

**‘The Unexamined Death’: Patients’ Experiences of the
Premature Termination of Analysis Due to the Sudden
Death, or Terminal Illness, of the Analyst**

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'The Unexamined Death': Patients' Experiences of the Premature Termination of Analysis Due to the Sudden Death, or Terminal Illness, of the Analyst*

'All stories are haunted by the ghosts of the stories they might have been'.

Salman Rushdie

Chapter 1. Background

Throughout, the usage of the terms 'analysis' and 'analyst' will include psychoanalysis, psychoanalytic psychotherapy and their corresponding practitioners.

I became acutely aware of the topic of this research in 2010 with the traumatic, untimely termination of my own nine year analysis due to the analyst's terminal illness. I was conscious of the impact on my psyche of working with a seriously ill, but seemingly in denial, analyst for many months and subsequently experiencing a sudden untimely termination. The quality and appropriateness of the aftercare raised concerns for me. The year before I had qualified as a psychoanalytic psychotherapist, had a private practice and also worked for a training organization. I was therefore surrounded by members of the analytic community but still felt confused and isolated. Talking to colleagues I came to realise that mine was not a rare problem. I started to reflect on how this experience would be for someone who was not a member of the psychoanalytic community. This was not a topic that had been covered in my extensive training and so I turned to psychoanalytic literature to gain a greater understanding of the nature and extent of the phenomenon. I discovered, through briefly reviewing the literature, that research

*This title refers to a statement attributed to Socrates as follows – *'The unexamined life is not worth living'* and to the title of Stephen Grosz's (2014) book *'The Examined Life'*.

and theorizing were very limited – a ‘taboo’ topic as some writers had suggested. I was particularly concerned that so little attention had seemingly been given to listening to patients. Particularly uncomfortable in our society’s present day culture, where the principles of consumer/patient participation and choice in the provision and delivering of services are considered as good practice and a fundamental human right, including in the NHS. There were indications that some patients had experienced traumatic physical/emotional effects and the provision of aftercare appeared ill informed and patchy in quality. This was surely an important topic that needed more attention. Shortly after this I attended a talk on the Professional Doctorate programme at Essex University that had been arranged by the training organization that employed me. That evening I knew that this was an appropriate, rigorous way of examining the worrying issues I had identified.

Chapter 2. Literature Review

1. Introduction

The trend in the generally sparse literature on the premature termination of analysis due to the sudden death or terminal illness of the analyst, is to side-line the fundamental issue of the effect of this experience on the patient's psyche in favour of related issues. Moreover, in Rendely's words -

'The patient's voice is rarely heard' (1999, p.136).

The latter is surely paradoxical, for a fundamental analytic requirement is to listen to patients and base interpretations, underpinned by theory, on their expressed material. Is it not strange that what aftercare has been put in place by the psychoanalytic profession for bereaved, and perhaps traumatised, patients is only backed by a sparse body of research and literature that has focused directly on *their* experience? Gabbard 2015 (cited Kantrowitz 2015, p.xiv) states -

'The conventional wisdom has been that the patients' transference distorts the accuracy of their reporting about such matters. In the contemporary zeitgeist, however, we have moved closer to the view of Bion that patients may be our best teachers'.

The issues most commonly dealt with are as follows:

- That the subject of death in the medical profession in general, including psychoanalysis, is 'taboo' and the conscious and unconscious denial by analysts of their own terminal illness is commonplace. This includes hypothesising why it might be so.
- The impact on the client of the premature termination of analysis for reasons other than death of the analyst.
- The plight of the terminally ill analyst as opposed to the patient.
- Difficulties encountered by analysts 'picking up' bereaved patients.
- Suggestions in terms of aftercare, including subsequent analysis, but neither based on a consolidated body of research, or giving attention to the voice of the patient.

Interspersed amongst papers primarily covering the above topics is some limited material highlighting how an analyst's terminal illness/ death has affected a patient's psyche, how this may differ from a 'normal' bereavement or a planned termination and how an analyst's approach to their illness may affect the outcome. Very little of this limited material gives attention to the direct voices of patients.

In the body of this chapter the literature will be considered under the following themes:

- What **are** patients expressing directly about the psychic impact of this phenomenon? Have they felt listened to, supported and their experiences acknowledged?
- As above, but where patients' voices are heard via an intermediary.
- How does the impact of this event differ from losing a family member or close friend?
- Why is the thought of terminal illness/death of an analyst so seemingly resisted by analysts and professional organizations? How might this impact on patients?

2. Main Body of Review

A. The Patients' Voice Direct

Lord, Rivo and Solnit (1978), published what appears to be **one of only three empirical studies** on reactions of patients to their analysts' deaths based on questionnaires to patients whose analysts had died whilst they were in treatment. An unusually high 93% (27) responded - all mental health professionals, mainly psychoanalysts. The authors highlighted that this was a preliminary enquiry that raised many questions about '*the effects of this traumatic event*' (1978, p.189) that warranted further research -

'We are aware that the nature of our undertaking does not permit in-depth observations or conclusions' (1978, p.196).

11 patients replied **directly**. 16 were completed by another analyst. The authors considered that the accounts of the former described more complex reactions but that the latter were more objective. The main findings were as follows: 10 experienced '*pathological*' mourning reactions – defined as lasting more than one year and including anguish, helplessness, profuse crying,

recurrent dreams and imagined glimpses of the analyst. These 10 manifested somatic symptoms e.g. insomnia, anorexia and gastrointestinal complaints, and everyday functioning was impaired suggesting a regressive transfer at the time of termination, or just following. Early loss and deprivation, according to the researchers, appeared to be the most important factors associated with this *'pathological'* reaction, as opposed to those whose mourning was judged to be normal by the researchers. There was some indication that older patients were more adversely affected and psychoanalytic trainees less badly. The authors suggest that the former could be because older patients might have less hope that their problems would now be resolved and the latter because trainees would likely have more ego strength and be part of an analytic community. 5 non-trainee participants had major problems with relationships. Other reactions noted that were more evenly distributed were anger (at least 16) – at abandonment, betrayal of trust, the analysts' lack of self-care. Also relief (4), including relief from an analysis distorted by illness. 26 patients entered further treatment with over half having at least initial difficulties with establishing a working alliance.

Rizk and Voller (2013), undertook an empirical enquiry based on one phenomenologically-orientated case study of a trainee analyst who had lost her analyst to cancer two years into the work. She describes excruciatingly painful feelings of loss, anxiety, abandonment, jealousy and isolation that had a surreal, disconnected quality, including a sense of disconnection from the analyst as he increasingly withdrew into himself. She was frightened to expose this vulnerable part of herself to others and wanted to die. These emotions started when she first was told of the analyst's illness and continued for the remaining few months of their time together. Prior to being told of his illness she experienced extreme anxiety for many months, aware that something was wrong as her analyst missed sessions due to medical tests/an operation, but not being told the nature of the problem. She became acutely aware of her position as a patient rather than a relative and began to fear that her sense of a close relationship with the analyst was an illusion. In the last

few months of analysis, with her analyst unwilling to discuss their past relationship and help her think about the future, she decided she must leave. After his death, three months later, she felt part of herself had also died. Eight years later the emotions were still raw and painful to express. Expressing them in the research interview was felt to be therapeutic. For example, the author believed that in sharing her grief the patient was helped to re-connect to the parts of herself she felt had died with the analyst.

Kantrowitz (2015), undertook an empirical enquiry in the States on the direct experience of termination for 82 former analysands, 15 of which had an analyst who had become ill and died. She undertook largely unstructured, one to two hour, telephone interviews with the patients. The findings are described in a book devoted to exploring the gap between the myths around analytic endings and the reality for patients. As the findings mostly do not differentiate between those who lost their analyst through illness/death and patients who had an ending that for other reasons was not mutually agreed, the usefulness of the data to this research is very limited. Also the references to the support patients received from professional organizations applies to American analytic institutes. She concluded, from her data that -

'Having one's analyst become ill or die during the course of analysis inevitably causes distress for an analysand. But when the analyst denies this reality and/or the analytic community fails to communicate with or offer support to the analysand, the difficulties and distress are compounded. In this study...where there was support from the community, analysands were better able to deal with the loss and continue their own analytic progress and development' (2015, p.162).

There appear to be four autobiographical articles and a fifth article (by Pinsky) which briefly includes the author's response to her own analyst's death in a more general article on the plight of patients experiencing this phenomenon.

Rendely (1999), an analyst, describes the impact on her of the terminal illness and subsequent death of her analyst after five years of work. On learning of his terminal illness she describes initial feelings of isolation, helplessness, anxiety and fear complicated by her position as a patient, in that the boundaries that had initially offered protection had been *'transformed into an*

impenetrable wall' (199, p.134) – no means of direct contact, no softening of pain through giving care to the analyst. She struggled with doubts for many months about the reality of the mutuality of her relationship with the analyst and this complicated her grief. She highlights how the patient must come to terms, depending on their particular circumstances, with a contract suddenly cut short that involved hope, time, energy and money; a situation where transferences have been only partially worked through and internalization is not yet secure; with the loss of an intense, personal, *real* relationship the latter's significance not adequately recognized by the psychoanalytic community. Rendely, referencing Winnicott, considers that if the patient is in a place where dependency has deepened and regression has occurred but working through is incomplete, a sudden rupture of the analytic relationship can be likened to a too early, or too severe rupture, in the early infant- mother dyad. This may result in a state of existential terror – a threat to the sense of self. This is heightened by a regressed patient's distress being unheard or recognized by others - *'This is no ordinary loss. Profound grief ensues'* (1999, p.139).

Adams (1995), not an analyst, wrote a memoir of her nineteen year analysis which finished abruptly three months before her analyst's death. Terminally ill for some time, he had not conveyed this to her. The paper was written a month after his death and largely consists of memories preceding the years before his illness, recorded as a means of holding on to what she knew of the analyst, because the ending had been so confusing and uncharacteristic -

'One week he was there.... Then a phone call from a strange woman saying he would not make his next appointment. Then the letter, written in an impersonal, stiff English, signed shakily in his own hand, ending his practice' (1995, p.727).

At the last session his physical appearance had changed *'horribly'* (1995, p.738) but he denied that he knew what was wrong, which Adam's subsequently realised was a lie. Desperate for information she scoured obituaries, eventually being told by an associate of the analyst that he had died a week previously.

The next two authors contributed to what appears to be the only book, apart from Kantrowitz (2015), addressing this subject. Garfield (1990 cited Schwartz & Silver 1990, pp.253-266), writing of his training analyst who was terminally ill whilst continuing working, describes how the relationship shifted so that Garfield felt more like the carer. He believes that, for him, acting out and grievance detrimentally replaced true grief and mourning for around seven years after the analyst's death.

He contributes the cause to a combination of factors, such as lack of opportunity and inability to speak of his grievance and be truly heard; of having to be strong for his own clients; of the reawakening of old losses. He says -

'Perhaps what is most disabling about grievance is not that it results in pain and suffering but it can result in being lost and not knowing it. Grieving may not be able to begin until all grievances are heard and until one's voice has been found' (1990, p.265).

Wolman (1990 cited Schwartz & Silver 1990, pp.267-298), a Clinical Assistant Professor of Psychiatry, was bereaved six months after a planned termination. Wolman describes fantasies and dreams that connected the cause of his analyst's death with the analysis -

'...a slow acting poison which might not take full effect for six months' (p.273).

This is perhaps indicative of unconscious hostile feelings towards the analyst. Wolman's account suggests that he had difficulties locating the death in time and space because he had so few factual details of the event. In dreams and fantasies his analyst's death became entwined with his own childhood traumas. Wolman, like Rendely, considers that the death of an analyst during the process, or in the post termination phase, may require the suspension of a patient's self-analytic work whilst the task of mourning takes place.

I have discovered four papers written by analysts that, amongst other material, report on or quote from material they have collected directly from patients.

Barbanel (1989), reports on a project undertaken by herself and several colleagues in response to making contact, or working with, patients whose analysts had died during their analysis or been

ill during it and died shortly after. They were perturbed to discover that there was no comprehensive body of literature to guide them. It is difficult to get a clear idea of the reliability of this study's findings as the methodology is unclear e.g. there are no figures for the number surveyed. However they remark that there was a great eagerness for patients to tell their story and an emotional intensity of response (even after 10 years). The following trends were observed:

- All said that they did not know the death was imminent, although one analyst died ten minutes before the patient arrived. However there are indications that patients may have known unconsciously. Patients spoke of having been deceived and felt angry and betrayed, particularly when there was evidence of an analyst's prior knowledge of illness.
- All reported that the attachment to a second analyst was weaker.

Barbanel considered that -

'Certainly the nature of the experience of betrayal would seem to relate to the stage of analysis the patient is at, the nature of the attachment' (p.418).

Tallmer (1989), reports briefly on 8 patients she directly requested information from regarding their analysts' deaths. Another 8 had replied (the number approached in total is not given) and she states that their responses reiterated the issues detailed by the eight she reported on.

Patient 1 – Denial by the analyst despite obvious signs of illness, including missed sessions.

Notification of death was by a note on the door. Resentment at the analyst for preventing expression of feeling in the sessions by this denial, alongside self-blame. In the latter stages boundaries became blurred. A subsequent analysis was detrimentally affected.

Patient 2 – Reversal of roles and anger with the analyst/analytic community.

Patient 3 – Guilt for leaving an analyst who was terminally ill and still working.

Patient 4 – Felt cheated because she had lost out.

Two patients working with an analyst of 96 years of age seemed to have anticipated and accepted his death. Towards the end one patient felt he became minimising of her problems.

Two other patients maintained their analyses had been profitable although the quality had somewhat deteriorated as their analysts' conditions progressed.

Pinsky, writing of her analyst's sudden death says -

'... I felt lonelier than ever in my life' (2002, p.173).

She turned for comfort to friends and colleagues whom she found wholly satisfactory and also to literature and psychoanalytic theory. Within the latter she found -

'Instead of comfort a great deal of avoidance, confusion, condescension, self-delusion and dissimulation. Rarely did I find the voice of the patient' (p.174).

Traesdel's (2005) paper entitled 'When the Analyst Dies: Dealing with the Aftermath' includes a case vignette written by a patient, herself a professional therapist, whose analyst died suddenly.

For several months her body ached and for many months she felt as if her mind was divided in two – within the second compartment it was as if the analysis continued there -

'Semiconsciously, blurred, in the absence of any framework and focus, very chaotic and painful' (p.1242).

A subsequent analysis quickly failed and added to her mental confusion. She believes this was because she simply needed a space to grieve rather than develop another analytic relationship - it felt *'intrusive and seductive'* (p.1243).

B. The Patients' Voice via an Intermediary

Under this heading I have grouped the literature into:

- a. Observations from analysts of patients whose previous analyst had died, or analysts who had talked to colleagues who had encountered this experience.
 - b. Analysts writing on the effect of their own terminal illness on patients.
- a) Halpert (1982), cites Brunswick's (1928) report on the Wolf Man, whom she saw for five months after his initial treatment with Freud. Halpert maintains that there are indications that the Wolf Man's anxieties over Freud's illness and possible death induced sadistic fantasies at possible abandonment, linked to guilt and a need to protect the ill analyst. Halpert considers that

if, as in the case of the Wolf Man, sadistic murderous fantasies precede the illness, guilt is intensified. He also describes a consultation with a patient whose conflict over murderous wishes was a predominant factor in her pathology. These had been stimulated by a previous analyst evading the interpretation of material she brought to sessions concerning his noticeable disabling terminal illness. She eventually colluded with his denial. This, combined with a sudden notice of termination, had prevented her from working through the feelings that had been stirred up in her. It was also a re-enactment of a previous experience. Her fury was displaced onto Halpert whom she suddenly abandoned. He cites a second patient of his whose existing guilt-laden masochistic fantasies had been reinforced by her previous analyst's denial of his terminal illness and her subsequent collusion/identification with the silent, suffering analyst.

Simon (1989), comments on a patient referred to her from a dying analyst. The patient guessed she was dying but had felt discouraged from openly discussing her fears and believed this had created a distance between them. She felt guilty, ashamed and bad that she knew something she should not – a major theme in her life. At the same time she felt betrayed by the analyst. Feelings of self-doubt generated by what she knew, and what was being seemingly denied by a trusted person, created an iatrogenic disorder. She believed that her '*badness*' had perhaps caused the analyst's illness/death and her subsequent abandonment. As a punishment she denied herself pleasure. These issues were worked through in the subsequent analysis but Simon expresses concern that without this the patient's pathology would have been reinforced.

Freedman (1990 cited Schwartz & Silver 1990, pp.299-331), reported on some patients (number unclear) of three analysts who had died whilst in practice. He utilised a combination of discussion with (and perusal of notes of) one of the analysts, discussions with colleagues and some interviews with patients. He interviewed two of the three patients of a specific analyst who had worked for over a year with terminal cancer until his sudden death. He believes that all three would have had a more satisfactory termination if the analyst had been more open about his

condition and had sought analytic help to guide him over the termination phase. The sudden deaths were communicated to one by a chance meeting with a colleague and another by reading an obituary. With the third patient analytic boundaries became blurred and the patient took on a caring role. Most patients Freedman reported on had been adversely affected by working with an ill analyst and by poor notification of their analyst's death.

Firestein (1990 cited Schwartz and Silver 1990, pp.333-339), reports on information given to him by colleagues on 13 patients who had consulted them after their analysts' deaths. Although there had been warning signs in most situations, chances to achieve a more satisfactory termination were missed and the analytic work invariably compromised. For example, analysts' denials inhibited interpretations in material that contained reference to patients' anxieties about illness/death and patients' angry feelings were inhibited because of analysts' perceived fragility. Firestein noted that where there was strong attachment, grief was particularly intense and where there was resentment and anger, around thoughtless notification and aftercare, the mourning responses were closer to depressive symptoms. Firestein likens the extent of the catastrophe to - *'A surgical operation during which the surgeon collapses'* (p.337).

Galatzer-Levy (2004), bases his observations on his treatment of 10 patients whose analyst died during analysis, 2 whose analyst died shortly after termination and consultation with two terminally ill colleagues. For reasons of confidentiality clinical findings have been generalized.

They are as follows:

- All patients had observed signs of illness and made direct reference to it but none had been given a clear explanation or indications of its significance. They were met with denial, or an interpretation linking the question to the patient's pathology. Often there appeared to have been an analyst/patient collusion in order to avoid the topic. Some analysts made grandiose statements such as *'I will live forever'* (p.1005). All felt

unsupported, particularly by the psychoanalytic community, and trainees experienced anger towards their training organizations.

- For some the situation repeated an earlier experience with a sick parent but deeper understanding and working through was not achieved. Some believed they were keeping the analyst alive by staying, others that they were 'special' by being the last patient – the latter seen as oedipal victories, or receiving the final wisdom of the analyst.
- Many experienced boundary violations initiated by the analyst, or the patient who was then responded to inappropriately - including disclosure of personal information and sexual activity.
- Most experienced inefficient handling of the actual death causing confusion and distress, such as receiving notification through notes on analysts' doors and newspaper obituaries.

The author considered that as far as he could determine initial reactions of patients were similar to those seen in acute grief which for most -

'Merged into feelings of sadness and reminiscence' (p.1013).

Some (no numbers given) became fixated in the interrupted transference. Some, particularly where they had felt special, could not engage in further analytic work - particularly when there had been boundary violations.

Traesdal (2005), from the personal untimely loss of two analysts, and discussions with colleagues, maintains that after an analyst's death the capacity for free association stops and it is through free association that a patient's normally private inner dialogue is conveyed to the analyst -

'The analytic dialogue is unlike any other dialogue in the patient's life and as such is irreplaceable in real life...to see a patient after such a loss requires recognizing a severe crisis or trauma, even if few signs of this are evident' (p.1246).

b) Literature written by analysts themselves dealing with life threatening illnesses who continue to work, and those who have had some personal experience of dealing with more minor illnesses

in themselves, seem to coalesce into two groups – those who believe it is therapeutically valuable, even essential, to tell patients something about their condition if it is noticeable and known, as opposed to those who feel that this contradicts the need to maintain an anonymous environment where the transference can be deepened. For this group, disclosure should be limited to essential facts.

Those who favour the latter include:

Abend (1982), who believes additionally that -

'The transmission of factual information...sub serves unconscious needs in the analyst' (p.378);

Dewald (1982), who based his decisions on the amount of information to give to patients on the basis of an individual assessment; Schwartz (1987); Lasky (1990).

Included in the former camp are:

Silver (1982); Morrison (1990 cited Schwartz & Silver), who wrote from the experience of working for six years with a life threatening illness and who felt that her openness with patients enriched the work; Friedman (1991), who felt that openness and honesty when patients asked about her illness was essential but that she needed to maintain silence early on when she was coming to terms herself with cancer; Pizer (1997); Feinsilver (1998); Fajardo (2001).

There is a general consensus that there needs to be more investigation and discussion around this issue.

C. Mourning and a Comparison with Deaths of Close Friends and Relatives

Freud's theory around the process of mourning is outlined in his seminal paper 'Mourning and Melancholia' (1917) and the development of these ideas in his paper 'The Ego and the Id' (1923) in which he sees the bereaved as identifying with the lost object, which has been incorporated into the ego, to prevent the loss being experienced as a complete loss. As Abraham (1924 cited in Frankiel 1994, p.80) states -

'My loved object is not gone, for now I carry it within myself and can never lose it'.

Rendely (1999), comments on how internalization of the analyst is likely to be insecure if death, or illness, of an analyst forces termination prematurely; that the patient must first accept the external loss and then begin the process of internalization and mourning -

'Arduous under the most auspicious conditions...almost impossible without the support of others' (p.142).

Bereaved patients' isolation and lack of support is identified in the literature with the following:

Lack of socially defined roles for the bereaved patient as, for example, at funeral services (Foulkes 1989; Tallmer 1989; Garfield 1990 cited in Schwartz & Silver 1990; Rendely 1999; Galatzer-Levy 2004; Rizk & Voller 2013; Robutti 2010).

Lack of support from the analytic community (Tallmer 1989; Rendely 1999; Galatzer-Levy 2004; Robutti 2010).

Lack of information that would be available to relatives and friends (Firestein 1990 cited in Schwartz & Silver 1990; Freedman 1990 cited in Schwartz & Silver 1990; Simon 1989; Rendely 1999; Adams 1995; Ritz & Voller 2013).

Klein (1935), and in other papers, highlighted how introjected objects are deeply tied up with the identity of an individual and that hostile feelings in internalization fantasies can create rifts in the personality and may be involved in paranoia, depression and hypochondriacal complaints.

Winnicott (1968), stressed the necessity for mothers to survive their infants' psychic (and physical) attacks. Hostile feelings towards the analyst surrounding the event under consideration are mentioned in many papers including (Lord et al. 1978; Halpert 1982; Simon 1989; Barbanel 1989; Dattner 1989; Rendely 1999; Galatzer-Levy 2004; Traesdel 2005).

It has been noted (Rendely 1999; Galatzer-Levy 2004; Traesdel 2005) that death of an analyst carries additional problems in that the nature of the process renders it probable that defences will be brittle and a regressive transference be in place.

