CHAPTER 4

Individual psychotherapy

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> "Experience has taught me that the complexity of the fully grown personality can only be understood if we gain insight into the mind of the baby and follow up its development into later life. That is to say, analysis makes its way from adulthood to infancy, and through intermediate stages back to adulthood, in a recurrent to-and-fro movement according to the prevalent transference situation."
>
> Melanie Klein, "Envy and Gratitude" (1957, p. 178)

or to put it another way:

FATHOMS
Young I visited
this pool; asked my question,
passed on. In the middle years
visited it again. The question
had sunk down, hardly
a ripple. To be no longer
young, yet not to be old
is a calm without
equal. The water ticks on,
but time stands, fingerless.

Today, thirty years
later, on the margin
of eternity, dissolution,
nothing but the self
looking up at the self
looking down, with each
refusing to become
an object, so with the Dane's
help, from bottomless fathoms
I dredge up the truth.

R. S. Thomas, "No Truce with the Furies" (1995, p. 10)

One of the leading themes in working with people who are older is the weighting of external realities in old age such as illness, accumulation of loss, traumatic history, sheer life experience, and so on. It is impossible to get away from the facticity of age—there really is a concrete representation of loss in the older person who has experienced the actual deaths of many others. Freud, in his early paper "On Psychotherapy" (1905a) thought that the sheer accumulation of lifespan material contraindicated analysis as a therapeutic method in old age. He, of course, disproved his own point of view by continuing to develop his own thinking and writing about his ideas right up to the end of his life. Freud's own theory of mind, along with contemporary psychoanalytic thinking, emphasize the need to free oneself from the, at times, overwhelming amount of external reality that can enter into a patient's session in order to be able to function in role as a therapist, where the work task is to understand, interpret, and think about the patient's psychic reality. The psychoanalyst Wilfred Bion thought that when working with so much reality, it was important for the analyst or psychoanalytic psychotherapist to extricate him/herself or there can be pressure to become something other than the analyst. This is one of the most difficult areas in the countertransference response. Readers may identify from their own experience in working with a particular patient the pull to respond as a social worker or daughter or son or mother and start to operate outside the transference. Of course, it is important for the therapist to be open to the patient's transference and temporarily step into whatever pair of shoes the patient requires the therapist to fit into at a particular point in the session—that is the basis for empathy on which normal projective identification rests. The problem arises if the therapist cannot step back out of the patient's

shoes and into his or her own, at which point the patient has lost her or his therapist.

Areas personal to the therapist may affect the countertransference response.

Many clinicians, as they start to work in a therapeutic capacity with people much older than themselves, may still be facing issues in connection with separation from their own family of origin. The "sandwich effect" of simultaneously having and taking care of young children while taking care of a career outside the home may well coincide with parents becoming more frail and dependent . While this is very common, it is worth taking account of in terms of the peculiarly vulnerable set of internal and external circumstances that clinicians themselves may need to notice and be aware of.

> For example, a therapist described in supervision her feelings of panic after hearing from the wife of a 70-year-old man she was seeing for once-weekly psychotherapy that her patient had been taken into hospital following a minor illness. The patient had stabilized well and would be discharged over the following few days. The therapist found herself offering advice to the patient's wife on the phone and then immediately went to visit the patient in hospital. She was perplexed by her own behaviour and degree of upset, but in supervision she realized that while there was inevitably some anxiety in relationship to the patient, her leading anxiety that had driven her into action was actually in connection to her own father who had become ill very suddenly and died in hospital some months previously.

Caper (1999) draws attention to the internal constellation of the clinician regarding the relationship the therapist has with her or his own internal objects. Understanding more about what belongs to the therapist and developing a capacity to differentiate this from what belongs to the patient is a core part within the NHS of specialist training in psychoanalytic psychotherapy, which includes at its heart the experience of a personal analysis or psychotherapy.

The search for psychic truth is part of what makes us human, and one aim of psychoanalytic psychotherapy is to allow the individual to reclaim disowned aspects of their personality through understanding. One way in which this understanding comes about is through enactments in the relationship between therapist and patient in the treatment process itself, which allows for an unconscious repetition of

past and present forms of relating to external figures such as parents in the past, as well as to partners and colleagues in the present, and so forth, but also to internal figures. Freud thought that the past had to be approached a little like an archaeological dig—if you kept going through the layers, an accurate reconstruction of memory and history would eventually come about. However, current psychoanalytic thinking would suggest that the past is not a series of facts from much earlier times, but something that is alive and well in the present and can be experienced directly through the therapeutic relationship, so that "in psychoanalytic treatment we can observe the psychic structures that keep the past in the present—we don't just construct the past, we construct internal object relationships in the present" (Feldman, in press).

