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PART I
DIRECT FACE TO FACE
THERAPY

1

TO LOVE LIFE AND MOURN ITS END

Introduction

The shadow of death brings an exquisite poignancy to therapy with older people. It means the therapist and older client have to manage various tensions: to appreciate the life that has been lived whilst bearing the pain about what has not been possible, the mistakes and regrets; to hold onto and savour what remains whilst being assailed by inexorable losses; to explore and pursue the developmental and creative possibilities of this last phase of life whilst knowing it is an ending, and recognising the limits imposed by one's history, constitution and ageing. In therapy these limits include the therapist's training, skills and personality, and the time that is available. In essence the tension in this work is to retain a love of life whilst mourning its end.

Mourning is central to this therapeutic work because mourning involves recognition of whom and what are valued and loved, as well as recognition of their loss. The pain evoked by loss is a reflection of our love, passion, involvement, hopes and ambitions, whether for a person, career, hobby, interest or country. The work of mourning also means acknowledging our own and others' limitations, including hatred and destructiveness, and the limits of life itself. If who and what are loved can be truly mourned then, though no longer part of our external world, they can be established in the internal world of the mind and continue to nourish and sustain our lives and our love of life. Mourning can therefore be enriching and support development and creativity in old age, as it does through all life transitions (Noonan, 1983, p. 3).

Although the theme of loss threads its way through each chapter of this book, it is important to keep in mind that the losses are reflections of the lives that have been lived, and of who and what have been cherished. Older people suffer a multitude of losses which are indicative of

a multitude of experiences. They suffer loss of work and vocation because of retirement, redundancy or incapacity; and can therefore draw on histories of work, interests and hobbies, some of which they may still be able to pursue. As their bodies wear out they experience losses of physical and mental capacities, and consequent losses of independence especially when they may need others to care for them; the wrinkles, wear and tear of their bodies and minds are markers of the lives that have been lived. Children leave home. Colleagues, contemporaries, neighbours, friends, partners and pets die, and inconsolably their own children may die ahead of them. Therefore they have influenced and may continue to influence a multifarious world of interpersonal relationships, and are influenced by these relationships in their internal worlds. They face the inevitability of the ending of a long life. They have experienced, witnessed, endured and survived the joy and pain of life for a long time.

The understanding of how external losses become internal resources has come from psychoanalytic studies of mourning. The following section describes two seminal works on mourning, and introduces key theoretical concepts as they evolved in these studies and which inform much of the therapeutic work in this book.

Two seminal psychoanalytic studies of mourning

In Freud's study of mourning and depression he understood how unconscious hatred could obstruct mourning. Klein showed how such obstacles could be overcome through bearing painful feelings of guilt and sorrow leading to reparation and the establishment of the lost loved one in an internal world.

Early in the history of psychoanalysis there were two outstanding studies of mourning and depression which led to the development of what is known as the Object Relations School of Thought in Psychoanalysis. Object Relations theory essentially reflects the recognition that from the beginnings of life we seek a loving relationship, and our early relationships play a critical part in our emotional development and our identity. (See Caper, 2000 for an excellent introduction to the development of Object Relations theory.) The two seminal papers were by Sigmund Freud, titled 'Mourning and Melancholia' published in 1917 and Melanie Klein's 'Mourning and its Relation to Manic-Depressive States' published in 1940. Both these papers examine the similarities and differences between mourning and depression. Freud and Klein were pioneers in the study of the unconscious, and bravely drew on their own experiences to extend the frontiers of psychological knowledge. Both papers were

linked with personal grief. In Freud's case we know that he first sketched the ideas for his paper a year after the death of his father. Klein wrote her paper several years after the tragic death of her son and she even included a thinly disguised case study about her own grief in the paper. Both these seminal works were written from the heart.

Freud understood that mourning the loss of a loved one has to be worked through in minute detail; as he said 'Each single one of the memories and expectations' of the loved person has to be summoned up against reality to reach the verdict that the loved one is dead and lost forever. He described how 'extra-ordinarily' painful this process could be and puzzled over why it is so painful. Freud saw that depression, like mourning, involved an important loss but which the depressed person was unable to mourn because of strong ambivalent feelings towards the lost loved one. He recognised that in apparent self-criticisms that a depressed patient made, there were concealed criticisms against the lost one, and that these self-criticisms were in fact disguised complaints about being abandoned and left. Part of the self or ego became identified with the lost person, as Freud so memorably and poetically wrote 'the shadow of the object (the one who was lost) fell upon the ego'. Later in his work Freud realised how any loss, especially early in life, leads to important identifications that shape the ego and the nature of our character.