D. Denial of Illness and Mortality by Analysts and the Profession

Within the last fifty years there has been an increase in literature relating to bereavement and the termination phase of analysis. In addition a fair amount of attention has been given to forced termination because of the analyst moving away. However, as the majority of authors have commented, the death of an analyst has received relatively scant attention. Vlachos considers it '*a never-ending taboo*' (2011, p 93). Reasons given for this are as follows:

- Identification with Freud's silence and stoicism over his own life threatening cancer, which he continued to work with (Halpert 1982; Dattner 1989; Barbanel 1989; Fieldsteel 1989; Clark 1995; Bram 1995).
- A general fear of death in society. Freud (1915), considered that nobody can believe in his or her death. Stern (1968), emphasised that anxiety over death appears in every analysis and must be worked through if an analysis is to be complete.
- The isolation of the work and the extent to which analysts encounter timelessness in the unconscious (Cohen 1983; Barbanel 1989; Dattner 1989).
- General difficulties in the medical profession about coming to terms with one's own illness and death - entry to the medical profession may itself be a means of defence against these anxieties (Eissler 1955; Burton 1962; Bates 1968; Burton 1978).
- The extent to which everyone denies terminal illness, particularly in the early stages - a facilitation to loss (Halpert 1982; Vlachos 2011).
- The need for patients, and unfortunately perhaps the analyst sometimes, to see the analyst as immortal – superhuman and god-like (Becker 1973; Clark 1995; Pinsky 2002; Vlachos 2011). Dewald (1982), states that maybe analysts fantasise that their personal analysis will protect them against illness.
- Issues such as loss of clients, income, status, personal satisfaction (Halper 1982; Tallmer 1989; Lasky 1990; Feinsilver 1998).

- That analysis encourages analysts to view all of a patient's material as deriving from an underlying pathology (Burton 1962; Galatzer-Levy 2004).

3. Conclusion

My conclusion from the limited research and other relevant literature, was that there are strong indications that premature termination through an analyst's sudden death, or terminal illness, has the potential to impact in a traumatic, longstanding manner on a patient's psyche. However it was not possible from the sparse often poorly documented research and the limited, unconsolidated body of other literature, to be at all clear about the nature and extent of this trauma; the best way for the affected analysts to prepare patients; the most effective aftercare for patients; the variables, for example in terms of patients' differing pathologies and life circumstances, that may predispose certain patients to be more susceptible to the trauma that may be induced by this event. It was also concerning that there seemed to be so much denial in the profession and that, as Rendely (1999) had indicated, very little attention has been paid to the **patient's experience** of this potentially traumatic event. There seemed to be the potential for much research into the various aspects of a topic that seemed to have been, at best, scantily addressed by the profession. Where to start? An essential first step seemed to be to **listen directly to patients' experiences** of this phenomenon, as a researcher and psychotherapist, in order to gain a deeper and broader understanding of how this event can affect patients psychically, including an examination of the impact of different variables on the psychic outcome. This greater understanding may hopefully enable the psychoanalytic profession to better assist patients if they are subjected to this unfortunate event.

Chapter 3. Methodology

The research question is as follows:-

What can the analytic profession learn **by talking directly to patients** about the psychological impact of the premature termination of analysis due to an analyst's sudden death or terminal illness and how could this knowledge be utilised to improve other patients' experiences of this phenomenon?

The hypothesis is: - That premature termination of analysis due to the terminal illness/death of the analyst is likely to be a distressing, or in some cases traumatic, experience affected by numerous variables, such as aftercare, and that this whole area has been largely unexplored by the psychoanalytic community. That if we listen to, and think about, patients' accounts of this phenomenon they will indicate the way that the profession can help minimise the potential detrimental effects of this event.

1. Background

a. Researcher Reflexivity

A researcher's attention to reflexivity can enhance objectivity, particularly if the research is qualitative, because -

'There are so many points in the research process where personal and subjective factors can influence choices that are made' (McLeod 2011, p.275).

The motivation for undertaking this research was personal experience, beneficial for enhancing insight into the issues and for inciting passion in terms of -

'Committing to the creation of a better world' (McLeod 2011, p.21).

However there are also dangers requiring vigilance as there is the possibility of making unconscious assumptions and choices based on this experience that skew the research.

Aware of this danger, conscious attention has been given to equally consider as valid any data that the participants have entrusted to the project and to try to incorporate all of it in some way

within the documented findings. Interviews were conducted four years after my own experience which allowed some necessary distance between the two events. Identification with some of the participants' emotions was inevitable but space and time was given to process this.

My psychoanalytic training was eclectic, with an emphasis on Object Relations, and this will be reflected in the theoretical underpinning of this research. Having a social work background has perhaps encouraged an over determination and passion to give priority to the voice of patients/clients and value social justice.

b. Aims of the Research and Rationale for Choice of Methodology

The ultimate desire is that this research will assist analysts and professional bodies to most appropriately support patients through an analyst's untimely demise in order to minimise the potential for a negative outcome in terms of their psychological well-being. It seemed from the Literature Review and personal opinion that, to best fulfil these aims, the research needed to focus on the patients' accounts of, and the meanings that **they** gave, to their experiences. At the data collection stage it also needed to include some structured researcher intervention to allow focus on some of the problematic areas identified in the Literature Review, whilst at the same time allowing enough flexibility for the participants to freely express **their** experiences in a spontaneous and creative manner. At the data analysis stage it was felt that a psychoanalytic researcher's interpretations and opinion of the participants' expressed experiences would be the most appropriate way of achieving the research aims. Expressed experience would include verbal description, patients' attributed meanings to the event, body language, emotions and nuances of speech. A qualitative research approach which is underpinned philosophically by phenomenology, hermeneutics, rhetoric and social justice (McLeod 2011, p.42) seemed to be most appropriate for this purpose. This approach would only allow for a relatively small sample and so the findings would not necessarily give a definitive cause and effect outcome, but would likely offer rich, fairly detailed material for further research and discussion.

2. Study Design

a. Participants

The original aim was to include a sample of 12 adults. However as there were 15 suitable participants from the first round of recruitment the decision was made to give more research time commitment in order to interview all 15, rather than make a selection. One interview was to be a pilot study. There was a requirement that a patient must have been in analysis for at least six months before termination, but the length of time thereafter to be as variable as possible amongst the sample. A criterion of a participant having experienced the phenomenon subsequent to 1990 was also set. This sample is too small to be able to draw definite conclusions as to how variables may affect the outcome of premature termination for the patient, but would to some extent counter the criticism, that an individual case study might attract, in that the result is idiosyncratic. The preference was to have a mixture of participants who were analysts/trainee analysts (who may now be qualified) and non-training patients. The latter might potentially be the worst affected as suggested by Lord et al. (Literature Review, p.7). There were ethical concerns expressed by the University as to the potential risk of interviewing ex-patients who were not analysts/trainee analysts – it was important that any emotional distress/trauma induced by an analyst's death was not compounded by the interview and that there was adequate support in place if needed. In the light of this, and accepting that it was unlikely that those who had dropped out completely from any further analysis could be reached and interviewed within the limits of this particular project, it was a bonus to have the following - 5 participants who had not had any form of psychoanalytic training **when** the event took place, although they trained at a later stage; one participant who trained as a counsellor many years before but had not practised for around ten years; one participant who is a teacher with no analytic training. The latter was accepted after careful consideration of her support network, which included a trainee analyst, and

her knowledge of where to access analytic support if needed. In terms of recruiting participants the following means were used:

- An email was distributed to all members, including trainees, of a member institution of BPC. It was sent via their Administrative Department.
- An email was sent, by the researcher, to all members of BPC whose surname initial came between A –E inclusive.

13 participants came from the former. No participants who responded to the request dropped out before interview.

There were several other responses but they did not meet the criteria for interview.

Participants were offered a choice of interview venue so that they could feel as safe, relaxed and comfortable as possible – the researcher’s private practice, the participant’s private practice and/or home, a room in a training organization the majority were familiar with. Travel expenses were paid as necessary. Of the 14 (excluding the participant in the pilot study) 9 chose their own premises, 1 chose the researcher’s premises and 4 the training organization.

Potential participants were sent an information sheet (See Appendix 1) and consent form prior to interview. The consent form was returned at interview.

Communication prior to interview was by phone or email depending on an individual participant’s choice. Most participants preferred to communicate via email. The first participant that replied was chosen to be the pilot study, with the second to be included in the pilot study if it was felt necessary after the first interview, which was not the case.

b. Collecting Research Data

An Interpretative Phenomenological Analysis (IPA) approach was used for collecting (and analysing) data. This approach will be described in more detail on p.28 of this document. Semi-structured interviews are almost exclusively used by researchers undertaking IPA where –

' ... people are encouraged to freely recall their experiences. The questioning style is designed to encourage richly detailed descriptions of experiences of phenomena' (Howitt 2010, p.271).

It is recommended in this method that questions are open-ended and pre-planned. Probes can also be pre-planned. However they need to be used flexibly so, for example, questions do not have to be answered in a fixed sequence but the interviewer needs to ensure that at some stage all the necessary information has been gathered. This more participant-led style encourages new, unexpected issues to emerge. It is important to note that because some potential themes had been identified in the Literature Review these would have influenced and under laid my questioning, both consciously and unconsciously, and therefore the outcome will have a bias not found to such an extent in say a pure Grounded Theory approach. Here a literature review is purposely not undertaken before the interviewing of participants to allow for a more open-minded approach both in the collecting and analysing of data. However without some form of thematic structuring to the questions it would have been difficult to gain details on the areas identified from this Literature Review that seemed to be significant. Smith and Osborn (2003, p.63), make some interesting suggestions as to the style of questioning appropriate for IPA, including changing the style of interviewing if a particular participant is experiencing problems; giving participants sufficient time for thought; sensitivity to the use of probes as they can disrupt the participants' accounts. A point made by Kvale (1996), was also interesting and perhaps owing a debt to psychoanalysis. He suggests maintaining an empathic stance without responding in too emotional a manner to participants' responses. As a result of conducting the pilot interview and the interview following, it was found helpful to generally ask the first six questions in sequence. After this, where the interview moved on to focus more directly on the events surrounding the illness/death of the analyst, most patients seemed more spontaneous, relaxed and able to freely associate if they were allowed a looser rein to talk about their experience. As described above, this was accompanied by intervention from the researcher to ensure that all the areas included in

the questions had been covered at some point in their narrative and to be certain that the interviews kept within an identified time scale.

One to 1.5 hours was allowed for each interview. In reality interviews varied between 50 minutes and 1.5 hours, with the majority taking 1 hour and 15 minutes. The thirteen questions, outlined in Appendix 2, were designed so that the first few questions ease the participant into what might be a very emotional experience. The last few questions were designed to provide extra containment and encourage hopeful thoughts around the future. Throughout the interview emotional containment was uppermost in my mind as ethically the well-being of participants is always paramount in research. In that light, the interviews might need to be shortened and/or revised if a participant became too distressed, as they were with one participant in this research who became very angry (See Chapter 4, p.95 in this document). Also noted by Smith and Osborn (2003), as described in p.24 of this document. Moreover it felt important that the participants receive some therapeutic benefit from their interviews. As it happened, in the interviews, participants to a greater or lesser extent connected to their emotions surrounding the event – sometimes very intensely – but seemed contained and calm on leaving. One participant was asked permission to be contacted by email a few days after the interview because, as researcher, I had some concern about the number of losses she had experienced and some aspects of her emotional presentation in the interview. She readily agreed and, on further contact, there were no particular concerns identified.

At the start of the interview each participant was given a sheet of paper with a short factual questionnaire, included in Appendix 3. The findings from this questionnaire, plus a few other factual pieces of information, can also be found in Appendix 3 and may be helpful if future researcher's wish to undertake a similar project. In order to protect anonymity each paper was numbered and the same number was used on the audio digital recorder (which was used to record the interview) as a means of identifying the participant. After filling in the questionnaire,

and before the formal questions, there was a brief introductory stage as outlined by Howitt (2010, pp76-77), to include an introduction of myself as interviewer; purpose of the interview; amount of time allowed; ethical basis of the research, such as telling participants they are free to withdraw at any stage and for the data to be destroyed on request (this had also been included in the introduction sheet sent prior to participants agreeing to the research); an opportunity for any questions at this stage in the interview.

At the end of the interview time was allowed for a short de-briefing phase, to include thanking the participant; allowing time for participants' questions; checking that they are still in agreement that the recording can be used as part of the research (Howitt 2010, p.79). After the interview a few short notes were made by the researcher to record data that would not necessarily be picked up in an audio recording, for example, manner/body language of participant, where the interview took place, researcher's counter-transference.

Below are outlined the areas underlying the interview questions. However vigilance was also given to new areas that emerged and these were followed up with unplanned questions.

- A history of previous therapies/ analyses, duration of the analysis under scrutiny and the frequency of sessions.
- A patient's pathology and attachment pattern.
- A history of significant losses, particularly in childhood.
- The status of the analysis i.e. beginning, middle, end.
- Quality of the analytic relationship both real and in the transference. The level of regression both before and after the final contact with the analyst.
- When the patient first knew, or suspected, the analyst was ill or dead and how did this come about. To include indications of denial by patient and/or analyst.

- A patient's emotions, thoughts and physical response e.g. insomnia, panic attacks, during the whole process of the experience including in the present day. To include feelings towards the analyst and the profession as a whole.
- Some details of the analyst e.g. approximate age, gender, location of practice, theoretical preference.
- Quality of aftercare including support from family, social networks and professional organizations. To include a patient's thoughts about how this could have been improved.
- A patient's thoughts around how this experience differed from other bereavements they might have suffered.
- The position in terms of further analysis or other support a patient might have accessed after cessation of their analysis e.g. medication or other forms of therapy.
- What a patient might have felt helpful or unhelpful about this subsequent analysis.

3. Transcribing

The data was transcribed as soon as possible after the interviews and kept in a locked cupboard with no names to identify the source. It will be destroyed following University guidelines. All the transcribing was undertaken by the researcher. This is generally recommended in terms of enabling the researcher to become immersed in the data and for consistency. Orthographic transcription was used but additionally incorporating some of the notation symbols that are used in the Jefferson approach to indicate pauses, emotions, stress on certain words and pitch. In terms of emotions these were described in more detail in the margins.

4. Data Analysis

The following approaches were considered:

- Grounded Theory
- Interpretive Phenomenology Analysis (IPA)
- Thematic Analysis

Philosophically, ethically, practically and on a personal level IPA seemed to be the most appropriate choice. Philosophically IPA's roots are in phenomenology, hermeneutics and symbolic interactionism (A sociological theory). IPA was developed in the 1990's as a way of understanding health issues. The primary concern of IPA, as Howitt (2011) states -

'Is with how individual's experience phenomena and the psychological interpretation of these experiences.... IPA assumes that people attempt to make sense of (give meaning) to their experiences' (p.271).

The main processes of data analysis in IPA are initial case familiarisation and initial comments, preliminary theme identification, search for theme interconnections and construction of a systematic table of themes (Howitt 2011, p.283). Themes, or categories, do not just emerge from the data but are constructed by the hard work of the researcher and theory (in this case psychoanalytic) can be an aid to interpreting coding into overarching themes. The written report, using this method, needs to identify all of the themes which seem important and these should be illustrated with precise quotes. In the written report it is important to distinguish between participants' material and the researcher's interpretations and opinion.

This process was adhered to in the analysis of the data collected from the interviews in this particular research. Transcribing the data myself was invaluable in familiarisation. Before the formal coding process, the material from each participant was read several times in its entirety in order to try to gain an overall feel for the meaning of the event to that particular participant. The verbatim accounts were then coded line by line, or by small chunks of material, dictated by the most appropriate way to capture a theme. Themes included participants' emotions and thoughts.

The identified major themes and overarching themes are to be found in Appendix 4. Only a small percentage of the data did not fit in some way into a theme, perhaps five percent.

5. Reliability and Validity

‘Reliability’ - *‘The possibility of obtaining the same results on two different occasions with two different researchers’* (McLeod 2011, p.265).

This is much more difficult than in quantitative research as it is inevitable that factors such as a researcher’s skill, theoretical approach, manner etc. will to a much greater extent influence the findings. However there are specific processes included in the research design that hopefully will contribute to the quality of the study, in terms of reliability, as follows:

- Descriptions of the participants in the research report.
- Inclusion in the research report of the planned questions that are to be asked of all participants.
- Use of the same transcriber and data analyst throughout, which will enhance internal reliability.
- Description in the research report as to how the data was transcribed and analysed.
- Use of a published and well-tried method of data analysis i.e. IPA.

According to McLeod, in quantitative research ‘validity’ -

‘Refers to the capacity of a measure accurately to capture or reflect some characteristic of objective reality’ (2011, p.265).

This notion is more problematic in qualitative research as, for example, some researchers question that there is a fixed, knowable, external reality. Have the measures used in this project been appropriate to the study’s intended purpose? The measures used within the IPA approach have already been described, and they seem to be have been the most appropriate in terms of the aim of the research, which was to capture the essence of patients’ experiences in order to contribute to a body of knowledge that will help future patients. For example in terms of transparency, the liberal use of exact quotations in the report will in some measure allow readers

to understand how the researcher came to their choice of themes, made their interpretations and formed opinions. McLeod makes an important point as follows -

'An important aspect of validity in qualitative research is trustworthiness. A great deal of the knowledge-production process in qualitative research depends on the integrity and openness of the researcher. Readers of studies therefore look for clues about how much they can trust the researcher' (2011, p.274).

Interestingly one participant said that she knew she could trust me because I had trained at the same organization as her and so she knew the quality of my training. As researcher, I believe that within the **Findings and Discussion** (Chapter 4) the emotions, thoughts, ideas and opinions of the patients shine through, which was always the paramount aim.

6. Ethical Issues

Throughout the Methodology chapter there has been reference to ethical issues. For clarity these, and others, have been gathered together in this section. To ensure that this research followed ethical principles and guidelines the following measures were put in place:

- The research was accepted by the Ethics Committee of the University of Essex.
- Participants were issued with an information sheet (See Appendix 1) and consent form prior to their formal agreement. This included more information about the project and their part in it - payment arrangements; confidentiality and anonymity issues; participants' rights with regard to withdrawal; contact details for the University.
- Paramount to the research was the well-being of participants. Attention was given to appropriate selection of participants in terms of their support networks; monitoring of their emotional well-being during the interview and adjusting the interview as/when necessary; de-briefing at the end of the interview and checking support networks; follow up contact where necessary with permission from the participant; choice of interview venue decided by participant.

- IPA is a methodology that very much respects and values the meanings that the participants themselves give to their life experiences. The interviews are in some measure more participant-led than in, for example, Thematic Analysis. The choice of IPA therefore seems to be ethically sound for the purposes of this research.

Chapter 4. Findings and Discussion

Five Superordinate Themes have been identified from the data of fourteen interviews. Fifteen experiences have been analysed as one patient had two consecutive happenings. For simplicity the words analyst/analysis have been used throughout, although the participants worked with both analysts, psychoanalytic psychotherapists and analytical psychologists. The only exceptions are within the verbatim material.

Theme 1.

11 patients (12 experiences) recounted **changes in their analyses which they believe were connected to their analysts' illnesses prior to and including their final session, or notice of termination by other means.** These changes related to deteriorations in, or violations to, the fundamental principles of analysis which include the provision of a secure, consistent, 'thinking' (as opposed to 'acting-out') environment where the needs of the patient, as opposed to the analyst, are paramount. Pertinent to these changes is the position of the analyst and patient in relation to their awareness of the illness and their communication of this awareness to each other. The table below outlines the identified Master Themes feeding into the first Superordinate Theme.

<u>Superordinate Themes</u>	<u>Master Themes</u>
<p>1. Changes in Analysis before Termination</p> <p>e.g. <i>'So perhaps for the first time in our relationship there was something odd going on'</i> (Babs).</p>	<p>a. Role Reversal</p> <p>e.g. <i>'She wanted me to care for her...and I did'</i> (Pam).</p> <p>b. Framework Slippage</p> <p>e.g. <i>'There had been a lot of change of days and times'</i> (Fay).</p>

c. Interpretations

e.g. *'He seemed to be missing the point'* (Gill).

d. Boundary Violations

e.g. *'He came and sat with me (In the coffee shop)...it felt very intrusive'* (Steve).

e. Re-enactments

e.g. *'We both fell into the same trap...the thing I came into therapy for'* (Pam).

f. Knowledge of illness

e.g. *'She didn't tell me she was ill but I could see she was in pain'* (Clara).

These Master Themes will be described below in more detail. Although Master Theme f. is included as a separate category it has been necessary, for clarity, to allow some spillage of this data into Themes a. to e.

a. Role Reversal

This theme relates to a reversal in the analyst/patient role. **8 patients (9 experiences)** described situations where they had uncharacteristically become the carer, listener, protector or advisor of a vulnerable analyst with variations of the phenomenon in terms of duration, intensity and insight. In this section participants' accounts have been largely paraphrased. As one participant had two relevant experiences (1) and (2) will be added after the name of 'Clara'.

Pam considers that for the final year of an eleven year analysis she had increasingly become the *'caregiver'* for her *'in denial'* frail, elderly, ill analyst. Pam had some minimal awareness of the role reversal at the time.

For **Babs**, over the last eighteen months of an eight year analysis, the analyst-patient role had increasingly reversed, culminating in the final session when she felt drawn to listen to and reassure what **she** could see was her imminently dying analyst. Babs believed **he** was not equally aware of the gravity of the situation. He died ten days later. The role reversal had never been acknowledged between them. Symbolically (researcher's interpretation), because of the analyst's physical condition they had to exchange chairs in this session.

Gill, at the final session of a nine year analysis, saw her analyst's '*awful*' deterioration. She knew immediately he was near to death and this session was for **his** needs. She complied -

'I knew when I walked through the door this was not going to be about me. That this was as much about him dealing with prematurely having to leave his work and his own feelings about it'.

He died five days later.

Jane, one year before her analyst's death and one year into analysis, found out by chance that he had a serious heart problem. When asked he admitted to it, but was dismissive of the need for treatment, talking of his immortality. Consequently, Jane felt that she needed to advise her analyst to have treatment and implement executor arrangements. Jane eventually colluded with his denial of the possibility of his death.

Clara (1), for the last six months of a two year analysis, felt protective and concerned about her analyst as she seemed in pain. Clara felt unable to voice her concerns, to this day remaining uncertain as to the reason for her reticence. Her analyst gave other explanations for premature termination, but Clara guessed, correctly, it was because of serious health issues.

Clara (2), for the last six months of a nine year analysis, felt concerned and protective of her analyst who had signs of serious health issues e.g. weight loss, loss of sight in one eye, confusion. Clara was reticent to pursue her concerns, believing her analyst was discomforted when she did so and was trying to hide her symptoms with make-up and thicker clothing.

Perhaps an explanation might be, as Freedman (cited Schwartz & Silver 1990) states -

'Patients who think their analyst is sick or will die might have a fear of hurting him (or her) if they talk about it' (p.325).

Steve's analyst notified him of the termination of a twenty year analysis by phone. Steve enquired if **the analyst** *'would like a final session?'* and elaborated on this by saying *'I was thinking of his needs'*.

Rose, in the twelve weeks between her analyst going off sick and the final notice of termination, had no communication from him or knowledge of the nature of the illness. Rose experienced conflict - she wanted to text to enquire when he would return but was reticent to do so because she was concerned about putting pressure on him. In an unsent letter to him she wrote -

'I feel pulled between wanting to look after you and wanting you back, wanting you in your role as a therapist listening to me, looking after me'.

After a seven year analysis, **Lily's** analyst disclosed that she was seriously ill with cancer and they must terminate after another four sessions. In these final sessions Lily felt ashamed and reticent to burden her analyst with her own grief and anxiety when now the analyst had her **own** serious concerns.

b. Framework Slippage

This theme relates to slippages in the accepted formal framework of analysis. For the **8 patients (9 experiences)** encountering this phenomenon it involved experiencing changes in what previously had been a consistency of time and frequency of sessions and/or a consistency in the room setting and analytic venue. It also involved receiving an unacceptable notice of termination, after taking into consideration the analyst's circumstances.