Unlike classical psychoanalysis, where an individual attends sessions four or five times a week over a number of years, the basic framework for psychoanalytic psychotherapy in the public sector is much briefer. It may include an extended consultation of two to four sessions; brief psychodynamic psychotherapy, which is usually twelve to sixteen sessions; individual once-weekly psychotherapy of usually about one to two years' duration; intermittent open-ended treatment on a fortnightly or monthly basis; and psychoanalytic group psychotherapy, which may be time-limited (usually one to three years), or more open-ended if the therapist is running a slow/open group. It is important before treatment begins for the therapist to be clear in his or her own mind what the treatment frame is and to communicate this clearly to the patient.

In terms of formal psychoanalytic psychotherapy, it is important to establish a secure frame that will contain both the therapist and the patient. Quinodoz (1992) points out that this basic frame

> helps to bring out the three-dimensionality of the analyst–patient relationship: I am thinking of everything a violation of the setting, or any need to make an exception to the rule, can reveal about a patient's psychical mechanisms. Now in order for a setting to be violated, there must first be a setting; and to make an exception to the rule, there must first be a rule.

Within the secure containment of an agreed setting, the relationship between patient and therapist can begin to unfold. At the very least, the setting—as a representation of the clinician's state of mind—needs to be a neutral space, protected as far as possible from outside distraction, in which patients feels free to bring their thoughts and the therapist is open to whatever the patients brings into the session. In terms

of the therapist's state of mind, Klein (unpublished lecture) described the analytic attitude as one in which:

> Our whole interest is focussed on one aim, namely, on the exploration of the mind of this one person who for the time being has become the centre of our attention. . . . If we are not bent on labelling our patients as such and such a type, or wondering prematurely about the structure of the case, if we are not guided in our approach to him by a preconceived plan—trying to evoke such and such a response from him—then, and only then, are we ready to learn step by step everything about the patient from himself. . . . This rather curious state of mind, eager and at the same time patient, detached from the subject and at the same time fully absorbed in it, is clearly the result of a balance between different and partly conflicting tendencies and psychological drives, and of a good co-operation between several different parts of our minds. . . . Our critical faculties undoubtedly remain active all along, but they have, as it were, retreated into the background to leave the way for our unconscious to get into touch with the unconscious of the patient . . . fruitful analytic work . . . will only be effective if it is coupled with a really good attitude towards the patient as a person. By this I do not mean merely friendly human feelings and a benevolent attitude towards people, but in addition to this, something of the nature of a deep and true respect for the workings of the human mind, and the human personality in general. [Klein, 1936]

Problems of abnormal or failed mourning are very common in many of the people who are older referred for assessment and treatment to old age and psychological therapy services. While Freud thought that it was impossible to contemplate one's own death, Klein asserted that the fear of death was present in the unconscious from the beginning in terms of primitive fears of annihilation. The psychoanalyst Hanna Segal wrote the first detailed published account of a psychoanalysis with an older person in her classic 1958 paper "Fear of Death: Notes on the Analysis of an Old Man", and she suggested that many people in later life come for help because they are unable to face the death of others or the prospect of their own death. This mirrors very early difficulties in facing ambivalence with regard to loss and separation in early childhood, and therapists often raise anxieties with regard to ending treatment with a patient who is older.

Time is a crucial concept in thinking about old age, where a key representation of time is death. Bell (2006) noted that it is far more common to locate persecuting rather than peaceful fantasies in our representation of time, while Birksted-Breen (2003) sees that "time as

non-repetition is particularly hated because it is immutable, inevitable and leading to loss and death". She pointed out that the therapeutic setting is a representation of time, with a beginning, middle, and end to each session, and finite reality being confirmed with the eventual ending of the treatment itself. The therapist is the "guardian of time", and the fact of time in the therapeutic encounter is what Birksted-Breen calls "the third element", which stops the "folie à deux" in terms of the illusion of treatment going on in some infinite way. She links this to the oedipal situation, in which "With the toleration of the oedipal situation and of the depressive situation, time can 'elongate'. Memories replace 'reminiscences'; thought replaces action; The past can be faced, accepted as past and distinguished from the present. Equally the present can be lived in the present as distinguished from an idealised or persecutory future" (p. 1507). In order for this to take place, the dead person has to be relinquished through mourning in order for the individual to find and strengthen her or his own internal capacities. This is a very different process from identifying with the dead person (lost object) as a way of hanging onto that person, which forms the basis for many of the cases of failed mourning seen within old age services or in older adults seeking out analysis in later life.

