many times and, in between, Ms. B also had many short-lived relationships. Ms. B would throw temper tantrums and employ self-harming behaviors when she expected to be abandoned by her boyfriend. In January 2018, they reunited. The couple agreed that they would not lie to each other, and there would be no personal privacy in the relationship. Her boyfriend promised that he would not do anything harmful to her. Ms. B also treated her boyfriend better as a kind of compensation.

However, later, Ms. B searched her boyfriend's smartphone and found that he had sent WhatsApp messages to two female colleagues with flirtatious content. Ms. B was so angry that her boyfriend was not totally loyal to her. Upon confrontation, instead of explaining the meaning of the suspect WhatsApp messages, her boyfriend would linger on her past maladaptive coping and unstable emotions. He

labeled her mentally ill. She was dissatisfied with her boyfriend's response, implying that she was the only one who should bear the responsibility for their disharmony. She slashed her wrist to get the painful feeling and to remind herself that she did not treat her boyfriend well at the beginning. She had poor sleep when she ruminated about her boyfriend's WhatsApp messages. In the previous month, Ms. B had two episodes of drug overdosing and one episode of climbing at the edge of a high slope. She had left a suicidal note to her family. Yet, Ms. B denied a pervasive depressive mood. She still enjoyed part-time work as basketball match referee assistant. Her self-care and hygiene were satisfactory.

On the day of admission, Ms. B reported that she and her boyfriend had been arguing from morning to night. She had discovered in WhatsApp a message in which her boyfriend had asked his friends' opinion whether he should send a bunch of flowers to his former girlfriend. She calmed down a little after an afternoon nap. The couple later went out and met their shared friends. Ms. B consumed two bottles of apple cider and became emotional again. She scolded their friends as she felt that they were colluding with her boyfriend for his unfaithfulness. She cried loudly and threw an empty glass bottle on the floor. She impulsively banged her head on a lamppost and hit the gate of a street shop. She also attempted to rush into the traffic but was stopped by her boyfriend. Later, her father and maternal aunt were called for help. She hid in a restaurant's toilet and expressed negative ideas to relatives: "You will regret this. . .. you can never find me; this will be the last time that you saw me." Ms. B was subdued by father and was eventually sent to casualty.

There was satisfactory self-care and hygiene, and she was cooperative and respectful to the staff. Her mood was stable; she was not overly depressed and presented with congruent affect. Her speech was coherent and relevant, and she freely shared her feelings. She was not psychotic, suicidal, or aggressive. She had mixed feelings toward her boyfriend with grievance and guilt. She showed no psychomotor retardation.

Ms. B was physically fit. There were many old slash marks over the volar aspect of both wrists. There was a tattoo (with the boyfriend's name) on her right thumb.

Family History

Her mother and maternal grandmother had been diagnosed with depression. Her mother committed suicide by jumping from height at the age of 32. Her father is 55 years old and, together with her stepmother, owned a logistic company. He suffered from hypertension, dyslipidemia, and ischemic heart disease. Her stepmother, 32 years old, had moved to the city from the country. Ms. B has a distant relationship with her stepmother. Her stepmother was thought to be greedy and irresponsible because she kept buying luxury goods even when the logistic company had financial deficit. Father and stepmother are currently living separately. Ms. B has three younger half-siblings ages 15, 12, and 4. Ms. B has a close relationship with her second younger sister.

Personal History

Ms. B was born in the city; she felt that she was deprived of love from her parents. Her mother died when she was 2 years old, and she has no recollection of her. She felt that there was lack of emotional caring and love from her father who otherwise provided the patient with enough money and other material goods. Ms. B was brought up by her maternal grandmother. Ms. B felt that she was spoiled by her maternal grandmother and felt loved by maternal grandparents, uncle, aunt, and cousin. Ms. B described her primary school life as happy and had a good relationship with her teachers. Ms. B's academic results were below average.

When she was in higher forms in primary school, she was betrayed by one of her best friends in the class who had hacked into her internet account and spread a rumor about her relationship with some classmates. Ms. B was promoted to a local band three secondary school (not for high achievers). Ms. B felt isolated and picked on by classmates; she played truant. Her school attendance was around 80%. Ms. B maintained good relationship with her teachers.

Ms. B achieved a pass grade on four subjects in the city diploma of secondary education examination. Ms. B then stayed in abroad for 1 year with her boyfriend who studied while there. She came back to the city and worked in her father's logistic company as a clerk for 1 year. She also worked in sales in a computer company for few months. Ms. B is currently employed as part-time basketball match referee assistant. She is financially supported by her father.

Ms. B has had many short-lived courtships since Form 2. She started a relationship with the current boyfriend while in Form 3. They broke up and reconciled many times. Ms. B agreed that she was manipulative in the relationship and not loyal to her boyfriend; she initiated breakups on a few occasions. She had threatened her boyfriend with self-harm behaviors and made suicidal threats during conflicts and when she was worried that she would be abandoned.

Ms. B has no forensic record. She had made regular use of "ice" (an amphetamine) under peer influence at the age of 17. She stopped taking ice for 1 year when she lived abroad. She restarted taking ice at the age of 20 for 1 year after she came back to the city. Ms. B denies having used ice in the last year but believed that "amphetamines" gave her increased energy, euphoria, and weight loss. Ms. B experienced transient auditory hallucinations after taking ice. Ms. B made less frequent but regular use of cannabis at the age of 17; the last use of cannabis was a few days before admission. Ms. B also took slimming pills prescribed by her general practitioner from January to June 2017.

Ms. B had a personality of being "hot tempered," impulsive, outgoing, and willful. Her hobbies were outdoor activities, basketball, hiking, swimming, and badminton. Ms. B is not religious and enjoyed good past health. She is a smoker of about seven cigarettes per day and a social drinker.

Past Psychiatric History

Ms. B has been known to a private psychiatrist since 2011 when she experienced depressive symptoms after a relationship breakup (in her first relationship in Form 2). She consulted a private psychiatrist on an "as necessary" basis. In the last 2 months, Ms. B consulted a psychiatrist on three occasions. She presented with unstable emotions attributed to relationship problems Ms. B commented that "she had too much to ruminate about negative thoughts." She felt that the doctor did not understand her needs and concerns. Ms. B was not known to the public mental health service.

There is a history of a drug overdose of 20 tablets of Panadol/clonazepam (medications from maternal grandmother), which she took with alcohol in April 2018. She had then been admitted to the casualty and discharged. There is a history of overdoses with 80 tablets of hypnotics and an incident of climbing over the railing of a high slope in May 2018. Ms. B would eventually vomit the medications.

Present Treatment and Management of Case

Ms. B was given the diagnosis of Borderline Personality Disorder, adjustment disorder, and cannabis misuse with the possibility that she may have been suffering from a depressive episode. She was treated with antidepressant medication and counseling, which was focused on her relationship difficulties and her maladaptive coping techniques as well as anger management. She was offered a short stay (1 week) at the psychiatric hospital.

