

The final challenge: ageing, dying, individuation

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Abstract: This paper¹ is about the psychotherapy of a woman who passed from what Waddell (1998) would term ‘older age’ to ‘later life’, by which latter I mean the inevitable decline into dying and death. However unwelcome these developments may be to the individual, they are none the less activities of the soma, and therefore activities of the self—deintegrates. Much of the work of the psychotherapy centred around the task of enabling the patient to relate to and accept the bodily and emotional correlates of this process, which she tended to want to disown and deny by means of a split between mind and body along the lines of a long-standing internal depressive relationship. Permitting her contact with herself allowed her a much greater sense of internal company and peace, and arguably facilitated an easier process of dying, involving a self reconciled with itself rather than one at odds. Technically, the approach involved a greater concentration on the intrapsychic relationship rather than on the relationship between patient and analyst, and this is briefly discussed in terms of the work of Armando Ferrari who had himself died, shortly before the paper was first presented, and to whom therefore it is in part a homage.

Key words: death, depression, deintegrate, dying, Ferrari, Matte Blanco, old age, self

Introduction

This paper concerns the struggle of one woman with her rapid decline at the end of her life. It was written by request for a programme of papers in Oxford about psychotherapy at different life stages; shortly afterwards, Armando Ferrari invited me to give a paper in Florence for a conference on mourning and melancholia.

When the topic was first proposed to me, my initial impulse was to refuse, thinking that I had nothing particular to say about psychotherapies at different

¹ This is an expanded and somewhat modified version of a paper which was given in Florence in 2006 (Romano, Romanini & Taurielli [eds.] 2007).

ages and that there wasn't any particular difference in what one addresses in someone who is 'old' as opposed to what one might address in someone 'young'. A case in point was a woman of 70 who presented in a state of apparently irresolvable rage because her older sister, on whom she had always counted as a companion, had recently found herself a partner. My patient felt unbearably excluded and disillusioned. Her psychotherapy started in a way which was indistinguishable, I suspect, from the way it might have started had she presented 40 years before. And this has been my experience with the various patients that I have started seeing in, or have seen into, their 50s, 60s, 70s and even 80s. Some way into her work with me, the patient I have just mentioned painfully discovered her lost and denigrated sexuality. She was like many people, who, as they age, begin to feel invisible at best, or repulsive at worst, while still having powerful sexual longings, or at least yearning to be held, if only for the eros of physical contact. Yet while the pain of what this woman had lost and could not recover, the pain of her un-lived sexuality, of the babies she had not conceived, was truly agonizing, there was none the less a sense of growth in the sense of recovering aspects of her self, even in the absence of any obvious external requital or consummation. She felt more herself, less depleted. This of course involved the lifetime project of Oedipal and depressive renunciation. She had to renounce the likelihood of a partner at her age, as the Oedipal child has to renounce possession of the parents, or the individual life in the face of death. At the time of her work with me, death was a future reality for this woman: it was not yet immediate. But death is the last act of depressive and Oedipal renunciation in the face of the ineluctable reality that all of us have to face, even though many of us might have had a lifetime of difficulty doing so.

There seems to be a watershed at the point at which the individual hits incontrovertible and compelling *evidence of a decline which presages death*, whose recognition likewise does not preclude the sense of growth: *death is part of the self*. The patient whom I am about to describe was someone who had consulted me earlier in her old age, and who crossed this threshold during the period in which I was seeing her psychotherapeutically. The differences in focus over the two periods thus defined will be apparent though my focus will be on the second of these periods. I commend Margot Waddell's lucid and moving chapters on both phases in her book, *Inside Lives*, in which she refers to them as 'later life' and the 'last years' (Waddell 1998).

It will become apparent that it began to occur to me that what I am more bluntly calling 'old age' was a topic I might after all address, and that many of the issues in the material were pertinent to the theme of Ferrari's conference which was, as I have mentioned, mourning and melancholia, because of my patient's struggle against the temptation to collapse the process of mourning her life into a melancholic holding on. At the same time, Ferrari's technical approach had informed my own in relation to this patient. Sadly, Ferrari, who was himself elderly, died shortly before the conference after prolonged ill health. Poignantly,

the last email exchange I had with him was to send him a version of this paper which therefore stands partly in homage to him. I will discuss the theoretical and technical issues at this point, though only briefly, because I think that the material pretty much speaks for itself.