Clinical illustration: Mr E

Mr E was a man in his late sixties who was referred for help with his depression following the death of his wife, who had been killed in a traffic accident while they were on holiday four years previously. He was immaculately presented, to the degree, he said, that his doctor had once joked with him about it and enquired whether his house was as tidy as he seemed to be. In talking with him, he described in detail the circumstances surrounding his wife's death as though it were yesterday. This, of course, is a very clear feature in trauma and conveyed immediately to me a sense of timelessness that rendered him unable to move on at any level. He survived but felt he was no longer living his life. This was true, as he was identified with an object that he felt he had to keep hold of in a particular way in his mind, which ultimately evaded the painful work of mourning. During the course of brief treatment, Mr E brought the following dream:

He was standing inside a large impersonal room, a bit like a terminal. At one end of the room was a large, glass window, which made up the wall.

Outside he could see nothing other than a red ether. He thought that it looked a bit like a Rothko painting. A figure emerged from the ether, slightly shapeless at first, like a genie emerging from a lamp, and somehow seeped through the glass into the lounge area. He knew the figure was going to land somewhere and that its name was "Guilt". The patient stood frozen to the spot and the figure went into his wife standing next to him, who curled up like an old shrivelled foetus. He knew she was dead.

In his associations to the dream, Mr E thought that it was guilt that would kill him and that if only the figure had gone into him, then it would be he who would have died, not his wife.

Mr E had been married for forty years, and his dream vividly brought in the guilt of the survivor—after such a long marriage, following his wife's death he felt unable to live with the guilt of carrying on living, and he continued to deny himself the possibility of new relationships or experiences. Guilt can take different forms, both depressive and persecutory, and it is possible to see in this example the way in which Mr E was consumed with persecutory guilt, which left him in a state of terrible isolation.

Limits and possibilities in an individual psychotherapy: trauma, remembrance, and reparation

In his book *The Emigrants* (1996), W. B. Sebald described his discussion with his factional character, the artist Max Ferber, who moved to Manchester from Germany in 1942. In their conversation, Ferber described the way in which:

> It grew steadily harder for me to write my letters home or to read the letters that arrived from home every fortnight. The correspondence became more of a chore, and when the letters stopped coming, in November, 1941, I was relieved at first, in a way that now strikes me as quite terrible. Only gradually did it dawn on me that I would never again be able to write home; in fact, to tell the truth, I do not know if I have really grasped it to this day. But it now seems to me that the course of my life, down to the tiniest detail, was ordained not only by the deportation of my parents but also by the delay with which the news of their death reached me, news I could not believe at first and the meaning of which only sank in by degrees. Naturally, I took steps, consciously or unconsciously, to keep at bay thoughts of my parents' suffering and of my own misfortune, and no doubt I succeeded sometimes in maintaining a certain equability by my

> self-imposed seclusion; but the fact is that that tragedy in my youth struck such deep roots within me that it later shot up again, put forth evil flowers, and spread the poisonous canopy over me which has kept me so much in the shade and dark in recent years.

Ferber then gives Sebald a brown-paper package containing his mother's memoirs. These were written between 1939 and 1941 and showed, said Ferber,

> that obtaining a visa had become increasingly difficult and that the plans his father had made for their emigration had necessarily become more complex with every week that passed—and, as his mother had clearly understood, impossible to carry out. Mother wrote not a word about the events of the moment, said Ferber, apart from the odd oblique glance at the hopeless situation she and Father were in; instead, with a passion that was beyond his understanding, she wrote of her childhood. . . . In the time that had passed since they were written, said Ferber, he had read the memories his mother had committed to paper only twice. The first time, after he had received the package, he had skimmed over them. The second time he had read them meticulously, many years later. On that second occasion, the memoirs, which at points were truly wonderful, had seemed to him like one of those evil German fairy tales in which, once you are under the spell, you have to carry on to the finish, till your heart breaks, with whatever work you have begun—in this case, the remembering, writing and reading. That is why I would rather you took this package, Ferber said, and saw me out to the yard, where he walked with me as far as the almond tree. [pp. 190–193]

I want to describe something of my experience with a patient who came from a not dissimilar background to Max Ferber and part of "the package" that I think he needed to hand to me in a very particular way in the early part of the treatment. The issue of survival and its impact on the individual and those around the person, including, in this case, me as the therapist, are explored in the following account of once-weekly psychotherapy over a one-year period with Mr F:

Background

Mr F was an 80-year-old man referred to the clinic by his GP. The practice counsellor had seen him briefly for difficulties arising when his much younger wife had left Mr F with their three children, the youngest of whom was in his late teens and still living at home. The counsellor had been concerned at the degree of anger and distress

voiced repeatedly in the family sessions with Mr F's repeated query, "Who will look after me as I get older?" At the point he sought help, he was clinically depressed, finding it difficult to sleep at night, with early morning wakening, uncontrollable bouts of weeping, and various reported difficulties with memory loss. Mr F moved himself day after day into the waiting-room of his GP practice or onto the bench outside the GP's surgery. He felt he now had no buffer to deal with so much of the past that still invaded his present and impacted on those around him—particularly his children. When I first saw him, his nights were spent in an agitated, sleepless state in which he felt tormented by his wife's departure, was emotionally labile, and wept constantly. The GP conveyed a sense of helplessness and irritation with Mr F, who insisted on talking to him every time he left the surgery. The GP had suggested repeatedly that his 80-year-old patient be seen within the old age services, and Mr F had repeatedly refused, only accepting a referral to the Tavistock because it was to an outpatient adult psychotherapy service.

Mr F was born in Eastern Europe to a prosperous Jewish family. His brothers and sisters had been born at different points before, during, and after the First World War, with father away in the army throughout most of the war. Mr F described to me his escape from his country of origin, telling me that his father had arranged for him to work his passage on a ship that eventually arrived in England. Mr F ended up in Manchester and was then, because of his country of origin, immediately interned as an "enemy alien" for the duration of the war. At the end of the war he learned that both his parents had perished in a concentration camp. Mr F quickly built up a successful business and went on to marry three times. On each occasion, he married women literally half his own age, and it seemed, as he spoke, that his wives and the children they bore him contained his projected youth, through which he felt secure that his world could continue indefinitely.

The shattering of this perspective came in three ways. First, upon his retirement; second, when his wife left him to live with a man her own age; and third, his fear of the loss of his youngest son, who would soon be leaving home. Mr F said that while he knew his youngest son's leaving home eventually was natural and inevitable, he was afraid that he would respond in some catastrophic way in terms of some unbearable constellation of pressures in himself being triggered off, connected to his own unnatural and precipitate leaving of his own parents at the age his son was now. Mr F was quite specific in the first meeting that he could not afford to wait until then, as he felt it would not leave

him enough time to deal with what he termed "the soreness" inside himself. He said he felt he suffered from the loneliness of old age. By this I thought he was referring to both the external reality in terms of his marriage breaking down, but also to what Klein calls "This state of internal loneliness" which, she goes on to describe,

> is the result of an ubiquitous yearning for an unattainable perfect internal state. Such loneliness, which is experienced to some extent by everyone, springs from paranoid and depressive anxieties which are derivatives of the infant's psychotic anxieties. These anxieties exist in some measure in every individual but are excessively strong in illness; therefore loneliness is also part of illness, both of a schizophrenic and depressive nature". [Klein, 1963, p. 300]

Klein (1963), Cohen (1982), and Hess (2004) in writing about loneliness have noted that a major fear in being alone is that the individual is afraid of being left with feelings of overwhelming persecution, with no one to project into.

Assessment and treatment

Mr F conveyed both despair and courage in his approach to assessment and treatment with his implicit understanding that issues he had managed to evade in a particular way through the structuring of his work and family life were no longer holding fast, and that while he felt his life had broken down with his wife's leaving, he felt that if he did not gain some understanding of himself at a deeper level, it would completely shatter at the point that his youngest child left home. In our first meeting, Mr F said that he had taken his son to see the film *Four Weddings and A Funeral* and described the phenomenon of reaching a certain point in the lifecycle where the opposite was true—invitations he received were no longer to weddings but to the funerals of old friends and colleagues. Each time he received one of these invitations, he would weep for the friend and simultaneously feel relief and triumph at what he called his illicitly held thought that "at least it wasn't me this time". This, of course, is something many people who are older describe as they look through the obituary pages of the newspaper, but for Mr F it took on a particular meaning in the light of his history.