Babs, Gill and Fay had the same analyst. They first became aware that he was unwell when he was hospitalised eighteen months before termination, coinciding with a move to a smaller house/practice and disruption to sessions. All three cited this combination of illness, move and session disruption as having a detrimental effect on their analysis and moreover that the analyst

was surprised when informed of this. The analyst did not mention illness again until his final letter of termination. The following quotes are examples of the general sense of unease:

Fay, in relation to this eighteen month watershed said -

'It was never quite the same after that. Then he had a few weeks when he couldn't see me, then we met - It was very sporadic after that. He tried to get some continuity'.

Babs, at the eighteen months watershed, said to her analyst -

'Now is the time in my life when I might need to 'man-up''.

She added -

'I don't think I particularly ever settled in his new place I moved to sitting in a chair because I didn't like his new couch'.

Gill referring to her *'hatred'* of the analyst's new accommodation said -

'There is a sadness that our last sessions were not like other sessions'.

The following five cases have been largely paraphrased:

Clara lost two consecutive analysts. With the first, the analyst suddenly went off work sick for several months. Uncertain as to the nature of the illness, and duration of the break, Clara became anxious. On return a retirement date of **possibly** another six months was set by the analyst, not citing illness as a reason. This was a little later brought forward to two months. Clara felt very unsettled, not only by the not discussed issue of illness but by the uncertainty over the continuity and continuation of her sessions. She said that to her analyst's surprise sometime during this period she felt too unsettled to continue on the couch and thereafter sat up.

With her second analyst Clara returned from a break to what eventually turned out to be her last session. She was expecting her analyst to meet her, as usual, within the consulting room.

However the procedure had changed in that the analyst was waiting outside the room and ushered Clara in with an accent that was startlingly strange and uncharacteristic. She entered after Clara, barely managing to walk. Clara observed that the invoice awaiting her had different handwriting. Having been concerned for six months about her analyst's health Clara realised that

something dire had now happened. However the session bizarrely proceeded as usual until near the end when the analyst said she would be taking a four week break. She handed the invoice to Clara saying she could not write. Clara left uncertain as to whether the analyst had in a confused way been trying to conduct a final session. She never saw her again.

Steves's analyst started to attend hospital out-patient appointments one year before termination. From then onwards sessions were increasingly changed/cancelled as appointments became more frequent. There was also a two week hospital admission. The consulting room was redone and Steve asked the analyst if he was selling the house. Steve felt that this question, and other material relating to his anxieties, was met with enigmatic answers by the analyst and that he, in return, was not picking up on hints around illness given by the analyst - they were colluding to deny an inevitable loss of the analytic relationship. As a result the end came suddenly and abruptly – *'a bloody mess'*.

For the above five patients the framework had been shaky for six to eighteen months. For the following two it was for a shorter period, probably due to the nature of their analysts' illnesses. They both had pancreatic cancer which is often not diagnosed until the latter stages of the illness, as both participants informed me.

Rose had ten years of therapy in which the framework had been consistent and secure with the analyst never missing or changing session times. Suddenly he texted to say he was unwell and Rose waited without any further professional contact/support for twelve weeks until she heard, through an executor, of his death several weeks previously. Rose is not an analyst or trainee. She had relied for ten years on the consistent containment provided by an analyst. She knew her analyst must be seriously ill as this was so out of character and she was anxious and *'bereft'*. She was relieved to hear that he died from pancreatic cancer as that, for her, explains the twelve week absence without communication – it was the seriousness of the illness, not lack of care for her.

Sally perplexingly noticed for several months that the cushions on the couch were not in the usual place. The analyst looked a little different but she could not pinpoint the cause. She imagined that he might be resting on the couch before her session, disturbing the cushions. Then she received a call from him to say that he had cancer and the analysis was over.

Pam was shocked to be told by her analyst, in the session before Xmas, that she could not return after the break; that they had been working towards this end date for some time. She blamed herself for '*not hearing*' but after many more years of analytic work accepted that her **ex-analyst** had made a '*bad mistake*' in that she had inappropriately managed this analytic ending.

c. Interpretations

This theme relates to **4 patients'** perceptions of changes in the quality and frequency of interpretations given by their analysts. The reports have been largely paraphrased.

Babs and **Gill**, who had the same analyst, reported that for eighteen months the analyst's analytical capability appeared to have deteriorated. Gill said '*he seemed to be missing the point*' and Babs that '*he was not so strong professionally*'. He did not provide for either of them a satisfying interpretation of what they felt was their over intense dislike of his new accommodation and this adversely affected the analytical work. Gill in particular is still distressed and very perplexed as to what might be the explanation. In the researcher's opinion, if moving to new accommodation **was** tied up with the analyst's illness, it might have been either consciously, or unconsciously, an area he did not want to explore with patients.

Tina, who had a three year analysis, reported that for many months prior to her analyst's fatal heart attack she was aware that some of the material brought to sessions was not being interpreted. She was wondering at the time if the analyst could cope. It left her feeling angry and confused which she felt affected the grieving process after his death.

Pam, for a year, felt responsible for her analyst. For example, she phoned to ask her analyst if she would like a lift back from the hospital. Having some realisation herself that this was not appropriate, she became anxious and puzzled as to why this was not explored and interpreted by the analyst in subsequent sessions.

d. Boundary Violations

This theme relates to **6 patients'** experiences of boundary violations - changes in their analysts' adherence to the professionally recognized acceptable boundaries between patient and analyst and/or the slight variations, within acceptable limits, that may occur in particular analyses and that become the norm for the patient. The following accounts have been largely paraphrased.

Pam reported that before termination her analyst asked her for the contact details of a professional carer that Pam knew. Pam imagined at the time that this was because her analyst needed care. In, what felt like a return favour, she gave Pam the name of **her** financial advisor. Pam felt some discomfort but, unsure as to why, went ahead and employed him for her business. The reasons for her discomfort were born out after termination as this financial advisor, at the analyst's request, informed her of the analyst's death. Pam was mortified that he should know that she had been in analysis and realised it was a breach of confidentiality.

Babs, Gill and Clara were subjected to seeing their analyst, without prior warning, in physical/mental conditions that they reported were shocking and distressing to them. They all added that fortunately they had some experience of seeing people with terminal conditions. Babs and Gill believed that this meeting was primarily for the analyst's benefit, although he was maybe not conscious of this. Clara thought the analyst was just very confused.

Babs was told by her analyst, and his executor, that the former had a serious illness requiring him to stop work. No specific details of the illness were given. The analyst offered a final session. She had not seen him for around eight weeks and his physical appearance at that time

had been reasonable. Babs was presented with someone ten days from death through cancer, wrecked in body and confused in mind -

'I had no idea what to expect ...and he was on crutches...and he looked dreadful. He had the sunken look and the kind of waxy skin and he looked like people I have seen who are dying... He was in a pretty desperate state, he barely could get through the hour'.

Gill had the same analyst as Babs, but had been told by the executor that he had lung and secondary bone cancer but not the extent of his bodily deterioration -

*'His face was Belsen like, but the worse thing - I'll never forget – he was a very thin man but his legs were **this** width (held her hands wide apart) He had two **enormous** legs, and was wearing shorts. I think his liver had given up.... It was just awful. His legs were huge'.*

He was confused so that, for example, he was talking about his wife as if Gill knew her. Gill felt she was only able to hide her shock because she had cared for a husband with terminal cancer.

He died five days later.

Although **Clara** had seen signs of physical illness in her analyst for some time, on a return from a break she was unexpectedly presented with a distressing deterioration which she knew (as an ex-nurse) was probably attributable to a stroke – facial signs of dehydration, a swollen and weak arm, a tottering gait, a confused mind and a strange accent/speech pattern.

All three participants reported distress to the point of horror and shock, heightened by the fact that they were unprepared for what they experienced. Both Babs and Gill said they preferred to have that final session despite the distress - and with Gill the '*awful*' image she is left with - than not to have said 'goodbye'. However, and this is the researcher's comment, it could be said that it is unacceptable to present patients with such images and experiences without preparation; without the knowledge to make an informed choice as to whether they want to go; without subsequent de-briefing; managing the session alone (except for an analyst whose 'fitness to practice' is questionable).

Steve reported what he referred to himself as a boundary violation. This did not apparently occur as a result of illness, as it was around five years before termination, but it subsequently affected

the impact of the analyst's illness. It had been the norm for his analyst to frequent a local café near his practice if sessions were cancelled. This was also regularly used by Steve after sessions, but the analyst always sat alone in a corner. On this occasion the analyst came and sat with Steve, talking to him for some time. Steve, partially deaf, was concerned he might have appeared 'weird'. He felt frightened, uncomfortable, confused and intruded upon. This new approach felt unprofessional. Moreover he was by then in psychotherapy training and believed his training organization would have seen this incident as a boundary violation. He thinks the analyst understood his discomfort because he did not try again. It was not mentioned in subsequent sessions. After his analyst terminated the work Steve felt that he wanted to, and should, preserve the analytic boundary and therefore did not contact the analyst to see how he was faring. Sadly (the researcher's comment) he is now feeling much guilt for what he fears the analyst might have seen as Steve's lack of care for him. He expressed general concern and confusion around analytical boundaries, including what the session in the coffee shop might have indicated in terms of the analyst's feelings for Steve and the appropriateness, or otherwise, of his own response.

Jane feels that there had been a boundary difficulty throughout her analysis because, prior to the commencement, she had a working relationship with the analyst. He had helped her, and other staff in a Special Needs school she worked in, with a therapeutic technique to use with children. A few weeks prior to his death Jane had been due to help him with a training workshop. He suddenly decided this was inappropriate and the tightening of, or change in, a normal boundary triggered conscious anger with him for the first time in their relationship, mirroring an incident that happened just before her father's death when she was aged twelve. The analyst's death prevented sufficient exploration of this anger.

e. Re-enactment

In this section I have included **6 participants** who recounted scenarios connected to the illness of the analyst where they considered there had been a re-enactment of a significant early relationship. These re-enactments had not been interpreted by the sick analysts. The participants' accounts have been largely paraphrased.

From infancy, **Pam** had felt responsible for protecting her perceived emotionally frail and needy mother. Her mother was a Holocaust victim, losing most of her family. Just prior to analysis mother died, having been seriously ill for many years, with Pam as her main carer. Pam chose a female analyst who physically resembled her mother feeling that she '*had come home*' – but this time to a mother who was independent, strong and capable of instigating firm boundaries in their relationship. However this deteriorated with the analyst's increasing age, illness and frailty. Pam now believes that they both slipped into re-enacting the mother/daughter relationship she had been trapped in. Pam had some limited awareness as to what was happening at the time but there was no exploration of it in the analysis. Pam now thinks that her analyst was in denial of the situation and/or or was simply too ill and confused to adequately manage an analytic relationship.

Steve, throughout his life, been in a mutually emotionally dependent relationship with his mother. She died a few years before the commencement of analysis. He now sees that any attempts to leave her had been met with emotional pressure which he succumbed to, whilst feeling smothered. He said that there had been much mutual denial around the impending loss of his mother through death. He could not deal with the overwhelming reactions to her death and feels that his marriage soon after may have been a coping mechanism. Steve believes that there had been some re-enactment of the maternal relationship throughout his analysis but this was never fully explored or interpreted. However it became more intense during the last eighteen

months as the analyst's illness progressed and he feels that a collusion between the pair of them to deny impending loss through death (as with his mother) prevented a worked through ending. As a child **Sally** had been passed repeatedly between different adults whilst her mother looked after elderly relatives. Through analysis she came to understand that she had acquired, as a defence, a pseudo-independent persona concealing an internal vulnerability to separation with a propensity from childhood to somatise anxiety and distress. For example, at aged nine years she travelled to school alone via two buses, but for a time she couldn't change to the second bus, feeling so sick that she had to return home. Sally gave this as an example of somatisation of distress. Symbolically, in the researcher's opinion, it also seems to represent the anxiety she might have experienced in infancy when passed from mother to an alternative carer. This travel problem was never thought about within the family. Sally had resentfully left her first analyst prematurely because of training requirements. When told on the phone by her second analyst that he could no longer see her due to illness, he would give no further details but told her confusingly to phone the head of a Therapy Centre where she had once trained. To gain further knowledge and support Sally was then passed between numerous people. She felt very angry and *'like a parcel'*. Later in life she came to recognize the similarity to her childhood situation where she had been passed around with what felt like little priority given to her emotional needs.

Gill was the fifth child of a mother who could give her little attention after babyhood because of the demands of working to support her children and seriously mentally ill husband. Gill suffered chronic anxiety and insecurity from childhood intensified by the unexpected death of an elder brother when she was aged fifteen and mother when she was twenty two years old. She craved love and attention from mother in adolescence, impeding healthy emotional separation. She found some security with a husband and three analysts - the third being the subject of this research. However her husband died of cancer and three analysts left her prematurely, the first moving but forgetting to tell her until a few weeks beforehand and the second retiring through ill

health. For Sally feeling '*special*' is of paramount importance in any relationship – likely a defence against the pain of feeling overlooked, insignificant and abandoned. (researcher's opinion). The scenario with the third analyst felt to her like another secure person becoming shaky and eventually leaving her. In the interview she found many examples to demonstrate how '*special*' she had been to him and other lost professionals.

Jane considers her father's death at aged twelve years had been the most significant event of her childhood, shaping her relationship with all subsequent males. Dying at fifty one years, he had been seriously ill for some time with a terminal prognosis. However when Jane asked her parents and medical staff if he was going to die they evaded her questions, or denied any possibility. Jane knew from the start of analysis that there was a strong paternal transference and was very fearful that her analyst would die when she learnt he was ill. It felt like the situation with her father when nobody paid attention to her anxieties. Unfortunately her analyst also died at fifty one years of age. He said he would not die and eventually she colluded with this denial. She believes now that his sense of omnipotence was part of the charisma that had drawn her to work with him.

Lily believes that her mother lacked the capacity to contain her childhood anxieties, including those around separation, and consequently she became disconnected from painful feelings. Analysis had helped her reconnect with them. Just before the interview she recalled a situation when at aged six she was left in a crèche whilst abroad on holiday. She felt disorientated, confused and '*not able to think*'. Her mother, as always, said everything was fine. In the interview Lily likened this to her experience of the last few weeks of analysis, subsequent to learning of her analyst's illness and imminent departure. Lily was in training and needed to find a replacement analyst. Her present analyst, on whom she was very dependent, gave her the contact number of a possible alternative. Lily left a message for the latter but, receiving no response, feared that with only a few sessions remaining she would be left without an analyst.

Lily mentioned it to her sick analyst but was anxious about worrying her with her own concerns.

Lily '*started to feel blank*'. She felt unable to take action herself to find a new analyst. In the researcher's opinion it seems as if Lily's regression at the time had significantly reduced her capacity to act independently.

The table below summarises Themes a-e within the first Superordinate Theme, a '*' representing the inclusion of a participant in a category.

Table 1

Name	Role Reversal	Framework Slippage	Interpretations	Boundary violations	Re- enactments	Number
Pam	*	*	*	*	*	5
Gill	*	*	*	*	*	5
Steve	*	*		*	*	4
Babs	*	*	*	*		4
Jane	*			*	*	3
Clara (2)	*	*		*		3
Clara (1)	*	*				2
Sally		*			*	2
Lily	*				*	2
Rose	*	*				2
Tina			*			1
Fay		*				1
Harriet						

May						
Ella						
Total	9	9	4	6	6	

f. Knowledge of Illness

In this section there is a summary of each participant's awareness of their analyst's illness prior to termination (including the last session or termination by other means) and **their** perception of the extent of the analyst's awareness. The nature of the illness is added if known. 'Exploration' encompasses the extent of an analyst's non-evasive responses to questions; the discussion and interpretation of pertinent material brought to sessions.

Table 2

Name	Patient's Awareness of Illness	Exploration	Analyst's Awareness
Pam	Consciously for 1yr. Frailty, unspecified illness and brief hospital admission.	None	In denial
Gill	Consciously for 18 mths. Hospital admission followed by increasing frailty. Lung/bone cancer diagnosis given to patient just prior to final session.	None before final session.	Participant uncertain except for analyst's conscious awareness at final session.
Steve	Consciously for 1yr but in denial re. seriousness. Hospital appointments and hints given by analyst. Cancer diagnosis given at termination.	Limited – in collusive denial.	Consciously aware but in denial re. seriousness.
Babs	Consciously for 18 mths. Hospital admission followed by increasing frailty. Lung/bone cancer diagnosis given to patient at final session.	None before final session.	Participant uncertain except for analyst's conscious awareness at final session.
Jane	Consciously for 1yr - heart problem. In collusion with analyst's omnipotence.	Limited	Consciously aware but defending against the potential seriousness.
Clara (2)	Consciously for 6 mths. Signs of strokes.	None	Partially conscious.
Clara (1)	Consciously for 6 mths. Hospital admission/ physical signs of illness (unknown)	None	Probably consciously aware.
Sally	Indications of unconscious awareness for 3 mths***. Pancreatic cancer - diagnosis given to patient after termination.	None	Participant uncertain.
Lily	Consciously for 4 weeks – breast cancer.	Limited	Aware

Rose	Consciously for 12 weeks – patient told he was unwell. Pancreatic cancer - diagnosis given to patient after analyst's death.	None	Participant uncertain.
Tina	Indication of unconscious awareness for 1yr**. Heart problem – found out several months after analyst's death.	None	Consciously aware.
Fay	Partially conscious for 18 mths. Hospital admission followed by increasing frailty. No knowledge of nature of illness.	None	Participant uncertain.
Harriet	Noticed breathlessness for several weeks* Heart attack- patient informed by executor.	None	Participant uncertain.
May	None. Aneurism - informed by executor.	None	Participant uncertain.
Ella	None. Heart attack - informed by executor.	None	Participant uncertain.

*** **Sally** brought to the interview a recently discovered recorded dream experienced just before termination. She gave her present day interpretation of it. She is almost certain she took it to an analytic session just before termination. She is convinced it represents an unconscious awareness on her part of the seriousness of the analyst's illness. There do seem to be strong parallels and it might well be so. However there are obviously dangers in interpreting retrospectively in this way. She also had ideas, in the same period of time, that the cushions were often in a different place on the couch, imagining her analyst might be needing a rest.

** Tina was aware that the analyst's interpretations had deteriorated. She cannot be quite sure if it was before or after his death that she wondered if it might be that he could not cope. It is possible she was unconsciously aware that he was ill.

* Harriet noticed her analyst had been breathless for several months before her death but believes she had not given it any thought in relation to illness. It is possible that she had been anxious about illness and defended against it.

It would seem that **9 participants (10 experiences)** were to some extent consciously aware of their analysts' illnesses prior to termination and possibly at least three others unconsciously.

However it would also appear that there was very little exploration in sessions of a phenomenon that would almost certainly have engendered anxiety in patients.

Discussion on Superordinate Theme 1

Looking at the Master Themes in relation to the findings from the Literature Review the following similarities have been identified (numbers refer to pages in the Literature Review):

- Reversal of Roles. Identified by Tallmer (11), patient 2; Garfield (10); Freedman (13), patient 3; Halpert (12), regarding the Wolf Man's need to protect his ill analyst; Firestein (14), regarding patients' inhibitions at expressing angry towards frail analysts.
- Framework Slippage. Identified by Rizk & Voller (7); Tallmer (11), patient 1; Barbanel (11); Adams (9); Halpert (13), all with regard to unacceptable notice of termination.
- Interpretations. Identified by Rizk & Voller (7); Firestein (14); Galatzer-Levy (14); Halpert (13).
- Boundary Violations. Identified by Galatzer-Levy (15); Adams (9), with regard to seeing her analyst in a 'horrifying' physical condition.
- Re-enactment. Identified by Halpert (13); Galatzer-Levy (14); Simon (13).
- Knowledge of Illness. The analysts conscious/unconscious denial of illness identified by Barbanel (11); Tallmer (11), patient 1; Adams (9); Halpert (12); Simon (13); Kantrowitz; (8); Galatzer-Levy (14).

Most of the findings identified above were written about by analysts in the 1980's and 1990's and their papers included comments/discussions outlining their concerns for patients and the areas that need further exploration by the analytic community to better safeguard patients' wellbeing, including in the pre-termination stage when working with a sick analyst. For example Halpert stated -

'...the most basic obvious question is whether it is possible for an analyst to continue to analyse patients once he has begun to suffer from such an illness (chronic, life-threatening). The answer seems to be 'no'. In such circumstances, the analysts interest in his patients, his access to his

own affects and associations, his capacity for empathy, neutrality and objectivity, particularly in response to aggressive drive derivatives, are all severely limited' (1992, p.384).

In a similar vein Freud stated -

'It is universally known...that a person who is tormented by organic pain and discomfort gives up his interest in the things of the external world, in so far as they do not concern his suffering...the sick man withdraws his libidinal cathexes back upon his own ego, and sends them out again when he recovers' (1914, p.82).

There is also, dating back to that time, the issue of whether it is therapeutic or not for analysts to be open about their illness/imminent death with patients, as discussed in the Literature Review (15), and why there is seemingly so much denial about illness/death by sick analysts and the analytic community as a whole, as discussed in the Literature Review (18).

It does not appear that the recommended discussions have adequately taken place within the analytic community. Within **this** research, those participants who worked with analysts who showed signs of, or openly declared, serious/potentially fatal illnesses (some as late as 2013) appear to have experienced similar detrimental changes in their analyses as those described years before.

All the pertinent patients in the present research felt that the quality of their analyses prior to these changes had been acceptable, and in most cases excellent. When changes occurred it could be questioned whether, in some cases, the services received could be legitimately even called analysis as the fundamental structure and process had so deteriorated, not to mention the detrimental effects on the psyche, which will be discussed further in Superordinate Theme 4.

In this vein Firestein (1990 cited Schwartz & Silver 1990, p.334) states -

'Once the patient has inferred that the analyst is seriously ill, or if the news has been directly communicated, the treatment has ended. Even if (they) continue to meet, the treatment of the patient has concluded. This is true because roles are instantly reversed; the patient feels that he or she must in many ways serve as therapist for the analyst. The setting for the work has lost its usefulness for the patient who no longer can feel free to verbalize whatever comes to mind'.

This of course raises serious ethical questions for sick analysts and the profession as a whole. The findings from this, and previous research, suggest that there is a strong possibility that when an

analyst continues to work with a chronic life-threatening illness whether in denial or not, including to himself and the patient, changes will occur in the analysis before termination that will be detrimental to the fundamental principles of analysis. It seems that this is a whole area that urgently needs further examination both in the form of research, discussion, education and training. In the researcher's opinion some of the questions/topics needing to be openly researched and discussed are:

- How can analysts be helped to better understand the potential impact on patients of working whilst they are seriously ill? Does there need to be more support and guidance for analysts in this predicament and how should this be provided? Freedman (1990 cited Schwartz and Silver 1990, pp.326-327) advises that terminally ill analysts should seek psychoanalytic consultation to guard against their own unconscious conflicts at this time for analysis is normally -

'A controlled situation with a set of constants in which one strives as far as possible to keep the patient as the only variable.... Anything which makes the state of the analyst the most important variable at that time must be considered to be an interference in the analysis and must be dealt with.... (For example) If it causes an unconscious need for gratification from the patient –countertransference- this has to be analysed' (p.326).

- Why is denial still so common? The pros and cons of analysts being open with patients about their illness.
- Are there sufficient safeguards in place for the profession to identify when someone is 'unfit to practice', bearing in mind that it can occur fairly suddenly?
- What is 'unfit to practice' in this scenario and are there situations when, for the **patients sake** (never for the analyst's), it is better over-ridden? For example, is it better to have a final session when clearly someone is 'unfit to practice' than not to do so? Who makes this decision? The analyst, the executor if they are already involved, or a fully informed patient?

