Article

Antissocial aspects in ageing

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Abstract: According to Winnicott, antisocial tendency etiology is an experience of deprivation that occurs during the fusion between instinctual and motor elements. These elements defusion impairs creative development of object relations and leads to an expression of aggression. In this scenario, the antisocial tendency is expressed by an environmental disorder, through lies, stealing, and destructivity. This article presents a clinical case of antisocial behaviors in an older person, describing the therapeutic setting for the treatment of such condition. Considering that ageing often presents with physical decadence and instinctual decline, it also discusses the association between this life period and a deprivation expressed through multiple disorders that are usually understood as signs of mere senescence but could possibly signify the expression of an antisocial tendency.

Keywords: antisocial tendency, old age, psychotherapy, Winnicott.

Introduction

What I intend to discuss in this article is whether certain behaviors accepted as part of what is seen as "mere ageing" may be seen as manifestations of what Winnicott called *antisocial tendency* (1987/2012) and, in the case it is true, which are the implications in the context of the psychotherapy care rendered to these patients. It is common to speak of the self-indulgence of the older adults, some loss of capacity for involvement, and the weakening of guilt feelings. A certain irritability, impatience, and selfishness are easily attributed to ageing, as if they were intrinsic characteristics of this phase of life. The young adults allow the older adults some rudeness, in an attitude of both reverence and contempt, extending to them the rights granted to a person with a disability. Could we gather these social perceptions toward the older adults within the concept of antisocial behavior?

There are many aspects to be considered in these behaviors, which are are attributed to age, both from the standpoint of the older adults' physical health and the social and family conditions in which they live. My intention, however, is to bring into focus those elements that belong to the psychology of older adults. To do so, I intend to use the views by D. W. Winnicott, Harris Guntrip and Leslie Tizard (1960) and Gilberto Safra (2006a, 2006b, 2006c, 2006d) on the period of maturity and inquire about the factors that might be related to the emergence of an antisocial tendency in this stage of life.

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The antissocial tendency concept

It is not hard to see that a given individual presents antisocial tendencies: there is always in their behavior some degree of lying, aggression, and breaking the rules of coexistence, and the motivations for these behaviors do not even the subject who practices them seems to understand. In Winnicott's view (1987/2002, 2012), the person with antisocial tendencies is those who – at the time when the capacity for concern is expected to be established and when the baby's ego is in the process of achieving the fusion of the libidinal (or erotic) and aggressive (or motility) roots – suffers a disruption in the care offered by the environment. This care was considered by the baby to be good enough until then. This disruption lasts long enough to overcome the ability of the infant ego to cope with it. As a result, the defenses collapse and defensive reorganization into a new model of inferior quality occurs

It is fundamental to remark that, at the moment when the deprivation occurs, the child ego already has, albeit precariously, an integration that allows the baby to perceive that the rupture in care has as its origin something external to it. The loss of hope, occurring at such a primitive time, when the individual has very limited resources to deal with it, results in a loss of the integrative processes that would lead to the capacity to worry about the other, to experience a feeling of guilt, to reach the capacity for involvement.

It is when the individuals have the (unconscious) perception that their environment is reliable and stable enough to resist their destructive impulses, and when the (unconscious) hope arises again that they can be cared for

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so as to regain the experience of the good environment that has been broken, that the antisocial behaviors manifest in all their intensity. In this sense, antisocial tendency is a defensive organization that involves hope and in which the child complains of deprivation through dissociated antisocial behaviors.

Winnicott (1989/2005) presents us with two fundamental modalities of antisocial acts. The first are those linked to the search for a creative encounter with the object, which are expressed by stealing and originated from problems in the presentation of the object, made by the mother. The second are those linked to the search for destructiveness, expressed by the creation of chaos, aggression, and rupture of the norms of coexistence – these are more linked to the father figure and affect mainly boys (or the boy inside the girl). If the original deprivation occurs at a time when there is already some fusion between the aggressive and the libidinal roots, the antisocial behaviors manifest themselves by a combination of the two modalities, both stealing and aggression. However, if deprivation occurs when there is less fusion between these two roots (aggressive and libidinal), object seeking and destructive seeking are more apart from each other, and the individual's behavior exhibits a greater degree of dissociation.