Mr F went on to say that he wanted to have nothing to do with old people, as he felt they were all locked into their own worlds, with little interest beyond their own narrow confines. Over time I was able to think with him about a narrow, rigid part of himself that he felt stuck and imprisoned with, conveniently lodged elsewhere in those

he termed the "oldies" whom he then, contemptuously, wanted nothing to do with. He had been relatively happy so long as his world was populated with younger people—his wife, his children, and, in the early months of his therapy, his at first hidden thought that I might be his young companion throughout his old age. At the time of seeing my patient, there was a great deal of coverage in the papers and on television and radio about the anniversary of the liberation of the concentration camps, and he was approached at various points by museums and film-makers who were keen to record his story. In the early months of treatment, I rapidly became in the transference the son or wife whose role was to act as his secretary and notate his life story (one of the reasons, Mr F had told me in the preliminary meeting, his wife had eventually left him).

I enacted this dynamic by, for example, keeping copious notes at the end of each session, or finding myself upset at the end of each session sometimes, carrying this over into a preoccupation beyond the session itself. Over time I began to see how the quality of Mr F's telling me of his story captivated and ultimately controlled me in a particular way. I became aware that my response was similar to the way I had felt as a young woman when I first learned about Auschwitz and Belsen and had stood in the Imperial War Museum seeing a silent reel of film, repeating again and again the liberation of Belsen, finding myself unable to move away from the screen of the piles of dead bodies, and the living dead. I realized that I had become as consumed with Mr F's past as Mr F felt consumed by his past. With supervision it became possible to think more flexibly about what the experience of his wife and family may have been living with Mr F, and for Mr F what his experience of living with himself may involve.

My ability initially to function with Mr F as his therapist who could understand and interpret the pressures arising in the transference and countertransference was hampered so long as I felt identified with Mr F's external story. And yet the hampering was inevitable in terms of an enactment that ultimately enabled me to understand more about the internal pressure my patient felt driven by, and which he exerted on those around him. In the countertransference I was able to experience and become more aware of how controlled Mr F felt by his inner objects and, in return, how he then controlled others by projecting guilt and responsibility into them. The pressure seemed for me to be the solution, rather than think with Mr F about what solutions there may be to his extreme fear of getting older in isolation, with his youngest child about to leave home and no real friends. Beyond this external

situation, I thought Mr F felt haunted, persecuted, and alone with the internal "older ones"—namely, his dead parents.

Earlier in the book I referred to Freud's great paper "Mourning and Melancholia", which gives a detailed description of the internal world of the depressed person in identification with an object that is dead or decaying. With Mr F, I think it possible to understand something about the nature of his identification with the decayed objects—his parents in the concentration camp—and the way in which, at an internal level, he feared the envy of the dead, feeling accused by his objects that he survived into old age while they were unable to. In his initial questionnaire prior to being seen for an assessment for treatment, Mr F had responded to a query about his parents by writing starkly: "They were both murdered in a concentration camp. I am uncertain whether I am coming to terms with this or not." Garland (2002), writing about the nature of trauma and the impact of traumatic events, takes up the way in which, at an external level, perhaps there are some things that we are unable to come to terms with in terms of "getting over" them. The issue for Mr F was not so much the getting over things—some things it is not possible to get over—but more the *getting on* with things. With Mr F, psychotherapeutic treatment was able to provide a secure framework within which he and I could learn more about and understand the defences that earlier on in his life had been a necessary means of survival and, over time, had become rigid and unmoveable. The challenge for the treatment was whether these defences would stay calcified, in identification with the bones of the dead that lived within him and he felt controlled by, or whether there was still the possibility of something more flexible developing in his feeling freer to grow older and plan for his old age in the way his parents had been unable to. "Psychotherapeutic treatment which analyses such anxieties and defence mechanisms may enable the patient to experience ambivalence, to mobilise the infantile depressive position and work it through to sufficiently re-establish good internal objects and face old age and death in a more mature way" (Segal, 1958). For Mr F, this meant the painful task of repairing within and without. Rey (1994b) noted that the object has not got to be restored to the exact condition in which it was before the damage (p. 227). So with Mr F, the damage had already been done, things could not be restored to the state they were pre-retirement, pre his parents deportation, but, to some degree, there always remained the possibility of reparation. An indication of this at a follow-up meeting two years post-treatment was to hear that he had negotiated the emotional challenge—which at the start of his therapy

he thought would lead to a catastrophic breakdown—of allowing his last child to leave home freely. It seemed that Mr F's capacity to leave go of controlling his objects ("I will die if you move away") paradoxically allowed in a warmer relationship between Mr F and his children as well as with his ex-wife. Rather than continue to identify with the internal objects he felt haunted by, Mr F managed, to some degree, to separate from them and in this way regain the life available to him with his children in the present.