- Is it ethical for an analyst to accept a patient for what is likely to be long term work of many years when their age is such that statistically there is a strong possibility they might not be able complete it in good health? Do patients have a right to be informed of this risk before making their decision?
- The whole issue of patients' rights, including to receive from the analyst the service they were contracted to provide and that **their** well-being throughout should be the paramount consideration.

Theme 2

All 14 participants (15 experiences) experienced some form of **aftercare which appeared to affect the psychological outcome of this event** including from other professionals, colleagues, family and friends. The aftercare experience was in some cases affected by the impact of the ill analyst's actions prior to, or after termination, and this is included as a Master Theme. The term 'executor' refers to a professional colleague appointed by an analyst to undertake the role of a professional executor (also called professional trustee) as required by the procedures of their professional institution. In the verbatim material patients may have used this term to describe a professional who took a similar role before the advent of a formalised system. The table below identifies the five Master Themes feeding into the second Superordinate Theme.

Superordinate Themes

Master Themes

2. Aftercare in Relation to Outcomes

e.g. 'A good or bad person – what a difference that can make' (Lily).

a. The Analyst's Legacy

e.g. 'He didn't even get my address right' (Sally).

b. Executor or Alternatives

e.g. 'For a time it (action of executor) was destroying my memory of him' (Tina).

c. Family and Friends

e.g. 'I had my husband...and so I had a lot of comfort' (May).

d. Other Professionals/Colleagues

e.g. 'The Therapy Advisor encouraged me to go to the next therapist' (Clara).

e. Subsequent Analysis

e.g. 'I think if this second therapy had been supportive ...things would have been different' (Lily).

Below is a vignette for each participant, in ascending date of termination, incorporating the five Master Themes which, when first mentioned, will be identified in bold type. Each vignette is a combination of verbatim and paraphrased material.

TINA

In 1992, before the advent of the formalised procedure of appointing executors, Tina received a phone call from a **colleague of her analyst**, cancelling her following session. He would give no explanation. The following week another colleague rang to say Tina's analyst had died suddenly and would she like one session with another analyst. Tina agreed, presuming it was to talk further about what had happened to her analyst. She was a trainee psychotherapist at the time. **A colleague** gave her some informal support just after the call. Tina spent much of the research interview expressing her anger at the session that ensued and the inappropriate behaviour of the **analytic community** as a whole, so the following is very condensed -

*'(Around) ten days after I went and met **a woman (analyst)**.... My first questions were 'what happened? Did he have a heart attack?' Silence. **Absolute** silence.... She conducted the whole thing as if it was an analytic session.... I found it **most** highly intrusive, inappropriate.... I wanted to say things like 'I'm shocked. Really shocked. What happened?'' She didn't even say he had a heart attack. She didn't say anything.... It felt like a violation. I really resented that interview and I've never forgotten that'.*

Later Tina found out from other sources that her analyst had a heart attack. Of the analytic community as a whole she says -

'There's a kind of the cavalry rushing in and we must pick this person up, but they never think what they are doing. I really didn't feel it was for me.... Asking me what I needed I still feel angry with them.... They go somewhere that is sacred and walk all over it.... It's form ticking'.

Tina considers her **training organization** was helpful in finding a **subsequent analyst** and she commenced two months later. She has not *'thought deeply'* about her dead analyst either in analysis or privately – *'my choice'*.

HARRIET

In 1994 Harriet received a phone call from a **professional colleague** of her analyst (also Harriet's friend) to inform her that her analyst of five years standing had died suddenly from a heart attack. Although not a trainee/analyst at that time, Harriet had close friends in the analytic community. The executor, as Harriet calls her, had previously checked that Harriet's lodger (a psychiatrist) was in the house. The **lodger** was supportive, as was her **partner and analytic friends** but Harriet felt in her desolation that *'nobody could be of any help to me'*. She realises now that this response partly reflected her lifelong difficulties in *'relying on anyone emotionally'*. She also said *'it would have been too exposing'*. Harriet confusingly had a call a little later from someone saying she was also an executor but Harriet told her she already had one.

Harriet realised she needed another analyst as she was struggling not only with the analyst's death but with serious personal issues. The friend/executor recommended a **subsequent analyst** to whom she went several months later. Harriet rejected her after two sessions - *'I found her distant...and she didn't engage with the baby in any way'*.

A new baby had been born to Harriet after the analyst's death which she took to sessions. Perhaps, (researcher's opinion) Harriet did not feel the regressed part of herself was being fully attended to. A third analysis quickly failed and Harriet decided to have a break. About six months later she went to a fourth analyst. Despite initial difficulties she settled with her and stayed thirteen years.

ELLA

In 1994, after four years of analysis, Ella received a phone call from an analyst belonging to her **analyst's professional organization** to say he had died suddenly from a heart attack -

'They probably didn't have what we would call executors now but maybe they nominated it to someone'.

Ella's **husband** gave support after the call and throughout her grieving. Ella was not a member of the analytic community at that time. She was offered **subsequent sessions**, she believes with the analyst/executor, but cannot remember exactly -

'I went but not for very long. I couldn't use it. I think I went four times. I just didn't want to be there really, there was nothing coming. I couldn't relate to her. I just couldn't do it.... I don't think she did anything wrong.... I think I rejected any offer of help.... The Organization said "would I like to go and see the room?" and I was almost disdainful of it, contemptuous.... Maybe a follow up call in a couple of months after I stopped would have helped, somebody saying "Are you OK? ". Something a bit more pro-active, a bit firmer might have made me stop to think because that's what I wasn't doing. I was doing what I always did'.

Ella found some support from **other patients** she had met at the funeral, meeting up with them intermittently for a few years. Ella returned to analysis in 2007 as a requirement of group analytic training.

MAY

In 1995, after four years of analysis, May received a call to say that her analyst had died. The call was from a **colleague** of his – *'she was completely brilliant'*. May was not connected with the analytic community at the time. May described in detail why she considered this analyst to have been so *'brilliant'* -

'She rang me up, established she was talking to me and said she had some news. She pretty much told me straight out and then offered me a session. I burst into tears...but she stayed on the phone and managed my reaction... I probably saw her the next day. I only saw her for a few weeks because we established early on that she couldn't be my therapist.... She could offer me sessions to decide what to do next and kind of make sense of it. She was enormously helpful because what she did was put into words the benefits of my therapy. She gave me a way, a formulation really, I mean she didn't say "Here it is". I experienced her as warm and interactive. I worked out that as I had been about to work towards an ending that I did not want a referral to someone else straight away.... Too raw, too frustrating'.

May found out later that this death occurred in the days before formal executors and although the analyst's colleague had given the impression of the aftercare being '*a well-oiled machine*' in reality it was all '*pretty haphazard*' - the analyst's wife and the colleague had looked through his address book and tried to work it out. May considered that the essential components of this effective aftercare was that the analyst gave '*containment*' and a '*lifeline*' from the start. She was not intrusive but gave information when May indicated that she was ready to hear it. She was '*enormously human*'.

May also had support from her **husband**, including at the funeral. May started a new analysis in 1999 when she commenced training.

SALLY

In 1998 Sally, a trainee counsellor, received a call from her analyst cancelling a session due to ill health. The following week, having not heard from him, she phoned to establish if there was to be a session -

'His wife answered and called him to come to speak to me and it was a very brief conversation.... He said he was unwell and couldn't see me any longer. I asked if I might know what was the matter and he told me to ring this woman who was actually the director of an affiliate where I had done my first training course and was still seeing clients...and I couldn't understand what that person had to do with it, but I did ring her to be told he had cancer'.

Sally later came to the conclusion that her analyst had not remembered which course she was now on. She was then passed repeatedly from one **training centre** to another with neither knowing who should be responsible for her. There seemed to be no appointed person -

'It was a muddle. A real mess' (Analyst's Legacy).

Sally sent the analyst a card and a cheque for unpaid sessions, but received no response until after his funeral when she received an invoice for outstanding fees, wrongly addressed. Believing the latter was due to her analyst forgetting her address, her already existing anger towards him intensified. Eventually her present training centre took responsibility for finding Sally another analyst and her first centre gave her the number of someone termed an **executor**. When she rang

him she was told her analyst was seriously ill – she did not hear from the executor again. A few weeks later Sally went to her first centre to see clients -

'I went to my pigeon hole and there was a note in it and it was typed.... It had been distributed to everyone and it just said that this person, whom some of you may know, has died at the weekend and giving the name of somebody else to speak to about funeral arrangements...and that was the way I found out'.

Sally found the **analyst in the note supportive**, attending the funeral with her.

Sally found **subsequent analysis** difficult initially, experiencing anger and resistance towards the new analyst. The analyst worked with this and she eventually settled.

Sally commented that in the confusing weeks after termination it was her **training colleagues** not the professionals who *'turned up trumps'*.

CLARA

When Clara's first analysis finished in 2001 she was a trainee counsellor and so an alternative analyst was found for her by a **therapy advisor**. The analyst had not informed Clara that she was terminating from ill health and so there was no talk of an **executor. (Analyst's Legacy)**. Clara felt she had been in the early to middle stages of the work. When the analyst subsequently died Clara found out by chance from a friend who lived near the analyst. At termination Clara was distressed for a long time -

*'There weren't many people I could speak to about her, but I had a **colleague** who had been in therapy with her too...and my **second therapist**. I talked about it throughout my therapy and it affected my relationship with her because I found breaks difficult.... When I thought about her I would immediately think about the first one. I'm not going to get as hooked on **you** as I did on **her**'.*

Clara discovered, by chance, that her first and second therapists were colleagues -

'It did help. It made me feel more at ease although I never told her what it was like to be with my first therapist. It was a kind of trust between me and the first therapist.... In my dreams I would not know which one I was dreaming about – sometimes I saw the first therapist in the second therapist's house in my dreams'.

Clara felt that without the encouragement of the therapy advisor she might not have entered her second therapy and her training would have been affected. She said -

'I felt like a parcel. I wasn't happy at feeling like a parcel'.

In 2010 Clara's second analyst was seriously ill and informed her in a session that she could not work for four weeks but confusingly conducting what felt like a final session, saying at the end -

'Well one of the family will let you know' (Analyst's Legacy).

A few days later a **colleague of the analyst** phoned to say her analyst was hospitalised. Just before the four weeks break expired Clara was contacted by another colleague asking how she was coping. She then received a typed letter from the analyst terminating the analysis and supplying contact details for another analyst if she required further work. After that there was no further contact from any professional. Four months later a colleague, who had also been with Clara's analyst, told her unofficially of the analyst's death and funeral arrangements. There appears to have been no formal **executor**. She had received a similar termination letter to Clara but, unlike Clara, had gone to the recommended analyst and been given this information.

At the funeral Clara met her own **supervisor** -

*'She said "so I hope you'll have closure now"', which I find extraordinary. Ever since I've wanted to hit her...it certainly **wasn't** closure'.*

JANE

In 2004 Jane received an e-mail saying -

'Urgent message re. Bill (the analyst). Can you contact me?'

Fearing the worse, she phoned what turned out to be the **executor**, to discover her analyst had died of a heart attack. The executor arranged to see her a few days later. In the interim her **adult daughters** supported her. Jane had no connections with the analytic community at that time. The executor became her **new analyst** and Jane is still with him. She felt she had been in the early to middle part of her analysis when the death occurred. This subsequent analysis was fraught with conflicts and difficulties for many years -

'I resented John (new analyst) but I kept going back.... I wanted John to be Bill. I wanted immediately to have that same sort of connection.... I felt very alone again.... I felt disloyal to

John because I was talking so much about Bill.... Disloyal to Bill by being with another therapist.... But that man saw me through it’.

Jane felt that at that time it was very important that she had an analyst connected to the dead analyst -

‘A link. Someone who went to the funeral’.

Jane feels that she was given adequate space in the subsequent analysis to work through her relationship with her previous analyst.

PAM

Pam, at her last session in 2004, asked the analyst -

‘When they would start again after Xmas and she said ‘we’re not starting again’’, which was for me like a bolt out of the blue. I had no idea and said ‘we didn’t discuss an ending’ and she kept on saying to me ‘but we did’ ...and so we finished.... I tried to hold it together for a couple of weeks but I really struggled’.

With no admission of illness there was no **executor** and no subsequent analysis was recommended (**Analyst’s Legacy**). Pam had no connections with the analytic community at that time. By April 2005, still confused and struggling to function, Pam realised she must find another analyst. She recalled her ex-analyst recommending a child analyst for her children many years previously when she was divorcing. On contacting her, Pam discovered she also saw adults. Although this **subsequent analysis** was fraught with difficulties for many years Pam persevered and is still with her -

‘It took a very long time to trust her.... It took four or five years where I interrupted her. I didn’t give her space in sessions. I’m not sure how much I respected her and how much I resented her for being there’.

Pam also asked her to have a medical to ensure she was healthy; resisted discussing material explored with her previous analyst; felt resentful at having to spend longer in analysis than she had anticipated because of the negative impact of the termination. Reflecting on her choice of analyst Pam said -

'I could have gone to look for other therapists but somewhere I wanted a connection to her, somebody who knew her as well because somehow I wanted a validation that what I'd done over the last eleven years was not totally useless and senseless'.

Pam believes she was given adequate space in this subsequent analysis to work through her relationship with the previous analyst.

STEVE

In 2009 Steve's analyst suddenly terminated the twenty year analysis citing his cancer as being worse than he had realised. Four weeks later Steve received a letter from an **executor** offering six support sessions. Steve never replied and there was no follow-up by the executor. Steve said - *'If I look at it now I could say I was declining therapy possibly at a time I needed it most'.*

Steve is a psychotherapist but did not feel able to talk to his **colleagues** about his loss – *'It wasn't safe enough'.*

In terms of **family and friends** Steve said -

'Well I don't live in a social circle where everyone's in therapy. They're all very disparaging about therapy and so it would be a bit like saying my accountants died. Nobody would have appreciated it and I didn't talk to my wife about it and she wouldn't have understood what it quite meant either. So I was kind of left very much on my own'.

Steve explained that coping alone had been a lifetime norm -

'Finding and accepting that I could have support just didn't exist. I thought here I am in a demanding job (in a Therapy Centre). Everyone worrying about an Inspection and I could hardly say but my therapist died'.

Eighteen months later Steve started with an **integrative therapist** feeling that he had experienced enough of analysis. There have been no particular difficulties although Steve realised, through the research interview, he had detrimentally spent very little time in sessions exploring his previous loss -

'This is really the first opportunity I've had to talk about it in a meaningful way'.

Steve is critical of his ex-analyst in that he sees a connection between the devastating long term impact on him of the abruptness of the ending and what he feels was the analyst's denial of the

seriousness of his illness and his shortcomings in exploring the inevitable loss with Steve (**Analyst's Legacy**). He has no criticism in terms of the other Master Themes. However, in the researcher's opinion, a four week gap between an abrupt termination and subsequent executor contact could be seen as unsatisfactory, as with the absence of follow-up after a patient's total lack of response.

LILY

In 2009 Lily's analyst told her that due to a return of her cancer they must terminate within four weeks. She gave Lily, a trainee counsellor, the contact details of another analyst. Lily contacted her but she did not respond for several weeks. She was not given the name of an **executor**. In the interim, very distressed, she went to speak to her **supervisor at the training organization** -

'So I found her in a room and she was having lunch. I said "I'm sorry to be troubling you but I really need to talk to you" She said "OK" I could tell she wasn't pleased.... I sat down next to her and started telling her about it and it made me cry a lot and she was as cold as a block of ice...and then that's why it sort of - why my life carried on and this other thing was happening in parallel - and I don't know when things happened and what I did'.

Four weeks after termination Lily went to her **new analyst** -

'She was difficult...very cold...a bit dogmatic. I said "Well it was really long for you to contact me" and she said "Oh, was it?" (Surprised tone)'.

During the four weeks between termination and seeing the second analyst Lily felt unable to talk in depth about her distress to anyone. She mentioned it to her **husband** -

'I think that if I'd told him my tennis coach had cancer and I had to stop it would have been exactly the same for him'.

She tried her **experiential group** -

*'It didn't go very far but I wasn't feeling very safe in the group so that couldn't have helped. I talked about it to **a few colleagues**. Nobody could really relate to it'.*

Six months later Lily talked with a colleague who had a similar experience -

'But even that's not easy - so private, so personal. It's really hard to find, except perhaps in another therapy - the understanding'.

After three months with the second analyst Lily noticed that her analyst's eyes kept closing -

I said ‘I don’t know what’s happening. I don’t know if you’re here’ and she said ‘I’ve got a very bad case of hay fever’.

Lily believes that in a subsequent session she slept for several minutes but denied this when questioned.

I just couldn’t take it’.

Lily’s **tutor** at her training organization was supportive, putting her in touch with a **therapy advisor** who found her an alternative analyst immediately -

‘They contained me really well.... It made a huge difference because I really could have left everything’.

Lily found the second analyst *‘more containing and attuned and able to listen to me’.*

Lily sent her ex-analyst several short e-mails over a period of a year, receiving a brief response. Then one bounced back. Lily became highly anxious and tried unsuccessfully to trace her on the Web. Lily frequently imagined she saw her in the street. She eventually contacted a colleague of her analyst to discover she had died some months previously. When Lily’s analyst had her first bout of cancer she asked Lily if she would like to be contacted in the event of her demise. Lily agreed and thought this agreement was still in place. Lily was informed by the colleague that the list had been destroyed after the analyst’s return to work the first time and not been resurrected after her final retirement. Lily had not been told this by her analyst (**Analyst’s Legacy**).

ROSE

In 2012 Rose’s analyst informed her by e-mail that he was unwell, without telling her the nature or severity of the problem. Rose is not an analyst/trainee. She waited for twelve weeks without further communication and only limited support from a **Buddhist friend** and a **trainee psychotherapist friend**. Rose was reticent to tell others imagining they might be judgemental -

‘Well I didn’t know there was anything wrong with you Rose’.

After twelve weeks an **executor** e-mailed, saying her analyst was dead and offering phone contact -

'She was proper and professional but not pompous and cold'.

Rose phoned to discover her analyst had died three to four weeks previously. The executor apologized for the absence of a letter, saying that she was handed a list of patients and needed to ensure the message was received. Rose felt that this analyst was doing her best to *'look after me'* but was very anxious about the ex-analyst's twelve weeks silence, in terms of what it might indicate about their relationship. **(Analyst's Legacy)** She was relieved to hear it was pancreatic cancer -

'It didn't feel like he was hiding something. Like he could have done anything at all about it. That he could have looked after me any better. Like he just suddenly got it and what do you do? Presumably you're too busy dying'.

Rose also questioned the appropriateness of a patient first hearing of an analyst's death four weeks after it had occurred. As a researcher it was not possible to establish the reason for this but it did seem that Rose was justified in questioning the professional management of those twelve weeks between the analyst leaving her and the executor's e-mail.

The executor arranged **six weeks bereavement support**. Rose wanted this to be from the executor, feeling she needed to connect with at least one person who knew her analyst, but was told it was better to have someone who did not know him. Rose found it *'awkward'* but it helped a little to approach *'the gaping hole'*.

Rose decided not to pursue further analysis. She felt *'resistant to having to start again'* when her previous analysis had been coming to a natural end.

FAY, BABS and GILL

All three had the same analyst and **executor** - there were interesting differences as well as similarities. Babs and Gill felt that their analysis was coming to a natural end whereas Fay felt she was in the middle phase. In June 2013 they all received a phone call informing them that the next session was cancelled as the analyst was unwell. All three now have difficulty recalling the series of events over the next few months as they received frequent communications from both

the analyst and executor, some of which were contradictory e.g. Both Babs and Gill were offered final sessions by the analyst which the executor seemed surprised and concerned about, indicating he was not well enough to see patients. Babs commented as follows -

'He said he was trying to see everybody to say goodbye. But that came with conflicting messages from (the executor) saying 'He's very ill, he'll never see anybody'. So it was a lumpy old process and very confusing'.

Fay was not offered a final session. All three agree that at some time they received a letter from the analyst saying that he would be ending his practice immediately due to ill health. Some of the communication difficulties were because this event happened between June and August when patients and executor were at times on holiday.

The executor informed all three about the analyst's death. In general there were very mixed feelings about the executor.

Fay was a newly qualified psychodynamic psychotherapist. She was informed by phone of the analyst's death. She did not ask for the cause and is not concerned to know. In speaking of the **executor** she said -

'I think he did the best he could. He phoned me initially, he did a follow up, he emailed me with information and he emailed me to ask if I wanted a therapist and when I said 'Yes' he found one. He also offered to see me for a few sessions.... He was very professional'.

However this remark was qualified by the general feeling Fay has about the inability of anyone, including friends, executor and colleagues, to understand how it was for her -

'I don't think you can get it unless you've had a therapist who died'.

Fay declined the sessions but requested help with finding a **new analyst** several months later -

'I'm not sure at the time I even wanted to see a therapist but I went because I knew I needed to. I wasn't in the right place at the time to be working with clients'.

Six months into this analysis Fay is still feeling quite 'guarded' and says -

'I'm working in the room with her but not so deeply'.

Fay had a support network of **colleagues, a supervisor** and another analyst. She said -

'They kind of get it on some level I suppose, but on a deeper level...? I'm not sure I want to share it with anybody but I think if you're not a therapist.... It's like losing a parent without support. Can you imagine someone who went to therapy who's in the Civil Service...? I mean people don't get it'.

Fay asked the executor about attending the funeral but was told -

'You don't really know anyone'.

Babs had a very different experience with the **executor**. Babs is a psychodynamic

psychotherapist. She had several phone conversations with the executor before termination -

'I didn't feel it was well handled by Bob (the executor).... Part of it I can understand. Bob was obviously very upset about what was happening.... There was a real cloak and dagger thing about it which made me quite angry in the middle of it all.... Obviously (the analyst) was dying but there was this whole sort of mystery about what was wrong with him It was a kind of abstract strange communication - unhelpful. And Bob never said anything like "this must be a very difficult time for you" or "you don't have to decide anything now"'. It was odd and confusing.... I felt I was being treated with all the kind of boundaries of a therapeutic relationship in a situation that had become something quite different. So almost like a training level protocol around confidentiality but it was nonsensical in the circumstances and quite infantilizing.... It made me feel jolly cross because I felt it was attempting to be professional for all the wrong reasons and in all the wrong ways. A kind of inflexible professionalism and not really dealing with one's humanity'.

Consequently Babs went to the final session unaware of the nature of the analyst's illness. The executor left a message to say that the analyst had died. Babs replied, asking about the funeral arrangements, but heard nothing further. She later heard that another patient had attended because his new analyst had insisted.

Babs had a few **therapy colleagues** who had also lost analysts and they were a good means of support. Babs has not pursued further analysis -

'I needed to give space to process (the analyst's) death'.

Gill

Gill went to a meeting with the executor just before her last session with the analyst. The executor informed her then of the nature and potential seriousness of her analyst's illness. They also talked about the possibility of another analyst. Gill is a retired counsellor. She was told of the analyst's death on the phone, by the executor -

'The executor was very good. The quality of his care was fantastic...and knowing he was there. If I had wanted his help to find another therapist – that was really important to me. That enabled me to think really I don't need another therapist. I don't think I want to go there again'.

The executor phoned Gill a short time later and said -

'I'm just going through everybody and I just want to check'.

When Gill asked the executor about the funeral arrangements *'he said he couldn't tell me'.*

Throughout the process she found the use of e-mails as a primary means of communication with the executor very helpful. She still has them -

'It feels so wonderfully unobtrusive.... I knew I could email him always'.