Antissocial tendency and ageing

Can we say that, in the older adult, does a progressive defusion undergoes between the libidinal and aggression roots? Well, we must recognize that ageing witnesses physical decay and the impoverishment of instinctual life. Yet, does this represent something that can be called instinctual motor defusion? And, if this occurs, could it give rise to the emergence of an antisocial tendency?

The answer to this question depends on the view one has of this stage of life. The authors I mentioned (Winnicott, Guntrip, Tizard, and Safra) see human existence not only within the biological, psychological, and cultural records, but also from a viewpoint that contemplates the ontological point of view. It means that from the original conditions inherent in human existence, which are present in the concrete events of the individual's life, but whose presence is not perceptible, because they are situated beyond the references of time and space (the representational, therefore). These issues refer to precariousness, loneliness and orphanhood, finitude and death, which are present in all human life and at every moment of it, as well as incompleteness and freedom. Safra (2006a) states that, in maturity, the individual has an appointment with the ontological questions of human existence.

According to Safra (2006a), in other stages of life, the access to the perception of the ontological axis remains veiled, forgotten by the individuals who, in their development, find themselves occupied by the needs of each moment. For the baby, constituting himself; for the child who goes to school, socializing; for the adolescent, establishing his own sexuality; for the young adult, choosing his future; for the adult, living the family, work, and sociability. In ageing, with the decline of vitality, a deconstruction of identity and of the self begins to occur, which puts the individual face to face with the ontological record.

The decrease in vigor experienced by the older adults, says Safra (2006a), requires a new positioning. Subtle changes occur, so that the reduction in physical strength and disposition can be incorporated not necessarily as a hopeless loss, but as a new way of being in the world. Sexual life no longer revolves around excitement and performance, and gives way to tenderness, to the search for a loving intimacy linked to the quieter aspects of existence. The individual's identity, built around work, around actions destined to reach certain social positions, is crumbling and giving rise to a non-identity, in which the center of gravity of life becomes the vital experience itself, and not the possible gains of social projection that may came from it. In this repositioning in the face of existence, the individual realizes what Winnicott (1975) calls "growing downwards"; says the author: "The feeling of loss in oneself can become a way of integrating experience" (p. 38). In maturity, the self is "getting small" in order to pass through the narrow hole of death. Safra (2006a) states that such a process is only possible when the older adults have the ability to make a change in existential anchoring, in which attachment to the self, attachment to identity, gives way to experiencing the self as a crossing, as a passage. In this new configuration, one obtains tolerance in relation to losses, and death itself, in the happiest conditions, can be seen as a good (Safra, 2006c).

For this new positioning in face of life be achieved, the older adult will need to count on the support of family, those who are close, and the cultural environment of the place where they live. The possibility of counting on this interlocution and on the required care is what will enable this achievement. In this sense, when we think about the place of older adults in the contemporary world, we cannot avoid pessimism. The current culture (Safra, 2006b) is made in such a way as to obstruct ontological questions from the view of the older adults. There are no references or interlocutions on which they can rely. What we find is the denial of ageing (in this sense, the Brazilian expression "better age" contains the euphemism needed to camouflage reality). The projects for the later adulthood aim at distancing the older adults from what they actually experience.

Not finding support in the people around them and in the culture to which they belong, the repositioning becomes complicated and the delicate process degrades. Losses give rise to anguish, and anguish triggers defensive

movements of sickness in which old traumas are reactivated and even current traumas can emerge (Safra, 2006a). As a reaction to the losses, to the suppressions, to the deprivations imposed by aging, the development of an antisocial tendency may occur.

Reactive suffering to deprivation, according to Winnicott (1967/2005), has the following characteristics: "By suffering, I mean a state of confusion, of disintegration of personality, an everlasting fall, a loss of contact with the body, a full disorientation" (p. 90). In the complaints of the older adults who have been disappointed by the people with whom they relied on, there is a kind of "madness" that is not really madness; they often do not understand themselves and seem to live immersed in a state of confusion and with some impairment in the integration of personality. We notice, in ageing, a loss of contact with the body, which becomes the "body that is no longer theirs". In this sense, physical dysfunctions place the body as an external object to the older adults, not integrated to the self, as something persecutory that comes from the environment, outside the ego's area of omnipotence.

