The Struggle Between Living and Dying: The Analytic Treatment of a 90-Year-Old Woman

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I should like to present the case of a 90-year-old woman, Mrs. R, whom I saw in therapy from the time she was 90 years old to the age of 97, when she died. She was in a large urban nursing home where she needed 24-hour nursing care, and was a severe management problem. Mrs. R was obstreperous, at times paranoid, and occasionally banged her bedpan against the wall. She was severely depressed and was given antidepressants and tranquilizers. In addition she had a history of gastrointestinal problems that required her to go to the bathroom frequently and caused constant bathroom accidents. Shortly after having been admitted to the nursing home, she had an amputation of her left leg necessitated by gangrene from a diabetic condition.

My first impression of her when I came into the room was that I was talking to a corpse. She herself felt empty, frightened, and lonelier than ever before; life was not worth living and she felt worthless. She described the aides and orderlies as cruel, unfeeling, neglectful, and, most importantly, she felt as though she were in a concentration camp. Frequently it was impossible to tell the difference between her accurate observations and her paranoid distortions. Obviously I wondered whether she could be available for treatment. If so, at what point might a psychoanalytic approach be possible?

I remember as I walked into her room for the first session she greeted me without looking up and said, “You are wasting your time with me. Nobody can help me. I am nothing. I wish I would get pneumonia because one dies fast that way.” I stood at the door for a while and she finally looked up as if seeing me for the first time, and asked, “Do you like music?” I nodded. Her positive transference was intense and immediate. The following session she confided: “Life is beautiful but not the life I have here.”

In spite of many doubts, I decided to work with Mrs. R, and so began our long journey together. Thereafter I saw her two or three times weekly, almost always in her room, in the nursing home.

Over the course of treatment I heard the history of Mrs. R. As we spoke I learned that she was born and raised in Vienna, Austria. She came from an extremely wealthy, upper class, Jewish family. Beginning
early in childhood Mrs. R was shielded from the world, kept home with governesses and tutors, which was appropriate to the family's social position. Her mother was a mild, timid woman to whom Mrs. R did not relate well. She experienced her mother as critical, unempathic, and emotionally unavailable. This may have been due to the fact that her mother suffered from severe depression and often was too ill to take care of her. Her father was a politically and socially influential lawyer. She remembers him as adoring, warm, and loving with her. She also remembers sitting on his lap for hours and often affectionately being teased by him for being “beautiful but dumb” because she could not remember her multiplication tables. Thus he both devalued her and pampered her.

Mrs. R went on to tell me about her life in her adult years. She married a man very much like her father, a banker, who was also politically and socially influential and of whom her family approved. She admired his brilliant, intellectual abilities and claimed that he enhanced and contributed to her position in life, because without him Mrs. R explained, she would have been “nothing.” She worshiped him and was totally dependent on him and his judgment. She submitted to his temper tantrums in silence and attended slavishly to his every need. Thus as an adult she married a man who she thought bolstered her self-image but who, like her father, devalued her. In fact, Mrs. R resembled Annie Reich's (1953, 1960) female character type, who maintained her self-image by seeing herself solely as an extension of her idealized husband.

Mrs. R and her husband had one child, a daughter, whom he indulged and she resented. Mrs. R reported that she was never very close with her daughter and left her care to governesses.

Shortly after the Nazis took over in 1938, a series of losses took place in her life, and the entire family fled penniless to the United States and took factory jobs to survive. Obviously, this constituted for them an enormous loss of both social station and self-esteem. Mrs. R and her daughter worked side by side in a sweater factory for long hours and her husband worked at creating artificial flowers. After a few years Mrs. R's daughter married a man from out of state and moved away, which constituted another loss. In addition, a serious blow to Mrs. R's self-esteem occurred when her husband became seriously depressed. The transition from prestigious financier to working in a factory was an adjustment he was not able to make. He made several suicide attempts. Finally, when Mrs. R was about 68 years old her husband died of a stroke.