Death and deintegration: the ‘vertical axis’ and Ferrari

My paper is about one individual, and does not claim any comprehensive experience of the topic of ‘old age’². By the word, ‘individuation’ in my title, I understand the rather straightforward easy, un-self-conscious interchange between conscious and unconscious processes, largely if not entirely via the demand for the somatic and emotional to be translated into mind. It is therefore very much a process of the acceptance and elaboration of emotion as it rises into consciousness: if it is overwhelming, unassimilable for whatever reason, consciousness can neither accept nor elaborate it, so that the process of individuation is perforce interrupted. The equation between unconscious process and emotion is one that Matte Blanco (1975) makes on logical grounds, and this lends validity to Jung’s idea of the archetype as a structure with an ‘instinctual’ (or, as I would prefer, emotional) pole and a ‘spiritual’ pole (Jung 1946, para. 407, 414). Internal evidence suggests that by the word ‘spiritual’ in this context, Jung meant ‘thought’ (‘reason, insight and moral judgement’, Jung 1963, para. 673). Matte Blanco’s understanding of the logical properties of the unconscious and emotion help to explain without recourse to destructive psychic processes, such as the death instinct, why it should be that deintegration, the emergence of something out of unconsciousness, should be so potentially disruptive to consciousness, that a product of the unconscious should be feared because, emerging from the unconscious, it threatens to dissolve and therefore annihilate the conscious ego. While it would be consistent with the theory of the death instinct that the ego should fear death itself as the apotheosis of the death instinct, my own approach has been more towards the fear of deintegrative process and its symmetrical properties as an explanation for the refusal of *death* as the last deintegrative phase of life.³

Michael Fordham’s model explains how archetypal exigency arises as what he calls *deintegrative* processes in the infant which need to be met accurately by the

² I am making no claim to extensive or comprehensive experience. For those of you who want a more comprehensive approach, there is, as well as Margot Waddell’s chapters, a book edited by Evans and Garner called *Talking over the Years*. I also commend Brian Martindale’s recent paper in the *British Journal of Psychotherapy* (2007) which has obvious relevance to the issues raised in this one; and there is the chapter by Cook, Gallagher-Thompson and Heple in the *Oxford Textbook of Psychotherapy* (Gabbard, Beck & Holmes 2005).

³ Klein posits that the ego splits in response to threats from the death instinct. What we will see in this paper is the deployment of paranoid-schizoid mechanisms against the registration of the reality that is death. A discussion of arguments against the validity of the concept of the death instinct is out of the question in this context, but see Matte Blanco’s paper ([1975a] 2006).

mother, so as to be tolerated and not overwhelm him/her. Ferrari (1992) suggests that in this process, while the mother's mediating presence is all important, the infant-mind's first object is his own body with its random bombardment of sensation and emotion. Its emergence into mind Ferrari calls the *vertical axis*—that is, the axis along which body becomes mind. When this process is adequately held by the mother, on what he calls the *horizontal axis*, the development of mind in relation to sensation and emotion proceeds smoothly, so that psyche and soma form a seamless ensemble, with mind becoming largely oblivious of body, until such time as the latter insists on being noticed and accommodated again. This obliviousness of body that we can feel in health allows us for instance to run down stairs without thinking about it—when we do, we are likely to fall. Ferrari calls this obliviousness 'the eclipse of the body'. In circumstances when we are bombarded with physical sensation—intense pain is a good example, we can become mindless, as if our minds were eclipsed. Clearly infancy is a time of maximum bombardment; and adolescence, which Ferrari calls the *second challenge*, is another. Obviously, trauma and illness are others. Growing old with the loss of previously taken-for-granted faculties, and so on, is another. *But the final challenge, the final deintegrate, is death.*

I say that death is a deintegrate because there can be no doubt that it is an activity of the body. We know that it is genetically programmed, and that cells are primed and timed to die—a process called *apoptosis*. And if it is an activity of the body, it is an activity of the self. But like the decline of old age in its earlier stages, death is a deintegrative process about which we usually don't want to know—not every deintegrate is welcome; so the defences against knowing are disruptive to the process of individuation, and so to the self which is consequently depleted.

The transference

Technically speaking, Ferrari's approach to the idea of body as mind's first object suggests that the transference is not the *primary* consideration when, in Fordham's terms, deintegration is the most obvious issue at hand, even when deintegration most obviously involves the use of the mother's or the analyst's body. This approach follows from the logic of Matte Blanco's delineation of the symmetry of the unconscious whereby any element in the unconscious can be exchanged for any other. This means that no fixed points can be defined, including time and space. The absence of time and space precludes the possibility of process, including the process of projection (Matte Blanco 1988). This is the logic of Freud's original unconscious which as Matte Blanco (1975) points out is an *unrepressed* one, as is Jung's collective unconscious. Like Jung's unconscious, it is also 'collective' in that there is no possibility of defining where one unconscious ends and another might begin. On logical grounds alone therefore, where the emergence of contents which may be attributed to the unrepressed unconscious is concerned (such as archetypal contents or

deintegrates), it may not be meaningful to invoke a process such as transference between objects which cannot be defined and across space which does not exist.

Finally, as mentioned above, where there are no separate objects in the unexpressed unconscious and no space between or within them, it makes no sense to invoke a mechanism such as projective identification or indeed, simple projection, both of which are also of course processes. This resembles Jung's position in the fifth Tavistock lecture that emotion might be experienced in the analyst as a result of 'participation. . . where there is no conscious distinction between subject and object' (Jung 1935, para. 322).

These are the *logical* grounds for suggesting that where primitive affective and somatic material is concerned, the transference may not always be relevant. It can also be argued *clinically* that in circumstances, where the clinical issue is the mentalization of affect (Fonagy et al. 2002), or the facilitation of the vertical axis, to insist on the horizontal axis (Ferrari 1992), i.e., to insist on the transference, might be distracting and obstructive. This is argued vigorously by Lombardi (2000, 2003, 2004). It will be appreciated that this approach represents a considerable departure from that of the British object relations school, including that of the Kleinian school, in that it suggests a 'position' anterior as it were to the paranoid-schizoid one. Matte Blanco (e.g., 1988). argues that the latter requires more definition between objects and psychic contents than is available in strata of deeper symmetry (see Carvalho 2002).