Discussion on Superordinate Theme 2

Patients' experiences of aftercare have been arranged in alphabetical order, as the increasing formal procedures for executors that institutions have put in place in the UK in this century would hopefully be reflected in better experiences for patients. For example in the case of the British Psychoanalytic Council (BPC), in 2012 guidance on executors that had previously been the responsibility of member institutions, was moved to the BPC to improve the regulatory processes. The procedures that have increasingly been put in place in this century have moved towards a process, in the case of BPC, that now makes the appointment of two professional clinical trustees a requirement for members under the Code of Ethics. These trustees must hold a list of the members' patients. The prime responsibility is, according to the BPC Register (2013/2014) -

'To ensure patients, supervisees and trainees are informed of their options' (p.169).

Supplementary tasks may include offering to see patients or arranging for other professional colleagues to do so; providing names of appropriate analysts; informing the analyst's member institution of their death.

However these procedures, although valuable, do not completely address some of the more qualitative concerns and dilemmas that were raised in the past, particularly in the 1980's and

1990's, including the problems patients seem to be encountering when they accessed subsequent analytic support. Some recommendations for improvement were incorporated into the discussion sections of several of the papers included in the Literature Review, for example Halpert (1982); Simon (1989); Galatzer-Levy (2004); Firestein(1990), but detailed information on these discussions was not included in this research document as the focus of this project was on extricating information about the direct experience and concerns of patients.

The issues that were identified as problematic at that time through the Literature Review were as follows (numbers in brackets identify the page number in the Literature Review):

- Subsequent analysis as identified by Lord et al. (7); Rendeley (16); Barbanel (11); Traesdel (12); Tallmer (11), patient 1; Halpert (13); Galatzer-Levy (15).
- Professionals' failings including lack of understanding and/or poor practice from the psychoanalytic community as a whole as identified by Rendeley (17); Tallmer (11), patient 2; Pinsky (12); Galatzer-Levy (14): inadequate/inappropriate notification of death as identified by Adams (9); Tallmer (11), patient 1; Freedman (13); Galatzer-Levy (14): inadequate support from training organizations as identified by Galatzer-Levy (14).

Looking at the problems experienced by those research participants who lost their analysts in this century, including those in 2013, it would seem that the same difficulties are being experienced as those identified in the Literature Review from the 1980's and 1990's, apart from perhaps notices being left on doors. Within the research sample, there are good and bad experiences that seem to have been encountered in equal measure irrespective of when participants lost their analysts. Surprisingly perhaps the most positive response around aftercare was provided by May who lost her analyst in 1995, before the advent of professional executors. Her aftercare appears to have been handled sensitively, skilfully and in a timely fashion by a colleague of her dead analyst who informally took the role of an

executor. That is not to say that other executors did not do the same as other factors may be impacting on the outcome. This was highlighted in the case of Babs, Fay and Gill who all had the same analyst and executor. From their perception, Babs had a very negative experience with the executor, Fay's was reasonable and Gill's was very positive. It is not possible from such a small sample to draw definite cause and effect conclusions around why some patients' experiences of aftercare were more positive than others but there are indications in the research and these would benefit from further investigation. They are as follows:

- Patients bring to the aftercare experience their personal life experiences and their individual pathologies and psychic structure. For example, we have seen that some patients, such as Harriet, Ella and Steve, found it difficult to accept the help that was offered; for Sally being passed from the analyst (a parental figure) to other carers was reminiscent of a painful childhood experience.
- Patients have had very different analytic experiences prior to termination and subsequent aftercare. In this vein Traesdal (2005, p.1237) states -

'It is becoming increasingly clear to me that an important factor determining the degree to which an analyst's death becomes traumatic is the manner in which (or indeed whether) the issue was handled in the course of the analytic process. It is extremely helpful to a patient to have discussed with deceased analyst how to handle the situation if what must not happen does happen'.

For example, Steve and Jane felt that the possibility of loss, including loss through illness/death, was not handled adequately throughout the analysis and particularly when it became so pertinent in the year before termination; some patients had a long period suspecting that their analyst was ill either consciously or unconsciously, as opposed to those whose analyst died without warning. Both phenomena will carry their own

particular emotional/psychological difficulties and it is likely that these will impact on subsequent aftercare.

- This research, conducted subsequent to the advent of formal executors, has highlighted problems that can occur in the interface between analyst and executor that had not been so clearly identified in earlier research. For example, Babs and Gill found it confusing and worrying to be given mixed messages as to whether the analyst would be fit enough to conduct a last session. This perhaps contributed to some of the anger Babs felt towards the executor: the executor is also reliant on the analyst passing them information in order to act in a timely fashion. In the case of Rose and Steve there was what would appear to be an unreasonably long delay but it is difficult to be sure who was responsible – analyst or executor. May and Jane both stressed how important had been the early containment they experienced, whereas Lily, Rose and Sally painfully struggled when it was delayed longer than they could psychologically manage. Reminiscent of Winnicott's (1965, p.88) concept of the anxiety experienced by an infant when mother is absent for longer than they have the psychic capacity to manage: bringing the executor role into play will usually depend on the analyst if they are still alive. In the case of Pam, Clara (2) and Lily this did not happen. Pam's analyst brought the work to a sudden close citing reasons other than illness. Lily and Clara's analysts gave the address of an alternative analyst to contact but this was solely to commence further analysis. All were left struggling and uncontained with no adequate means of finding out about their analyst's subsequent death.
- The role of executor seems to require more thought, including an exploration of some of the difficulties inherent to the role. Babs and Tina were very angry at not being given details of the nature of the analyst's illness by the executor, or substitute. However there

is the issue of the analyst's right to confidentiality which may conflict with this demand. The executor may have very little understanding of a patient's pathology and nature of the analytic relationship unless the analyst leaves notes. Patients in the research had individual needs and expectations of an executor. The role requires time, sensitivity and flexibility based on some individual understanding of the patient and a more general knowledge of the potential impact of this phenomenon on patients. Executors are simply analysts and, as we have seen, there is much denial and little research/discussion around this topic. The participants in this research have found that there are professionals who have been supportive and others who have been the reverse. What happens if your executor is the latter rather than the former?

- The issue of subsequent analysis/bereavement support raises innumerable questions that do not seem to have been progressed since raised by analysts writing in the 1980's and 1990's. This is just an example – Should there be some form of interim support before a patient enters another analysis? If so, who is the best person to do that – someone who does or does not know the dead analyst? How is it best to conduct that interim support? Freud said –

'In states of acute crisis analysis is to all intents and purposes unusable' (1937, p.232).

The participants in this research all struggled with subsequent analysis and had very differing approaches from their analysts. There is also the question for patients as to whether they **want** further analysis and/if they have the financial resources. This was very problematic for some of the participants. Steve had already been in analysis for twenty years, Pam eleven, Gill twenty two years in total, Rose nine years – an enormous investment in time and money. The last three had considered they were nearing the end of their analysis. Pam took four to five years of analysis to work through the trauma of

the ending of her previous analysis, so it is unlikely that any traumatised patient will be substantially helped with a short spell of bereavement counselling. This raises serious ethical questions – If a patient is traumatised/damaged by a professional service should they pay themselves for the support needed to help them recover?

- 3 trainees who are at present undertaking training, or have recently finished – Jane, Pam and Lily – felt their training course paid insufficient attention to this research topic. They did all come from the same organization, so this might not be representative. It seems a wasted opportunity and a surprising omission.
- 10 participants reported that many of their analytic colleagues did not really understand the problem. 5 of these indicated that they felt colleagues would only understand if they had experienced something similar, which is surely rather strange as analysts would be expected to empathise and work with patients who had problems that they, as analysts, might not have directly experienced.

It would seem essential that all these issues are given more attention by the analytic community. It is surely a patient's right to have the best researched and thought out aftercare possible if they suffer such a difficult ending to their analysis.

Theme 3

This theme looks at the impact of **the inherent nature of psychoanalysis, including the requirements of training organizations/registering bodies**, on the phenomenon under investigation. The table below identifies the five Master Themes feeding into the third Superordinate Theme.

Superordinate Themes.**Master Themes****3. The Inherent Nature of Analysis inc.****Requirements of Analytic Training.**

e.g. 'There was a lot of regression and buckets full of transference' (Jane).

a. Analytic Boundaries

e.g. 'Twelve weeks.... I had no way of finding out how you were' (Rose).

b. The Analytic Relationship

e.g. 'I was hugely, hugely dependent on her' (Pam).

c. Trainee Requirements

e.g. 'They (Training Organization) gave me one month to leave the first therapist.. and look at this one' (Sally).

d. Seeing Patients

e.g. 'Just before my first client...there was a note and it just said he had died'. (Sally)

a. Analytic Boundaries

For all **14 participants** the professional boundaries, inherent to the analytical process, were highlighted in unexpected ways due to the particular nature of the termination of their analysis.

In the majority of cases what had been seen as a means of protection - albeit sometimes frustrating and resisted - became a source of confusion and anguish, including a questioning of the value/nature of their relationship with the analyst, and of analysis as a whole.

In the table below the issues cited by participants have been grouped into four categories, a '*' representing a participant's inclusion in a category. There is also a column to identify whether a participant attended the funeral.

Table 3

Name	How do I reach my sick analyst?	Funeral attendance	How do I mark the end?	What do I hang onto?	Who was I to my analyst?
Pam	*	No	*	*	*
Lily	*	No	*	*	*
Rose	*	No	*	*	*
Steve	*	No – but invited	*	*	*
Gill	*	No	*	*	*
Babs	*	No	*	*	*
Clara1	*	No	*	*	
Clara2	*	Yes	*		
Jane		No	*	*	*
Tina		No	*	*	
Sally	*	Yes	*	*	
Ella		Yes	*		*
Fay	*	No	*	*	
Harriet		Yes	*	*	
May		Yes			

Column 1 - How do I reach my sick analyst?

9 participants (10 experiences) had analysts who did not die suddenly but stayed alive for some time after termination. They had to cope with knowing that their analyst was seriously ill/dying, but the formal boundaries around patient/analyst contact outside the consulting room deprived

them of the normal channels by which people know what is happening to, and show their care towards, a relative, friend, colleague etc. Participants had been intimately involved with their analysts for between two to twenty years and their anxiety/grief was intensified by this restriction particularly if there was no executor, or one that they experienced as difficult, to act as an intermediary.

Column 2 - Funeral attendance. Column 3 - How do I mark the end?

6 of the 14 participants (15 experiences) were invited to the funeral and 5 attended. Irrespective of funeral attendance this was cited by **13 of the 14 participants** as a difficult area for them and one which highlighted how professional boundaries can deprive patients of the comfort, support and ‘movements towards healing’ experienced, by relatives and friends, through attending funerals and mourning with others the death of a mutually loved person.

Column 4 - What do I hang onto? Column 5 - Who was I to my analyst?

13 participants (14 experiences) struggled over the weeks/months/years (variable) after termination, and including at the funeral, with finding ways to hold onto the reality and nature of the relationship, including who **they** were to the **analyst**. This would happen to some extent after any bereavement but is aggravated for patients by professional boundaries which limit free access to experiences and tangible reminders that would normally be available to the bereaved – funerals, memorial services, graves, memorabilia, knowledge of the final days/nature of illness, other people who knew the deceased. Conversely, they might find it difficult to process and incorporate into an existing mental schema new found knowledge about the analyst’s life/death acquired through attending funerals etc.

Below is a brief scenario for each participant incorporating columns one to five and using paraphrased and verbatim material.

After termination **Pam**, with no executor or contacts in the analytical community, had no means of finding out about her analyst. When she died a year later she was informed by a mutual

financial advisor and told that her age was 92 years of age. She felt shocked and angry on both accounts – the breach in her right to confidentiality and that her analyst had been practicing at such an advanced age -

'I asked him when the funeral was and he had no idea and I said "could I go to the funeral?">'.

Pam felt unable to pursue the funeral question as she felt it would be too uncomfortable -

'He (financial advisor) will know that I've gone to the funeral'.

Pam still questions who she was to her analyst – did she **really** see her as a substitute daughter?

That was how it had felt.

Rose brought to the interview an unsent letter to her analyst written in the twelve week period between their last meeting and notification of his death -

'I don't feel able to ask how you are.... I have no one else I can ask about you, no way of finding out how you are.... I feel bereft.... I wonder what is wrong with you I imagine two scenarios. If you've got cancer my fear is that I won't see you again. Ever. But an almost worse fear is that you've got depression. What would that be like for you?'

Rose also said -

'I think one of the most difficult things is that nobody else had met (the analyst). It's like having a secret relationship. The only parallel I could think of was that it would be like having a secret affair with somebody for a long time and then you were not invited to the funeral, you can't grieve.... I want to talk to other people who had him'.

After termination, **Steve** waited anxiously for seven months for the call to say his analyst was dead. Invited to the funeral he started out but getting caught in traffic did not make it in time -

'So whether I had sabotaged it a little bit myself? Maybe. But I felt annoyed. I've driven all the way down this shit road and now I'm driving back again. It was awful, awful. The whole bloody thing I think. It feels like a mess the whole ending, the funeral'.

A year later Steve went to the coffee shop (p.41) and then to the grave. He said that in the shop -

'There was a guy who looked just like him...and whether he was taking care of me or not, maybe. It felt like he was there. I still like parking there...and interestingly my car's parked right there now'.

Of standing at the graveside Steve, breaking into tears and sobbing, said -

'I remember standing there and it had his date of birth on it...and I can't remember what I said to him now. He did fifty five minute sessions and I thought I'd stand there until five to two. Then

*I called time which is what **he** would always do. It's like **I'm** the paternal figure now. **I** get to call time'.*

Two years later Steve was invited by the analyst's wife to go back to the consulting room and choose some books. Steve declined -

*'The idea of going back into that room in this new context and without him. I wanted to preserve that as the room of my therapy. I could preserve the therapy intact but once I got into that room it would fall apart... It felt as if I'd violate the therapy taking those books out of the therapy space.... What am I going to do with them, put them somewhere in **my** bookshelf? It felt as if the books would somehow become bastardized as well and they would lose their significance as the book in that space I would look at on the couch'.*

When **Bab's** analyst went off sick for several months she was given no knowledge as to its nature/severity, receiving conflicting messages from analyst and executor. She described it as -

'Sailing towards an inevitable doom ... It was undoubtedly clear something catastrophic had occurred.... I suppose I had all sorts of fantasies about what was wrong with him'.

She asked the executor about a funeral/memorial but there was no reply.

Babs felt as if there had been nothing to mark the analyst's death – she had been left *'high and dry'*. She said -

'We spend our time talking to clients about marking loss. And actually if I hadn't managed to see (the analyst) it would have been very difficult'.

The research interview occurred roughly a year after termination. Babs said -

'It feels helpful in marking that time for me'.

Gill, with her analyst off sick for several months, had no knowledge until just before the final session of the nature/severity of his condition. However, like Babs she had -

'A bad feeling about it'.

She was not allowed to attend the funeral, although she requested it, but there is a sense of ambivalence -

'I felt happy about that, better about that actually...thinking of my own husband...you know if something had happened to me the thought of people I had worked with piling in. I didn't want to see his life'.

In the researcher's opinion Gill was demonstrating, throughout the interview, her struggle to maintain a defensive structure that allowed her to feel she had with her analyst -

'A special relationship and I think all my life I could never feel special'. (See Superordinate Theme 1.e.).

Perhaps she was afraid that this defence would be overly challenged by hearing of *'his life'* at the funeral.

Gill mentioned the loneliness of having only one friend (a psychotherapist) who she can talk to about the analyst.

Clara, after termination, had no means of finding out about her analyst's illness/death. She only found out about the latter months after the funeral. Clara sent an Xmas card (unanswered) and -

'I did ring her once or twice because she had a phone recording...and I would still hear her voice'.

With her second analyst Clara was very concerned about her wellbeing for the five months in between termination and her death. She said it was *'a kind of limbo'*.

Hearing of the death through a colleague she attended the funeral -

'It was very important to go to the funeral and it was lovely like all funerals. I knew a lot more about her after the funeral...but it certainly wasn't closure'.

Jane did not attend the funeral -

'I remember saying to (the executor) at that first phone call "Well when is the funeral?"' And he said it would just be the family for the funeral and again it was that kind of extreme - nothing. No way to grieve. What I did was a little kind of ceremony on my own. Played a couple of songs, lit a candle, but that didn't seem good enough. What it felt was he'd gone but he hadn't really gone because I didn't know that he had gone'.

Also -

'I think the hardest thing for me was it really brought into focus how little I knew about him. The thing is when someone dies you want to keep a bit of them and you don't know what bit to keep (with the analyst). You've had this really intense relationship and yet you're shut out of all the funeral type things.... His wife, his mother, his sister, close friends came and people like that. So there was me who'd had this really intense relationship with him, but what was I? The secret mistress who doesn't get invited to the funeral? She sneaks in at the back'.

Lily, without an executor, was emailing her ex-analyst intermittently. When one bounced back she searched for a year to find out what had happened, eventually discovering she had died several months previously -

'What I remember is relief to know. At least I'm not in this in between, trying to find her'.

Lily compared her analyst's death to that of her father's -

'It's something that can't be shared.... (With father) everybody knows...people come to you and say 'I'm sorry' and that helps. People you haven't spoken to for a long time they contact you. With a therapist people say 'OK, your therapist died, well?''.'

Also -

'I found it quite strange to have nothing to hold onto....You go to church and there's a eulogy And you know where the person's buried and there are lots of visual things...and it doesn't exist with a therapist....Yes I think it's this feeling of hanging, of floating. And you're left wondering...well this is going to make me cry...do I miss them more than they miss me? It's painful'.

Tina was not invited to the funeral and any questions put to the analyst allocated to support her were met with silence. She said -

'The worse thing is there was no way of saying to them (the professionals involved) 'How dare you do that''. It was destroying my memory of him...it's like somebody saying 'We're taking him back - he's not yours he's ours and you think you had a relationship with him. No you didn't, he belongs to us. We hold the gates of the graveyard and you are not welcome into it''.'

Sally felt concerned about her analyst in the four weeks between termination and his death.

However she had no means of finding out what was happening apart from through an executor who she had difficulty tracking down and with whom she felt angry. She went to the funeral but there were complications -

*'Amongst the congregation there was my previous therapist whom I hadn't seen since I finished...and I found that difficult. It prompted all sorts of questions in me. What was **her** relationship with this man? What was she doing there?'*

And limitations -

'I would very much have liked to go back into that room, conjure him up and have a final session.... It was important to go (to the funeral) but it's nothing like a final session.... I had to find my own way of making a final session'.

In order to do this Sally drove past the consulting room at a time she would have had a session only to see furniture being removed. She went and bought a book and in it wrote – *‘Remembering Alan’*. Sally said – *‘It was a sort of something’*.

She also said -

*‘I think it’s the helplessness of there being nobody. You can talk to therapists about it in a sense but it’s not like a family where you **share** memories of the relationship with a person’.*

Ella attended the funeral -

‘It was tremendous. There were a few of us (patients)...we would meet up subsequently...and realising who he was. I had no idea he was so well respected.... He became a real person which of course doesn’t happen usually and actually I think that was quite a good thing’.

However after the funeral Ella, with the other patients, fantasized that they were all his **real** daughters as they learnt at the funeral that his children were adopted. It is possible (researcher’s opinion), that at the funeral, they had felt somewhat insignificant and uncertain of their relationship to the analyst and defended against this by fantasizing a special relationship.

Fay’s analysis was terminated several months before his death. She believes that she was in denial about the seriousness of his illness during those months, convincing herself that he was simply retiring due to a minor health problem and so consciously felt little concern for him -

*‘It doesn’t make any sense, but in my brain I thought he’s just going to retire. I had no idea he’s going **to die**’.*

News of his death came as a great shock. Fay wanted to go to the funeral but the executor said -

‘Well you don’t really know anyone’.

And -

‘He finally came back to me and said they were taking donations to some animal charity and I pooh-poohed it to be quite honest. I didn’t think that was quite significant... I just couldn’t get my head around that’.

Also -

‘You can’t really mourn in the same way - in the States you see the person laid out... It seems kind of surreal to me (the analyst’s) death. He’s kind of alive somewhere. Nothing concrete’.

Harriet attended the funeral and felt it provided some benefit -

'I thought that it was very important, to go to her funeral'.

However there was a problem as she saw a woman who she believed her husband was having an affair with and who she did not know had any connection to the analyst – *'that was very shocking'.*

Harriet felt very alone with her grief for years -

'Nobody could make this right for me, particularly because it was a therapist. If a member of the family dies, or a friend, you've got much more support but it was a very, very private, very lonely grief... You don't go around saying your therapist has died and it's not known'.

When she was sixteen Harriet's mother had committed suicide -

'When my mother died everybody knew and everybody kind of 'woofed in' to be supportive and all the rest of it.... I remember shortly after (the analyst's) death going to visit some friends with my two little ones and partner and having to be normal and feeling utterly desolate. Sitting on their sofa feeling bereft'.

Harriet tried to help herself by various means – a trip back to look at the house, keeping a letter the analyst had once written to her and taking her new baby to an exhibition of her analyst's pottery which was arranged some months after the death.

May, tearfully at times, said -

'I went to the funeral which was enormously helpful.... Listening to the eulogy and learning things.... Going up to his wife who I didn't know and paying my respects. I said I was a patient and she immediately said "Are you being looked after?" It was human and normal and it made him a real person in his own life which was helpful in letting him go. He wasn't just in my fantasy'.

b. The Analytic Relationship

Working with, and through, the transference is a fundamental requirement in psychoanalysis.

However when termination occurs prematurely transferences may be only partially worked through. The patient may also be deeply dependent on the analyst. In life in general, significant bereavements may engender a more regressed state for some time and trigger emotions connected to previous bereavements. When a patient suddenly loses an analyst these common states are likely to be intensified because of the nature of the analytic relationship, although with

variations depending on what stage a particular patient is at when their analysis terminates. The table below identifies where patients felt they were at termination in terms of dependency and/or the researcher's perspective; the nature and strength of the transference from the patient's perspective and/or the researcher's perspective. This information will be taken forward in the fourth Superordinate Theme.

Table 4

Name	Dependency Level	Transference State
Pam	*High Dependency	*Maternal – High Intensity
Steve	*High Dependency	*Maternal/** and Paternal – High Intensity
Jane	*High Dependency	*Paternal – High Intensity
Lily	*High Dependency	*Maternal – High Intensity
Clara (1)	*High Dependency	*Maternal – High Intensity
Clara (2)	*Low Dependency	*Maternal – Low Intensity Working to an ending
Rose	*Moderate Dependency	*Paternal – Moderate Intensity Could foresee an ending fairly soon
Tina	*High Dependency	*Paternal – High Intensity
May	*Low Dependency	*Paternal – Low Intensity About to set an end date
Harriet	*High Dependency	*Maternal – High Intensity
Ella	*Moderate Dependency	*Paternal – High Intensity
Sally	*High Dependency	*Paternal/** and Maternal – Moderate Intensity

Babs	*Moderate Dependency	*Unspecified
Fay	*High Dependency	*Paternal – Moderate Intensity
Gill	*Low Dependency	*Unspecified

* Patient’s Perspective

** Researcher’s Perspective

c. Trainee Requirements

4 participants were in training at the time the phenomenon occurred. **3 of these participants** commented on the difficulties of having to transfer to another analyst within a relatively short space of time to meet training requirements. Lily had different issues. These difficulties/issues are outlined below.