Ms. B settled well and was cooperative throughout the admission. She had no overt or pervasive depressive symptoms. She had no craving for substances or alcohol. She could sleep well without hypnotics. She was quite attentive and constructive when talking about relationship problems. She had no intention of giving up her boyfriend even though he appeared to be suspicious and unfaithful. She kept daily phone contact with her boyfriend. When her boyfriend visited her in the hospital (once), she mentioned that he cried in front of her. Ms. B said she missed the ward "a bit" at the time of discharge. She considered the hospital a safe and secure place. Ms. B also respected the staff and her doctor and asked to be followed-up in the public sector.

It was felt that the following factors were playing a part in her condition: a strong family history of depression; mother committed suicide; insecure attachment to parents; lack of care, love, and emotional expression from father and stepmother; lack of discipline from maternal grandmother who often satisfied her demands, irrespective of whether they were thought to be reasonable. There was a history of being betrayed by peers in primary school, which may have further intensified her feeling of insecurity. Repeated self-harm behaviors and suicidal threat as a kind of manipulation to induce the boyfriend's guilt whenever Ms. B considered the relationship unstable, which contributed to a vicious circle.

Consultation

JM thanked the doctor for the thorough presentation and for developing a good relationship with Ms. B. JM then asked the doctor to state what the treatment plan was. The doctor explained that the treatment plan had been discussed with Ms. B, her father, and her aunt, and it was jointly decided that she should have counseling psychotherapy by a private professional. The doctor explained that one of the factors determining treatment provision was the limitations of the health service. JM pointed out that an additional factor probably was the doctors need to have the experience of seeing patients through to the end of treatment. JM pointed out that Ms. B had not managed to improve her ability of dealing with her emotions in a more constructive way despite the years of therapeutic efforts.

JM then asked the doctor about his understanding of the reason why Ms. B finds it so difficult to manage her feelings in a more constructive way, without resorting to destructive actions. The doctor responded that her early life experience could provide an answer. He pointed out that Ms. B had lost her mother at the age of 2 and that her father was not available for her because he was preoccupied with the survival of his business. The doctor pointed out that Ms. B felt insecure in her childhood and that this feeling was accentuated with the betrayal that she experienced in primary school. Her upbringing led her not to feel secure in any environment. JM then asked the doctor if he could clarify in what way Ms. B did not feel secure at present because history is important, but the present is equally significant. The doctor pointed out that the main source of security for Ms. B was the relationship with her boyfriend, and unfortunately, his behavior had given her grounds to feel less secure with him.

JM then drew a distinction between the realistic insecurity and the "core" insecurity that Ms. B carries with her all the time. The realistic insecurity is appropriate in her case because her boyfriend does not give her grounds to feel that the relationship is stable and long term. Her perception is not a matter for treatment. In contrast, a matter for treatment is the insecurity that she carries with her and that she perceives in many other settings.

Ms. B enters relationships without expecting them to be secure. She does that at a level that is well beyond the understandable and expects uncertainty in any new relationship. By beginning a relationship with excessive suspiciousness combined with a tendency to act destructively, Ms. B plays a part in damaging the relationship and bringing about the thing that she fears (i.e., the breakup and the resulting insecurity). This was a description of the vicious circle through which one's feelings and

behavior cause their worst fears to become reality. JM pointed out that the doctor had correctly identified that this was a pattern that she developed from early age and that she applies at present.

JM then moved on to the immediate therapeutic task of enabling Ms. B to move out of this vicious circle. The focus of therapy needs to be on making Ms. B stronger emotionally so that she can cope with difficult feelings in a more constructive way. JM redefined the question of "how can this Ms. B be made to feel secure enough so that she can handle her emotions more constructively?" JM suggested that the first secure attachment that this she could have is that with the therapist. A therapist can become a secure figure for her if they are able to provide a strictly professional and predictable relationship. The first parameter is being "strictly professional." The importance of the therapeutic alliance has been adequately researched. See studies by McCabe and Priebe (2004) and Krupnick et al. (2006). There is often the temptation to become friendly, parental, or, worse, flirtatious or amorous with a patient to respond to the patient's needs for a secure attachment. Medicolegal literature is full of cases in which therapists have not been able to maintain the professional role to the detriment of their patients and themselves.

The second dimension of the professional is that the appointments are prearranged, and the patient knows when they are going to take place, how long each session will last, and that this is not a forever relationship that has to end. In that way, the conclusion of therapy will be seen as that (conclusion of a period of treatment) and not as a further rejection. Additionally, the therapist will be able to support the patient not in the sense of colluding with her but in the sense of enabling her to reflect on her feelings and adapt them so that they correspond to reality and are not determined by the early life experiences. JM gave several examples where this process happens in a healthy and constructive way in well-functioning families and in well-functioning schools where staff help the children who get upset by various interactions to recover as well as mend relationships.

Finally, a therapist can help the patient develop a sense of perspective. This means that the patient will be more able to see their difficulties in context and to have hope that a better future lies ahead through a resolution of the present difficulties and the ability to develop better relationships in the future. These are some of the changes that psychotherapy can bring about. They are referred to in the scientific literature as transformative factors. For those interested in group analysis, see Garland (1982, 2015).

JM then decided to divert the attention to the area of Ms. B's view of herself. JM pointed out that the relationship between one's ability to have a relationship and one's view of themselves; for example, a person with a more realistic view of their self is more likely to develop a realistic relationship with others, and a person with a damaged view of their self is more likely to handle relationships in a dysfunctional way. At this point in the consultation, the doctor gave an excellent summary of the essence of the consultation so far, and it was natural then to move on to exploring Ms. B's self-psychology. JM pointed out the need for the therapist to retain credibility with Ms. B and that the main basis of credibility is that they should be realistic. A tendency to idealize or to be overly hopeful often reduces the therapist's credibility in the patient's view and therefore reduces their ability to be effective. In Ms. B's case, reality means that she has the future potential to develop appropriate and functional relationships, but she will need to do some work to reach that point.

The doctor pointed out that Ms. B does not like herself at present and that she does not see herself as loveable. This is made worse by her awareness that she has negative emotions. The doctor added that Ms. B does not like herself for her feelings or for her actions in the recent past. JM then pointed out that it seemed that Ms. B only defines herself on her negative characteristics and that she attends only to the negative responses that she receives from other people. JM pointed out that Ms. B may well be ignoring any positive feedback that may come her way. In search for positives, the doctor pointed out that Ms. B was happy when she was working as an assistant basketball referee.

The doctor pointed out that Ms. B remembered that there was little challenge to her decisions as an assistant referee and that when she was refereeing there was little argument in the game.

The doctor was finding it difficult to define further positive aspects of Ms. B's personality. JM then clarified that he was not asking the doctor as a teacher who knows what the right answer is but as a consultant raising issues with him that he could then explore together with his patient. In this way Ms. B would begin to look for the positive and realistically positive aspects of herself, so that Ms. B will develop a more balanced and realistic view of herself. This view will replace the damaged and almost totally negative view of herself that was based on her early traumatic life experiences. The doctor then added that there were times when Ms. B was attractive and charming. JM then concluded that a good professional relationship with the therapist would enable her to be more conscious of the positive attributes of her personality and, as a result, develop a more balanced view of herself.

References

Garland, C. (1982). Group analysis: Taking the non-problem seriously. *Group Analysis*, *15*, 4–14.

Garland, C. (2015). Group analysis: Taking the non-problem seriously. In J. Maratos (Ed.), *Foundations of group analysis for the twenty-first century* (pp. 53–70). Karnac.