The most important thing, from the Winnicottian point of view, is not so much the loss or the failure in itself of the supportive environment, but the individuals' reactions to this failure, that is, when the failure exceeds their ability to deal with the situation without compromising some part of the selves. In this sense, which older adults might develop antisocial behaviors in the face of expected deprivation for their age?

In chapter XXV of Through Pediatrics to Psychoanalysis, Winnicott (1978/2000) states, "Antisocial tendency is not a diagnosis. It does not compare directly with other diagnoses, such as neurosis and psychosis. Antisocial tendency can be found in *normal people* just as much as in neurotics or psychotics" (p. 408, emphasis mine). So any individual, depending on the severity (for them) of the disruption in their environment (or in the unity of the psychosoma), can develop antisocial behavior. However, throughout the book Deprivation and Delinquency, Winnicott (1987/2012) develops the idea that, prior to the time when the capacity for concern is established, a deprivation that the child considers significant can impair the fusion between the libidinal roots and the roots of aggression. In this sense, older adults who have experienced deprivation in this period of life and whose integrative processes have remained precarious are more likely to develop antisocial tendencies, a precariousness that possibly compensated by specific characteristics that have been organized in the life of these individuals. I am talking here about the relationship with work, marriage, family, friends, in short, the established routine, which may have played a protective and stabilizing role and that, during aging, present changes not always possible to assimilate.

Based on the notion presented by Winnicott (1975) – that the feeling of loss may have an integrating role – both possibilities for the emergence of an antisocial tendency, whether in the older adults with a history of childhood trauma or in those without this history, should be considered plausible. According to Safra (2006a), classical psychoanalysis overestimates the genesis of trauma during childhood, possibly because it occurs more often. However, to also consider the possibility of illness, even in those who have gone smoothly through childhood, is more in line with the thinking of the authors I am considering.

I stated at the beginning of this text that it was my intention to think whether certain behaviors present in the older adults, many of them seen as manifestations of mere ageing, could be seen as antisocial tendencies in the Winnicottian sense. I now make some notes to make my intend clearer here.

For understanding the case that I will present, it will be of interest to think about the relationship between the concept of antisocial tendency and the theme of transicionality. In a certain passage of the article "Transitional Objects and Transitional Phenomena", in which Winnicott (1975) refers to the fate of the transitional object, he states:

> At this point my subject widens out into that of play, and of artistic creativity and appreciation, and of religious feeling, and of dreaming, and also of fetishism, *lying and stealing*, the origin and loss of affectionate feeling, *drug addiction*, the talisman of obsessional rituals etc. (p. 19, emphasis added).

In the same article, Winnicott talks about how the child's way of dealing with separation (deprivation) can influence the transitional phenomena and reports the "string case" (p. 31). In this case, a boy overuses a transitional object (strings) as part of the denial of the threat of separation from his mother (who had in fact been distant from him on some occasions and for periods of time that he could not bear). This boy's situation evolved into a perversion and drug addiction. The recourse to the exaggerated use of an object, in its non-symbolic concreteness (which implies the loss of the transitional character of this object), seems to be a very common defensive strategy in the face of deprivation or threat and very present in conditions involving the development of antisocial behavior. There is, in this sense, very commonly, a psychopathology that manifests itself in the area of transitional phenomena.

The psychotherapy context that should be offered to these patients goes beyond the limits of the traditionally setting proposed for the treatment of neurotic patients. Winnicott called placement (1984/2000) this expanded therapeutic space in which intersubjective experience

is more important than transference interpretation and the experiential is more important than symbolization. This type of setting will be called here *therapeutic management.*

In "Delinquency as a sign of hope", the title of the aforementioned article, Winnicott makes a distinction between delinquency and antisocial tendency: delinquency would be an unfavorable development of the antisocial tendency, that is, it designates the moment when hope has already declined and the individual has become attached to the secondary benefits arising from the antisocial practice. What I am bringing to the discussion in this article refers only to antisocial tendency in the older adults, although often some of these manifestations can be impactful.

I do not think that any unpleasant behavior in the older adults deserves to be called antisocial. When, however, the behavior arises in a context in which hope has been awakened in the older adult; when, in some way, the upsetting situation created by the older adult brings up the losses suffered and the search for support in the environment (whose failure gave rise to a certain defensive organization), then yes, I think the denomination is justified.

