INTERNATIONAL PSYCHOANALYTICAL ASSOCIATION

IPA Webinar, 27th October 2023

Darkness and Light:

Shades of Death in the Analytic Process

Audrey Kavka

Brief description: When life threatening illness enters the scene of an ongoing analytic treatment, questions arise. The most sought after are often the most unanswerable. Will I die? When will I die? How will I die? What comes after the death of my body? Seeking care, protection and hope, intense focus is placed on the trusted or not so-trusted external objects chosen to treat them in their illness, including the analyst. Mature and primitive anxieties emerge and cast dark shadows in which it can be difficult to think or see. The analyst is neither omniscient or omnipotent, but the work of an ongoing analytic process brings shades of light in the capacity to keep focus on the role of the inner objects in experiencing what is frightening and unknowable.

Presentation: I am so pleased to be invited to speak in this webinar about things that are historically treated as unspeakable. In 2004, Franco De Masi wrote on Making Death Thinkable. In this webinar, we hope to break existing barriers to speak about death in the analytic process and move towards making death thinkable.

In a recently released book Psychoanalytic Intersections edited by Elise Miller, Nancy McWilliams writes: "…we should be talking together, as analysts traditionally do, about topics that are hard to keep in consciousness and that are not welcomed by our social conventions. And, we should be speaking in the presence of colleagues of all ages-about getting old, dying and other unalterable realities." Here we are today, doing exactly that.

And, although I have written and spoken on various aspects of bringing psychoanalytic perspectives to clinical work with aging patients, my brief talk today is the first time I have written and spoken on this specific aspect. I think of it as a work in progress and hope it will be enough to engage your thoughts, experiences and interests.

My first contact with late life patients dates to 1979 when I was a resident assigned to hospitalized patients. With attention on the inner person, the patients used the treatment to come alive and live, not to prepare to die. Years later, I found shades of this experience in the theoretical work of Guillermo Montero. His work on Maturescence shines a light on finding meaning and purpose-in-living from midlife onward.

This experience of older patients turning towards life was pleasing and repeated in my move to analyzing older individuals in private practice. The first-time actual patient death disrupted an ongoing treatment was quite a different thing. The patient's initial complaint was increasing social isolation, and it was sometime before she was able to acknowledge an increasing neurological disability contributing to her state of anxious depression. The internal focus of our work brought a sense of closeness and timelessness. We both felt nourished by the amazing vitality of her inner life and her growing capacity to bear inner conflict. We certainly could not ignore the progression of the illness, yet it felt like a shock when she was admitted to a nursing facility with death to follow in less than a week.

Our final visit was at her bedside. As I walked away, I wondered if it was worth it to continue this kind of work in which illness and death would inevitably force a grief-filled ending. This was a dark moment. Light returned with word from her

family about the awakened generativity the patient had shown through the course of our work.

This is not the kind of ending that we are taught about in our training years. I believe we are taught a model vision of termination. Given the complex realities of life, we all experience terminations that do not conform to the ideal but reflect our best efforts for a good-enough termination phase and final ending.

Patients may choose an educational, job or relationship opportunity that disrupts an unfinished analytic process, a process that enabled them to move forward in life. Other patients, leave prematurely, acting out the limits of their ability to bear the internal pressures aroused in the transference and analytic work.

Another unilateral ending that is not taught or spoken about often enough, is analyst retirement. I am currently in the process of retirement. This unilateral decision has introduced shock waves into each treatment and t-ct constellation. For many, analyst retirement evokes a symbolic death with fears of actual pending death My patients study everything about me to detect if I am ill or dying. They wonder if they have harmed me, are they too much for me? How will they know if I die after we end? They want to comfort me if I am dying.

Analyst retirement strips away the soothing thought "Maybe I will return for more treatment if and when I need you in the future" I too feel the powerful sorrow of forever and finality. I think we all feel this.

Some colleagues have explicitly replaced the harsh word "termination" with the softer word "ending" in their clinical lexicon.