For these reasons, the reader will notice in the material which follows, my interpretive stance is almost exclusively in terms of the relationship between the patient's mind and her body. The transference was barely an issue, apart from the pain of my absences between sessions and over breaks. But this was not about the emergence or toleration of the negative, of hatred and envy for instance in relation to me, it was the experience of the pain in my absence, associated with her difficulty relating to herself, so that she felt out of touch with herself, lonely as a result of this lack of internal connection and companionship, and 'less sane'.

Melancholia as a defence against unwelcome deintegration

At the stage at which I wish to start my account of my work with my patient, she was well into her decline and severely incapacitated, so that she was dependent on others for all aspects of care. She had an intact mind, but her general level of weakness meant that she was unable to walk or even to move herself out of an uncomfortable position in bed.

As she put it herself, she had 'no outcome, no future'. She was tacitly acknowledging the fact that she had crossed the watershed that I mentioned earlier, that she now had to face *catastrophic deintegrative processes, whose outcome held out no promise of growth into a future, but only that of decline into death.*

The speed and intensity of degenerative change in old age is such that it is often impossible to accommodate and come to terms with it before the next disaster strikes, and the level of discomfort, inconvenience and hardship may be such that it is extremely difficult to have a mind at all because of the unrelenting physicality, pain and inconvenience of what is happening to the body. All of this, of course, is often accompanied by a *sense of bewilderment and grief* which also tend to overwhelm thought. All of this was sadly true of my patient.

The deintegrative bombardment of this phase, then, is the experience of *physical decline*, compounded with the *grief* about it, as well as by the tremendous fear in the face of *the immediacy of the reality of death*, however much death might also be longed for as a relief from suffering.

My patient deployed *two major defences* against this challenge. The first of these was to, as it were, take refuge in the decline, to make what might be seen as a virtue of necessity, and *to abdicate her mind* to the eclipsing tribulations of her body, even to actively attack her mind and its capacity to link. The second was *to convert grief and the work of mourning into depression or melancholia* by splitting her mind and body into an antagonistic relationship along the old battle lines of a previous depression.

The clinical material which follows concerns the slow decline of this erstwhile fit intellectual. It concerns my attempts to facilitate her process of mourning as a necessary component of individuation. She was coming to terms with her increasing disability and helplessness, the loss of her recognizable self, her health, mobility and independent existence. Her tendency was to retreat into a litany of repetitive physical complaints about her body and the way she was treated at the hands of her environment. Her tendency to short circuit her mourning and grief into a depressive process had its foundations in infancy. Depression recurred at various points in her development, including what might be understood in retrospect as the first intimations of her descent into the helplessness of her old age, and it was this depression which originally prompted her to present for analytic help.

Maintaining her process of mourning permitted my patient a much improved quality of life, a greater sense of connection with herself and an accompanying diminution of loneliness, together with greater creativity, so that she became aware of feeling less unhappy, even if her circumstances made happiness as such difficult to achieve. Some serenity became possible. *Melancholia*, on the other hand, involved a split within her self which was characterized by bitter enmity and contempt. This split self however left her lonely and disconnected, sterile and miserable, deprived of individuation.

Presentation: isolation and abandonment

My patient consulted me through much of her eighties. I saw her until her death. I should also say that she was pleased when I asked her permission to use her material for this paper, and gladly gave her consent.

She had first consulted me several years before on a family matter. When she became profoundly depressed some years later in her late 70s, it was natural for her to return. On that occasion, her depression was profound enough for her general practitioner to have put her on anti-depressants, though only for a limited period. At this stage in her life, the work of analysis was, as for the woman I mentioned earlier, indistinguishable in any fundamental respect from that with patients who are much younger.

Now in her mid 80s, though in remarkable health and with all her faculties, my patient was becoming increasingly unable to travel. Ostensibly, the onset of her depression coincided with various members of her family being in far flung, exotic destinations, leaving her feeling bereft and unwanted. In particular, she was unable to arrange a trip to a family gathering in their property in the Western Isles of Scotland, the remoteness and primitive nature of which made it impracticable for her to attend. Once again, the rest of her family were foregathering there, and she felt desperately left out.

I will not dwell on that period of our work together beyond observing that what was evident at this time was a particular mechanism which we can easily recognize as *melancholic*. We can understand that it was deployed against the registration of grief at the recognition of the onset of ineluctable old age in which, as Giacomo Leopardi says in his sublime poem, *The Setting of the Moon*,

<i>'undiminished is desire, hope extinct</i>	<i>incolume il desio, la speme estinta</i>
<i>dry the wells of pleasure, pain</i>	<i>seche le fonti del piacer, le pene</i>
<i>ever growing, and good withheld</i>	<i>maggiori sempre, e non piú dato il</i>
<i>forever'</i>	<i>bene</i>

In retrospect, it is clearer that the next task in her life was to mourn the passing of her youth and vigour, and to face not only the 'setting' of her youth, but the inevitability of her death.