After the death of her husband Mrs. R became severely depressed. She went through wide mood swings and experienced feelings of extreme worthlessness. Shortly thereafter Mrs. R decided to move into a senior residence. In her words, “Now I am nothing and I feel like garbage. I was frightened and there was nobody that could help me; I couldn't hold it together.” At the age of 88, her situation changed again as a result of severe health problems, deteriorating vision, and vascular disease. This prompted admission to a 24-hour nursing home facility.
Freud’s conceptualization of the life and death drive became a major theme running throughout our work together in that it helped me to understand the powerful struggle within Mrs. R, between those forces pulling her toward growth and development and those forces pulling her toward self-destruction. Although the death instinct is one of Freud's most controversial psychoanalytic concepts, I still found it very useful both as a metaphor and as an organizing principle. At first Mrs. R projected her will to live onto me, leaving the matter of her survival in my hands. It was only much later that she was able to deal with this issue.

Psychoanalytic Literature on Aging

With the exception of Settlage (1996), there is almost no literature dealing with the psychoanalysis of adults above the age of 85. Most of the literature deals with people in their fifties, sixties, and, more infrequently, seventies (Abraham, Kocher & Goda, 1980; Coltart, 1991; King, 1980; Sandler, 1978).

There are basically two traditions. First, in his 1905 paper “On Psychoanalysis,” Freud took the position that “near and above the fifties, the elasticity of the mental processes, on which the treatment depends, is as a rule, lacking-old people are no longer educable” (p. 258). Following Freud, most psychoanalysts have been reluctant to treat persons over fifty by classical psychoanalytic technique. Until recently Freud's beliefs about aging have discouraged analysts generally from the application of psychoanalytic principles to the treatment of older people.

Second, there is a small but important contrary tradition within psychoanalysis. The earliest example is the work of Karl Abraham: He wrote in 1919 that chronological age does not necessarily preclude the intellectual and emotional capacity for analysis. Erikson's (1980) contribution to the treatment of older adults was derived from his reconceptualization of development as a series of epigenetic stages starting with early childhood and continuing into late adulthood. Erikson believed strongly in generativity, which continues throughout the life cycle. In this way his theoretical orientation allows us to look at the possibility of treatment for the older person in a more favorable way.

More importantly, Jung (1933) was the first to recognize the importance of the later stages of life and their powerful central developmental potential. Although outside the mainstream of psychoanalysis, Jung was always fascinated by the psychoanalysis of people in the second half of life and truly believed that this was the crucial time for them to actually achieve complete unity of their personality. He worked with many patients in the second half of life and thought there was great therapeutic potential for them.
More recently, changes in psychoanalytic understanding and technique regarding narcissistic and borderline psychopathology may prove significant for the treatment of the older patient. These more recent frameworks, as developed originally by Kernberg (1975, 1980) and Kohut (1971, 1972), are perhaps the first to inform us concerning the significant changes that take place throughout adulthood. Now we have a better conceptualization of how the aging process can be understood in terms of narcissistic depletion and of injury to one's narcissistic stability. As an individual's ego function declines, whether as a consequence of certain aging or as a product of institutionalization, he or she may deteriorate to the point where narcissistic or borderline features appear to predominate (Turner, Tobin, & Lieberman, 1972).

Perhaps narcissistic and borderline psychopathology are especially prominent among the elderly because one of the basic problems is dealing with loss. How does one maintain self-esteem and a sense of self with the many losses associated with aging (social, psychological, and biological), especially if one lives in an institution that may be degrading, disempowering, and in many cases compassionless? Boundary lines between borderline and narcissistic psychopathology and aging are not always clear. Several basic questions arise in connection with the presentation of the following case material. Are the patient's limitations due to aging per se, institutionalization, or the nature of early childhood and later experiences? Are there defenses used more frequently by the older adult, which are not due to deep character pathology, but rather to changing life circumstances, such as admission to a hospital or nursing home? Lastly, can one really make genetic interpretations that span eighty to ninety years, or is the understanding of the multigenerational transferences in these instances more relevant?

Meerlo (1955) makes an additional observation, suggesting that because of the possible shorter time together, the older patient and therapist may avoid forming a close, meaningful relationship.