Tina was grateful that her training organization appreciated that she needed **some** space but still had to return to analysis within two months. Commenting on the difficulty of this she said - *‘There has to be a space.... There has to be an empty chair - nobody should sit in that’.*

Clara met her new analyst whilst working on the ending with her sick analyst. She said - *‘I thought it was absurd to go straight into therapy with someone else because in any other situation in life that would not be thought to be a good idea. There really needed to be time to grieve and I definitely was’.*

Sally had been required to leave her first analyst by her training organization if she wished to pursue more advanced training and consequently had an ending of only a few weeks. Eighteen months later, barely settled in, her second analyst died and she was required to move immediately to a third. Sally felt angry with the training organization -

‘For having brought about this change of therapists and “look at this therapist” There was no gap because I was in training. I don’t think I would have chosen to move in with someone else.... It felt like “there we go again”.’

The fourth participant - **Lily** - had the reverse difficulty in that, irrespective of training requirements, she felt unable to function in the four weeks she was without an analyst, believing

she needed a replacement immediately. However she now considers that this could have been prevented by the provision of other support mechanisms. She would then have had some time to explore her options. We have seen (Superordinate Theme 2) that Lily had not been provided with an executor.

d. Seeing Patients

The 4 trainees, plus 3 qualified analysts, were seeing patients when their analyses terminated. **5 of these** directly commented on the difficulty of seeing patients.

Steve, angrily, recounted the scenario of taking the termination call from the analyst whilst at the same time having it on his mind that -

'I've got to go out and see a client in twenty minutes'.

Sally, also angrily, said that after she discovered from a *'round robin'* that her analyst had died -

'I had to go straight into a session with my (four) clients'.

Both **Lily** and **Fay** struggling to function and process their own emotions, as will be described in Superordinate Theme 4, commented on how stressful seeing patients was for them at that time.

Babs mentioned that it was fortunate that she was on a break from her patients when at the height of the crisis with the analyst. She said -

'When I first had to sit in this chair on my own I found that really hard'.

When we look in Superordinate Theme 4 at the psychic impact on all seven participants in this Master Theme, it would seem to be questionable as to whether they were in an appropriate place to be seeing patients when they did.

Discussion on Superordinate Theme 3.

Looking at the Master Themes in relation to the Literature Review, the following similarities have been identified (the number in brackets corresponds to a page in the Literature Review):

- Analytic Boundaries as identified by Ritz & Voller (7); Rendeley (8); Adams (9); Tallmer (17); Foulkes (17); Garfield (17); Galatzer-Levy (17); Robutti (17).

- Analytic Relationship as identified by Rendeley (9); Galatzer-Levy (15); Traesdel (17); Lord et al. (7).
- Seeing Patients as identified by Garfield (10).

As we have seen with the participants in this research project, when the analyst becomes seriously ill/dies some of the innate conflicts in the analytic relationship are thrown into the spotlight: that this close, intimate relationship carrying the transference projections of significant people in the patient's life, is at the same time a professional relationship with professional boundaries. Analysis is a unique situation and it is perhaps inevitable that these particular conflicts will occur if analysis is chosen as a treatment. However it is important that the pain and confusion that this conflict may induce is sensitively recognized and acknowledged.

Unfortunately the research participants did not always feel this to be the case. Perhaps indicative of the level of denial still in the profession.

It is also important that the vulnerability of the patient, in terms of the potential regression and resulting deterioration in functioning that may inevitably occur after such an event, is recognized and sensitively addressed. For example, that the patient may need more help than normal to access further psychological support, as we have seen with Lily; that they may struggle to function in their work situation, as with Pam. Grief at the loss of the analyst may be intensified by the nature of the transference relationship and the state of the defences at termination. Notes left to the executor by the deceased analyst about the potential risks for each patient if this event occurs, based on their psychopathology, social networks, life experiences etc., are likely be helpful, to some extent, in alleviating this problem. However this does raise a potential dilemma around a patient's right to confidentiality – a conflict around the right to confidentiality as opposed to a right to receive the most well-informed aftercare possible in these difficult circumstances.

It is worrying that patients such as Steve and Sally were given shocking news when they were just about to see their own patients. Were **they** fit to practice at that time and perhaps for some weeks after? Does having to be strong for patients detrimentally impact on and delay the grieving process, as suggested by Garfield (10)? This is an area that perhaps could be improved on with more research and discussion. It certainly should be possible to improve professional communication and organization so that patients are not told bad news before seeing clients. Supervisors and supervisory peer groups are also in position to support trainees/analysts who have been bereaved and additionally assess if they are 'fit to practice' at that time. Unfortunately we have seen that Lily, a trainee, felt that her situation was made worse by a supervisor (p.60). The issue of attendance at funerals/memorials, being given information about the analyst's condition before or after death, being given mementoes etc. is complicated and contentious. As we have seen from the research it has the potential to be helpful but equally can be confusing and painful. For example Sally (p.77) felt attending the funeral contributed to giving some sense of an ending but was pained and confused to see her previous analyst there. What was her ex-analyst's relationship to the dead analyst? Should she talk to her? She had not been aware that they knew each other. Sally wanted to see her analyst's room again but it was not offered, Steve was given the opportunity but felt uncomfortable about it. Each patient brings their individual needs to the event and there is no blanket solution. Once again this area appears to need further research and discussion.

In most of the above areas there is a conflict between the analyst's (and his relatives/friends) right to confidentiality and privacy, and the needs of the patient for the best possible means available to ease a painful situation.

More thought also needs to be given by training organizations to the potential emotional anguish (and perhaps psychic damage) trainees may experience when they have to suddenly change analysts. In the case of Sally this happened twice over a period of a few years – both endings

were sudden and traumatic. One was for training requirements and another due to the analyst's terminal illness. She then had to enter a third analysis very quickly for training purposes. During this time she was seeing patients. There are obviously inherent conflicts here as trainees need to have appropriate analysis during training, particularly whilst seeing patients.

As the issues raised in Subordinate Theme 3 are largely innate to the practice of analysis fundamental change is likely to be problematic to achieve, but it may be possible to make some improvement to the situation, for example, by considering some of the researcher's suggestions outlined above. Superordinate Theme 3 is also an area that has been seen, through this research, to need further examination by the profession.

Theme 4

In this theme the **psychic and emotional effects of the phenomenon** under review will be described for each of the 14 participants (15 experiences). The table below outlines the three Master Themes feeding into Superordinate Theme four. The material will be a combination of verbatim and paraphrasing.

Superordinate Themes

Master Themes

4. Emotional/Psychic Effects

e.g. 'It had a really profound effect in a way that I had no idea it could be like' (Lily).

a. Magnitude/Emotional Intensity

e.g. 'For about six months I couldn't speak about her without crying' (Sally).

b. Psychological Processes/Mechanisms

e.g. 'Was there something I'd done that wouldn't allow him to live anymore' (Ella).

c. Patients' Present States

e.g. 'I've come to terms with it.... I see her shortcomings ...but also the goodness I got from her' (Pam).

May

May appears to have experienced the least complicated grief process. She had not lost any significant person in her life before the analyst, but had many moves to different locations in her childhood -

'I think I became accustomed to this kind of wrenching loss'.

She had an ambivalent relationship with a *'very narcissistic'* mother. Of her father she said tearfully -

'He was a lovely man and I loved him dearly'.

She was about to agree an end date with her analyst when he died. She described the analytical relationship as generally *'containing and positive'*, although sometimes she would experience the analyst as *'silent, powerful and a bit frightening'*, as with her father. May's outside life was settled and happy at the time her analyst's death occurred. She had at one stage been very dependent on her analyst but believes she had largely worked through it.

As described in Superordinate Theme 2, May felt shocked and saddened by her analyst's sudden demise but was supported admirably by the executor, who provided six sessions, and by her husband. Seemingly, for May, some of the variables that could likely impact on the outcome of this event were stacked in her favour.

May felt that she had worked in a normal, natural way through her grief and in 2000 went back into analysis, with a woman, as part of a counselling training. After two years she went onto the couch, as with her previous analyst, and at the Xmas break (her ex-analyst died at Xmas) she dreamt her present analyst had died and was lying on the ground staring at her with *'persecutory, lifeless eyes'*. After that she dreamt of her death in every break of the seven year analysis. She took it to her analyst -

'And what I learnt was that there was something I was holding unconsciously that had not been worked through in spite of having worked through the death of my analyst.... That I was afraid that if I went on the couch, or maybe just forming another dependent relationship, that I would

run the risk of losing her again. It was a great learning for me professionally around what is carried.... Entirely not accessed in a good enough grieving process'.

May believes that if her analyst had died several years before she would have been in a place in her analysis where she might have had more difficulty. She also believes that to some extent she has kept her dead analyst - like father- safe and idealised, with the second analyst becoming - like mother - the target for her anger.

Ella

Ella's grandfather, a *'very solid figure'* for her, died when she was twelve years old from heart problems. Father had been stricken with Parkinson's disease from her babyhood, dying suddenly when she was twenty one. He was almost immobile from when she was around the age of two and the family *'all looked after him'*. However she also said -

'It was a bit like having a therapist, I could go and talk to him. He couldn't speak properly but I felt very accepted and loved'.

Ella said that after her father's death -

'I had a real manic, psychotic episode and was hospitalized and then came home and was terribly depressed for months'.

She was using hard drugs at that time in her life and believes this may have contributed to her psychotic state.

At the time of her analyst's sudden death from a heart attack Ella and her analyst had been discussing an ending. She felt she had got as far as she could at that time and he had not disagreed.

When Ella received the phone call about her analyst's death she said -

'I immediately burst into tears'.

She felt at the time that this was a step forward as she cannot remember doing this with father or grandfather's death. Her husband was around for her children and she remembers thinking -

'I can do this because I do not have to look after anyone else'.

Ella said -

*'I was gutted but I knew it was about my father as well. I became aware of **my** destructiveness. Was it me? What did I do to him? Was there something I'd done that wouldn't allow him to live anymore? It related back to my father. What have you done to make a parent ill? Very early stuff.... I felt angry about it happening again and that relates back to my father. Not being angry with **him** but the world. God or whatever you want to call it'.*

Ella said that it took years for that sense of responsibility to fade.

Ella feels that she sadly rejected, without thinking, all offers of help from other professionals as that was her usual pattern -

'You see I put all the illness into the youngsters (as a teacher) and helping others. Fairly classic stuff'.

Ella had been aware throughout the analysis that she saw her analyst as a father figure. As described in Superordinate Theme 2, at the funeral she learnt that her analyst's children were adopted and for many years after she had fantasies that **she** 'was somehow the daughter'. In the researcher's opinion possibly as a means to feel 'special', in response to a sense of relative anonymity and lack of identity engendered by the funeral and/or as representing an unconscious fusing of analyst/father in the psyche.

Two years later Ella's mother died and she had some helpful bereavement counselling.

Ten years later Ella went back into analysis - part of her training to be a Group Analyst, which is a role she now practises. Today, twenty years later, she has fond memories of her ex-analyst and feels she has eventually been able to work through the grief of his loss and this has helped her with grieving for the loss of her father. In the interview Ella's account was presented in a thoughtful, consistent, clear and calm manner.

Pam

As described in Superordinate Theme 1.e., during the final year of analysis many essential aspects of the process had deteriorated so that even prior to termination Pam was experiencing anxiety/confusion and was entangled in a re-enactment of the childhood situation that had brought her to analysis. Not having experienced any significant loss herself in childhood Pam grew up surrounded by a sense of loss -

'I think I got it intravenously with mother's milk. This sense of loss, the sense of death, the sense of not worked through mourning of a vast amount of family. My whole family was murdered in the Holocaust'.

Pam was 'very shocked' when her analyst suddenly announced termination insisting they had worked towards an ending. It was Xmas and Pam was due to fly abroad but panicking had to get off the plane -

'I tried to hold it together for a couple of weeks but I really struggled and through me it showed itself though a symptom. I get a fear of flying when my life comes to great difficulty.... I couldn't function.... It's about lack of control and my life was out of control, absolutely'.

After Xmas Pam requested one more meeting, but throughout the session her analyst kept repeating that they had worked to an ending. Pam began to take the blame -

'I was very cross with myself I doubted my mind.... I thought 'Pam you thought you were quite switched on but you have a very dangerous mechanism that doesn't hear'' I lost my confidence in my thinking capacity'.

In the researcher's opinion this is reminiscent of Fairbairn's (1943) concept of the 'moral defence' in which the child prefers to be the bad object so as to maintain -

'...that sense of security which an environment of good objects so characteristically confers' (p.65).

Pam said of the event -

'I'd had a shock, a trauma. I didn't know how to handle it. I fell apart. I picked myself up and I was the little child, very much of what my parents wanted of me 'pull yourself together... you've made the mistake'' I drew on my upbringing of self- sufficiency'.

However, and very fortunately (researcher's comment), Pam said that when four months later -

'I knew I still couldn't fly. I thought this is not right I need to see a therapist.... It took me four or five years to actually realise and take my former therapist off the pedestal and say she's made mistakes'.

When comparing her analyst's death to that of her parents Pam commented -

'I feel enormously guilty saying this but it had a much greater emotional impact on me.... I missed her more than my parents and I didn't fall apart after my parent's death but I did after hers'.

Today, ten years later, Pam is in the final stages of a psychodynamic psychotherapy training.

Still with the second analyst she has spent many years working with her on the untimely ending

of her first analysis. This was born out by her account to the researcher which was coherent and thoughtful. She seemed connected in a balanced way to the feelings surrounding the event. She said that for many years her first analysis had been very positive -

*'And that's what I see today. It was **enormously** positive and I put it today that towards the end of her life we both fell into the same trap...that I became the caregiver. I've come to terms with it and I see her shortcomings and my vulnerability but I also see the tremendous goodness I got from her'.*

She also understandably (in the researcher's opinion) expressed strong anger and concern -

'What I'm still stumbling over today is that somebody who seemingly was so extremely senior in the analytical crowd could on her own make such a major mistake. I find it actually very scary. I wonder why there wasn't a kind of supervisor...if she'd had more support.... How quickly one can act out and lose one's ability'.

Jane

As discussed in Superordinate Theme 1.e., for a year prior to termination Jane was aware that her analyst had a heart problem, Jane had been very fearful that he would die as her father had done when she was aged twelve. She eventually colluded with his 'god-like' denial of the possibility of his death. A similar situation had occurred with father when her fears around his death were fobbed off by her mother and medical staff and so she was unprepared for his death. She had no support with the grief of this bereavement.

When Jane had an email asking her to urgently contact another analyst about her own analyst she initially felt 'numb' -

'Too unbearable to think he was actually dead'.

She could not believe in his death for a long time -

'He was gone, but he hadn't really gone because I didn't know that he'd gone. I used to keep thinking I saw him, I even thought maybe he's not really dead. Maybe he got fed up with seeing me. The sort of things that happen in a bereavement but made worse by the isolation'.

Jane described her feelings as of 'absolute devastation'; of 'being alone again'; of being 'totally overwhelmed'; of 'crying and crying all the time'.

She said -

'I've never known sadness like it. Even when my husband died two years ago it wasn't like that...It was as if the whole purpose of my life, that person who had held my life in his hands and suddenly he was gone and what happened to me then? What happened to the bit of me he was holding?'

The latter part of this quote is reminiscent of Ogden's statement -

'The analyst's death forecloses for the analysand the possibility of fully retrieving his mind (a mind that has not been exclusively his own personal possession for some time.... It is a mind that can be appropriated by the analysand only gradually in the course of an uninterrupted analytic experience' (1997, p.10).

Jane knew that she was also grieving for father. Both analyst and father died at fifty one years of age.

Jane said -

'It took longer to get over his (analyst's) death than any other loss I've had before or since...I was in the depths of grieving for him for about two years.... It was the biggest abandonment that he could have ever done.... I felt so abandoned that I wouldn't have been able to find (another) therapist myself'.

Jane did not have any negative feelings about her analyst for around two years when, with the help of the new analyst -

'I gradually came to see (the analyst) for the reality he was.... I got to the anger'.

Ten years later Jane is still with the replacement analyst and has just started psychodynamic psychotherapy training. She believes that with years of further analytic work -

'I feel as if I'm the way I should feel. He's (the dead analyst) now stopped being a hero. He's now human'.

However she is very concerned that insufficient attention is given in the profession to the subject of the research.

Like Pam, in the interview Jane's account was coherent and thoughtful. She also seemed connected in a balanced way to her feelings surrounding the event.

In the researcher's opinion it is fortunate that that both Pam and Babs had the inclination and financial means to stay with an analyst who could support, and work through, the impact on their psyche of their untimely termination. It took many years. The next ten participants, in the researcher's opinion, are still struggling to a greater or lesser extent.

Steve

As described in Superordinate Theme 1.e., for a year Steve was colluding with his analyst to deny the possibility of loss through death, as he had previously done with his mother -

'It gave me cold shivers really. The panic that this would really come to an end'.

Steve feels that separation/loss was an area that had been skirted around by both parties throughout the analysis: that there was an unspoken mutual agreement that analysis would continue until one party died -

'I was too frightened. I don't know about him. It was too scary for me to even raise the possibility'.

There also seemed to be an issue around oedipal rivalry (researcher's opinion), with associated unexplored angry feelings -

'I felt at times he would aggrandize himself over me. I felt that sometimes he was telling me how much bigger he was than I was. As I started to become a therapist how much more experience he had. How many more clients. I felt kind of angry but unfortunately it never felt safe to bring it into the relationship'.

When Steve received the analyst's termination call he felt -

*'Numbness and a bit of a shock. I knew intellectually that this isn't going to go away. I'm not going to be fine, there will be a long term ramification but what that will be I don't know It was almost **too** big'.*

Steve consciously experienced little sadness but found that he was becoming very angry in a generalized way and eventually it became focused onto his work situation -

'I felt very put upon but I was really struggling with the death of my therapist. I felt overwhelmed by it and there was nobody I thought I could talk to'.

Steve's anger when he talked about the sudden ending of his therapy was still very intense. He felt that the analyst could have better prepared him by exploring endings more, particularly as he felt he had given him hints of his anxiety in the material he brought to sessions.

During the interview, as we reached the part where he described the final contact with the analyst, Steve said -

'Well actually for the first time, or maybe the second, I'm starting to feel it (his emotions) now'.

As he told me about his visit a year later to the coffee shop and grave Steve began to remember the loving and caring aspects of the relationship, breaking down into prolonged sobs. He had only done this once before at the graveside. There was a sense of oedipal triumph (researcher's opinion) at the grave as Steve remembered feeling -

'I'm the paternal figure now. I get to call time'.

Steve is angry that his analyst did not have supervision.

'He made a big thing about that. He was too big to go to supervision. He needed to go to supervision'.

At the end of the interview Steve remarked -

'This is really the first opportunity I've had to talk about it in a meaningful way. I've never really felt the urge to bring it into therapy in this way and I can now see just how much it has affected me. At the time it was all rather too confused and angry. Just a complete confusion of feelings'.

In the interview it was clear that Steve was still burdened with intense unexplored feelings relating to his twenty year analysis, including sadness, anger, guilt, resentment. It is hard to envisage how Steve, with no support, could have adequately grieved over those first eighteen months. He has been with his present integrative therapist for three years now but he still (in the researcher's opinion) seems to be struggling to connect with, and work through, his feelings.

Lily

As described in Superordinate Theme 1.e., Lily felt her mother had been unable to adequately contain her childhood anxieties so that she became disconnected from painful feelings, particularly around separation. Drawing on Bion's 'theory of the container' she lacked -

'...an object to convert unbearable states of mind into bearable ones....' (Bion cited Caper 1999, p.140).

Analysis was helping Lily to connect with her emotions but at termination she was still very much in the middle phase of the work and at a critical place in the transference. Lily said -

'One month before she told me she was ill again I remember telling her it would be a disaster if we were to finish then and I think it was. It became a disaster because of the timing'.

In the researcher's opinion it also became a disaster because of the lack of adequate support to contain Lily's distress, as in childhood. When Lily was told of the termination she felt '*shocked*', she remembers little else except restraining her grief throughout the remaining four weeks to protect the analyst, and an image of the final hug. Towards the end of these sessions, with no response from the new analyst she had contacted, Lily said -

'I think that's where it started to feel all beyond – where it got blank'.

After failing to get support from her supervisor at the training organization Lily said -

'Then my life carried on and this other thing was happening in parallel and I don't know when things happened and what I did'.

Lily also said -

'I remember feeling very bad. Really like I was just functioning.... It had a really profound effect in a way I had no idea it could be like, it felt like, just felt like everything was. I don't know. I'll think about it. I'm sure I can'.

The last few lines above represent the struggle and distress Lily was experiencing throughout the interview at her inability to provide a coherent narrative and access her feelings surrounding the event.

It was four weeks after termination before Lily started with her new analyst and she felt completely unsupported by everyone throughout these interim weeks. She started crying as she said -

'It was horrible.... I remember waiting in my bed for her (the new analyst) to call me back and her not calling'.

This new analysis lasted three months. Lily felt angry, confused and uncontained throughout -

'I'm still very angry with her and I feel it hard to let go of this anger. And that gets, it's like it's hard for me to know sometimes if what I feel is about the therapist who died or the therapist who let me down'.

Lily had started to be aware of angry feelings towards her dead analyst in the last few years of their work together, but it was too dangerous to pursue. She feels that this is still largely the

case - considering that she might feel anger towards her dead analyst still makes her feel very uncomfortable.

After three months the new analysis came to a crisis. Lily said -

'Well when the woman fell asleep it was a real, real shock and I thought I can't take that and if anybody tells me you have to work with it I'm just going to leave this training and do something quite violent'.

Fortunately her distress was then picked up by her training organization and she quickly accessed a third analyst -

'I really felt contained. They contained me really well'.

Unfortunately Lily subsequently experienced a long period of anxiety as she was not informed of her ex-analyst's death, as described in Superordinate Theme 2.

Five years on, now a psychodynamic psychotherapist, Lily is still with the third analyst. They have spent limited time talking about her traumatic experience and at the end of the interview

Lily expressed a wish to undertake more work on the event -

'It is still so raw in me. Because I know I'm sad but I didn't realise it was so unprocessed in me.... What I remember are like little images that are very clear and then I don't know what happens'.

The raw intensity of Lily's feelings was very apparent to the researcher in the interview, as was her anguish and anxiety at being unable to her access and express her memories of the event in a clear, consistent manner.

Tina

Tina's father died in her late twenties some years before she started analysis -

'It was a huge and traumatic, totally unexpected loss'.

She recounted two *'traumatic'* incidents of separation from her parents when around seven years of age – one concerned a hospital admission and the other a one night separation when she was looked after by a female babysitter.

Tina did not want to answer most of my questions – she felt they were inappropriate. She wanted to be free to talk about the intense anger she is still feeling towards members of the analytic profession who became involved with her after her analyst's death. So this is what we did. Twenty two years after the event she is still consumed with anger and resentment, particularly that no consideration was given to what **she** needed in that moment of crisis. It felt, to the researcher, as if that got played out in the interview where Tina was not happy to be constrained by a researcher's agenda. Once Tina had more freedom to take the lead most of her annoyance with the researcher seemed to evaporate.

Tina said that on hearing of her analyst's death -

'I was totally, totally shocked. I could not believe it. I was absolutely devastated that he had gone just like that. I think I did have a huge range of emotions. How could he go? Why did he leave me? That did resonate with my father's death. My father had unexpectedly died...he was sixty...nearly exactly the same age'.

Tina did not directly explore her analyst's death in her next training analysis but believes that in a sense she did because she explored her father's death. She said that she was aware she hadn't thought deeply about it at all. Tina is now a psychoanalytic psychotherapist.

To the researcher, it felt as if all Tina's emotions around the event were consumed and overshadowed by a burning anger and resentment that had endured two decades.

Clara

Clara had a childhood in which mother would regularly leave home for short periods due to marital problems, leaving Clara behind. Clara was *'very disturbed and distressed by it'*. She witnessed her mother's attempted suicide at thirteen years. She loved, but was frightened of, her mother who would physically punish her. Her relationship with father was less conflicted. Clara believes that there was a strong maternal transference to her first analyst. Initially terrified throughout each session, just before the three month disruption caused by her analyst becoming ill, as described in Superordinate Theme 1.b., Clara had started to settle and to feel very dependent on her.