On the face of it, the canvas, when she first presented with depression, was somewhat more restricted. It seemed that faced with her sense of exclusion from the family, my patient was faced with the recrudescence of a childhood dilemma which she had solved by developing a sort of long term grudge with her carers, and a relationship with them as super-egos in which she herself became an acerbic and self-righteous critic of 'stupidity' wherever she encountered it.

Background

My patient was one of several girls, and her intrinsic and initial failure was to have been 'not the longed for boy'. Not part of the grouping of elder siblings, nor of the younger, her memory is one of perpetual apartness, walking in hunched

isolation and biting her nails. Her greatest weapon was her obstinacy, and she remembered chewing the rind of her breakfast bacon all morning until lunch time. She came to equate this over the course of our work with 'nursing a grievance'. There was no memory of any physical affection from a mother whose narcissism was reflected most eloquently perhaps in her outrage, late in life, that the plebeian gardener should have had the temerity to have developed the same terminal illness as her patrician husband. Nanny was sharp and unsympathetic enough for an aunt, who perceived how miserable my patient was, to try to persuade her mother to replace her; but 'nanny was too convenient'. As she grew up, my patient capitalized on her intellect and prowess at games. She felt that at least she could embody aspects of her father's intellect and features of her mother's artistic talent. Mind and intellect were largely used to keep body and emotion at bay. But these formed an internal landscape that was punitively and judgementally bleak enough for her to have been seriously suicidal, at least during her 20s.

So now, in this crisis of immobility, where all her family and the family home in Scotland had become inaccessible, it was as if once again she had become locked into a vicious stand off with a nanny/mummy who refused to find her or include her, and with whom her only and compulsive relationship was one, in her mind, of mutual denigration. She continuously deprecated herself as 'stupid' or 'inadequate' or as 'poor value', all Britannically understated insults, that, in her family lexicon were none the less vicious. To call someone stupid in the nursery was to be punished severely. 'Oh', she would say, 'you must think that I am so STUPID', trying to draw me into complicit assent. 'You must think that I am such *poor value*, going on and on like this'. Or with others, she could be peremptory and highly judgemental, leaving them in no doubt as to their own 'poor value'.

In time, with analytic work, it was possible for her to come out of this compulsive relationship which constituted her depression through the realization that it was what she had nourished herself on, like the bacon rind, in the absence of anything more sustaining. At least it represented a continuous and unstinting presence which, as painful and malicious, could not be missed, and which could be omnipotently conjured at any moment as instant, if painful, company. With this understanding, her internal world became much less punitive and judgemental, but while its punitive companionship had lost its compulsion, it still constituted a complex which was the template in later years for her relationship to her body into which she could easily slide, either reflexively, or in defiance of the realization of her situation and her consequent grief. *Each session of our work together represented a struggle to maintain her compassionate relationship with herself, to maintain her capacity for reflection against the temptation to slide back into mindlessness again, to maintain the work of her mourning against the temptation of melancholia.*

Deterioration

Sadly, however, while and at the same time as my patient's depression abated in this way, her physical capacity diminished rather rapidly. She was admitted to hospital at various times for falls which, due to the instability of her legs, became increasingly frequent, and after a few weeks, was unable to get to my consulting room, even by taxi, or to negotiate the distance between the taxi and my door. I continued to see her, therefore, in her home on a once weekly basis, until it became clear to her and to her family that she would have to move to a residential nursing home with 24 hour care. This was, I think, in retrospect, the watershed I have mentioned between what Waddell refers to as 'late life' and 'last years', in this woman's case, months.

This is the situation in which I continued to see her until her death. Her intellect which had always been considerable was barely diminished. She was unable however, to walk, even with a frame, without the assistance of two carers. Even this was to become increasingly hard. She could not use the commode without two carers. Whatever the level of help, falls were inevitable, with cuts to her poorly perfused shins. Because these needed to be dressed for long periods, and kept dry, she was sometimes unable to have a bath for weeks. Even shifting her position in bed required assistance, which was a torment since her ankles became very painful at night. The sense was of the agonizingly slow and inexorably cruel decline of her body in which her mind was imprisoned.

I am reminded of the passage from the Gospel of St. John (Ch.21, v.18), which Pope John Paul II quoted shortly before his death, I think as a commentary on bearing his life and continuing his pontificate, right to the bitter end, despite the tremendous suffering of his declining body: *'When thou wast young, thou girdedst thyself and walkedst whither thou wouldst; but now when thou shalt be old, thou shalt stretch forth thy hands, and another shall gird thee and carry thee where thou wouldst not'*. (This is taken to be Christ's reference to Peter's crucifixion, and so it deepens the emphasis on the helplessness and torture of old age, with its culmination in death.)

Her helplessness was abject, and she did indeed need to stretch forth her hands to be girded and looked after in every other respect by others. This once helpless and humiliated little girl now felt and was a helpless and humiliated old lady, at the mercy of a system that when it was busy with many other residents, might leave her for agonizingly long with a painfully full bladder or bowel, or with a painful leg that needed to be shifted. She experienced some of the staff as surly and uncooperative, and felt additionally humiliated when her patrician speech was incomprehensible to them. This then prompted her to rise to her patrician hauteur and make it clear how 'stupid' she thought they were, ensuring that they would be even less likely to be well disposed to her.