In other words, there can be covert resistance both in the transference and in the countertransference. However, perhaps the opposite might be true. The most difficult, but also the most challenging, aspect of working with an aged patient is the inevitable time limit, the sense of urgency, and the feeling that the patient now has only one last chance to come to terms with his or her past. Although complete resolution of a patient's problems is rarely possible at any age, the small victories and signs of change, the increased freedom, and the ability to find worthwhileness in living may make psychoanalysis with the older adult a most rewarding therapeutic investment (Pollock, 1981).

Establishing the Psychoanalytic Treatment Relationship

Because Mrs. R was in such a deteriorated unrelated paranoid state and the situation was so chaotic, my first task was to establish a working treatment alliance. I established a pattern of regular visitation. At first she would wait in the hallway for me, always expressing concern that I would not come. As she became more trusting, she would wait for me in her room. Most important, I began by being a
sympathetic and empathic listener about her numerous woes in the nursing home. Gradually she also began to talk more about herself and express the full range of her unhappy feelings. These included paranoid feelings about staff. Often she was not completely wrong.

Although I shall be focusing on the unfolding of the psychoanalytic process in this paper, it must be understood that the analytic work was inevitably interspersed with numerous reality constraints and demands. I found myself working closely with the staff to stabilize Mrs. R's condition, reduce her state of extreme frustration and agitated anxiety, and make hers a more therapeutic environment. I felt that by helping to make basic practical and attitude changes with the staff, she could learn to trust me and see me as her therapeutic ally. I attended team meetings and often acted as her advocate. She responded quite well: Her behavior gradually began to improve and she was less agitated, stopped cursing, and became more cooperative.

For a long time she continued to talk about her feelings of distress at her present situation. She felt abandoned and encased in a body she hated. She often cried: “I have lost every friend. People used to come and visit me, but now nobody even calls. Nobody cares. My daughter comes only once a year because she lives in Pennsylvania. Why doesn't anyone come anymore?”

On her 91st birthday she greeted me and told me, “You are my only visitor. For so long there has been nothing for me and I have felt like I am nothing. Why do you bother with me? I have nothing more to give. You are fighting so that I should live, even though I really want to die.” I felt that this statement represented a crucial step forward in the establishment of our working alliance. She began to count on me.

Anger, Blame and Depression

Mrs. R was now more and more able to talk about the story of her life and gradually became more capable of simple insights: “How unhappy I was when I first came to the United States, after having lived a life of such status and elegance and then losing everything. What a comedown!” Obviously Mrs. R had felt cheated, humiliated, angry, and ashamed. She was angry with her daughter for leaving her alone. She was angry with her husband for being depressed and then dying. Finally, she was angry with the doctors for amputating her leg. Most of all she was angry with herself for being so dependent. She was, however, able to realize that these were not simply external losses but that they also grew out of a lifetime of dependency.

She also continued to tell me how she had been depressed all her life, but now that feeling was stronger than ever. I was able to connect her present depression to the early maternal depression and the consequent emotional unavailability of her mother during her years of growing up. Again she was able
to understand how this had affected her adult life and even might have predisposed her to her present depression.

Two Important Dreams

In this phase of treatment Mrs. R reported two important dreams. The following dream came after several months of analyzing her history in treatment:

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“I was at the seashore walking along the beach and it was foggy. In the fog there suddenly stood my husband. I became very frightened and ran the other way. When I turned around he had disappeared.”

After telling me of the dream, her associations turned to the night of her husband's death. She remembered sobbing and listening with closed eyes to Wagner’s “Tristan and Isolde.” She also remembered her fantasy of dying with him in his embrace and that it would have meant eternal love and togetherness. She herself understood the dream to mean that her husband was beckoning her, and was disappointed because she had not yet joined him. Gediman (1995) describes Liebestod fantasies as an expression of the wish for reunion and merger with a loved one. The motif depicts “the twin nostalgia for oneness in the ecstatic release of dying together” (p. 39).

In the analysis of the dream, we also discovered another dimension of meaning connected to our own relationship. The dream is about union, merger, separation, and loss. On another level, these themes also refer to our relationship. Will I disappear the way her husband disappeared? Does she want to live and work with me or join her husband in death? The dream foreshadowed much of the course of the transference.