Krupnick, J. L., Sotsky, S. M., Elkin, I., Simmens, S., Moyer, J., Watkins, J., & Pilkonis, P. A. (2006). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Focus*, *4*(2), 269–277.

McCabe, R., & Priebe, S. (2004). The therapeutic relationship in the treatment of severe mental illness: A review of methods and findings. *The International Journal of Social Psychiatry*, *50*(2), 115–128.

Mrs. A

Mrs. A is a 60-year-old widowed housewife living with her two grown sons.

Presenting Condition

Mrs. A presented with a depressive mood of 1 month, with negative ruminations, chest tightness, dizziness, and insomnia. She had decreased motivation and was barely able to maintain her usual interests in exercise and church activities.

History of Present Complaint

Mrs. A had two recent stressors leading to the current episode of depressive mood. The first was that her younger son, who lives with her, was having some work problems but did not elaborate the details to her. She said her son was quiet and she was afraid that he might have depression.

The second stressor was that she had a gathering with her old classmates and during that, she compared herself to her classmates. She felt herself shorter, widowed, lower financial status, and could not achieve what her friends had achieved in their careers. She felt that she was inferior to them. She ruminated about these two ideas and started to develop a pervasive low mood, chest tightness, dizziness, and insomnia.

Family History

Mrs. A had no known family history of any mental or mood disorders. She had two older sisters.

Personal History

Mrs. A was married at 21 years. She enjoyed a good marital relationship. She described her husband as tall, strong, reliable, and caring. She felt grateful for having a good husband, and her husband was not bothered by their difference in height. Her husband died in December 2015 of cancer.

Mrs. A has two sons and one daughter, all in their early 30s. Her older son divorced and is currently living with her. Her older son worked in the government in the environmental and health department. Her younger son is also living with her and is currently working as a fireman. Her younger son will be getting married early next year and will be moving out later this year to live in a flat, which he has bought with his fiancée. Her daughter lives abroad and is currently a student in nursing school. Mrs. A. has regular contact with her daughter over the phone. Her daughter has a stable boyfriend abroad and has no plans to return to the city.

Mrs. A is happy about her younger son's upcoming wedding. However, she preferred them to have a private marriage, perhaps somewhere overseas, instead of having a big banquet. She felt that it would be troublesome for her to organize a banquet, and she would have difficulty finding a suitable dress because she felt she was short and not good looking.

Personal History

Mrs. A. was born in another city. She had two older sisters, who were caring toward her during her childhood. She grew up in the country with normal upbringing, and her childhood was uneventful. She was educated in the country until secondary 2 level. She then came to the city early in her 20s and got married.

Mrs. A worked in a garment factory and in a restaurant as a food seller before. Her longest employment was for 3 years in a restaurant. After she got married, she became a housewife.

Mrs. A is a nonsmoker and nondrinker. She has no substance abuse or forensic record. She is even-tempered, a little prone to anxiety, pessimistic, and passive in her personality. She enjoys exercise every morning as a hobby. She is a Christian and goes to church weekly. Her friends are mostly her old classmates, neighbors, and "church-mates."

Past Psychiatric History

Mrs. A was first known to the mental health service in 2006. She was seen twice in the clinic at that time for generalized anxiety disorder with insomnia, but she defaulted at follow up. That episode was triggered by an event of a gas explosion in the flat below her apartment. This event was widely publicized in the city. The explosion occurred in the context of domestic conflict. There were three deaths in the incident including two residents of the flat and an old lady of a neighboring flat. The person who set the gas explosion was an elderly man who was the owner of that flat and who was later jailed. In the afternoon of that day, Mrs. A was suddenly woken up by a loud noise and some smoke. She saw her own windows and glass drawers broken. She evacuated downstairs immediately. When she arrived at the balcony, she looked up to see the fire scene and was overwhelmed with fears. It was arranged for her to stay in the community center for one night and then in a temporary housing unit for 3 months. Afterward,

she suffered from a startling response and apprehension whenever she heard a loud noise or passing the floor of the incident when she returned to live at home. These symptoms lasted for about a year and then gradually subsided. She was referred by a social worker to receive a psychological intervention at that time. She recalled that the clinical psychologist taught her some relaxation techniques involving muscle relaxation and listening to relaxing music. She did not practice the techniques often and the psychologist service was terminated after 1 year when her symptoms subsided.

A few years later in 2011, Mrs. A presented to the psychiatric clinic again. This time she was troubled by menopausal symptoms. She developed low mood, poor sleep, and appetite, was feeling anxious, experienced chest tightness, dizziness, and had poor motivation. She attributed these complaints to depression because she felt her symptoms were similar to the description of depression she read in newspaper articles. She was started on fluoxetine and had regular follow up in the clinic. She achieved remission shortly after the start of antidepressants.

Two years later, in 2013, Mrs. A suffered a relapse of depression. This time it was triggered by her daughter having a road traffic accident abroad. It was a minor accident; her daughter was only mildly injured and made a good recovery. She was worried and then developed persistent low mood, poor sleep, loss of appetite, chest tightness, and dizziness. She had lack of motivation, and she did not want to see anyone at that time. She stopped her usual habit of daily exercise with her neighbors. She was added on Deanxit in the clinic. She achieved remission again shortly after adjustment of the medication.

In the next 2 to 3 years, her husband suffered from multiple physical problems, including cancer of the lung and prostate, with brain metastases, complicated by epilepsy. Her husband was physically frail in the last few years of life, and she had to take care of him. Her husband eventually died in December 2015. She had a normal grief reaction. She missed her husband, but she soon accepted the loss. She felt that his death was a good way to end her husband's long-term suffering from the illness.

Mrs. A then had a stable mental state until the current episode of depressive mood, which was triggered by younger son's change in work duty and her gathering with old classmates. She advanced her clinic appointment this time, and her antidepressant dosage was adjusted. She soon achieved remission again after around 1 month.

Present Treatment and Management of Case

The diagnosis for her was recurrent depressive disorder. Her current medications included fluoxetine 40 mg daily, Deanxit (mixed medication of flupentixol and melitracen) 1 tab daily, zopiclone 3.75 mg at bedtime when necessary, and propranolol 10 mg twice a day as necessary. She achieved remission again after 1 month after medication adjustments. She was keen on psychological intervention for relapse prevention, reducing reliance on medication, and learning relaxation techniques.

She was seen a few times and reported that her greatest concern at this stage was reliance on sleeping pills. Sleep hygiene was discussed, and she successfully cut down the use of hypnotics. She reported no other distress at this moment. Further work would be needed to focus on relapse prevention for her.

Consultation

JM congratulated the doctor for the excellent presentation. JM first focused on the timing of Mrs. A's remission after the onset of medication and whether the remission could be pharmacologically explained or if the timing was related to some other factor. The doctor believed that the timing of her improvement was earlier than what would be expected pharmacologically. JM then asked about the significance of this early remission. The doctor wondered whether this was related to a placebo effect. JM then asked about the nature of the therapeutic factor, which was called "placebo." The doctor found it difficult to respond to this question, and JM suggested that a doctor is not expected to know all the answers but when a matter like this confronts a patient and doctor, then it is worthwhile

exploring it with the patient. For example, JM suggested that the doctor mentions to Mrs. A that they have noticed that her recovery occurs earlier than medication had time to have effect and whether doctor and patient could explore this and come to a shared insight. That exploration would help the patient to start thinking more psychologically and less organically. The doctor repeated that Mrs. A's understanding was that it was the medicine that was making her better, and JM pointed out to the doctor that he was aware that the build-up of serotonin in the synaptic cleft takes longer than the first 2 or 3 weeks to make a clinically significant improvement.