Clinical material: general

The emergence of 'language registers'

As this decline set in, the sessions became somewhat repetitive and rambling, and the experience was one of mindlessness. They would inevitably start with a catalogue of complaints, about the latest symptom and the fear that it was no better. Perhaps it was getting worse. Why wasn't it getting better? She would complain about the home, about the inefficiency of the organization and of the person in charge, the food and so on. There were stories about the carers—who was 'good value', who 'bad'. She was enraged by the fact that visitors told her how nice her room was: it was in fact very pleasant, with French windows onto a garden with mature trees, vistas of the open country beyond, and a large variety of birds that were quite tame. For her, of course, it was, however, a 'prison': she couldn't get out into the garden, she longed to see the stars, to be in Scotland and so on; and meanwhile, she was at the mercy of these 'low quality' carers who were so 'stupid' and whom she felt to be her gaolers. She hated her body which now refused to do her bidding. She still had her mind and she tried to read the paper in order to get some perspective: after all, her troubles were so insignificant in relation to Niger, Iraq. . . . But it made no difference, apart from reinforcing her sense of inadequacy that it didn't. And all of this was interspersed with reminiscences about her childhood, her past, her parents and so on.

All this was very repetitive, and as much of it was to do with matters of fact, about the paucity of staff, the level of their training or commitment and the length of time it took them to respond, it seemed hard to find a way of intervening usefully for some time, beyond sympathizing with her situation and avoiding the sorts of would-be comforting platitudes she felt that she suffered from her friends. She was rambling and, as I have said, rather mindless. It was as if her once considerable mind, the intellect with which she had protected herself from her feelings, had been eclipsed by the body she increasingly loathed. Meanwhile, she looked for cures for her ills, as if her mobility might improve, the vascular cause of her painful ankles might be remediable. It was as if by not having a mind she could deny the obvious fact: that she was not suffering from an 'illness' or 'disease', however 'ill at ease', but from the irreversible effects of the 'arrow of time' (Ferrari 2005).

In time however, it seemed that discernable patterns emerged which in retrospect I would see as communicative patterns, what Ferrari (1992) would call *language registers*.⁴ It became possible to understand that the idea of her room as a prison conveyed her feeling that she was a mind trapped within a body that was increasingly disabled; just as the feeling that she was at the mercy

⁴ The concept of 'language registers' has for Ferrari the specific significance of connecting mindless bodily states with mind, and is akin to Jung's idea of the communicative and symbolic function of symptoms, illness etc. It would contrast with the idea that such phenomena were merely evacuative, defensive or concerned with minus K states for instance, though their communicative value does not preclude such defensive potential.

of the carers whom she experienced as sadistic was the experience of mind at the mercy of a body in pain. To that extent, it was as if her body were her sadistic mummy and nanny. On the other hand, her contempt for the carers as incompetent and 'poor value' echoed the contempt which she felt from her family and which her mother exercised, for instance, in the direction of the gardener. In this her mind was as it were the contemptuous mother in relation to an abject child-carer-gardener-body. *This was the sort of melancholic defence against the grief that she would have otherwise felt for all her 'losses': her youth, her life, her vigour, her mobility, her independence, her ease, her comfort, her friends, her future, 'her good value'.*

Gradually, it became possible to remark to her, for instance, how she felt imprisoned in her body rather than the room, or that she was treating her body cruelly, with contempt and without sympathy, as she had felt her mother and nanny had. This enabled her to relate more directly and more ruefully to the facts of her physical condition, and in turn to confront their nature as the irreversible effects of ageing. She could then think about how tired she felt, how much easier it would be to die, but how frightened she was of death as an eternity of waiting for mummy and nanny to come and find her, of death as nothing and terror. In time, she came to laugh at the idea of the reality which was that, in the real event of her death, she might not in fact have the conscious faculties to register these fears. On other occasions, she was able to talk about the guilt of *wanting* to be dead, given that her family would be upset; and she registered her guilt that within the wish to be dead was nested the self destructive fantasy that she could kill off her 'bloody body' and be left as 'pure mind'. In short, it was possible in this way, by picking up the repetitive 'factual' themes as patterns of communication, as 'language registers', to restore her to mind. At the end of one of our sessions, she was able to say that she felt saner, on another that she felt better and less lonely. This I related to her feeling that she could be more of a companion to herself now that her mind might be less 'pure', her body less 'bloody'.

Session material

The result of this was that the process of our work became much more affective, much more feeling. She was able to complain much more vigorously, rather than 'whinge' self deprecatingly, and she was able to be much more directly angry about her situation. In parallel, I began to be more aware of my countertransference experiences. I became aware of my revulsion at the smell in her room at times, and of my occasional reluctance to visit, all of which I assumed to be my identification with my patient's revulsion towards herself. I also started to have dreams that related to her: one morning that I was due to see her for instance, I woke from a dream about visiting her in my mother's house. This was followed by another about a woman friend of mine who, like my mother, was dead. In the dream, this woman was covering the walls of a room with black sticky tape. I awoke with a terrible sense of foreboding that my

patient was dead. This developed into a hope, as I drove out of London to see her, that she might be. This was akin to my wish for my mother, towards the end of her life, that she would permit herself to let go of a life that had contracted into misery. She too had contracted her existence into one that was mindless and confined to an obsessional preoccupation with the distance between her and her commode. As I drove to the session however, my wish for my patient to have been able to die turned to panic that I would find her dead when I arrived.