In relation to the use of psychoanalysis in older adults, it is common to hear that little can be expected in terms of transformation, that defenses have hardened and that, most of the time, treatment translates into mostly welcoming listening. I agree that this kind of therapeutic attitude is positive, and I believe that to actually offer listening to older adults is not something simple or trivial, and that such a procedure can indeed produce some positive results for them. However, my intention here is to draw attention to numerous situations caused by older adults and that can be better addressed by the technique here called therapeutic management.

Clinical case report

V., a patient I see exclusively as a psychiatrist, asked me if I could also see her mother, W. She explained to me that in the last semester, W. had had some episodes of severe alcohol abuse and that in the last one, which occurred about ten days before, the situation had gotten so out of control that the family, who were at a dinner party, was forced to call an ambulance. V's mother was taken to an emergency room, where she was placed under mechanical restraint until her behavior was reasonable again (it was feared that she might injure herself amidst her furious agitation). During the episode, W. gave the impression that she was not conscious and uttered severe curses against her family members, the contents of which were not reported to me.

I asked V. if it would not be better if a psychiatrist who did not know anyone in the family rendered care to her mother. My patient explained that this was not her request, but a request her mother made to accept the treatment. It is worth mentioning that until then I had no contact with W., who was not even brought up as a subject in the consultations. I had limited myself to the role of psychiatrist for V., who had obtained a good response with the use of medication for depression. Our appointments took place at intervals of about a month and a half. There was, it seemed, a manipulative intent in this condition imposed by my patient's mother; however, I accepted the case: I would meet her for a first appointment and better evaluate the sort of demand that was being presented to me. I recorded to myself that I had been hooked by curiosity, which meant that I had been effectively seduced.

In this first appointment, V. came with her mother. She said that her mother asked her to participate in the consultation to report her last drunken episode, since she could not remember anything about it. Besides the account of what happened, which added little to what was already known, V. made some remarks about her mother. She said that saw her mother as a strong and hardworking woman who raised her children virtually on her own (V.'s father had moved away from the family and moved with another woman in a distant state, no longer contributing both materially and affectively). She also said that her mother, about three years ago, had been forced to close her shop and had come to depend on the help of her children to survive. This situation, in her opinion, had prematurely cast her mother into a condition of ageing and dependence that did not correspond to the vitality she still witnessed in her.

Once she finished her participation, I asked V. to leave; I wanted to hear W. express herself without interlocution. There were indeed no signs of dementia in this lady. Her eyes contained something mischievous and melancholy, in strange proportions. I learned that when she was eight years old, an older child in the family, intending to hurt her during an argument, threw in her face that W. was an adopted daughter. The parents, a Lebanese couple, confirmed this, they said that they were going to tell her and had not yet done so because they were waiting for the girl to grow older a little more.

W. says that she had always felt uncomfortable comparing the age of her friends' parents with her own, who were noticeably older. She also reports that they were very loving and cared for her, their only child, in a very devoted way. The adoption occurred when she was one year old and in an orphanage. Her adoptive parents, already deceased at the time of our consultations, gave no information about her biological parents due to W.'s lack of interest in the subject. At first, the surprising revelation brought no noticeable modifications in her habitual behavior; in her adolescence, however, she went through a period of some years of alcoholic excesses and sporadic consumption of other drugs. Why she acted this way, she cannot say, just as she does not know now why

she is back acting the same way, "*I felt a desire to get away from reality and would drink as fast as possible*".

The abuse ceased shortly before W. became an adult. She also could not say why it stopped. She married a man of her own choice, unsure if she loved him, but she adapted well to the daily life of wife, mother, and small vendor of clothing. She had three children: two women (the youngest is V., my patient) and one man. When W. was 36 years old, her husband left and went to live in Pernambuco with another woman. There he started another family, becoming distant from the first from every point of view. W. did not give in to despair; on the contrary, she worked very successfully to improve the financial condition of her family and managed to provide her children with a comfortable life through her clothing business and to make the necessary investment for them to properly finish their studies adequately. The eldest daughter graduated as an architect, got married, and moved to Rio de Janeiro with her husband; the middle son opened an import company, prospered, and moved with his family to Miami; the youngest, my patient, did not want to go to university and is her husband's partner in a diner.

W. says that, with her children already grown, business began to go less smoothly. Changes in the market caused her business to go bankrupt; the money that had been saved was being used up, and W. had to watch, surprised and helpless, as her resources dwindled away, until she had to depend on an apportionment among her children to survive.