After termination Clara was annoyed at having to go into another analysis straight away because of training requirements, although she appreciated that she needed support with her loss. She found the months following termination very painful both emotionally and physically -

'There needed to be time to grieve and I definitely was although it was an extremely difficult relationship. It was physically painful. I cried a lot and I had a pain here (pointing to under her ribs on her left side). A real physical pain...when I thought of her which was often. And I did ring her once or twice because she had a phone recording and I thought I would still hear her voice.... I couldn't actually speak about her without crying'.

Clara felt the pain in her body for at least six months. She would use night time to abandon herself to crying for her analyst.

Fortunately Clara was able to talk to some extent about her ex-analyst throughout her next ten year analysis although loyalty to the ex-analyst, who represented mother, prevented a full exploration of the event. She eventually settled with her although the intensity of the analytic relationship was never quite the same. She was nearing the end of her second analysis when the next untimely termination occurred. This time there was anxiety for months about her analyst's wellbeing, sadness at losing her and shock at her appearance in the final session, but not the intense anguish of the previous experience -

'It was a different sort of loss.... I never had those physical symptoms.... A more straightforward kind of grieving. And of course it was a different stage because I'm sure we would have come to the end of our time together quite soon after that anyway'.

Four years later Clara is a practising psychotherapist. Clara still feels intense anger towards the supervisor who she felt was insensitive towards her grief at the funeral of the second analyst, as described in Superordinate Theme 2 -

'Ever since I've wanted to hit her'.

Perhaps, (researcher's opinion) the supervisor is a focus for an anger Clara feels to the other parties involved with these two experiences. She is also very concerned at how a patient who is not a trainee or analyst could have coped with similar experiences -

'I wonder what on earth that would have been like because I think I did have more containment because I was in training'.

Clara believes that she is largely reconciled to the ending of the second analysis but with the first still feels cheated and perturbed -

'That could have been the end of my training, the end of my therapy couldn't it? It wasn't but it could have been'.

She also said -

'I've thought what a shame I didn't go into therapy much earlier in my life because of course going in in middle life your therapists are going to be older and this is much more likely to happen'.

Her analysts were mid-sixties and seventy seven years respectively.

Harriet

Harriet's childhood was badly disturbed by many, often lengthy, separations from mother from the age of two years and court battles for custody. Her family was split apart. She feels her mother was *'depressed and extremely narcissistic'*. She committed suicide when Harriet was aged sixteen years. Harriet was often looked after by a father she *'hated'* and other little known relatives. In later childhood she had some sense of emotional containment from a paid family helper. Harriet has a long history of depression and autoimmune conditions. Her coping method is *'to shut down'*.

She said of her analysis – *'I loved it'*.

When Harriet heard of her analyst's death she said -

*'I immediately felt this sense of desolation. Utter, utter, utter devastation and of course the person I wanted to talk to wasn't there. That was the toughest bit.... I think the feeling was nobody could be of any help to me in this.... It took me a long time to get over it. It was massive absolutely massive. And I suppose in hindsight it was history being repeated. Most definitely.... I didn't feel angry. Just sadness and loss. The person I had been closest to and I was **very** needy. Things were very bad at home (with her partner) and I was pregnant'.*

Harriet was then asked -

'Did you have any physical symptoms?'

She replied -

'Well um. Oh this is absolutely astonishing. I hadn't put this together before. I developed rheumatoid arthritis and I'd always put it down in my mind to my stepdaughter who took me to the edge. During this pregnancy (after the analyst's death) I had very difficult symptoms – swollen joints and all that and pain.... Then I had my second son and in six months went into full blown rheumatoid. And I have a history of autoimmune. I worked my way through all the autoimmune'.

Harriet felt unable to seek emotional support from friends and subsequent analyses failed. After a year she found someone she felt able to work with and stayed there for thirteen years, eventually completing counselling training. She said of her dead analyst -

'I think I grieved much more for my analyst than I did my mother'.

Today, twenty years later, Harriet works as a psychodynamic psychotherapist. Her body shows the marks of severe rheumatoid arthritis from which she still suffers. She said of the event -

'Now I'm very much at peace with it. I don't find it particularly upsetting to talk about it. It's been a long time. I have very fond memories of her'.

At the end of the interview she said -

'The very shocking thing about it (the interview), that has come out of it...it will take time to digest this - is the fact that I got the rheumatoid arthritis'.

Of course, although Harriet felt in the interview that there might be a link between the onset of rheumatoid arthritis and her analyst's death, this can only be taken as a possibility. In support of this supposition she had a history of susceptibility to autoimmune conditions; was managing existing extreme environmental distress exacerbated by the sudden shock/anguish of a beloved analyst's death (who had been the main source of her support); she was managing her grief with minimal emotional support for around a year; her mother had died suddenly and traumatically; as researcher I was struck, in relation to other participants, by a seeming absence of any description or expression of anger from Harriet surrounding this event. In this light, Joyce McDougall (1989) in 'Theatres of the Body' has sought to show how the body can mimic the mind's distress when an individual's normal coping mechanisms become overpowered.

Sally

Sally had a history of separations from her mother – the first for a month at seventeen months old and thereafter for shorter periods on a fairly regular basis. Prior to starting work with the male analyst under consideration, she had a female analyst for five years whom she had to leave with only four weeks of notice because of her further training requirements – the first analyst was not registered as a training analyst with the training organization. She felt close to, and dependent on, this analyst and was angry and distressed. She felt resistance towards her new analyst throughout the eighteen months of work, although she had started to become *'fonder'* of him latterly and was therefore surprised at how distressed she was at the sudden termination of her analysis and his subsequent death. Only after his death did she realise that there had been a paternal transference, intensified by his death. She had a warm, *'fun'* relationship with her father who had died suddenly and *'shockingly'* twenty years before at sixty nine years old. She said - *'My attention had to be focused on my mother afterwards so I didn't really take in that loss'*. Interestingly, in terms of the transference, she had thought her analyst was the same age as her father at his death and was shocked to learn at his funeral that he was aged eighty.

After his death, as described in Superordinate Theme 2, Sally felt let down by her analyst and *'passed around'* by other professionals for many weeks as had similarly occurred in childhood, with no real consideration given to **her** needs. She felt angry, confused and insecure. She also felt a sense of numbness, disbelief and sadness at the analyst's sudden illness and death. She realised retrospectively how important the relationship had been to her -

'The one person I wanted to talk to was dead'.

Sally recounted an incident a month after her analyst's death which she believes was linked to a sense of anger and a lack of containment -

'I fell and broke my elbow. A silly fall on the carpet but I broke it quite badly. Yes then I was being attended to. I couldn't think.... My anger was towards (the training organization). I'd sort of struggled to settle in and he just hadn't survived. He hadn't been as strong as (previous

analyst).... *I was just so shaken and I don't think that fall was unrelated. It knocked me for six and I fell over*'.

As a child Sally had somatised, through her stomach, grief and anxiety. Around the time of her analyst's death she suffered from stomach problems for a short while.

As the months passed Sally became more intensely angry at how the event had been handled.

Today, sixteen years later, Sally is a psychodynamic psychotherapist. She stayed nine years with her next analyst. She found it to be overall a good experience and time was spent exploring her previous untimely termination. However she knows she is still intensely angry, as was evident in the interview where it seemed to take centre stage – towards her analyst, other professionals and the profession as a whole.

She is now additionally angry at her analyst for not considering his age -

'At that age...to even have taken me on in the first place'.

To the researcher it felt as if there was so much behind this anger - perhaps with links to childhood - that had not yet been fully explored.

Rose

As described in Superordinate Theme 2, Rose's anxiety and distress started in the twelve weeks prior to termination when she knew her analyst was ill but had no communication from him.

Rose believed that at the time she was near to working on an ending and was *'not in any sort of desperate place*' and it was beginning to feel *'more like a meeting of two equals*'.

She began to feel that she had hurt her analyst – had made him depressed as **she** had been in the past. The following is an extract from the unsent letter Rachel wrote to her analyst. She sent it to the researcher prior to her interview -

'For all these years I've been offloading, positing, dumping all of my self-doubt...and insecurity. Fifty years of repressed anger have all come spewing out. What if you have been overwhelmed, drowned by the flood of my difficult emotions? I try to fight feelings of responsibility for you. But what if somehow I've transferred my bad feelings onto you and you've absorbed them? I can hear your voice in my head saying "they're not bad feelings Rose, they're just feelings" but after a deeply religious childhood where all emotion were considered selfish some of the negation remains'.

She felt some relief from this responsibility knowing that it was pancreatic cancer and not depression he had suffered from. Pancreatic cancer also seemed to offer a more serious reason for her twelve week abandonment. Rose had an overwhelming need to preserve a sense of a 'special' relationship (researcher's comment).

After the analyst's death she added the following -

'I feel devastated, alone with my grief.... I feel hurt, bereft, angry, betrayed. Empty. This emptiness feels like when I stopped believing in God. Such a sense of absence, a void, a gaping hole inside myself.... A terrible feeling of loneliness and responsibility. Again, I feel very young and vulnerable, as though I'm a child at home, not understood, not seen, not heard. There's no one who will listen and look after me.... I am so sorry, heartbroken, that I didn't get a chance to say goodbye and you will never read this letter'.

In her letter Rose addresses her analyst as follows -

'You are a kind and listening father.... You are a loving partner'.

Rose's father had also died of pancreatic cancer, thirty five years previously. She had been in her twenties. It had been an ambivalent relationship. There had been no other significant losses.

In her letter Rose mentions changes she had observed in her analyst just prior to his death which she *'did not want to know'* -

'The haircuts, new glasses, pointy shoes and trendy jeans, the new ring'.

In the researcher's opinion, drawing on the work of Melanie Klein, it is possible that some of Rose's anxiety around hurting her analyst might have stemmed from hostile unconscious fantasies evoked by the changes she observed.

Rose had some concerns at the start of the interview that eighteen months after the death she -

'Might unearth stuff that was reasonably buried'.

In the researcher's opinion, providing the letter prior to interview was possibly a way for Rose to convey her painful emotions without having to risk triggering material that was too distressing for her to cope with in the present. She did point me to the letter throughout the interview.

Rose felt she could not embark on further analysis -

'It makes me feel tired to talk about it'.

However six weeks bereavement counselling helped a little in the grieving process. Rose still misses her analyst, becoming tearful at times in the interview. She feels anger and concern that when she gave her letter to a trainee psychotherapist friend to take to a session on endings, her friend reported back that some of the trainees seemed surprised at the depth of her grief.

In the interview it **did** feel as if Rose's emotions - including anger at her analyst - had been largely buried rather than worked through. She eluded to this herself (p.102, line 23). However at the time of termination Rose had to continue functioning in a stressful senior teaching role and had very little emotional support throughout her ordeal.

Babs

Babs had no significant losses in childhood, nor problems with separation. She feels she was an independent child. As described in Superordinate Theme 1.b., Babs had started to feel anxiety eighteen months before termination when her analyst first became ill -

'Slightly panicky and shaken because he played such a huge role in my life'.

From then onwards she describes the relationship as changing, in ways that she felt indicated that it was coming to an end. In the researcher's opinion it seems possible that Babs was defending against her anxiety of losing the analytic relationship by adopting a pseudo-independent veneer and reversing the patient/analytic role.

Speaking of this eighteen month watershed she said -

'I think the nature of the relationship changed. It was a little bit more collegiate.... I would talk to him about work...about some of my clients.... (When he was ill) there was a disruption in our work, a short one and I told him off because it wasn't long enough for his health and I remember saying to him "now is the time in my life when I might need to man up".... He did move house and I don't think I ever particularly settled in his new place and I moved to sitting in a chair because I didn't like his new couch...and I think it made clearer the difference in our relationship'.

Some sixteen months later when Babs is notified of the cancellation of the session that is to prove her last, apart from the final goodbye session eight weeks later, she remembers –

'Feeling a little bit floaty and detached as if sailing towards an inevitable doom'.

For the next eight weeks Bab's anxiety about her analyst becomes mixed with feelings of confusion and anger towards the executor who gives her conflicting messages and, as described in Superordinate Theme 2, will not disclose the nature and seriousness of the analyst's condition. She remembers saying -

'I don't know where I am because I've got no kind of markers'.

In the final session Babs is very shocked. As described in Superordinate Theme 1.a., the roles continue to be reversed as they change chairs; she listens and seeks to comfort/reassure; she takes control of the ending. Babs decided not to pursue further analysis.

One year later Babs, who is a psychodynamic psychotherapist, was still tearful when she talked of her analyst - she is missing him. However, as with Tina, the emotion that dominated the interview in its intensity was the disparaging, overwhelming anger she still feels towards the executor. She is also concerned and angry that not enough attention is being given to the issue by the profession as a whole.

Fay

Fay did not have significant losses in childhood apart from a move from her grandmother's house where the family had lived until she was four. Grandmother had been a stable presence. She described mother as -

'Non maternal and mad. Nuts and out of control'.

She was unable to provide emotional support and containment. Fay learnt to be self-sufficient -

'I could only find calmness in the room alone, upstairs'.

Father, who had died suddenly four years previously, had been a littler calmer -

'He had a temper, but he didn't rain chaos'.

Fay, like Lily, struggled painfully to remember the sequence and timing of events. Her narrative, nine months after the event, was confused and difficult to follow as with somebody shocked or

traumatised (researcher's comment). Fay, Babs and Gill had the same analyst. Babs and Gill's narratives are fairly consistent whilst Fay's timing/sequence of events, over the eighteen month period before termination is very different. During these eighteen months she was also going through a traumatic divorce and financial difficulties, reaching a crisis point just after the analyst's death.

Fay shamefully feels she was largely in denial about the seriousness of the analyst's illness throughout the eighteen months, and including the weeks between termination and the news of his death. Also his importance to her throughout the analysis -

'I'm not sure what I felt.... How it affected me.... Actually it's embarrassing to say but I'm not sure I took much on board until he died.... I was very matter of fact. I thought 'fair enough he's not well. He's retiring''.'

She also feels ashamed that she still *'went on about herself'* even when he was noticeably becoming frailer. When she heard of his death, by phone, she was sitting on the bed -

'I just slipped off. I did the same with my father'.

And -

'I was shocked.... I was more dependent than I realised because it really hit me.... It was tricky because a lot was going on for me at the same time and I had to just carry on.... It was just a very challenging time. So I was just feeling this thing inside me with (the analyst) that no one can possibly understand...unless you've had a therapist that died'.

Fay felt that the grieving for her analyst was intertwined with grieving for father -

'I just felt sadness. A deep, deep sadness'.

Fay did not want to see another analyst but knew she must because she was a fairly recently trained psychodynamic psychotherapist carrying a caseload and additionally there were serious difficulties in her outside life. She has not spent time exploring her analyst's death in this new analysis. She is now deeply concerned as to how patients who are not connected to the analytic world could cope with a similar event. Fay struggled to contain her tears in the interview and although she talks about her sadness in the past tense (as researcher) it felt as if Fay is still experiencing, either consciously or unconsciously, many very painful emotions.

GILL

As described in Superordinate Theme 1.e., Gill has a history of feeling overlooked, insignificant and abandoned. This was similarly repeated in her analytic history – her first analyst forgot to tell her she was moving away and *‘that was very traumatic’*; her second analyst terminated prematurely and *‘traumatically’* due to ill health; her third analyst (the subject of this research) died. The second analysis was the most significant and *‘intense’*. In the third analysis Gill thought she was nearing the end of the work. Gill felt she had a *‘special’* relationship with the last two analysts, a supervisor who helped with finding the third analyst and the executor. She constantly referred to this in the interview.

In terms of family losses Gill’s father had a lobotomy, which changed his personality, when she was aged nine; her brother died suddenly when she was aged fifteen; her mother died suddenly when she was aged twenty two; her husband and brother died during the third analysis. Her husband was the same age at death as the analyst and also had cancer.

Prior to termination, as described in Superordinate Theme 1.b., Gill had an unsettled eighteen months followed by the *‘shock’* of the final session. When she had the letter of termination from the analyst Gill felt *‘shocked’* and *‘overwhelmingly sad for **him**’*. Her first thought was - *‘I won’t think there is anything about me that this happens to me’*.

She expanded on this by saying -

‘I’ve had so many losses.... Somehow it was the feeling that it was bound to happen to me. That I would lose everyone I care for’.

She had to make a conscious effort not to dwell on it.

After termination some thoughts/feelings around her husband were triggered. She felt some sadness and the *‘awful image’* of the dying analyst remained. She said -

‘All I could really think of was the loss to his family’.

Gill gave up being a counsellor after the loss of her second analyst. She is now retired and is not with an analyst. Today, eight months later, she retains the *‘awful image’*. She feels much

gratitude to the analyst and *'thinks about him a lot'* but is still very bothered and saddened that the last months were overshadowed for her by his move to a different accommodation. She believes that her response to the appearance of this accommodation was uncharacteristic. She felt it was a *'slum'* and *'like a student bed-sit'*. The analyst had said at the last session that her response was probably due to her background but this does not ring true for her.

She expressed some concerns about taking part in the research because -

'I wasn't shocked in a grieving, grief-stricken way'.

However Gill said that she **was** shocked that someone so relatively young, who had originally seemed very healthy, could die as he did. Perhaps, (researcher's comment) there are echoes here of the sudden loss of her twenty two year old brother.

In the researcher's opinion it felt as if Gill, with a long history of painful loss and feelings of insignificance, had perhaps defended herself against another similar trauma by distancing herself from her emotions through the mechanism of feeling *'special'* – a mechanism which enabled her to somehow bypass the painful emotions surrounding bereavement.

Discussion on Superordinate Theme 4

Throughout this discussion, where reference is made to the Literature Review, the page number of where it can be found in this document is given in brackets.

We have seen how significant the terminal illness/death of their analyst has been for all of the participants in this research project. They were all eager to tell their story and the memories still had a quality of freshness and intensity about them even after, for some of them, long periods of time. This quality of eagerness, vitality and a sense of desperate need to tell their story, even after a long period of time, was noted by Barbanel (10) and by Lord et al. (6). The latter in the form of the good response they received from their request for participants.

As we have seen some of the participants emotions still felt, to the researcher, very raw and unprocessed – Tina after 22 years, Lily after 5 years, Sally after 16 years, Steve after 5 years,

Clara (1) after 13 years, Rose after 2 years, Fay, Gill and Babs after 1 year. Pam indicated that it took 4 to 5 years to work through, with an analyst, her intense feelings (particularly anger) to a level where she felt she was able to gain a more objective, balanced view of her previous analytic relationship and fully engage in the new relationship, whilst acknowledging the values of the first analysis. It was a similar situation for Jane but she indicates that it took at least 2 years. Harriet and Ella indicated that the intensity of their emotions lasted for a long time (it was difficult for them to remember an exact number of years). May felt intense sadness initially but it seemed to fade naturally over the ongoing months. It is important to note that a request for participants might attract those who have had the most intense, difficult experiences. The potentially lengthy period of time it can take to work through this event (which could be seen as a bereavement with some particular characteristics of its own) in order to regain one's sense of psychic equilibrium, engage in life/personal development and maybe fully partake in further analysis, has been noted in the Literature Review as follows: - Lord et al. (6); Garfield (10); Rendely (16); Rizk and Voller (7); Traesdel (12). This raises some difficult questions. Jane and Pam both had very traumatic experiences but seem to have now reached a positive place, but that is after many years of further analysis which in the initial years was very much focused on mourning for the dead analyst. Would they have reached this place without that subsequent work? Possibly not, as we have seen with some of the other participants who either did not enter further analysis or did not give so much attention to mourning their dead analyst within a subsequent analysis. However it would seem questionable that patients should pay for work, either in the form of bereavement therapy or in the form of an analysis that is prolonged longer than might otherwise have occurred, in order to recover from a preceding piece of analytic work. This would not be acceptable in other areas of life. Registered analysts are required to be insured, but would patients be in a place psychologically where they would be prepared to seek recompense so that they could pay for the required additional analysis?

Feeling anger around this event was described, and in some cases tangibly expressed, by 12 participants and in 9 of these cases it was very intense. Lily, for example, describes a feeling of '*violence*'. Anger was noted by Lord et al. (7), in the majority of their participants; Rizk and Voller (7); Barbanel (11); Tallmer (11); Halpert (12); Firestein (14); Simon (13); Garfield (10). Three of the research participants – Ella, Gill and Rose – struggled with conscious fears that they had been responsible for their analyst's illness/death which, in Kleinian terms, could be seen as an expression of unconscious hostile fantasies. This reaction was noted in the Literature Review by Halpert (12); Wolman (10). Reasons given by the participants in this research for their anger mirrored those given by authors in the Literature Review and included anger with the analyst with regard to abandonment; denial of their illness and general lack of honesty; betrayal; lack of self-care; poor organization affecting aftercare. Also anger with regard to poor aftercare from the analytic profession; an unfair God/world. As we have seen in the main body of this chapter, the intensity and means of expression of this anger (as with other emotions) appears to depend on many variables such as an individual's psychopathology (inevitably tied up with life experiences), psychic structure, quality of informal and formal support networks, the nature of the analytic relationship, an analyst's handling of the event; the timing of the event in terms of the analytic process. With that level of complexity it is perhaps unrealistic to seek a simple causal connection that can be applied to other cases. However it is perhaps possible to say that experiencing anger (consciously and/or unconsciously) is likely to be inevitable in the event of an analyst's terminal illness/death but that an understanding of the individual combination of variables impacting on a particular patient, plus a more generalized understanding gained from research about the potential effects of this phenomenon, would assist professionals to help patients to work through their anger (and other emotions) in the most appropriate, timely way. Sadness was described and, in some cases tangibly expressed, by all the participants, but varying in intensity. For example Pam and Jane, who had lost partners and parents, indicated that it had

been the most painful loss in their lives. Clara cried every time she spoke of her analyst for many months. For Steve it was so painful that he had only connected with it twice in five years – one of those occasions was in the research interview. In contrast May had felt an intense sadness initially but it had become less raw over a relatively shorter period of time. How this emotion is felt and expressed, as with anger, seems to depend on the variables mentioned in the above paragraph. For some of the participants grieving for the analyst became linked with grieving for a parental figure who the analyst had represented in the transference, adding to the intensity of the experience. A sense of shock, abandonment, desolation, devastation are also mentioned by participants many times – indicative of a profound, life-changing experience for all of the participants at some level. Also mentioned (apart from May) is the sense of having to deal with this profound experience alone, either through one's own personality structure and/or because others do not understand or want to know. This sense of a profound life changing grief is mentioned in the Literature Review by Rendely (9) and Garfield (9), both of whom emphasise the near impossibility of grieving satisfactorily without support; Rizk and Voller (7); Lord et al. (6); Pinsky (11); Traesdel (12).

Lord et al. (7) suggest a link between what they term '*pathological*' grief and the experience of early loss and/or deprivation and/or abandonment. A direct comparison with Lord et al. is not possible as grief has not been defined in an identical manner in **this** research project. Also as **all** the participants in this research could be said to have had early losses/deprivation in some form or another a comparison within this research between those who did, or did not, experience this variable is not possible. However it could be said, from this research, that early loss/deprivation/abandonment is likely a significant variable (amongst others) affecting the psychological outcome for patients. Lord et al. found that non-candidates were more badly affected than trainees and hypothesised that this might be because trainees were more stable psychologically and had the support of colleagues. This research did not bear that out, but it did

indicate that early, appropriate containment and support in terms of aftercare seemed to be very beneficial in terms of outcome, as with May. Unfortunately trainees did not necessarily get the support Lord et al. might reasonably have expected. Lord et al. (7) also considered that there were indications that older patients fared worse in terms of pathological grief. This research has not borne that out.