She reported the second dream when she still appeared very depressed:

Mrs. R is in her childhood bedroom in Vienna, and she is looking out the window. There she sees a caterpillar squirming on the ground and hundreds of ants surrounding it. She rushes down the stairs to save the caterpillar from the ants. By the time she reaches the ground, the caterpillar is dead.

Her associations were that the ants were the aides and orderlies in the nursing home and that they were harassing her. She herself was the caterpillar. On this level, the dream was easily accessible to her and it had the meaning, “Will these people kill me?” But the dream also had a deeper meaning. Obviously she still was very depressed and had not been able to save the caterpillar because of lost energy and life force. However, the dream also tells us that there still was some youthful energy in her after all, because it was she herself-as a girl-who tried to save the dying part of herself. The caterpillar is a symbol that

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combines antithetical ideas from the unconscious (Freud, 1910). On the one hand it represents her dying or dead self, while on the other hand it represents just the opposite, the possibility of renewal of life. The caterpillar is the early larval form of a butterfly. The question here was “Will the processes of death destroy her before she has a chance to develop, to be creative and fly? Will she be able to survive? Will she at least be equal to life's forces or will death overtake her?

The first Liebestod dream is very pessimistic and represents a glorification of death. In the second dream, however, Mrs. R plays a more active role. We were able to analyze the dream. Initially she identified with the dying caterpillar. As we did some interpretive work together, she was able to admit there was a child-part in her that also wanted to save herself and that the dream showed some possibility of renewed life. These two dreams seemed to show a deepening awareness of her own ambivalence about living and dying.

The Deepening of Our Relationship

As time went on, our relationship deepened. There was an age difference of 38 years between us, thus creating the possibility of an interesting reversal of generations (Nemiroff & Colarusso, 1985). Rather remarkably, Mrs. R and I had some important experiences in common. We were both refugees from the Nazis. As we began to discuss our common cultural heritage, we found that we shared many interests, in literature, poetry, and music. She had actually known many celebrated personalities, for example, Fritz Kreisler, Albert Einstein, Franz Werfel, Alfred Adler, Arthur Schnitzler, and many others whom I had idealized in the past. Thus we developed an intimate parallel relationship in which she could feel self-esteem because she was in her milieu, and it was also enjoyable for both of us. Once she even recited the full text of Mahler's “Das Lied von der Erde.” Gradually we created a whole new world within the confines of her barren little room, which we both knew was the last stop before the end of her life.

On an object relations level our time together had complex transferential meanings. On the one hand it allowed her to have a close mother-daughter relationship, in which she felt accepted in a way she had not been accepted by her mother. In this regard I was playing the role of the mother-imago. But, equally important, we were both aware that in another sense she was still playing the mother and I was an idealized version of her own daughter, who had disappointed her in many ways. She had never been able to give much to her own daughter because so little had been given to her.

Most importantly, Mrs. R was given one more opportunity to have a reparative and healing experience. Prior to this she had felt like a bad, inadequate mother because she had not been capable of being caring and nurturing to her daughter. Now she had another chance to modify her mothering and improve the feelings she had about herself as a mother. Thus I had an opportunity to help this woman continue and complete her psychological development in the tenth decade of her life and bring her life
to a better completion. On a theoretical level, this is a remarkable testimony to the lifelong capacity of the human psyche to continue growth and development.

Of great interest is the fact that in this period it was music that became our deepest connection. It was through our listening together and discussion of music that she enabled me to understand her and validate her feelings of pain and disappointment. Sometimes I would bring in tapes of the music she wanted to hear and we listened together. We listened to Mahler and Bruckner's Ninth symphonies and Beethoven's Missa Solemnis. I pointed out to her that all this music had two things in common, namely, that each was written during the final stage of the composer's life and also that each was the composer's farewell to life. I remember that after my comment there was a moment of silence and then she exclaimed, as if she just had a new insight, “Ach wie schon? Wenn ich das nur konnte.” (How beautiful. If only I could do that). She suddenly seemed more stimulated and alive, as if she had found some new meaning in living in spite of her narrow, drab, and unstimulating surroundings. One might speculate that music had been known to break through the wall of melancholy and enable the depressed person to regain access to the feelings from which he or she has been alienated. Moreover, music can have a powerful effect and cause a general state of arousal rather than a specific emotion. On a theoretical level music is a way of communicating preverbal emotions and represents a nonverbal or preverbal form of communication related to earliest infancy (Kohut, 1978. For further discussion see Storr, 1992, p. 30).