JM then asked now that it was established that her mental state improvement took place before the biochemical effect of medication, do we have a better understanding of the therapeutic factor? The doctor pointed out that Mrs. A had said that when she tried to speak with her son or daughter, they only offered reassurance that seemed quite facile. Mrs. A felt that her children could not understand her illness. Mrs. A explained that she felt that the professionals at the hospital had a better understanding of her condition. JM then asked, "what was the reassurance given by the healthcare professionals?" The doctor responded that Mrs. A was probably not offered reassurance, but it was the opportunity to talk with professionals at a different level to that of the discussion with her own children.

JM then asked if the doctor had any thoughts of what the qualitative difference was in the communication with the healthcare professionals and with her children. The doctor replied that Mrs. A felt that doctors could understand her illness better and that the doctors could be more effective in helping her by adjusting the medication. JM then suggested that Mrs. A was given a sense of security on a false premise. The false premise being that it was the change in medication that would get her better. JM pointed out that although the premise was false, it was nevertheless effective. The therapeutic factor was that Mrs. A had a feeling that she was in the right hands and that she would receive the right and effective treatment. The contact with the hospital gave her the security that she needed and that was the therapeutic factor.

JM then raised the issue of whether it would be appropriate to disabuse Mrs. A of this false assumption and deprive her of a sense of security or whether the doctor should leave this "false assumption" unchallenged. The decision will depend on whether the doctor's assessment is that Mrs. A can cope with the new reality. JM pointed out that for some people this is the best that one can hope for: That they live with the belief that every now and then, events will overwhelm them and they will become depressed (meaning clinically depressed) and that they will then be sorted out by adjustment in medication by specialist doctors.

Only after the doctors form the opinion that Mrs. A can cope with being disabused—of losing a system of beliefs that she had to date found helpful—can one proceed with a more psychological exploration. For example, only then could she be asked why being short and being less successful than her fellow churchgoers is something that is depressing for her. For an exploration of the relationship among religion, spirituality, and mental health, see the excellent recent review by Dein (2018).

Mrs. A could be asked to reexamine the way she evaluates herself. For example, we do know that the value of people is not measured by a tape measure. Why is Mrs. A rating herself according to height rather than as a human being? Mrs. A was depressed at the thought of appearing at her children's wedding being as short as she is. Why has Mrs. A not gained a realistic evaluation of herself despite her height? JM then repeated the issue that if the doctors felt that Mrs. A could cope with this kind of exploration, this is one issue that they could begin to look at again with her.

JM then pointed out that Mrs. A rates herself by comparing herself to her "fellow churchgoers" on the dimensions of height, wealth, and career. JM asked the doctor about other dimensions along which Mrs. A could begin to rate herself so that she develops a more realistic evaluation of herself. The doctor pointed out that Mrs. A could begin to value herself as the mother of three good children, that the children are independent, they have good jobs, and they contribute to society. JM then pointed

out that Mrs. A may feel that she has not been as good a mother because none of her children are high-achieving professionals nor are they great earners. JM asked how the doctors could anticipate this depressive slant that Mrs. A is likely to give to her achievements. The doctor responded that the value of a job is not measured by the amount of money they earn but on the worth of the contribution to society. JM confirmed this as a useful line to follow with Mrs. A. JM then added that this was an excellent idea because the doctors could apply the same evaluation to how she values herself. For example, bringing up three children who are useful members of the society is of enormous value even though it brought no income to her. The doctor also added that the children's emotional development was also largely positive in the sense that they had not presented with any psychiatric conditions although they were reserved. It could be pointed out that with her husband, they raised three children who have not become a burden to society, who have not become dysfunctional, and who are dealing with the stages in their lives (like developing a career and personal relationships) constructively. Mrs. A has a good reason to feel proud of this achievement.

JM then asked the doctor if Mrs. A had good reason to feel proud in her role as a wife. The doctor pointed out that Mrs. A could feel proud of the dedication that she showed to her husband, especially through the last difficult years of his illnesses. JM then summarized that Mrs. A could value herself as a good mother and as a good wife and that she has contributed to society in that way.

JM pointed out that once Mrs. A felt secure in the relationship with a therapist, the therapist can invite her to reexamine the dimensions that she values herself and think not only of the limitations of her achievements but also of the positive contributions. This would enable her to have a more global, balanced, and realistic view and evaluation of herself and not judge herself only by comparing herself negatively. JM then summarized that contact with the professionals enables her to have a more realistic view of herself and also to develop a shared "understanding."

JM then expanded a little on the notion of understanding by pointing out that people feel understood only if the other person shares the same belief or the same view as they do. JM pointed out that young people particularly often accuse their parents of not understanding when their parents see the same events in a different perspective. The security of the relationship with a professional enables patients to reexplore their understanding of and their own interpretations of events or of themselves. In Mrs. A's case, the shared understanding that was based on a false premise was helpful in treating the individual episodes but was not helpful in preventing a relapse. Challenging the original shared understanding would lead to an improved evaluation of herself and an increased personal strength and resilience to face challenges and threats to her self-esteem. Put more simply, only if she values herself more as a person will she be able to face the reception of her children's wedding with the height and a dress that suits her and that she can afford. Only with an improved sense of self-worth will she be able to accept, for example, a reception that is appropriate to their financial status.

JM then suggested, as simple techniques, to use extreme examples of either intellectual brilliance or exorbitant wealth. JM pointed out that he sometimes challenges patients who present with such difficulties by pointing out that most people are not professors at universities and most people are not exorbitantly rich. This comparison often stimulates people to value what they can contribute rather than rating themselves negatively according to what they cannot. The doctor concluded that this was a line of approach that he had already initiated and that Mrs. A was already showing signs of improving.

References

Dein, S. (2018). Against the stream: Religion and mental health—the case for the inclusion of religion and spirituality into psychiatric care. *British Journal of Psychological Bulletein*, *42*(3), 127–129.

Bob

Presenting Condition

Bob presented with depressed mood, suicidal ideation, preoccupation, and anxiety.

History of Presenting Complaint

Bob is a 30-year-old married primary school teacher living with his wife. Bob is new to the mental health services. In early April 2018, he downloaded a new software called "FOX" on his computer, which would automatically download web pages and videos after entering a few keywords. He had entered words related to explicit sexual intercourse. He had difficulty engaging in sexual intercourse with his wife. He claimed that he did not know what videos he had downloaded.