Session 1

I concluded that I was in a state of unconscious identity with her intense ambivalence about dying. The ensuing session started with her telling me that she ‘hated, hated, hated!’ She ‘hated the carers, hated them!’ *I told her that I thought that what she really hated was her body and its ailments.*⁵ Yes, she said, she hated her body, hated its pain. She had pain in her neck, pain everywhere. She was sick to death of it. She wished she could be dead. The only time she was free of it was when she was asleep. *I said [aware of my dream] that I felt she was talking about her wish to be asleep-dead and at peace from the pain she was sick of.* She started on a rambling reminiscence about when she was a little girl in the country fetching the milk from a nearby farm, and having to brave the geese she was so frightened of. *I told her she was afraid of her desire to be dead as if it were an attack by her body on the mind that also wished to live.* Her reminiscence, again somewhat rambling, turned to a book about a Utopian vision of post-Versailles peace. *This, I took to be a reflection of her feeling that this conflict between her mind and her body might be resolvable within her.*

I understood this progression as one in which she had moved from a hateful rejection of her body and its intimations of death, its caducity, to one of some acceptance of it; from a position of ego rebellion to one approaching acquiescence to the imperatives of her body-self. This acquiescence seemed to be conveyed in the Utopian vision, but it was by no means secure. This is suggested by the rambling which might be understood as attacks on the mind, and by the element of idealization and its projection into the idealization of the utopian vision.

After this session however, it seemed to me that she became consistently much more focused in the sessions which followed. She seemed more reflective and less rambling, though her reminiscence inevitably made her more discursive. Here is some material about eight weeks later.

⁵ Attempts to take up such references to her visitors or her carers in terms of her hatred or envy of me as a negligent, absent and envied mother/nanny did not seem to be useful to my patient, because, in retrospect, the states of complaint were mindless. While it might be argued that this mindlessness was a state of minus K (Bion 1962) effected by the melancholic defence against the registration of her bodily state, I think that it was also attributable to bodily states being mindless until they can become ‘minded’ in the vertical axis. Certainly, while transference interpretation of this nature achieved nothing, interpretation in terms of *language registers* which aimed to connect bodily states with mind did indeed render her mindful.

Session 2

She left a message on my ansafone to tell me that she was in bed with an upset stomach. When I arrived, she explained that her bowels had been very upset overnight. She had assumed that my response to her message would be not to come. *I said that she assumed that I would reject her body as she wanted to.* She was ashamed of her condition. It felt as if she'd 'given in', 'given up'. *I said that it was as if she were giving up in a moral sense, rather than that her body was getting old and finding it difficult to continue in a way that was ineluctably physical.* She said that her mind was a snob. She [her mind] was ashamed of her [body]; she [her mind] thought she [her body] was 'stupid'. *I said that we both knew that this 'stupid' was the forbidden insult of her nursery, so it was obvious observing her that her snobby mind was rejecting her 'inferior' body, just as her mother had rejected the presumptuous gardener's temerity for having had the same terminal illness as her husband.* She said that she would have liked to have got rid of her body: her body was poison, poison to purge. *I said she wanted to get rid of her body's tiredness as if it were different to her mind's tiredness.* [It would be obvious to think of this upset bowel as a psychosomatic attempt to purge herself of her poisonous physicality—a sort of suicide, a topic about which she speaks later in the session, though I think its significance is different in the context in which it occurs.] She said that she realized that she would have liked to be dead. She could not, alas, hasten it, though she had thoughts of suicide, because the fact *was* that her mind was as tired as her body was. She talked about what an ordeal the night of illness had been. At one point she talked about her desperation to get the light on in the middle of the night, and of how she had managed it despite the physical difficulty. This prompted me to point out *the cooperation this required between her disparaged body and the ingenuity of her mind.* *I said that I thought that wanting to be dead because her mind and body were united in tiredness and effort was different to wanting to kill her body as the poison that comprised the realities of time, ageing and death which her mind was reluctant to accept.*

Following this session, I developed a severe gut spasm which I immediately associated in my mind with loss, and with the attempt psychosomatically to 'hold on' to the object: I had once experienced this symptom before in relation to a severely deprived patient who was approaching the end of her analysis. I thought once again that I was in a state of unconscious identity or 'participation' with my patient's wish to 'hang on for dear life'.⁶

This informed my response to the next session, which is, for the sake of brevity, the last I shall recount.

⁶ Although this might be understood as a projective identificatory process communicating to me the indigestible nature of the patient's situation, in line with the considerations outlined above, I would be more inclined to see it in terms of 'participation' (Jung 1935, para. 322). Similar considerations apply to my dreams prior to Session 1.