All this was reported spontaneously in this first meeting and developed in its details in subsequent weekly meetings, which were agreed upon in the first session. About her request that I be the therapist, W. said little, only that she thought she would prefer to be treated by someone who was already trusted by her daughter. It was also agreed that there would be a family meeting every two or three weeks, or when everyone was in São Paulo (her other two children lived out of town). Our arrangements, however, were constantly changed by events: the alcohol abuses would become even more frequent after the treatment started. Before, they used to occur at family gatherings or on dates close to them; now they started to occur when she was alone in her apartment, and family members were warned of what was happening by neighbors, due to the disturbances her behavior caused.

The individual sessions did not happen as regularly as would be desirable, at least for me. At the last minute they were rescheduled, sometimes the new appointment was also rescheduled, cancellations occurred due to all sorts of mishaps or even without explanation or prior communication. On the other hand, due to the constant intercurrences, unscheduled sessions were held with whoever was available. The climate of the meetings became hotter. On the part of the family, the understanding attitude was giving way to hostile nonconformity. Everything was said, W.'s frustrating existential condition was recognized, but it wasn't clear what the family members should do to make her happy. The children claimed to be victims, declaring that their mother wanted to take her misfortunes out on them. W. acknowledged that they were not to blame for anything, that they were good children, but that she felt useless and disposable. She assured them, with vehement appeals, that she did not want to cause any trouble and that she did not know why she was having those episodes: they "*just happened*" without her being able to control them.

The expanded setting in which the clinical management was constituted contained manifestations of anger, triggered by discrete and non-specific stimuli, (barely conscious) pleas for care, repudiation of the condition of dependence, and a (unconscious), paradoxically, dependent attitude. The elements of conflict never reached a synthesis in W.: she had no integration to coexist in her psychic reality with all these aspects. The continuous friction between these elements ended up producing more and more serious expressions, until a more serious incident happened: W., intoxicated, she fell and fractured her forearm. In the accident, she also suffered significant abrasions on her face. At the family meeting, it was decided that W. would undergo psychiatric hospitalization and that, when she was discharged, she would have therapeutic follow-up. And so it was: now W. could live her dependency in a deeper way.

A great deal of the therapeutic management time was spent trying to keep everyone informed of each other's efforts and to keep our actions moving in one direction. Then, in my interpersonal encounters with W., the conflict was being outlined, for the both of us, as follows: there was a feeling of helplessness and a search for shelter that expressed itself in the form of a resentment toward her children, although she did not find them guilty of anything. On the other hand, W. was horrified at the idea of depending on someone, felt repulse for the most tender feelings, and declared that, paradoxically, the best phase of her life was the one that followed her husband's abandonment and in which she had to fend for herself.

This was the most we could manage: for W., it was unbearable to maintain a conflict within her psyche. Her attitudes were very incoherent and thoughtless. The alcohol abuse, which did not completely cease, but diminished appreciably with the new therapeutic arrangement, was never satisfactorily elaborated; I would even say never thought through as one would expect. Thinking was a painful thing, the medium was supposed to think for her, and she, of course, would refuse whatever came from outside.

The new arrangement consisted, in addition to weekly appointments with me, of hiring caregivers capable of offering psychological support, weekly visits by a therapeutic companion, and meetings every two or

three weeks with the participation of all those involved in the treatment. These meetings were very fruitful, as they provided W. with the possibility of meeting from the viewpoint of each of the participants in relation to her. The compulsive drinking, which sometimes caused her to lose consciousness, became rarer, but new antisocial modalities were emerging, with a new character and acts that aroused concern. At the same time, timid indications of an authentic gesture for autonomy were emerging. For example, she appropriated the money, which was now controlled according to what was agreed in the meetings, and disappeared without the caregivers even noticing it. Most of the time she used the money to buy a piece of clothing or an appliance that her household really needed. At other times, however, she perpetrated the substance abuse with all its dramatic ingredients.