He was reported to be mentally well until April 26, 2018 at around 5:00 a.m., when police arrived at his home and arrested him for "possession of child pornography." He claimed that he was misled by police to confess that his computer was only used by him, although in fact it could be accessed by others (including his younger brother, wife, his wife's younger brother, and colleagues). He was brought to the police station, interrogated alone, and finally admitted the charge "under coercion." The case was opened for investigation, and he was concerned regarding possible legal consequences including imprisonment. Since then, he had pervasive depressed mood with weeping episodes. His volition was low. He developed psychomotor retardation, was slow in actions and thoughts, with memory and attention deficits. He was socially withdrawn and preoccupied. He had increased anxiety, and described constantly being "on the verge," with associated shortness of breath, chest discomfort, numbness of his fingers, and hand tremors. He had increased negative cognitions of worthlessness, helplessness, and hopelessness. He was admitted to the emergency ward of a medical center from April 29 to May 1, 2018, where he was seen by the visiting psychiatrist. He was given fluoxetine, diazepam, and lorazepam and was discharged. He sought help from legal advice on May 1, 2018, and the possible legal consequences were explained to him. He first attended the out-patient department on May 31, 2018, where a voluntary admission to a hospital was arranged. Since he was charged, he was suspended from duty as a primary school teacher and is on sick leave.

Family History

His father has depression with follow-up. His mother has a delusional disorder, with past admissions to psychiatric hospitals; she presented with a belief that there were ghosts following her since her paternal grandmother died. His elder brother (33 years old) has severe-grade mental retardation, attention deficit hyperactivity disorder (ADHD), and autism, with hospital follow-up. Bob is the second of three sons.

Personal History

Bob was born in the city. His father was a shop assistant, described to be hot-tempered, and often scolded and hit with bare hands, a bamboo cane, with hangers, or keys. His mother was a housewife, described to be even-tempered, but also used corporal punishment.

Bob was described to have normal development milestones but had poor social interaction with his classmates. He was reported to have poor eye contact, often felt scared to see people, and refused to talk to others. He had interest in memorizing bus and train lines. He enjoyed watching TV advertisements with jingles and often sang these jingles in the wrong social context. He reported that he

had been speaking only English since 2001 because he believed that he was an English teacher and that he "should not" speak the local language. He recalled watching the news in English and tried to imitate a British accent. Since then, he had been speaking in English obsessively, even when it was socially inappropriate for him to do so. For example, he insisted on speaking English to his students' parents even though they could not understand. He was told by his school principal and his colleagues that he shouldn't be rigid, but he ignored the advice. At school, he was described as socially awkward and weird. He had no friends. Growing up, he was bullied throughout primary and secondary school for being "weird." He had no confiding relationships. He reported various episodes of intense anxiety during his school years prior to school examinations or being asked to do public speaking. He described his baseline anxiety to be high, and trivial events were enough to cause a surge of intense anxiety.

Other than corporal punishment and physical abuse by his parents, he reported an episode of sexual abuse/harassment when he was 12. He was at home watching cartoons with his two brothers and the phone rang. A man claiming to be a policeman asked him how many people were at home and then asked him to do as he was told or else the police would come and arrest him. He was asked to take out his penis and to measure the size. He was then asked to masturbate and then measure the size again. He was then asked to do the same to his two brothers. He was then asked to stimulate his elder brother's penis with his mouth, but he found it disgusting so he sucked his own fingers instead. His mother then came home and asked what had happened. She told them to hang the phone up. Since this occurrence, Bob believed that some adult men were dirty, especially those who smoked and spoke foul language.

Bob met his wife at university. It was his first relationship. The couple started dating while they were still at university. His wife found Bob to be socially awkward at times but admired his ability to speak in fluent English. His wife was also a primary school teacher. The couple married in August 2016. However, they found it difficult to have sexual intercourse because Bob did not know what position he should be at. When he tried to penetrate her, he claimed his wife would experience pain, and he would stop to avoid hurting her. As a result, Bob and his wife developed a fear of sexual intercourse. As the couple wanted children, they downloaded pornography online to watch together and hoped that by imitating the actors, they would be able to have successful sexual intercourse. They tried for 2 years already without making any progress.

Past Psychiatric History

There is no history of other psychiatric episodes or of suicide or violence.

Present Treatment

His symptoms on presentation satisfied the diagnostic criteria for severe depressive episode without psychotic symptoms He also has predominant anxiety symptoms His rigidity/stubbornness, insistence to speak English even when it was socially inappropriate, lack of social reciprocity, poor social communication, and poor social interaction, all of which starting from childhood, satisfied the diagnostic criteria for childhood autism.

Pharmacologically, he was prescribed venlafaxine and quetiapine for mood regulation. He took lorazepam as needed to help with his anxiety. He was seen by the clinical psychologist for social skills training as well as for coping with stress.

The doctor concluded by clarifying that he wished to form an opinion whether this patient was likely to respond to psychological interventions.

Consultation

JM thanked the doctor for the comprehensive presentation. He also praised the doctor for managing to establish a good relationship with Bob because he is someone who has difficulties in interpersonal relationships. JM then proceeded asking the doctor to clarify if there was a diagnosis of severe depression as well as a diagnosis of autistic spectrum disorder. Regarding the sexual dysfunction, the doctor stated that he saw this as part of the autistic disorder. As such, he did not feel that it merited special diagnostic classification. The case of him suffering from pedophilia (a disorder of sexual preference) had not been established yet. And the difficulty in consummating the marriage was again seen as part of the autistic disturbance.

The doctor added that he knew that the couple had some help from a fertility clinic, which found that there was no physiological reason for them not to be able to have children. To JM's question, the doctor responded that the couple do not have sexual intercourse. JM then queried the logic of going to a fertility clinic when they don't have sexual intercourse, though this is not a rare phenomenon. The doctor stated that Bob had told him that he "was not sure" whether they have had intercourse. JM questioned the veracity of this statement and suggested that because one cannot be not sure whether they have had intercourse that Bob is avoiding answering this question meaningfully. The doctor added that Bob had expressed fear of penetrating his wife. What became clear was that embarrassment inhibits Bob from giving a full history of his sexual life, and a full history is essential for a proper diagnosis of his difficulties. The doctor then expanded on Bob's sexual development. The onset of secondary sexual characteristics seemed to have proceeded naturally. Bob began masturbating at the age of 11. The doctor added that Bob had told him that he thinks he is heterosexual. In recounting the images that were associated with his masturbation Bob made some vague mention of boys but subsequently he made it clear that he was only interested in women. The doctor remained unsure whether Bob was interested in boys or not. Bob did mention to the doctor that once he had been attracted to a 12-year-old boy.

JM then raised the issue of confidentiality and the law regarding pedophilia. JM pointed out that in the UK if a doctor is treating a patient who is a threat or a danger to anyone else, they have a duty to take whatever action is necessary to protect the public. This is much more so when the welfare of children is concerned. The legal situation will need to be clarified with Bob even before the psychiatric or the therapeutic consultations are initiated. The doctors need to be aware that according to UK law, a court can subpoena the records of a doctor if there is an issue of possible harm to children.

In view of the prevailing legal situation, it is important for Bob to know that if he has been found to be downloading pornographic pedophile material, that he accepts this as his own personal problem so that he can proceed to explore it openly within the therapeutic sessions and reach a level where he can receive the appropriate therapy and work toward overcoming this dysfunctional situation. It is not only that he may be attracted to boys aged 12 and that he feels trapped in a 12-year-old body, but it is also the global sexual dysfunction that he has and his attitude about tenderness, warmth, sexual foreplay, and the other aspects of heterosexual interaction.