Analyses that seem to never-end are also very interesting. Can there be a fantasy of putting off death?

This is a long way of getting to the situation in which neither patient nor analyst determine the ending of the analysis. I think this is the one we are least likely to prepare for as we unconsciously attempt to keep death away.

When patient illness and expectations of death enter the analytic space, analyst and patient alike are confronted with the realness of death with its frightening and disturbing characteristics of finality, uncertainty, the unknown and

unknowable. Neither patient or analyst will have the final say on the end of treatment. Both will contend with feelings of impotence, fear and grief.

The immediacy of life-with-illness come to the fore. Questions arise. The most sought after are often the most unanswerable. Will I die? When will I die? How will I die? What comes after the death of my body? The pressure to know what cannot be known awakens primitive terrors, revival of traumatic experiences of dependency and desperate feelings of helplessness. The analyst is likely to feel all this too.

It is a time of disequilibrium in the treatment. Intense transferences to the medical doctors spring to life. Tests and treatments disrupt the regularity of the analytic schedule. As external reality takes center stage,

the analyst may even wonder, what do I have to offer in this altered situation. Questions of what is analytic and what is supportive emerge. Can they co-exist?

From one point of view, the analytic frame is under tremendous distorting pressure. From another point of view, the internal analytic frame is the analyst's strength. Commitment to an ongoing analytic process in which patient and analyst struggle together to bear the present in anticipation of the future, both internal and external, supports the frightened and grieving patient. When I can deeply accept that I am helpless to treat the physical illness and prevent death, I am supported by my conviction that I am not helpless to be with my patient and let mourning enter the room.

In following this conviction, I have worked with a considerable number of patients both in therapy and analysis, to the end of life. The moment of death separates us forever. We are left as onlookers to the ever-mysterious experience of death. I have observed and learned, suffered, grieved and grown. An uncomfortable thought, maybe a truth, emerges from my experience.

Death is the ultimate experience of aloneness, unlike any other. I wonder if it is exactly this that is so terrifying to contemplate. I have observed that dying patients in treatment seem to apprehend this at some preconscious level and begin well before death to turn towards their inner objects. Inner objects will be the companions in the death experience. This is where we as analysts and our work come in. In the face of death, for both analyst and patient, the state of the

inner objects is of the greatest importance. Will the inner world be dominated by persecutory companions? Will loving and beloved objects be available within to soften the experience of aloneness?

What will be the inner self state at the time of death?

Every patient is different. How the work proceeds once illness and death enter the analytic process, is often shaped by three significant variables:

1) The state of the transference and working through when the illness intrudes

Imagine a chronically hypomanic patient who seeks the attention of men to keep the grief of early father loss at bay and in the transference, casts the analyst as another fantasied admirer propping up a vulnerable core. The analyst observes that as the patient's health declines, she begins to identify with her young, widowed mother whom she begins to see as sturdy and brave in the face of loss and widowhood. The patient suffers with punishing regret for lifelong devaluation of mother. Change is underway, but will there be time for the mourning process and internal reparation?

2) The state of countertransference

Imagine an analysis in which hard work has enabled the aggressively narcissistic patient who wants to believe he raised himself is now able to feel his dependency and loving feelings for the analyst, his wife and children. Yet, analysis seems to come to a standstill until the analyst recognizes they have colluded to keep out age and death and thus begin a termination process.

3) The *analyst's* dynamic ability to tolerate close contact with the vulnerability of mortality and death

I propose that we, as a psychoanalytic community, can do more to support each other in our individual struggles with the painful facts of life. We can increase attention to issues of vulnerability and mortality in our training analyses and

provide curriculum and education on the full life cycle, aging, retirement, illness, mortality and death early in candidacy and throughout the analytic career to help us to bear illness and death in our analyses and personal lives.

In conclusion, challenging as it is, if we can bear our own vulnerabilities attached to mortality, I believe that analytic treatment can play a crucial role and provide invaluable support to patients when illness and death enter the analytic process. This is a bright shaft of light that can break through the darkness.