For nearly two years, the treatment followed this pattern, to the deep and growing dissatisfaction of the family members, particularly the son, who came to question whether everything the mother wanted was not just a means of manipulating the family in the crudest way to become the center of everyone's attention. At one point, an event turned out to be very important symbolically by the reaction it triggered and the outcome it had. W. had exceeded the points for traffic offenses on her driver's license, and a consensus was formed that she should suffer the consequences of her negligent driving, and that no solution outside the strict terms of the law would be sought. The atmosphere at the meetings became more and more tense, and the indulgent attitude toward W. gave way more and more to the anger that the impotent efforts provoked. For a while, by that time, the therapeutic companion had been trying to convince me that I should request the conservatorship of W. He claimed that this would create a better condition for treatment; the two daughters also shared the same point of view. I, however, was not convinced of this for the simple fact that W. did not present the psychic limitations that configure the need for this instrument.

Back to the event that represented a turning point in the treatment: in one of the general meetings, one of the caregivers brought the information that W. had started driving again, and W. not only confirmed the fact but also added that she had "bought" a driver's license illegally. This made the water overflow that had already been dangerously accumulating. The very emphatic disapproval was general: on one side, the two daughters expressed their intention to put her under conservatorship, asking for the support of the others; on the other side was the son, not always present in the meetings because he lives in another country, but this time he was there and announced his withdrawal from that care network. He would keep his financial obligations, which he thought were fair, but he had grown tired of his mother's inconsequential behavior. W., in turn, doubled down, it was not her son, or anyone else who was giving up, it was she who was throwing away the care she had been receiving. In a very aggressive and indignant way, she said that she did not want to be "picked on" by anyone anymore, that she would no longer accept the caregivers and all the limitations they had been imposing on her, and that she knew how to take care of herself. She once again remembered the years in which she supported everyone with her work, said she was fed up with everything that had been done to help her, and said that from now on she would conduct herself according to what she thought was most appropriate. There was much discussion and mutual accusations, but nothing reasonable was reached at the meeting; the daughters ended up following the son and said they were very tired of all the investment that had been made and frustrated with their mother's behavior. This was it: without any need for verbalization, it was understood that things would run loose until a new fact indicated the need for that group to meet again.

About three months went by and I had no news of how things were going. W. then contacted me to make an appointment. She reappeared looking well, although complaining of depressive symptoms. Medicated, she got a good improvement and said she was satisfied. For about two and a half years, she has been coming for appointments every 40 to 50 days. Her relationship with her children has gradually normalized. V. has also resumed her appointments and confirmed that the tribulations calmed down. When I asked W. if she had been drinking, she answered no, that she no longer felt those impulses that led her to abuse. During consultations, W. and I talk freely, as if we were two old friends. What finally made her stop drinking? She claims she does not know.

Comments

Although the case exposed did not lead to a fully satisfactory outcome (although, in my opinion, the therapeutic management was what allowed the conflict to be lived by the patient, thanks to the support offered by her surroundings), I believe that, in the context of this article, some relevant aspects emerge.

I highlight a few points for discussion.

The first is the condition of W.'s life before the adoption, which is entirely unknown. The patient or her children reveal no data prior to the adoption, and no one is in a position to provide information. Much can be conjectured, but the gloom remains very thick. That W. was exposed in the past to severe rejection is certain, but the degree to which this rejection reached her is unknown. Can one speak of an early deprivation? I do not think so; despite the little information, it seems more appropriate to think of deprivation. In early life, despite what may have occurred, a certain degree of integration was achieved by W., removing the risk of a psychotic functioning. We must keep in mind that the

perception that my patient arouses in everyone around her is that of a normal person who had a reasonably successful life trajectory.

At three points in time, the problem of rejection affected W.'s life: when it was revealed to her that she was an adopted daughter, when her husband abandoned her, and when she became dependent on her children. During her adolescence, she had psychological care and everything seemed to be left behind, as she became an adult, got married, had children, and a good relationship with work. The rejection of her husband revealed that her relationship with him was less important than her relationship with her children and her work. The way she dealt with the situation seemed to have strengthened her.

Another aspect to consider is the understanding of W's object relations. When the feeling of rejection dominated the scene, the impulse to drink until consciousness was abolished arose. Here we have a person, her relationship with an object, and alienation as a result of this interaction. The object liquor has no symbolic value, does not lead to the creative illusion, nor does it place W. in becoming in relation to other objects (note the loss of the transitional character of this object). We see here the exaggerated use of an object in the face of loneliness and the feeling of rejection. With the use of the liquor, my patient managed to keep in dissociation everything related to the first year of her life – rejection could not be thought of, could not be taken as intrapsychic conflict. W. cannot get depressed, an integration of the rejection she suffered in the first year of her life with the fragile partial unity she achieved after the adoption is too threatening, and this is where the use of liquor comes in, short-circuiting and maintaining the dissociation.