JM then reflected on the management of pedophiles especially because this is a condition that is particularly resistant to therapeutic interventions. He should certainly avoid working in environments where he would be coming into contact with children and that means that he should change his job as a primary school teacher. In any case, if this case goes to court and he is found guilty, then presumably his name will be put on a register, and would have to disclose this with any application for job that he makes. JM pointed out the predilection of pedophiles for jobs that bring them into contact with children and that one finds frequently pedophiles among the professions of teachers, gymnastic coaches, foster parents, care workers, priests, and even doctors who deal with children such as pediatricians and psychiatrists for children. JM pointed out that many of these unfortunate people choose a profession

that will give them access to children. JM referred to the numerous cases of historical sexual abuse that have come to the surface and have shaken many institutions including the Catholic Church.

JM then referred to psychotherapy of pedophilia. This is a highly specialized branch that requires trained professionals who have experience in the field. General psychotherapeutic interventions have not been shown to be therapeutically effective. For practical purposes pedophilia should be considered a condition with guarded prognosis that needs to be managed as well as treated.

JM made a comment about the doctor's record and where he refers to ***facts***, information that is only an allegation against Bob. More specifically, Bob's attribution of his confession to pressure from the police must be clearly stated that this is what Bob felt not that this was a fact, although such interrogations are almost never without a personal sense of threat and pressure.

It is of interest that Bob seems to want to shift the responsibility for the downloaded images to the other people who had access to his computer. This is a matter for the police investigation and the psychiatrist needs to keep an open mind until a judgment is passed. JM pointed out that for the police to be involved, this must have been an activity that he was engaged in for some time and for which he probably paid money. He must have accessed these sites in a naïve way because currently, sophisticated pedophiles use the "dark web" and make themselves undetectable. The psychiatric approach needs to be informed by the details of this activity and by the methods Bob used to record this in his hard drive.

JM then pointed out that the event that Bob described when he was telephoned (aged 12) and ordered to carry out certain sexual acts may have been defining and traumatic for him, taking to account the overall personal structure of his psychology that was that of somebody who is suffering from an autistic spectrum disorder. JM pointed out that Bob does have some abilities that mainline autistic people do not have such as the ability to communicate and the well-developed language.

JM then questioned the diagnosis of a depressive illness. He pointed out that the present emotional state could be a reaction to an enormous stress and threat that he must be under. The present detection and interrogation by the police has implications on Bob losing his job, going through court, his private difficulties becoming public, having to register as a pedophile, having to declare this on every job that he seeks an appointment, and challenging the relationships with his wife and with his family. It would be surprising if somebody facing this enormous constellation of changes and losses was not in some emotional turmoil. JM then asked if the doctor knew if there was a service that was oriented therapeutically toward the treatment of people with sexual dysfunction of Bob's type. The doctor was not sure, although he had the impression that the forensic department does treat some cases with antiandrogens. JM's view was that prescription of antiandrogens was not a highly effective way of helping people with this condition.

JM then began his conclusion by saying that the role of a general psychiatrist would be to get Bob to accept that he has a complex problem for which he needs treatment. Denying its existence is not a good foundation for any kind of treatment.

JM then pointed out that Bob may not think that viewing child pornography is harmful. That is pure ignorance because he denies the process by which children are made to take part in acts that are then filmed and put on the internet. The process of developing the pornographic images is itself enormously damaging to children, and by viewing them, he is funding this crime. If he saw the viewing of this activity as innocuous, he simply needs to be informed why viewing these images is criminal.

References on Autism and Pedophilia

A good introduction to the subject of paraphilia is the chapter by (Fedoroff, 2009) in the *New Oxford Textbook of Psychiatry*. It is general and does not address adequately the issue of autism and these

disorders. The same limitation applies to the volume on *DSM-V*. Several studies establish a link between autism spectrum disorder and the paraphilias (Fernandes et al., 2016; Schottle et al., 2017). Of special interest is the study of Kolta and Rossie (2018), which describes a case with both these conditions.

Obviously, the fields of paraphilias and of autistic spectrum disorders are vast. Those interested in the psychoanalytic aspect of paraphilias could study the works of Socarides and Loeb (2004) and of Woods and Williams (2014).

References

Fedoroff, J. P. (2009). The paraphilias. In M. G. Gelder, N. C. Andereasren, J. J. Lopez-Ibor, Jr., & J. R. Geddes (Eds.), *New Oxford textbook of psychiatry* (Vol. 1, pp. 832–842). Oxford University Press.

Fernandes, L. C., Gillberg, C. I., Cederlund, M., Hagberg, B., Gillberg, C., & Billstedt, E. (2016). Aspects of sexuality in adolescents and adults diagnosed with autism spectrum disorders in childhood. *Journal of Autism and Developmental Disorders*, *46*(9), 3155–3165.

Kolta, B., & Rossi, G. (2018). Paraphilic disorder in a male patient with autism spectrum disorder: Incidence or coincidence. *Cureus*, *10*(5), e2639.

Schottle, D., Briken, P., Tuscher, O., & Turner, D. (2017). Sexuality in autism: Hypersexual and paraphilic behavior in women and men with high-functioning autism spectrum disorder. *Dialogues in Clinical Neuroscience*, *19*(4), 381–393.

Socarides, C. W., & Loeb, R. (2004). *The mind of the paedophile: Psychoanalytic perspectives*. Karnac.

Woods, J., & Williams, A. (Ed.) (2014). *Forensic group psychotherapy*. Karnac.

Mrs. C

Mrs. C is a 68-year-old woman, widowed, and living alone in a public housing unit. Mrs. C walks with the aid of a walker (a Zimmer Frame) outdoors and with a walking stick indoors because of arthritis in both knees. Mrs. C functions on activities of daily living, level I (can look after herself).

Presenting Condition

Mrs. C was referred to the psycho-geriatric day hospital from a psycho-geriatric center due to low mood, poor social support, and daytime engagement.

History of Present Illness

Mrs. C reported having fleeting suicidal ideas but no concrete plans or actions. She was diagnosed with a recurrent depressive episode, the current episode being severe, without psychotic symptoms. Upon receiving psychiatric attention since 2015, her mood had shown some improvement, but she still often maintained that she had fulfilled her duties to her family and had no reason for living any more. Mrs. C continued having a sense of worthlessness and hopelessness. She reported having an early death wish and that she wished for a quick natural painless death. Mrs. C had no actual suicidal plans because she was afraid that she would be a burden to her family if the suicide was not successful. She was dysthymic and tearful when husband was mentioned. There was no abnormality of speech. There were no psychotic symptoms. She was not suicidal or aggressive.

Personal History

Mrs. C was born in the city and was the third of four siblings. Her eldest brother died when he was an infant after a fever and before Mrs. C was born. Her eldest sister remained in the country under the care of her maternal grandparents when her parents immigrated to the city. Mrs. C and her younger brother were born in the city. Mrs. C has a distant relationship with her eldest sister because they have lived apart all their lives.