As our relationship became closer, this intimacy seemed to revive old conflicts with her daughter, and she became increasingly anxious. As I became aware of this, I inquired more about her early relationship with her daughter and the subsequent estrangement. I found out that they never had a close relationship and that she had always felt guilty for not being a more loving mother. She reported that her daughter was such an ugly child and she felt extreme disappointment. In contrast, Mrs. R had always experienced herself as very beautiful; men used to stare at her when she went out to the opera in her long black lace dress and corsage of red flowers. In fact, I even learned a more remarkable fact. Her daughter was born with one leg shorter than the other and had to wear a brace growing up. At one point she asked: “Was the loss of my leg God's punishment for how I related to my daughter's affliction?” At times she even obsessed guiltily that she would lose her other leg. I made a gentle interpretation to enable her to have a less critical and more loving and forgiving superego. I said to her, “Perhaps it was very difficult giving to your daughter, when you got so little from your own mother.”

The relationship with her daughter turned out to be more complex and ambivalent. At times she expressed great anger, saying: “Why didn't she stop the amputation from happening?” As her anger at herself and at her daughter gradually decreased, she was able to forgive herself more, and also forgive her daughter and see her in a more realistic light. Consequently, she gradually was able to develop the actual relationship with her daughter and have more telephone contacts.
At a certain point in the treatment I took my summer vacation. I felt caught in a very difficult symbiotic relationship. My absence affected her profoundly. She stopped eating and drinking, and the whole staff gave up working with her. In effect she was attempting suicide by starving herself. When I returned, I was horrified at what I saw. She looked emaciated, almost life-less.

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I walked toward her bed and held her hand. She somehow mustered all her strength, looked up at me, and with a little smile whispered, “You’re back. You’re fighting death in my behalf. Now maybe you will win after all.” On a theoretical level, Becker (1973) so eloquently speaks of the essence of transference as the “taming of terror.” He argues convincingly that: “The transference object always looms larger than life because it represents all of life…” (p. 146).

Psychological Rebirth and Creativity

After this time our relationship evolved further and became more personal and more intimate, but also in a way more separate. Her hope was reviving. My role in the therapy now shifted, and I was able to utilize her idealized transference toward me in a different way than had her father and husband. She seemed to have lived vicariously through them and derived her self-esteem through their achievements. I encouraged Mrs. R to develop herself, and I shared my idealized qualities with her. I used the idealized transference to restore to her for the first time her own sense of self-efficacy and personal creativity. Her many physical and emotional losses had left her with anger and envy, and with sorrow for her lost youth. My presence enabled her to resume growth and form new ties.

Gradually she began to concentrate on activities where she could actively express herself, especially art activities such as painting and ceramics. One day she announced, “Das Leben ist schon besser” (Life is better now). And indeed it was. She now began to paint for the first time since her youth, in spite of being almost blind. Painting was a way of enabling her to begin to separate from me and find pleasure in her own productions. Perhaps it could be said that she was going through a belated separation-individuation process. She would paint first and then use a magnifying glass, which I brought her, to see what she painted. I entered her fantasy world, which she shared freely, and we planned what she would paint next and the colors she would use. We talked about Monet and Seurat and Degas. With lots of persuasion on my part, she was given permission by the

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nursing home to visit the Metropolitan Museum of Art by ambulette.

After that there was no stopping her. Two of her paintings earned first prize in a citywide competition, in the senior category. With my encouragement for her to find new avenues of expression, she also began painting greeting cards, which she then gave to the other residents. She had two special exhibits of all
her paintings and cards at the nursing home, with residents and their relatives attending. Painting became a crucial part of Mrs. R S ability to manage, transform, and transcend the losses of old age and complete the mourning process. She finally encountered recognition for her accomplishments, something she had always yearned for. At one point she confided to me that this seemed to her to be the happiest time in her life.