The risks inherent to integration, which analytic work could conjure up, were always present for me, and the work with W. should not privilege the intra-psychic space, but rather the expanded inter-relational field. The destructive and even deadly feeling of rejection could be experienced in the concrete reality provided by the therapeutic management. The horror of accepting a relationship of dependence could be experienced in a dispersed way with me, with the caregivers, with the therapeutic companion, and with their children. The use of aggression and the search for personal destructiveness were enabled by the nurturing relationship provided by this set of relationships. Repudiation also took place, finding its highest expression when she undid her commitment to the therapeutic arrangement, of which she had already made the use she needed.

Something I tried to highlight – and I am not sure I did it enough – was a certain change of nature in the antisocial acts perpetrated by W. Whereas before they were purely destructive and alienating, as time went by they acquired a broader sense that also pointed to something constructive and in the direction of independence. The "stolen money" was sometimes spent just to get W. drunk, but other times it was used to buy appliances and clothes that my patient really needed. Bribery to get a driver's license was a misdemeanor, but it was also a desire for autonomy. The family members, who did not appreciate them when I brought them to their attention, did not always notice these changes.

Another element that, in my opinion, had a decisive influence on the course of events was the fact that, during the treatment, W. saw herself as an older adult and adjusted to this new identity. With the bankruptcy of her clothing business, my patient could have gone on to another venture, but she felt that she no longer had the youthful strength to go for it. The weight of age came along with the condition of financial dependence on her children. W. felt rejected by her family, an unwanted weight that her children had to carry. The grandchildren grew up and developed their own interests, among which visiting their grandmother was not in the foreground. W. felt helplessness, loneliness, and a lack of existential purpose: the privations she had suffered on various planes could not be lived within a depressive episode (as would have been healthier) because of the threat that an integrative movement would bring to the fragile unity she had achieved.

The losses caused by aging brought back to W. the original rejection he had suffered; in this sense, the antisocial tendency emerges as a cry for help. Nevertheless, due to the good quality of her supportive environment and the therapeutic management offered, W. was able to make the gesture that Winnicott calls "growing downwards" and overcome the equivalence between abandoned child and abandoned older adult woman. The disturbance caused in her surroundings, the antisocial acts that were somehow welcomed by her family members (who at no time gave the impression that they would succumb to the attacks), the possibility of experiencing these on a concrete level produced, it seems, a new accommodation in her internal reality. Thus, now W. seems to live the vulgar rejection to which all older adults are subjected by society. With the assumption of ageing, W. has been able to accomplish the integration that is possible at this time of life, that is, to assimilate the losses, and start living within this new reality. I want to believe that, in this new meeting in which losses are acknowledged, W. will be able to live his condition of incompleteness within the referential of culture, sharing his condition with millions of other people in the same situation. The impossibility of enduring contact with rejection linked to the first year of life, caused by the horror that such contact would arouse, has to do with the fact that there was no one there, no human face that would even offer itself to be feared, hated, and repudiated.

Final considerations

In this article, based on the discussion of a clinical case, I tried to draw attention to the possibility of establishing a diagnostic distinction between what can be perceived as a manifestation of what I called mere ageing and the emergence of an antisocial tendency in maturity. The views of some authors regarding this period of life called maturity and the Winnicottian concept of antisocial tendency were brought to the discussion. In addition, bearing a critical importance in the material presented are the changes in the therapeutic approach needed to deal with older people with this type of problem. These include the role of the environment as a protective cover (insertion of the therapeutic companion – placement – and intervention in the family) and psychotherapy care with expanded setting to cope with the demand.