Mrs. C reported having a good relationship with her younger brother and her parents; she claimed that her parents loved both her and her brother dearly because they did not have many children. Mrs. C felt that she had led a happy childhood despite being poor and living in a wooden hut. From a young age, she knew the importance of bringing money home. Mrs. C claimed that her mother died in her arms in her 80s and that her mother had waited for her to come to the hospital to see her final moment. Her father moved in with her, after her younger sister-in-law died, and stayed with her until his death. Mrs. C has no family history of mental illness.

Mrs. C studied until Form 2 at night school and then worked as a factory worker until she was about 50 years old. When her husband had a stroke, when she was around 60 years old, she attended a course to learn how to care for the debilitated and became a helper at an old age home after attending the course. She later studied at the open university (in 2009–2010) because she wanted to have a better work-life balance. Mrs. C was keen on learning.

Mrs. C married after dating for 2 years. She had a good relationship with her husband. Mrs. C commented that her husband was outgoing and liked small gambling but was never in debt. Her husband would take her to trips or buy her good food when he won on betting. When her husband suffered the stroke in 2000, she claimed there was not much support or education given to her at the time. She was told by the doctor that her husband may have recurrent strokes and told her to be careful, but she claimed that she did not know what was meant by this. Mrs. C felt that the doctors were not helpful in advising her how to look after her husband, and as a result, Mrs. C felt helpless. He had stayed in the intensive care unit with a Ryle's (nasogastric) tube at the time, and he was bedbound. Since his discharge from hospital, she had a transient thought of pushing him out the window and jumping from the height with him, but she later changed her mind after thinking that her husband's father was still alive. She later took him to see practitioners of traditional Chinese medicine (each appointment costing the equivalent of about US$50) and hired a maid to help care for him. She claimed she had spent her life savings and sold their minibus to pay for his medical bills. Her husband used to work as a minibus driver. When he entered hospital, she was mocked by relatives for placing him there. Mrs. C claimed that her husband's father was unsupportive, and he claimed that her husband deserved the stroke because he smoked. There was no further support from family members. He eventually had some improvement and was able to walk with a stick but then suddenly developed an infection and died within 3 days. She was disappointed that after she had achieved such an improvement in him, he would die so suddenly.

Mrs. C has two daughters and one son. Her son emigrated when he was in his 20s; her eldest daughter studied in Australia and later worked in the country. Her younger daughter works on a nearby city, she visits her weekly and gives her the equivalent of about US$300 a month. She reported having a quite distant relationship with her children because they work abroad and have their own lives.

Premorbid Personality

Mrs. C is a responsible and independent person who tends to bottle up her feelings. She feels that she is a good listener, a helper, and a giver instead of a recipient of help. Her present limitations (as in mobility) force her to a situation of dependency in which she feels uncomfortable. Mrs. C feels that

everyone has their own set of problems and understands that others do not have the time to listen to her difficulties. She is a Buddhist.

Past Psychiatric and Medical History

Mrs. C presented to the hospital in July 2015 with low mood that had persisted since her husband's death in May 2015. Her husband had suffered a stroke in 2000, and Mrs. C had cared for him since that time. Her husband had entered a sub rented old age home in 2004, and Mrs. C used to visit him daily. Her relatives were critical of her because they implied that she should have looked after him at home with the help of the maid whom they had employed. Mrs. C's husband died suddenly within 3 days after admission to hospital where he developed fever and vomiting. After her husband's death, Mrs. C reported to have lost her reason for living. She felt she had done everything she wanted to do in this world already and her responsibilities had been fulfilled. She developed low mood and a loss of energy and interest. She had early morning waking and poor appetite.

After her husband's death, Mrs. C reported to have seen her husband's ghost twice at night but did not feel distressed because she felt it was her husband visiting her.

She felt helpless and had thoughts of pushing her husband out of a window and jumping out of the window after him. Her sister-in-law had also died around that time. Mrs. C was known to the mental health services for more than 15 years. Her sister-in-law had died around that time, leaving her 8-year-old nephew behind. Mrs. C claims that she only attended a psychiatric clinic once and was given antidepressants that made her drowsy and for this reason she did not continue with follow-up. Since attending the hospital, she had tried various antidepressants, which she felt had doubtful therapeutic effect and considerable unwanted effects.

Mrs. C was limping and walking slowly supported by a walker. Mrs. C continued being worried about her progressive bilateral osteoarthritis of her knees, with varus knee, and back pain affecting her mobility. Mrs. C has suffered from dyspepsia, hypertension, hyperlipidemia, empty sella syndrome (which was thought to be nonsignificant at follow-up), spinal stenosis with left foot drop, and obesity.

Mrs. C had been on a waiting list for total knee replacement since 2015 but claimed that she had been advised that she needed to wait until 2018 for it to be done. Last year, Mrs. C also developed hypertension and felt more concerned about her failing health. Her knee pain and poor mobility had limited her from pursuing her interests, such as hiking and doing volunteer work. However, old case notes reported she had previous plans of hanging herself in the mountain, but Mrs. C denied it during current psychiatric clerking. She claimed that since her husband's stroke, she had already completed the bank account rearrangements and written her final notes in case something was to happen to her.

Present Treatment and Management of Case

Mrs. C had been advised to accept inpatient admission, but she strongly refused. She was referred to a clinical psychologist for grief therapy and to a community psychiatric nurse for community supervision; she was started on fluoxetine 30 mg daily. She was referred to PGDH for daytime engagement and support. Mrs. C is sensitive to the side effects of antidepressants and she often complained of fatigue.

Mrs. C had started attending PGDH in July 2017 with the aid of transportation service. She had been reluctant to attend at first, but after joining, she started to enjoy the activities (including physiotherapy and occupational therapy) and liked chatting with other patients. Mrs. C claimed that she had made friends and liked listening to other's problems She is receiving meals on wheels at home and

would also do volunteer work at the city society for the aged around once a week whenever her knee and hip pain is better. She had continued receiving cognitive behavioral therapy (CBT) from a clinical psychologist and felt that she had ruminated less about her husband and had resolved some of her anger regarding his death. Mrs. C was not keen to have further psychiatric medication because she was concerned about their side effects. Mrs. C felt that her primary difficulty was her mobility. She had also been referred to the district elderly community center for further support. She also applied for medical fee waivers because she is financially dependent on her daughter only and old aged allowance.

Consultation

The doctor expressed the feeling that, as a clinician, she felt helpless; as a psychiatrist she was in no position to improve Mrs. C's mobility (could not hasten the knee replacement operations) or address the other physical problems and medical treatment, which was within her field of expertise (antidepressants).

JM summarized the case as a case of a woman of 68 who had led an active and creative life, who became married, supported her husband, developed a good relationship with her husband, and had three children who they raised. The children have now moved and live in different countries and so, she had no role in caring for them; this was a major loss for her. The death of her husband is an additional major loss; the other enormous loss was that of her physical fitness. Mrs. C relied on her fitness to be helpful to others and also to be able to enjoy her life (as, for example, in hiking). Mrs. C has not readjusted her ideas and feelings to fit with her present life situation as an elderly, widow, and a woman whose children do not need her anymore and who can contribute little to the wider community.