If we look at the way participants managed this crisis in their lives, not surprisingly it can be seen that they (largely unconsciously) utilised their habitual coping strategies, including defences. For those patients who worked with an ill analyst this started before termination in response to their unacknowledged anxiety, distorting and damaging the analytic work. For example, Babs adopted a pseudo independent veneer as she had in childhood. Steve colluded with the analyst's denial of loss/death as he had with mother. Unfortunately all the participants' defensive strategies were largely not interpreted, and possibly not recognized, by their analysts. For some participants we have seen how their anxieties/emotions were so psychically overwhelming that they were expressed through their body – Harriet (possibly), Sally and Clara. Both Harriet and Sally had a history of psychosomatic disorders. This reaction was also noted by Lord et al. (6) although in their research there was a greater occurrence. No experience of anorexia was encountered in this research, as with Lord et al.

Pam turned the blame on herself as she was encouraged to do in childhood. Reminiscent of Fairbairn's concept of the 'moral defence' (p.89 in this chapter and Simon (13) in the Literature Review).

With both Fay and Lily it felt, to the researcher, that the experience had been so overwhelming and uncontained that primitive defences had been brought into play to dissociate them from the trauma. Kalsched's words represent how their narratives appeared to the researcher -

'Dissociation allows life to go on...by dividing up the unbearable experience and distributing it to different parts of the mind and body.... Experience itself becomes discontinuous.... The memory of one's life has holes in it –a full narrative history cannot be told by the person whose life has been interrupted by trauma'. (1996, p.13).

This is similar to the experience of Rendely (9); Traesdel (12).

For some participants their anger appeared to have been displaced from its original source onto others. For example Steve's anger with his analyst initially got displaced onto his colleagues at work. Lily wonders if some of the anger she still feels towards her first replacement analyst really belongs to her dead analyst. It is perhaps uncomfortable to feel anger towards the dead and/or there might be a desire to keep the dead analyst safe and idealised, as mentioned by May. This could perhaps account for some of the difficulties participants have experienced with executors and subsequent analysts.

Gill, Rose and Ella very much needed to feel that they were 'special' to their analyst. Most of the other participants exhibited this, but to a lesser degree. This defence has been noted by Galatzer-Levy (15).

5 of the participants acknowledged that even when help was offered it was difficult for them to accept it, as their normal coping mechanism in times of crisis was to manage alone. This is likely to be problematic for those providing aftercare, particularly if they do not have information from the analyst about an individual's coping mechanisms. There is a fine line between being intrusive and not interceding enough, and it will vary between individuals as we have seen in this research. Not an easy task for an executor.

There is a danger that if the analyst's illness/death re-enacts an early trauma that is once again not adequately processed, the patient will become re-traumatized. There is a possibility I would suggest that this occurred for some of the participants, for example, Lily, Pam, Fay, Gill, Maria. It is likely to need further appropriate analytic intervention if the patient is to successfully work through this re-traumatization, as we have seen with Pam and Jane.

Rizk and Voller (7) and Rendely (9) mention a sense of disconnection, existential terror and threats to the sense of self. They liken it respectively to the cutting of the umbilical cord/a boat being cast adrift and, in Winnicottian terms, a too early or too severe rupture in the mother/infant

dyad. Something similar was expressed by some of the research participants and/or sensed by the researcher. Bab's *'floaty'* feeling when she foresaw the loss of her analyst; the confused, at times incoherent, narrative of Lily with her feelings of *'floating'* and *'hanging'* because she has nothing tangible of the analyst to hold onto; Clara's sobbing at night for her missing analyst; Jane's anguish that she had lost the part of herself she had put in the analyst. Now he was dead, where was it?

There can be little doubt from the Literature Review and this present research that the terminal illness/death of an analyst is likely to have a significant emotional/ psychological impact on patients that can endure for many years: that this is a complicated phenomenon where numerous variables (outlined p.109 line,14) will contribute to the outcome for each individual: that there is the potential for this event to detrimentally effect (or damage) patients' psychological well-being, even over many years, and therefore particular attention should be given by the profession to minimising the risks for patients.

Theme 5

The table below outlines the three Master Themes feeding into the fifth Superordinate Theme.

Superordinate Themes

Master Themes

1. Experience Utilised

*e.g. 'If he'd (executor) just said 'Is there anything we can do that you think might be helpful''? Asking **me** what I needed' (Tina).*

a. Reasons for Participation

e.g. 'I thought it was a much needed area of research' (Tina).

b. Professionals/Professional Bodies

e.g. 'It's raising questions for us as a profession. I don't think we've thought about this enough' (Babs).

c. Training Establishments

e.g. 'On the training I'm doing now, that whole thing about a therapist dying, there doesn't seem to be much out there' (Jane).

The table below identifies the reasons given by the participants for taking part in the research – marked by a '*’.

Table 5

Name	To Help Others/Improve the Service	Therapeutic	Validation of the Experience
Pam	*	*	*
Jane	*	*	*
Clara	*	*	*
Fay	*	*	*
Lily	*	*	*
Tina	*	*	*
Rose	*	*	*
Sally	*	*	*
Babs	*	*	*
Gill	*	*	
Steve		*	*
May	*		
Harriet			*
Ella		*	

All participants spoke passionately about their reasons for taking part in the research. As can be seen from the table above **11 of the 14 participants** openly expressed hope that taking part would improve the situation for future patients facing this unfortunate event. One participant also directly expressed a hope that it would ease the situation for stricken analysts.

The areas that participants would like the analytic profession to give more attention to, based on their experiences, are to be found in a more detailed form throughout the body of Chapter 4.

However, for clarity, in this section they have been brought together in one place, albeit in a more condensed form. Included in this section are solely concerns that were clearly and directly expressed to the researcher as needing attention, rather than alluded to in a more generalised way.

Although some of the occurrences happened many years ago, the concerns included in this section are only those that the participants feel apply to the present day provision of analysis.

1. Advanced Age of the Analyst – Pam, Sally, Clara.

2. Supervision/Support for Analysts and Potential Speed of Deterioration – Pam, Steve, Jane.

3. Contribution of the Analyst to an Unsatisfactory Outcome That Could Possibly Have Been Avoided – Pam, Steve, Jane, Sally, Clara, Lily, Babs, Gill, Rose.

4. Aftercare Difficulties – Pam, Jane, Lily, Babs, Steve, Tina, Ella, Sally, Rose, Fay, Harriet, Clara.

5. Lack of Understanding of the Psychological Impact by Other Professionals/Trainees/and Lack of Research – Pam, Jane, Lily, Babs, Steve, Tina, Sally, Rose, Fay, Harriet, Clara, May.

6. Training Organizations Lack of Understanding of Various Issues – Lily, Jane, Sally, Clara.

7. Difficulties When Having Patients Oneself – Sally, Steve, Lily, Fay, Babs.

8. Lengthening of the Analysis – Pam.

9. How Will Patients not Analysts/ Trainees Manage? – Fay, Clara, Babs.

Discussion on Superordinate Theme 5.

12 of the participants taking part in this research are registered psychotherapists or trainee psychotherapists and it seemed, to the researcher, that they were very much wanting **their** profession to listen and take action – this research was an opportunity to get their voices heard. It felt worrying and sad that there was such a sense, in many of the participants, of anger, disillusionment and disbelief towards the profession (or parts of the profession) that they belonged to.

Throughout all of the first four discussion sections in Chapter 4, I also have identified areas that appear to require more research, discussion and action. They have encompassed all the areas cited by the participants, but with some additions and in more detail. They will not be re-visited in this section as I consider that they are better examined within the context of the previous discussion sections.

The participants who wanted change all indicated that this was something that needed to be taken forward by the profession as a whole - these were fundamental, complex issues to which there was no simplistic answer. As researcher I would endorse this. ‘Putting sticking plaster over the wound’ is not the answer.

Chapter 5. Conclusions

The research hypothesis was as follows:-

That premature termination of analysis due to the terminal illness/death of the analyst is likely to be a distressing, and in some cases traumatic, experience affected by numerous variables - such as aftercare - and that this whole area has been largely unexplored by the analytic community.

That if we listen to, and think about, patient's accounts of this phenomenon they will indicate the way that the profession can help minimise the potential detrimental effects of this event.

To what extent has this research, which has based its findings on listening directly to patients' experiences, helped to identify interventions that may ease the situation for future patients?

I would suggest that the five Superordinate Themes, constructed from analysed participant data, are helpful in understanding the variables that are likely to impact on a patient's experience. An experience which has been seen, in this research, to be on a continuum that ranges from a significant bereavement that the participant feels they have worked through in a natural, timely way (May) to an overwhelming trauma that may take many years to work through, probably with the help of an analyst (Pam and Jane). It is important to recognize that this research is based on a small sample of patients and that the request for participants may have largely attracted those who had a particularly difficult experience or equally, on the other end of the spectrum, those whose experience felt sufficiently worked through to risk resurrecting it. However the potential for the experience to be highly distressing/traumatic with long lasting effects is supported by the findings from the Literature Review and cannot be ignored.

If we are to look at how this research can be used in a practical way, I would suggest that it is helpful to separate the variables highlighted in this research into two categories: between those variables that are more fixed (less likely to be amenable to fundamental change) and those variables that offer more potential for change. The variables are outlined below:

More Fixed Variables

1. Patient's personality structure.
2. Patient's life circumstances from birth.
3. Patient's present life circumstances.
4. Particular nature of the analytic relationship for a specific patient.
5. Analytic boundaries.
6. Some training requirements

More Malleable Variables

1. Analyst's attitude to loss/death throughout the analysis.
2. An analyst's handling of the analysis once ill and still working.
3. Aftercare inc. executor, other professionals.
4. Subsequent analysis/bereavement work.
5. Some training requirements.

The variables in the left hand column are not necessarily helpful to think about in terms of effecting fundamental change but it would be beneficial, in the event of an analyst's illness/death, to understand their individual combination for each patient as this will give some guidance as to how the patient is likely to respond to the event, rather like a risk assessment. Also as a means to more effectively and individually tailor aftercare.

I would suggest that attention, by the profession, to the variables in the right hand column could produce quite substantial change for future patients. It has waited for long enough. Below are some quotes spanning the last five decades:-

'We hope that our preliminary undertaking...will facilitate further research' (Lord et al. 1978, p.189).

**'Neither those who reanalyse nor psychoanalytic institutes have devoted scholarly attention or policy guidelines to this matter in proportion with the frequency of its occurrence'* (Schwartz and Silver 1990, p.2).

'How can we avoid abandoning patients in the future...every psychoanalytic institute needs to address these issues' (Rendely 1999, p.143).

'It would seem an obvious responsibility of the profession, in an institutional and theoretical sense, to look hard at this contingency' (possibility of premature termination) (Pinsky 2002, p.177).

'We hope that the following case study...will inspire the psychoanalytic community to engage with the practical and clinical...implications of such an event' (Rizk and Voller 2013).

Below is a quote from **this** research -

'It's raising questions for us as a profession. I don't think we've thought about this enough' (Babs 2014).

In each discussion section within Chapter 4 of this document I have outlined in detail dilemmas and suggestions, based on patients' data, which I consider need to be addressed by the psychoanalytic profession in order to provide positive change for patients.

Finally let us return to the title of this research which makes reference to Socrates' belief that without examination of our lives they become *'not worth living'* and to Grosz's recent book which seeks to demonstrate that the principles and practice of analysis uphold and bear witness to Socrates' belief. For analysis is a process where a patient's psychological makeup, life experiences, the meaning they give to life and the essence of their very being are placed centre stage in order to be examined and valued. This is based on a body of knowledge built up for over a century but still being developed and refined. This is the process that participants encountered before the terminal illness/death of their analyst occurred but we have seen throughout this research how this, for most participants, radically changed in varying ways and degrees. Of course death and mourning is an inevitable part of life and will therefore need to be explored in every complete analysis, and it is inevitable that for some patients they will encounter it face to face with the death of their analyst. I would suggest that if the practice of analysis is to truly embrace the principles it espouses, the topic of this research cannot be denied or side-lined any longer but acknowledged, examined and acted upon so that patients in the future may tell a different story.

*It has not been within the remit of this research to quantify the frequency of the occurrence under consideration although informally I have made attempts to seek further statistical information relating to this issue, with little success. This would seem to be a necessary next step for the analytic community.

SUMMARY

Background: From personal experience, plus a brief overview of literature, the researcher surmised that the potentially traumatic impact on patients of losing their analyst to terminal illness/sudden death had received scant attention from the psychoanalytic community. Listening directly to patients (as opposed to analysts) had been particularly overlooked.

Literature Review: This initial hypothesis was confirmed/refined by this Review: it was felt that focusing on the account that **patients** gave of their experience would be the most appropriate means of eliciting information. Knowledge that would assist the psychoanalytic community to most effectively ensure the wellbeing of future patients.

Methodology: Interpretative Phenomenological Analysis (IPA) seemed to most appropriately meet the aims of this research. 14 semi-structured interviews were conducted, allowing the flexibility in questioning that is an inherent characteristic of IPA. For consistency collecting, transcribing and analysing of data were undertaken by the researcher. Accepted ethical procedures were followed.

Findings and Discussion: Five Superordinate Themes emerged based on 21 Major Themes – Changes in Analysis before Termination; Aftercare in Relation to Outcomes; The Inherent Nature of Analysis inc. Requirements of Analytic Training; Emotional/Psychic Effects; Experience Utilised. Within these 5 Superordinate Themes issues/dilemmas were identified that were detrimentally affecting, in some cases seriously, patients' wellbeing. The majority of these issues had been identified, in some form, over the past 50 years but not adequately acknowledged/acted upon. Some new issues emerged, including problems that are occurring in the interface between formal executors and sick analysts. Suggestions were given that might be helpful for the profession to take forward.

Conclusions: The researcher has separated out the variables that appear to affect the outcome for patients into those that are largely 'fixed' as opposed to those that are 'more malleable' and urges the psychoanalytic community to act speedily on the latter.

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APPENDIX 1

INFORMATION SHEET

1. This study aims to look at the effects on a patient's psyche of their therapy stopping prematurely because their therapist has suddenly died or has been diagnosed with a terminal illness. It aims also to look at how the support they have received around this occurrence affected the outcome. This study will aim to interview approximately 12 people.
2. The participant is required to meet alone with the researcher for 1 to 1.5hrs on a single occasion to talk about their experience of the above (1). The interview will be partly structured in that the researcher will ask questions, but there will be time for the participant to talk freely about their experience. The researcher will negotiate with individual participants around time and venue of the interview.
3. The interview will be machine recorded and subsequently transcribed by the researcher. There may be one other psychotherapist involved to provide a second opinion regarding the analysis of the data (the participants' names will be withheld from this professional). All data will be kept throughout in a safe, secure place that only the researcher can access and destroyed once the research project is completed. All data contained in the final report will be anonymous to protect the participants' identities and the identities of any other parties.
4. The data, in an anonymous form, may subsequently be published by the researcher. It may also be used by other researchers at a later date.
5. Participation is of a voluntary nature. The only payment will be for travel expenses to an interview, if incurred.
6. It is hoped that the interview will be beneficial to the patient in giving them the opportunity to talk further about an experience in their life and to assist in psychoanalytic research. To ensure that the participant has adequate support around emotions that may be present after the interview, participants who are not therapists themselves should be undergoing regular counselling/psychotherapy/analysis at the time of the interview and therapists have ready access to therapeutic support if needed.
7. The participant can withdraw from this research (including withdrawing their data) at any time without having to give a reason or explanation.
8. Contact details for the relevant Ethics Committee and the Research Supervisor are as follows:

Ethics Committee
 University of Essex
 Wivenhoe Park
 Colchester
 Essex CO4 3SG

(Supervisor's Name)
 Centre for Psychoanalytic Studies
 University of Essex
 Wivenhoe Park
 Colchester
 Essex CO4 3SG

APPENDIX 2

Interview Questions

1. I'm wondering how you felt about coming to see me today?

Note: Spend time helping client to feel at ease.

2. If we could now think about when you first started therapy with the therapist you lost. I'm wondering if you could tell me the reasons you wanted to have therapy? Any problems you might have been having?

Note: May need to probe to establish a patient's psychopathology.

3. Sometimes people go to therapy because they have had difficult losses and separations in their lives. I would like to ask you about any significant losses or separations you might have experienced in your life, going back to childhood?

And

How well did you cope with these?
What did you do to cope?

4. Our relationship with our parents can have an impact on our later relationships. I would like to ask you about how you got on with your parents in childhood. Could you give me three words that reflect your relationship with your mother?

And

Your relationship with your father?

Note: Ask the participant to tell you about incidents to illustrate these if they are able to do so.

And

Who did you go to when you were upset or hurt and what happened?

5. Now I would like to find out a little more about the therapist you lost. Could you tell me about his/her age? Gender? Location of practice? Theoretical preference?

And

Now let us think about how you related to **him/her**. Could you give me three words that reflect your relationship with him/her prior to your experience of loss, which we shall talk about later?

Note: Ask the participant to give you examples to illustrate this. May need to employ follow up questions to gain enough information around the transference relationship/real relationship/level of regression.

6. I would like to move on to the experience of losing your therapist. When and how did you first find out that she/he had a health problem?

And

What were your feelings at this time?

And

Are you aware of anything more that could have helped you at this time?

Note: Ensure that issues around possible denial by analyst and/or patient and/or professional bodies have been explored under this question. Did the patient know first?

7. Could you tell me how the situation progressed, including your thoughts and feelings, up to the last time you had contact with him/her which we will talk about in the next question?

And

Are you aware of anything more that would have helped you at this time?

Note: May need to probe on possible physical sensations if not covered. Also issues of denial, regression, blurring of boundaries and any change of feeling towards the therapist

8. Could you tell me about the last contact with your therapist, including the feelings, thoughts and sensations you experienced?

9. I would like to now go on to talk about what has happened since that time in terms of your emotions, your thoughts and any physical reactions you might have experienced?

And

What support have you had? For example from/medical personnel/therapists, informal support networks and professional organizations.

Note: Ensure issue of support from a professional executor is covered.

And

Would anything else have helped you?

10. If you have had a further therapy can you tell me about how the transition was for you?

11. If you have had other experiences of bereavement as an adult could you tell me how they might have differed from this experience?

12. Is there anything else you think I should know about this experience with the therapist you lost?

13. I am wondering how this experience has been for you?

Note: Give sufficient time to check how the client is emotionally and the support they already have and anything else they may need. Ensure they are still happy for data to be used and answer any further questions. Thank them.

APPENDIX 3

Questionnaire

Gender Male/Female

Ethnic Origin

Your age at time of therapy termination (please tick) Under 30

30 - 40.....

40 -50.....

50-60.....

Over 60.....

Duration of relevant therapy

Date of termination (approx.)

No. of sessions per week

Information from Questionnaire and Interview Question 5.

Table 1. Gender of Participants (14)

Female	Male
13	1

Table 2. Gender of Analysts (15)*

Female	Male
5	10

Table 3. Age of Participant at Termination (15)*

30-40 years	40-50 years	50-60 years	60 plus years
3	3	7	2

Table 4. Age of Analyst at Termination (15)*

40-50 years	50-60 years	60-70 years	70-75 years	75-80 years	80-85 years	85-90 years
2	1	8	1	1	1	1

Table 5. Status of Participant at Termination (15)*

Member of Public	Trainee	Psychotherapist
7	4	4

Table 6. Living Location of Participant (14)

London	Home Counties	Midlands
12	1	1

Table 7. Ethnicity of Participants (14)

White British	White American	White French	White German
10	2	1	1

Table 8. Status of Analyst (15)*

Psychoanalyst	Analytical Psychologist	Psychoanalytic Psychotherapist	Participant Uncertain
3	6	4	2

Table 9. Duration of Analysis, Frequency of Sessions and Use of Couch (At Termination) (15)***

Number***	Duration in Years	Frequency Per Week	Couch
1	8	1	No
2	7	1	No
3	10	1	No
4	2	2	No
5	20	2	Yes
6	5	2	Yes
7	4	3	Yes
8	11	4	Yes
9	5	1	No
10	7	1	No
11	10	1	No
12	3	3	Yes
13	1.5	1	No
14	2.5	2	No
15	9	2	Yes

*One participant had two experiences.

** Two of the 'no' participants had been on the couch prior to becoming unsettled due to their analysts' illnesses.

***These are in no particular order.

APPENDIX 4

Table of Themes

Superordinate Themes

Master Themes

1. Changes in Analysis before Termination

e.g. *'So perhaps for the first time in our relationship there was something odd going on'* (Babs).

a. Role Reversal

e.g. *'She wanted me to care for her...and I did'* (Pam).

b. Framework Slippage

e.g. *'There had been a lot of change of days and times'* (Fay).

c. Interpretations

e.g. *'He seemed to be missing the point'* (Gill).

d. Boundary Violations

e.g. *'He came and sat with me (In the coffee shop)... it felt very intrusive'* (Steve).

e. Re-enactments

e.g. *'We both fell into the same trap...the thing I came into therapy for'* (Pam).

f. Knowledge of illness

e.g. *'She didn't tell me she was ill but I could see she was in pain'* (Clara).

Superordinate Themes**Master Themes****2. Aftercare in Terms of Outcomes**

e.g. 'A good or bad person – what a difference that can make' (Lily).

a. The Analyst's Legacy

e.g. 'He didn't even get my address right' (Sally).

b. Executor or Alternatives

e.g. 'For a time it (action of executor) was destroying my memory of him' (Tina).

c. Family and Friends

e.g. 'I had my husband... and so I had a lot of comfort' (May).

d. Other Professionals/Colleagues

e.g. 'The Therapy Advisor encouraged me to go to the next therapist' (Clara).

e. Subsequent Analysis

e.g. 'I think if this second therapy had been supportive... things would have been different' (Lily).

Superordinate Themes.**Master Themes****3. The Inherent Nature of Analysis inc.****Requirements of Analytic Training.**

e.g. 'There was a lot of regression and buckets full of transference' (Jane).

a. Analytic Boundaries

e.g. 'Twelve weeks.... I had no way of finding out how you were' (Rose).

b. The Analytic Relationship

e.g. 'I was hugely, hugely dependent on her' (Pam).

c. Trainee Requirements

e.g. 'They (Training Organization) gave me one month to leave the first therapist.. and look at this one' (Sally).

d. Seeing Patients

e.g. 'Just before my first client...there was a note and it just said he had died'. (Sally)

Superordinate Themes**Master Themes****4. Emotional/Psychic Effects**

e.g. 'It had a really profound effect in a way that I had no idea it could be like' (Lily).

a. Magnitude/Emotional Intensity

e.g. 'For about six months I couldn't stop speak about her without crying' (Sally).

b. Psychological Processes/Mechanisms

e.g. 'Was there something I'd done that wouldn't allow him to live anymore' (Ella).

c. Patients' Present States

e.g. 'I've come to terms with it.... I see her shortcomings ...but also the goodness I got from her' (Pam).

Superordinate Themes**Master Themes****5. Experience Utilised**

e.g. 'If he'd (executor) just said "Is there anything we can do that you think might be helpful"? Asking me what I needed' (Tina).

a. Reasons for Participation

e.g. 'I thought it was a much needed area of research' (Tina).

b. Professionals/Professional Bodies

e.g. 'It's raising questions for us as a profession. I don't think we've thought about this enough' (Babs).

c. Training Establishments

e.g. 'On the training I'm doing now, that whole thing about a therapist dying, there doesn't seem to be much out there' (Jane).