Session 3

She was not in bed this time, but said that she felt extremely ‘down’. Yesterday, in contrast, she had felt exhilarated: she had been thinking about ‘becoming old’—not ‘old age’ which is a ‘thing’, and she’d been doing some abstract water colours which reflected this theme. But today she was ‘down’. There seemed no point, no outcome. Her breathing was worse (it wasn’t in fact, but no better, certainly), her body was ‘bad’, her bowels were upset, her ankles hurt, especially at night, her feet were twisted—she made a gesture of total disgust encompassing the whole of her body ending in her feet which indeed were at a deformed angle. I felt extraordinarily sad and moved and *I said that while she hated her body for hurting her and impeding her, her body was also herself suffering*. With this she became more reflective again and sadder. She’d have preferred to have ended it all, not that she would have done anything, even if she had been capable of it. *But perhaps, I said, she was saying that she’d prefer to be dead? Her mind would have liked her body to be dead, but her mind feared death, just as her body too was hanging on* [a reference to my gut spasm], *at the same time as signalling its wish to let go*. This seemed to enable her to talk about sitting very close to her sister’s coffin, close enough to have touched it. How strange it had been. She talked about the question of where her own ashes might be scattered, and how she would like it to be in that now inaccessible corner of Scotland, but she assumed that this would be too inconvenient for her family. This was, I said, once again, the depressive assumption that her family would deny her desire, as her mummy/nanny had, and as she in turn had denied her body.

Coda

These sessions give a flavour of the sort of issues that arose during this period of my work with this woman. Working through them in this sort of way resulted in a shift in the character of the material to one in which she found herself with the companionship of pleasant memories from her childhood and youth, and when she found herself thinking about the painful ones, they had lost their compulsive and bitter qualities. They had become matters of fact rather than the compulsive bad objects they had been. She stopped chewing her bacon rind, and at times attained something like serenity, which suggests the achievement of self once again. She talked, shortly after the sessions that I have described, of a ‘coming to terms’ with her situation in the home, which we translated into coming to terms with her body together with the idea of its dying. She had the idea of writing about the problem of carers. *I told her that I thought that she was talking about the failure of empathy and respect she had come across in some of her carers with whom she had felt at war, and that this failure mirrored her own failure of empathy towards her body*. She agreed and said that the phrase ‘come to terms’ did suggest that there had been a war going on. Coming to terms implied the need to meet as equals to be respected.

Very shortly after this point, perhaps three weeks, my patient slipped quickly into a coma in which she died serenely. It may be too fanciful to surmise that 'coming to terms' might have represented the ultimate acquiescence of ego to deintegrating self, and that it had allowed her, body and mind, to decide to die as self.⁷

Conclusion

I believe the challenges which my patient faced to be significantly representative of what we all have to suffer in old age and decline, and are relevant in thinking about those who suffer from certain chronic or terminal diseases as well—Leopardi, whose poem *The Setting of the Moon* I quoted earlier, is a case in point: he died in his thirties after years of ill health which dated from his adolescence, much of it associated with a severe deformity of his spine. My patient's challenges constitute what I have referred to, following Ferrari, as 'the final challenge': they are the last deintegrate. They do not allow the hope that things will get better or that they can be cured. My patient had wanted, understandably, to insist that they might be, or that her external circumstances might be reformed, in an attempt to deny the significance of her decline, in the hope that she might avoid the attendant grief and mourning, as well as her realization of the inevitability of her death. This involved her in a depressive split in which her 'stupidity'/body-self had been at the mercy of her contempt/mind-ego, or her suffering mind at the mercy of her cruel body. Thus, far from being a peaceful solution, being mindlessly body was fretful, persecuted, lonely and isolated; whereas when it was possible to restore her to 'terms' in the sorts of ways I have illustrated, despite the experience of grief, and because of the possibility of mourning, she felt less isolated and lonely and more at peace; and she was much more available to her creativity. But ultimately, perhaps, she was able to meet the very last part of her final challenge, death, with equanimity.

⁷ Anecdote is of course not evidence, but I remain impressed by my experience as a young house-doctor of a formidable woman whose consultants, her colleagues from her days as a senior nurse, were unable to bear the idea of her being allowed to know that she was suffering a recurrence of her ovarian cancer, and so forbade me to mention it to her. She was very angry and all the nursing and junior medical staff were frightened of her. She was unhelped by any of the hypnotics, anti-emetics or analgesics she was prescribed. One day, as I was performing a procedure which had become necessary with increasing frequency to relieve her abdomen of a build up of fluid (ascites) occasioned by her liver secondaries, she fixed me with a frankly malevolent and challenging gaze, and told me that she thought she must be suffering from a recurrence of her cancer: 'What did I think?' After a momentary struggle with myself, I said with circumspection that this was a conclusion that was difficult to avoid. Her whole demeanour changed, and she thanked me with complete sincerity. From that moment, the problems for which she was being ineffectually medicated ceased, she summoned her sister to put her affairs in order, and died in 48 hours, at peace.

 TRANSLATIONS OF ABSTRACT

Cet article traite de la psychothérapie d'une femme qui effectuait le passage de ce que Waddell (1998) nommerait le «older age» (troisième âge) à ce que j'appelle la «later life», c'est-à-dire le déclin inévitable vers la fin de vie et vers la mort. Aussi pénibles soient-elles pour l'individu, ces étapes constituent des évolutions somatiques inévitables et donc des activités de dé-intégration du soi.