An illustration of Freud's insight can be seen underlying the problems presented by a man in his seventies who complained of breathing difficulties for which there was no physical basis, but which severely impaired his life over several years. He was constantly in a weak state and had to be accompanied to the assessment interview by his wife. He tended to lean on his wife because he was afraid of falling. Five years previously his eldest son died of asthma. He was very close to his son and was still tearful when speaking of him. He had become identified with his son in this debilitating physical symptom which replicated his son's asthmatic condition. In a concrete identification he unconsciously denied the loss because he felt he was his son and had not lost him. He was unable to mourn and had become depressed. The shadow of his son had fallen on his ego.

In 'Mourning and its Relation to Manic-Depressive States' Klein agreed with Freud that the central tasks in mourning are to face the reality of the loss in the external world and establish the loved one internally. Klein discovered that, in the unconscious, experiences of bereavement revive our earliest experiences of loss first encountered in infancy in relation to the mother or primary caretaker. Furthermore, Klein developed an understanding of how in infancy and childhood the

experience of loss leads to identifying with and internalising important figures like our parents and family, with the result that the child builds up an internal world which is peopled with all these figures. Klein's work thus sheds further light on how in mourning the task of establishing the loved one internally is accomplished. Klein also went some way in explaining why mourning is so very painful and may endure for a long time. Following bereavement it is as though all the loved figures in the internal world are lost, and the internal world is in a state of devastation.

Mourning in infancy

It may seem strange in an introduction to therapy in later life to turn to infancy, but psychoanalytic and psychodynamic therapy is informed by an understanding of how early experiences of infancy and childhood crucially influence development of the personality and personal relationships. In particular the internalisation of early life experiences and relationships creates an unconscious internal world of 'object relations' which influences and is influenced by experiences and relationships throughout life. Later influences may include the experience of therapy, so understanding more about the internalisation contributes to insight into the therapeutic process. Infancy has particular relevance for therapy with older people because ageing often brings the need to be dependent again on the care of others and thus revives, consciously and unconsciously, our earliest experience of dependency and being in a dependent relationship. (Fears of dependency which are revived in later life are discussed in Chapter 7.)

The following is a sketch of Klein's understanding of how the internal world is first established, and of the nature of infantile states of mind that are revived in later experiences of bereavement. Klein emphasised that for the infant or small child with little or no sense of time or continuity, a temporary absence of the mother, as well as major losses experienced such as in weaning, can be experienced as irrevocable losses, equivalent in important respects to an adult's experience of loss and bereavement. So for the infant and child, when faced with an absence that may feel eternal, there is the mourner's task of needing to establish the lost loved one internally in the mind. Klein saw too that just as for adults, experiences of loss and frustration for the infant and child stir powerful conflicting feelings between love and hate for the one who is missed.

Klein introduced the concept of unconscious phantasy to describe what she understood about the infant's, child's and adult's unconscious

experience. Klein traced different phantasies and anxieties which were linked to how external figures are established in the internal world, to the infant's and child's capacities and to the love and care they receive. Klein proposed that just as the infant takes in food and nourishment so in unconscious phantasy the infant internalises experiences of nurture and security of mother's care; and just as the infant expels waste products such as faeces and urine so in unconscious phantasy the infant projects unpleasant emotional experiences into the external world. The fragmented and unintegrated state of the infant's physical and psychological capacities mean that at first what is internalised is also fragmented, such as isolated aspects of mother's care, like the sound of mother's voice, or her cradling arms, rather than an identification with mother as a whole person. It is the mother or primary caretaker who by physically and mentally holding the infant gives the infant an experience of continuity and coherence, essentially by *holding* all the different fragments of the infant's experience in her mind (Bick, 1968). For example the mother helps the infant to know that the infant, who was crying at one moment, is the same infant who smiles at the next. Gradually the infant becomes able to recognise a sense of continuity and wholeness in his or her own identity and recognise the mother as a whole person.

From the start of life there is a complex interaction between the internal and external world, especially between the ambivalence of loving and hating feelings and good and bad experiences. The infant does not have the capacity to manage the conjunction of opposite feelings and experiences, and at first needs to keep them as separate as possible, out of fear that the bad will spoil the good. Thus the infant *splits* feelings and experiences into either good or bad, and is inclined to exaggerate the differences, idealising the good as a necessary source of strength and inner security against the bad. Moreover, these very opposite feelings are projected into what becomes polarised loved or hated external figures who are then established as such figures in the internal world. Klein described this state of mind and the accompanying anxieties and defences as the '*paranoid-schizoid position*', indicating that it is a state of mind to which we can return throughout life especially when under conditions of extreme stress.