JM then added that although doctors and therapists pay considerable attention to feelings of sadness and loss, we do not pay as much attention to unpleasant feelings of anger. JM acknowledged that the anger toward doctors had been addressed somehow because she had expressed anger because they did not save her husband's life and because they had not given her adequate advice on how to help him and telling her to be careful was not good enough. The doctor added that she had acknowledged her anger at not being told on how she could prevent further strokes taking place—something that was likely to happen. The doctor added that Mrs. C had also expressed anger that the doctors did not save her husband from what was a febrile illness. JM raised the issue of anger toward her husband who inflicted part of the illness on himself by smoking. The doctor added that her husband's father had made that comment that he had brought the stroke on himself. The doctor added that she felt that her husband did not deserve to have a stroke despite his smoking because there are many people who smoke and do not suffer strokes. The doctor added that Mrs. C was forgiving toward her husband. JM added that it seemed to him that Mrs. C was idealizing her husband whom she loved.

JM referred to Mrs. C's hallucinations of widowhood (Dewi Rees, 1971; Olson et al., 1985). This was referring to Mrs. C imagining that she had been visited by her husband after his death. The doctor pointed out that she was aware of the various forms of pathological grief. JM pointed out that widowhood is, at that age, one of the most stressful events that could happen to a person (regarding mortality of widowhood, see Parkes & Fitzgerald [1969]). JM added that the only life event that could be more stressful than widowhood is the death of a child. JM then pointed out that the couple had had a good life together. They brought up their children together and they brought them up well; she was tolerant of her husband's little faults, like his gambling, which was measured (not excessive). Before the husband became ill, they had managed to have savings and some small property; they had been a well-functioning couple and it was difficult for her to readjust her thinking so that she could look forward to a future. The doctor added that having spent all their savings Mrs. C was now left with few resources and she was dependent on her daughter from whom she receives the equivalent of

US300 a month which is a small sum—a sum barely adequate to cover her needs. JM pointed out the predicament of having to live alone, aged, with difficulties and with little support from family. JM asked if Mrs. C receives any support from the Buddhist community of the city. The doctor pointed out that although she does have several friends, her mobility restricts her from visiting them. The doctor also pointed out that a visit to a Buddhist temple was not mentioned. The doctor added that it was not only her physical disability but also some reluctance to go out and meet people; she was concerned how she would appear to her peers walking with a walker. The doctor added that it would also be difficult for her to invite people to her home because the living space is limited.

JM repeated that the task for Mrs. C was to readjust her thinking on how to live the rest of her life as an elderly, physically compromised, lonely woman. JM invited the doctor to imagine what prospect could this woman have for her life in the following, say, 20 years. The doctor replied that if she were in that position, she would place most of her hopes on a knee operation taking place in the immediate future because if her mobility improved she would be able to go out a bit more and engage more in the activities that will improve her emotional state. Maybe she will be able to do some hiking again—something that she enjoyed in the past; she may be able to do some voluntary work or meet up with some of her friends. JM questioned how realistic the prospect of hiking would be for Mrs. C and asked if Mrs. C was also overweight. This was confirmed by the doctor. JM pointed out the vicious circle of arthritis limiting movement, and limitation of movement leading to increased weight, which in turn limits movement even further.

JM, having questioned the realistic level of the expectation of hiking, then moved on to invite the doctors to consider what would be a realistic prospect and asked the doctor if Mrs. C's hopelessness had become her own hopelessness as well. JM then introduced the psychoanalytic concept of *countertransference* (Heimann, 1950; Kernberg, 1965; Winnicott, 1960). JM made a summary of the concept as follows: Countertransference refers to the feelings that the therapist develops that arise not from the therapist's own experience or the result of an independent assessment, but they represent the adoption of the patient's feelings, which are seen by the therapist as their own. JM pointed out that in the case of Mrs. C, her own hopelessness became the doctor's hopelessness. JM asked the doctors whether the appropriate thinking and action for Mrs. C was to end her life because there was no realistic future for her. As this was not the case, JM started pointing out the positive elements of Mrs. C's predicament. For example, she still had her mind (she was not dementing) and still had a desire to be independent, caring, and giving. JM pointed out that Mrs. C based her relationships on her ability to offer. JM invited the doctors to consider how people who retire from active life adjust to this new pattern (Wu et al., 2016). Generally, older people are less able to offer and less able to earn. The first element on which they can rely is their history. They have a memory of a full life. This lady can have a memory of surviving adversity, coping with numerous changes, enjoying a good relationship with her husband, and fulfilling herself by bringing three children up. Mrs. C can rely on this history to feel that her life has not, to date, been wasted. That is a thought that is not depressing and is realistic.

One can be sympathetic to this woman who has lost her ability to function because of widowhood, disability, and poverty. It is going to be difficult for her to make this adjustment, but it is not impossible to use the residual resources that she has, which are her intellectual ability and her personality. Once she develops a more realistic approach to her future, she is more likely to accept help to engage in interaction with other people such as the interaction arranged at the psychiatric day hospital. Some other organizations, not related with provision of care, could perhaps be approached for her to participate as an equal member and not as a recipient of service. Mrs. C needs to value that she can be useful as a presence not only as somebody who does a job for others or somebody who offers a service. Any expectations of her offering work would be frustrated and, therefore, unrealistic. She could

value the realistic expectation of offering herself for who she is and not for what she can do for other people. She could make some people happier by just spending time with them. This, in return, could make her feel happier and more useful. This would increase her own sense of self-worth. The doctor confirmed that Mrs. C feels better when she is with other people at the day hospital. JM asked if the local Buddhist community has any programs to engage isolated members of the Buddhist community. The doctor undertook to explore this avenue. JM also pointed out that a physical objective within her reach could be some reduction in her body weight. JM suggested that she could be put in touch with a dietician and perhaps an exercise program appropriate to her disability could be devised.

JM concluded that the central focus of a treatment would be for the treating doctor and all the staff to resolve the feeling of hopelessness and replace it with one of realistic expectations for Mrs. C. The doctor concluded that Mrs. C does enjoy interaction with other people and that she is able to come forward with ideas that make other people feel better. JM added that this experience, that she has a positive effect on other people, could be pointed out to her and encourage her that she is still useful to others, and she should not write herself off because she is appreciated by others as a person and not as a job.

References

Dewi Rees, W. (1971). The hallucinations of widowhood. *British Medical Journal*, *4*(5778), 37–41.

Heimann, P. (1950). On countertransference. *The International Journal of Psycho-Analysis*, *31*, 81–84.

Kernberg, O. F. (1965). Notes on countertransference. *Journal of American Psychoanalysis Assessment*, *13*, 38–56.

Olson, P. R., Suddeth, J. A., Peterson, P. J., & Egelhoff, C. (1985). Hallucinations of widowhood. *Journal of the American Geriatrics Society*, *33*(8), 543–547.

Parkes, C. M., Benjamin, B., & Fitzgerald, R. G. (1969). Broken heart: A statistical study of increased mortality among widowers. *British Medical Journal*, *1*, 740–743.

Winnicott, D. W. (1960). Countertransference. *The British Journal of Medical Psychology*, *33*, 17–21.

Wu, C., Odden, M. C., Fisher, G. G., & Stawski, R. S. (2016). Association of retirement age with mortality: A population-based longitudinal study among older adults in the USA. *Journal of Epidemiology and Community Health*, *70*(9), 917–923.