Most important of all, there was a real change and growth in her relationships with the other residents, with the staff, and also with me. She was able to see me more and more as a separate person and reestablish feelings of self-worth and self-esteem. My visits were significant not only because of what was said but rather due to our feelings of warmth and understanding, as well as her discovery that some predictability and constancy in a relationship was possible (Pollock, 1981).

Death and Transfiguration

The last dream came four days before her death. She was on oxygen. When I came into her room she called me “mother,” and when I went over to her and held her hand she told me that she had the most wonderful dream:

“I was in Portugal where I visited many years ago. In my dream I saw the village of Sintra nestled between gardens and beautiful lush green hills. When I looked up, I saw the beautiful castle in the distance rising from the midst of rocks. I was so happy. “

Her dream was very striking. I wanted to think it represented more growth and even thought that she might be getting better. It was only afterwards that I understood the dream wish and my own countertransference wish. This was a dream of “Death Transfigured.” Grotjahn (1985) notes that dreams of death are frequently beautiful and that castles and magnificent landscapes represent the houses and places of dead parents and fantasies of life hereafter (p. 299). The dream was a summation of our work and time together. Death no longer represented a flight from life, resignation, or defeat. In her dream and in her final years, death was the culmination and the crowning pinnacle of her life.

When she died, the nursing home staff called me. I experienced intense sadness and loss. I had loved her for what she had become... a free spirit who could transcend the physical boundaries of her sad surroundings. I also realized how much she had enriched my own life and how I had learned that one can find hope in life against seemingly irreparable odds.

Epilogue

There is another dimension to this psychoanalytic therapy that deserves emphasis. From beginning to end I was well aware of the fact that countertransference is important, as it is in any analysis, but that it
may take special forms, and poses special problems, when dealing with the very elderly. In my opinion there is a very strong intersubjective process taking place that assumes a special meaning when we are dealing with the elderly, especially with the very elderly. We are compelled to face issues of death and the denial of death, and psychoanalysts, for the most part, have not been prepared to face this. Becker (1973) has eloquently stated: “Death becomes the ultimate narcissistic challenge, throwing the expectant self into crisis. The irony of man's condition, is that the deepest need is to be free of the anxiety of death and annihilation; but it is life itself which awakens it” (p. 66).

Margot Tallmer's (1989, 1992) research showed clearly that even when analysts were in their nineties they did not take into account their own mortality. Ironically, psychoanalysts have always been reluctant to treat older adults psychoanalytically (Mann, 1985). Why? Could it be more about their own personal fears of having to come face to face with aging and dying and confronting their own mortality, than an adherence to Freud's theoretical beliefs that the elderly are poor candidates for psychoanalysis and not capable of further growth?

In a certain sense, I must confess that in working with Mrs. R, I must have also denied feelings our relationship induced in me. Throughout this entire treatment we were on the one hand looking backward in the direction of her childhood, but both of us on the other hand were also in some ways looking in a forward direction, toward the inevitable finality of our own lives and our relationship. These existential limitations actually enabled Mrs. R to heal herself and to access strengths and abilities that she did not know she had.

As the therapist, our short time together evoked a wealth of deeply personal feelings in me. Until the last day of her life I probably retained fantasies of her continuing to live. About four days before she died, when no doubt I had a premonition that she was going to die, I had the following dream:

I came to see her as usual where she sat in her wheelchair outside her room. She stood up and ran toward me to embrace me.

In my dream Mrs. R is still very alive at the same time I had a premonition that she was about to die. As I approached her she rose from her chair and in an uncanny and mystical way ran down the hall to embrace me as though we were mother and child. Obviously, at that point, I wanted to defend myself against the pain of her impending death and in so doing transformed our separation into a kind of reunion. I even restored her leg, her mobility, and her will to live.

Perhaps most important for psychoanalysts working with the very aged is what Kernberg (1980) speaks of as an awareness of the attitude and conflict analysts have toward their own aging and dying. The possibility of facing and resolving these inner conflicts may affect how far they will dare to go with their own patients (p. 153).
References


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