Klein's child patients sometimes revealed harsh and cruel internal parental figures in contrast to their actual parents. Klein soon appreciated that as a result of projection of feelings there was not a direct correspondence between the external figures in reality and how they were internalised which she described as '*internal objects*'. She thus developed Freud's understanding of projective processes into the

concept of *projective identification* in which in unconscious phantasy parts of the self are split off and denied and projected into the other who is then identified with those aspects of the self (Klein, 1946). Projective identification has been widely recognised as perhaps Klein's most influential contribution to psychoanalytic understanding and has had far-reaching consequences in contemporary psychoanalytic schools of thought. Although projective identification refers to an unconscious phantasy, Klein's followers have discovered that it can actually have an effect on the recipient of the projection who through subtle influences of verbal and non-verbal behaviour, can come to actually feel what is projected into them. This discovery led to understanding more about the crucial role of the mother or primary carer.

Wilfrid Bion, one of Klein's most influential protégés, described the mother's capacity to *contain* the infant's projected emotional states as an essential contribution to the infant's development (Bion, 1962). So, by virtue of her capacity to hold together the fragments of the infant's experience, as well as her receptiveness to the infant's emotional states, particularly being able to take in his or her distress and transform it with love and understanding, the mother eventually enables the infant, then child, to bear difficult feelings. Thus along with the infant's developing physical and cognitive capacities, there is less splitting, less need to project, and a growing sense of being more emotionally integrated, whole and able to relate to whole people. Consequently the internal world becomes inhabited with whole figures.

However, these developments towards integration usher in new *depressive anxieties* which come from the realisation that the nurturing mother is the same mother who is sometimes absent, a mother who is both loved and hated, and that the self who loves is also the self who hates. Thus the experience of loss of the whole mother presents the infant or child with much pain, because in phantasy the mother is felt to be irretrievably lost and the infant or child feels responsible for the loss because of hatred and aggression. The infant or child is therefore faced with painful feelings of guilt and sorrow, pining for the lost mother and for him- or herself who has lost the mother. These are at first very difficult feelings for the infant or child to manage without recourse to the early defences of splitting, denial and projective identification and what Klein described as *manic defences* which are characterised by control, contempt and triumph. However with repeated experiences of mother's love and care, and with developing emotional resources there develops a capacity to bear the tragedy of the loss, guilt and sorrow which leads to reparation, a desire to make good the damage and the establishment of the lost loved one internally.

Although Klein emphasised unconscious phantasy and the internal world, she also understood the importance of external reality in establishing the loved one internally. It is the reality of the presence of the mother or primary carer, her reliability and consistency, and most of all her love that assuages the infant's and child's fears and worst phantasies stirred by her absences. The mother's loving presence brings hope in the face of devastation and ultimately enables a sense of duration and permanence in the internal world (Likierman, 2001), so that, as Freud understood, eventually as an adult mourning we can face the reality of loss of our loved ones and our own death. However, in order for this to be achieved the absences and losses in infancy and childhood have to be overcome by working through again and again the suffering and need for reparation, in order to restore and reestablish our loved ones in the internal world.

Adult mourning

The appreciation of infant experiences of mourning is especially important because these states of mind are revived in adult experiences of loss and grief. Following a bereavement the internal world is in a state of devastation, not only the loved one is felt to be lost but all the loved and loving internal figures, particularly important early primary figures like mother and father, are felt to be lost as well. The self can then feel at the mercy of hated and hating internal figures which may lead to frightening or even persecutory internal states. Thus the bereaved may feel in pieces, in a fragmented state and unable to manage other than by extremely polarised and split feelings, making a sharp divide between loving and hating feelings.

A woman was brought into hospital in a weak and malnourished condition, convinced her neighbours were plotting to have her evicted from her home. She had worked conscientiously in a commercial business that was like an extended family to her. She was devoted to her work, it was the centre of her world, and when she retired a few years previously she came to feel that she had lost everything. She then believed that anything good she had left would be taken away from her.

Klein understood that the mourner's task is 'with anguish' to rebuild the internal world, to reinstate the lost loved ones. In the unconscious the mourner feels responsible for the death and destruction, helpless to repair or restore the lost one, terrified he or she will not survive without the loved one and at the same time feels guilt and remorse about anger towards the loved one out of frustration about their limitations. If the

mourner has the capacity to bear the guilt, responsibility and sorrow, then these feelings can fuel the repair and restoration of the loved one in the internal world.