L'essentiel de la tâche de la psychothérapie avec cette patiente consista à lui permettre de se relier et d'accepter les corrélats somatiques et émotionnels de ce processus, dont elle tendait à vouloir se déposséder et qu'elle avait dénié au moyen d'un clivage entre le corps et l'esprit et d'un état dépressif interne de longue durée. Lui permettre de renouer avec elle-même lui procura un sentiment accru de compagnie intérieure et d'apaisement et facilita le processus conduisant à la mort grâce à une réconciliation du soi, jusque-là en proie à un conflit interne. Techniquement, le travail consista en une approche centrée sur la relation intrapsychique plutôt que sur la relation patient-analyste. Cette approche est développée succinctement, en lien avec le travail d'Armando Ferrari, récemment décédé au moment de la première présentation de ce travail, qui lui rend un hommage posthume.

Diese Arbeit befasst sich mit der Psychotherapie einer Frau am Übergang vom 'höheren Alter' zum 'Lebensende' nach Waddell (1998). Mit Letzterem bezeichne ich die unausweichliche Verschlechterung, die zum Sterben und zum Tode führt. So unwillkommen diese Entwicklungen für das Individuum sein mögen, sind sie dennoch auf Aktivitäten des Somas, und damit auch auf Aktivitäten der Selbst-Deintegrate zurückzuführen. Ein Großteil der psychotherapeutischen Arbeit zentrierte sich um die Aufgabe, es der Patientin zu ermöglichen, sich auf die körperlichen und emotionalen Korrelate dieses Prozesses einzustellen und sie zu akzeptieren, während sie diese nicht wahrhaben wollte und mithilfe von Spaltungen zwischen Bewusstsein und Körper verleugnete—ähnlich wie bei einer anhaltenden depressiven inneren Beziehung. Die Möglichkeit, Kontakt zu sich selbst aufzunehmen, gab ihr ein viel stärkeres Gefühl, innerlich begleitet und in Frieden zu sein, was möglicherweise den Prozess des Sterbens erleichterte—einen Prozess, in dem das Selbst eher mit sich versöhnt als uneins war. Technisch beinhaltete dieses Vorgehen eine größere Konzentration auf die intrapsychische Beziehung als auf die Beziehung zwischen Patientin und Analytiker. Dieses wird kurz erörtert im Rahmen der Arbeit von Armando Ferrari, der selber starb, kurz bevor sein Manuskript erstmals veröffentlicht wurde und dem die vorliegende Arbeit teilweise gewidmet ist.

Questo lavoro tratta della psicoterapia di una donna che passava da ciò che Waddell (1998) avrebbe chiamato 'l'età più avanzata' a 'un' età successiva', e con quest'ultima intendo l'inevitabile declino verso il morire e la morte. Per quanto sgraditi possano essere tali sviluppi per l'individuo, essi sono nondimeno attività del soma, e quindi attività del sé, deintegrate. Gran parte del lavoro psicoterapeutico fu centrato sul compito di rendere la paziente capace di entrare in relazione e accettare i correlati emotivi di tale processo, che lei tendeva a non riconoscere come proprio e a negare attraverso una scissione tra corpo e mente che comportava una relazione interna depressiva che durava da lungo tempo. L'aiutare il contatto con se stessa le permise un più forte senso di compagnia

interna e di pace, e forse facilitò un più semplice processo del morire, che comportò un sé riconciliato con se stesso piuttosto che estraneo. Da un punto di vista tecnico, l'approccio implicò una grande concentrazione sulla relazione intrapsichica piuttosto che sulla relazione paziente analista, e ciò viene brevemente discusso nei termini del lavoro di Armando Ferrari, morto anche lui poco prima che questo lavoro venisse presentato per la prima volta, e al quale viene in parte dedicato.

Este trabajo es sobre la psicoterapia de una mujer que pasó de lo que Waddell (1998) llamaría 'edad anciana' a 'vida posterior', por posterior quiero decir el inevitable declinar hacia el morir y la muerte. Cuando estos desarrollo no son bien recibidos por el individuo ellos son sin embargo actividades del soma, y por lo tanto actividades deintegradas del self. Mucho del trabajo de la psicoterapia se centra alrededor de la meta de capacitar al paciente para relacionarse y aceptar los correlatos corporales y emocionales del proceso, que ella tendía a no aceptar como propios y negarlos por medio de una disociación entre mente y cuerpo a través de una prolongada relación depresiva. Permitirle contactar con ella misma le concedió una mayor sensación de compañía interior y de paz, e indudablemente facilitó y suavizó el proceso de morir, conllevando la reconciliación del self consigo misma en lugar de ser lago uno y sus rarezas. Técnicamente, esta aproximación requería gran concentración en la relación intrapsíquica mas que en la relación entre paciente y analista, y ello es brevemente discutido en términos del trabajo de Armando Ferrari quien de hecho murió poco antes de que este trabajo fuera presentado por primera vez, y para quien este es parcialmente un homenaje.

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