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The psychoanalyst dies – an existential challenge

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In 2001, my 60-year-old analyst died from acute cardiac arrest, a few hours after my Friday session. Some four years earlier, she had succeeded my first analyst, a man in his late sixties who had to terminate his practice abruptly when he was diagnosed with pancreatic cancer and was faced with the reality of dying within, at the most, a year. Between the age of 18 months and 3 years, I had suffered several painful separation experiences. My mother got cancer and was undergoing hospital treatments and surgery. This was in 1950, and the impact of on young children of traumatizing separations was yet to be understood and taken into consideration. So, it goes without saying that the last thing I needed was having to deal with sickness and death in my analysts.

From the outset I had been confident that psychoanalysis would be the most, or maybe the only, possible road to repair some consequences of my early traumatic experiences. Thanks to my third, deeply meaningful analytic experience with a female analyst, I was indeed able to bring my analytic journey to a closure which provided integration and enhanced joy of life.

It took a while, though, before I was able to start yet another analysis, and waiting was painful. The fact that I was a therapist myself and could reflect on

what had happened to me, proved helpful. I read almost everything that had been written about the theme of illness and death in the analyst. I then wrote an article on the topic in the Journal of the American Psychoanalytic Association. Some ten years later, Gabriele Junkers invited me to write a chapter for her book "The Empty Couch". My presentation will represent a short summary of the main points that are discussed in these articles.

Firstly, I will talk a little about preventive measures. Sickness and death may happen to anybody at any time, even if we are inclined to deny it. Very often in long term psychoanalytic therapies the issue of losing the therapist will surface, especially whenever there was early separation or loss in the patient's history. Even though these worries for the most part ought to be treated as fantasy material and addressed or interpreted as such, I think that it is important that it is discussed on the reality level at least once, preferably early in the process. To me, it was very helpful to have talked with my first analyst about this on the reality level, remembering his suggestion that I might contact one of his colleagues with whom he shared premises. It helped me in my confused state to know that there was someone "out there" to whom I might turn. The way my analyst expressed himself, I felt no pressure, though, to follow his advice; I remained free to find my own solution.

Whenever the analyst is faced with terminal illness but still has some time to assist the patient as to how to proceed, it has been pointed out that it is inadvisable to assign the patient to a specific colleague for continued analysis. It is tempting to think that to provide a secure foster home for one's patient would be the most caring thing to do, but it doesn't take much afterthought to imagine that such an arrangement can in fact complicate matters for both parties. Time doesn't allow for elaborating this.

I will now focus on a few of the issues that arise by abrupt and premature termination of an analysis. From the literature and from personal experience, I think that one should avoid too many strong opinions about how to proceed. Questions like: Should the patient immediately enter a new treatment, should it be with someone who knew the deceased, etc., cannot be generalized but need to

be regarded in each particular case, depending on many factors, among them is of course the reality of availability of professionals to assist.

Most authors emphasize the importance of offering the bereft patient some immediate possibility to meet with another analyst who can help him or her in the first phase of grief, confusion, or whatever the reactions may be. In this phase, the exchange should be concentrated on helping the patient to share the loss. This is written about as a "bridging function", and it is recommended that this person should preferably know the deceased. The patient needs the opportunity to have his or her perception of the analyst as a real person confirmed. There is also the need to describe the impact of the loss, to speak about what the analyst meant to the analysand. Not much more is demanded of the therapist than simply compassionate listening, and such sessions will serve the purpose of dissolving some of the transference and making the analyst more real.

The patient also needs to sort out how to proceed further, whether or not to start another analysis, etc. It is important to be aware of the fact that losing one's analyst has a twofold meaning: one loses the analysis, with the investment of hope for change and possible alleviation of suffering, and one loses a very important real relationship with another person.

On the other hand, it is generally recommended that starting a new analysis, the new analyst should preferably not know the deceased. When I read this literature, I was aware of to what extent these ideas were irrelevant to small communities as here in Norway, where almost everybody knows everybody. I actually think that what is more important, is the quality of the relationship between the new analyst and the deceased. It goes without saying that dislike of or conflicts with the former analyst will be counterproductive, so will probably a very different theoretical stance. I think that competitiveness or narcissistic needs, for instance the need to become a rescuer of an analytic orphan, are more important factors than whether or not the analysts knew each other.

There is one aspect about the loss which I didn't see dealt with in the literature when I wrote my articles back in the days: An analytic patient finds him/herself in a unique situation when it comes to communicating with others. In everyday life, we have two sets of dialogues going on – one inwardly to ourselves, and one

in the exchange with other people. Within the analysis, the inner dialogue, through free association, is extended to include another person – the analyst. So, the analytic dialogue is unlike any other dialogue in the patient's life and is as such irreplaceable in real life. This extension of the inner dialogue gets to a sudden halt when the analyst isn't available anymore, but may continue in the patient's mind. It may then be very difficult for a bereft patient to communicate in a meaningful way about the analysis in everyday language. A colleague put it this way: The person with whom you need to share your feelings about what has happened, is the very person who is dead.

For me, it took a long time after my second analyst died to be able to talk sensibly about my state of mind. Unfortunately, a first "bridging" analyst had no intuitive understanding of how blurred and confused everything was, and I was completely unable to explain to her how I reacted. I think that the most important thing that is required of an analyst called upon to assist a bereft analysand, is to allow space and time for the patient to recover from the immediate trauma. I will strongly warn against being in any sense officious, whether that is in the sense of interpreting transference aspects of the relationship between the patient and the deceased, or in offering conclusive ideas about how the patient should proceed. Compassionate listening and refraining from conclusions will be the best recipe. Considerable time may be needed.

If the relationship between the bridging analyst and the patient develops into a fruitful working alliance, I think that there is no reason why they shouldn't continue the work developing into a new analysis. This would protect the patient from seeing more professionals than strictly necessary. The new analyst's schedule may not allow starting a new analysis on short notice, but then, I think that a low frequency contact until time will be available mostly will be better than another referral.

Finally, I shall briefly comment upon dyadic and triadic aspects of a new analytic relationship. Whatever one's theoretic stance may be, emphasis of the dyadic interaction will normally be the primary ingredient in any analytic process.

When starting a new analytic process with someone who lost his/her analyst, I think that it is important to conceptualize the work as fundamentally triadic.

The technical approach of interpreting most everything in terms of transference within the current analytic dyad will probably not be fruitful in this special case. To bring oneself too early into the picture as a transferential object may interfere with the deeper aspects of mourning. When leaving space for amalgamating the former analytic process into the new one by showing a non-judgmental curiosity about what went on in the dyad with the deceased analyst may eventually enrich the patient, who then is free to use the discoveries made through the first analysis as building blocks for further work with the new analyst. To be accompanied through one's inner landscapes by two knowledgeable escorts may presumably lead to a richer outcome, provided that the new companion refrains from competing with the first over who is the better company.