Aspectos antissociais na velhice

Resumos: Segundo Winnicott, a tendência antissocial tem por etiologia uma deprivação que ocorre quando está se dando a fusão entre os elementos instintuais e motores. A desfusão desses elementos resulta num prejuízo no desenvolvimento criativo das relações objetais e na expressão da agressividade. A tendência antissocial se manifesta através de um transtorno no ambiente, por meio da mentira, do roubo e da destrutividade. Neste artigo, apresento um caso clínico em que surgiram comportamentos antissociais numa pessoa idosa e como se constituiu o *setting* terapêutico para seu tratamento. Por fim, o texto discute se a etapa da vida que se conhece por velhice, por se apresentar amiúde com decadência física e declínio instintual, não causaria nos indivíduos uma deprivação que se expressaria por meio de múltiplos transtornos, normalmente percebidos como manifestações da mera velhice e que, na verdade, poderiam ser mais bem entendidos como expressão de uma tendência antissocial.

Palavras-chave: tendência antissocial, velhice, psicoterapia, Winnicott.

Les aspects anti-sociaux de la vieillesse

Résumé : Selon Winnicott, la tendance antisociale résulte d'une privation qui se produit au moment où s'opère la fusion entre les éléments instinctuels et moteurs. La défusion de ces éléments entraîne une perte dans le développement créatif des relations objectales et dans l'expression de l'agressivité. La tendance antisociale se manifeste par une perturbation de l'environnement, par le mensonge, le vol et la destruction. Cet article présente un cas clinique dans lequel des comportements antisociaux se sont apparu chez une personne âgée et comment s'est constitué le cadre thérapeutique de son traitement. Enfin, le texte propose une réflexion : cette étape de la vie, que l'on nomme vieillesse et qui se présente souvent comme une déchéance physique et un déclin instinctif, ne provoquerait-elle chez les individus une déprivation qui s'exprimerait par de multiples troubles, normalement perçus comme des manifestations de la simple vieillesse mais qui, en fait, pourraient être mieux compris comme l'expression d'une tendance antisociale ?

Mots-clés : tendance antisociale, vieillesse, psychothérapie, Winnicott.

Aspectos antisociales en la vejez

Resumen: Según Winnicott, la tendencia antisocial tiene por etiología una deprivación, que ocurre cuando los elementos instintuales y motores se están fusionando. La escisión entre estos elementos tiene como resultado un perjuicio en el desarrollo creativo de las relaciones objetales y la expresión de agresividad. La tendencia antisocial se manifiesta como una perturbación en el entorno mediante la mentira, el robo y la destructividad. En este artículo se presenta un caso clínico en el que surgieron comportamientos antisociales en una persona mayor y cómo se constituyó el setting terapéutico. Por último, se discute si la etapa de la vida conocida como vejez, por su decadencia física y el deterioro instintual en general, no les causaría a los individuos una deprivación, la cual se expresaría en múltiples desórdenes de la vejez que podrían entenderse como la expresión de una tendencia antisocial.

Palabras clave: tendencia antisocial, vejez, psicoterapia, Winnicott.

References

Khan, M. M. R. (1991). *Quando a primavera chegar: despertares em psicanálise clínica* (C. S. Bacchi, Trans.). São Paulo, SP: Escuta.

Safra, G. (2006a). *Tarefas ontológicas da maturidade: em busca do eixo axial*. São Paulo, SP: Sobornost.

Safra, G. (2006b). *Maturidade em face da cultura*. São Paulo, SP: Sobornost.

Safra, G. (2006c). *Maturidade e morte*. São Paulo, SP: Sobornost.

Safra, G. (2006d). *Maturidade: dramas e possibilidades*. São Paulo, SP: Sobornost.

Tizard, L. J., & Guntrip, H. J. B. (1960). *The middle age*. London: George Allen And Unwin.

Winnicott, D. W. (1975). *O brincar e a realidade* (J. O. A. Abreu & V. Nobre, Trans.). Rio de Janeiro, RJ: Imago.

Winnicott, D. W. (2000). *Da pediatria à psicanálise: obras escolhidas* (D. Bogomoletz, Trans.). Rio de Janeiro, RJ: Imago. (Original work published on 1978)

Winnicott, D. W. (2000). Residential management as treatment for difficult children. In *Deprivation and delinquency* (pp. 54-72). New York: Routledge. (Original work published on 1984)

Winnicott, D. W. (2012). *Privação e delinquência* (A. Cabral, Trans., 3rd ed.). São Paulo, SP: Martins Fontes. (Orignal work published on 1987)

Winnicott, D. W. (2005). *Tudo começa em casa* (P. Sandler, Trans., 4th ed.). São Paulo, SP: Martins Fontes. (Original work published on 1989)

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