An 83 year-old woman, Mrs Ames, was referred to me because she was having panic attacks, especially at night. She was soon to be admitted to residential accommodation because she had become too frail to live on her own. Mrs Ames told me that her husband had died four years ago. She said she was very attached to him. He was a carpenter and built most of the furniture in their house. She awoke one night to find him dead alongside her in bed. She thought 'Whatever has become of him!' She feared she might die too. Mrs Ames said she was the last surviving member of her family. Her father had died also 'quite suddenly', when she was just a girl still at school. The family were then threatened with being put in a home. I said I thought in her panic attacks she relived her husband's death and was in a panic that she would die in the night too; she was still grieving a much loved husband. She responded by saying how helpful her husband had been, he used to help her in the kitchen. She showed me a photograph of them both, a handsome couple. She said she could see that she had been ill since his death. Finally, she talked about going to the care home. She had visited it and liked the idea of being there. It was near a weekly club she attended, so she would be able to keep going to the club.

Mrs Ames was engaged in mourning again the many losses in her life. Her associations to her panics revealed the earlier losses which were revived by the imminent loss of her home: the death of her husband whom she was still grieving and the similarly sudden death of her father. She was thus bringing to the surface her infantile anxieties, showing me how this old woman was reminded of her father's death when she was just a girl and of the threat of being put in a home, which was now really going to happen. Showing me the photograph gave me a glimpse of her internal world and the happy couple she had inside her despite her external losses. This internal security helped her face the loss of her home and make the best of the move to the care home, keeping some links with her recent interests through her club.

Projective identification and mourning

Further psychoanalytic work has amplified the understanding of projective identification as a defence which obstructs mourning. The use of this defence is connected with the fears of one's own death triggered in bereavement.

Projective identification has various uses. It can be used to communicate emotional states, as described previously in mother and infant relationships whereby the mother gets to know her infant and then helps him or her to understand him- or herself. It continues throughout life to be an important means of communication, particularly for unconscious states of mind that we may find unbearable. In intimate relationships we may unconsciously lodge certain unmanageable aspects of ourselves in the other person with the hope that we may eventually retrieve these qualities and feel more integrated, as discussed in Chapter 5 about therapy with couples. It can also be used aggressively to possess and control and deny separateness.

The mourner needs to be able to tolerate separateness. Part of the unconscious hatred of the loved one comes from a fear of separateness and wanting to remain merged with the loved one. Freud observed that his very self-critical depressed patient had made a concrete identification with the lost loved one, effectively treating part of his own ego as the loved one against whom he harboured unconscious criticisms. It is then as though the loved one is possessed by the self and no longer lost. Anger with the loved one is denied by displacing the anger onto oneself. However, the anger is expressed indirectly by possessing and controlling the loved one in one's mind, not allowing him or her to die or be separate. We now understand the underlying process as projective identification being used to deny separateness by treating the other person as an extension of oneself.

The post-Kleinian developments of projective identification are therefore very useful in understanding more about the work of mourning and particularly the manic defences which, if they become entrenched, impede the work of mourning. An illustration of this projective process can be seen in a therapist who was feeling very guilty about his work with a woman. He felt he wasn't giving his client enough help or giving her enough time. The client kept complaining about her husband who had left her with a small child. However, apparently this woman had for some years been unable to look after the child herself. In the *transference* the client was treating the therapist as if he was her husband and had transferred unconscious feelings about her neglectful husband onto the therapist. In terms of the underlying projective process the internal figure of her husband in her mind contained her feelings about her own neglect of her children. In the transference she thus projected her feelings of guilt and neglect into her therapist who became identified with these feelings. In the *counter-transference* (meaning all the feelings experienced by the therapist) the therapist began to feel some of his client's projected feelings about neglect and guilt

which he mistakenly identified as his own. In so far as the client tended to dominate the therapist's thoughts she also began to exert some control over him.

The client complained that she couldn't stop thinking about her husband. She said she even thought about him in the shower. So, although she was tormented by this preoccupation, in a sense it meant that her husband was still very much with her and in this way she denied the loss which contributed to her difficulty in working through the grief. Moreover, in her internal world the figure of her husband was possessed and controlled by the projection into him of this neglectful aspect of herself. Her husband may well have been neglectful too, just as her therapist may have had reasons to feel guilty, but it is in the nature of this projective defence that it often finds realistic hooks for the projections. The therapist therefore needs to engage in a careful process of self-monitoring to tease out what may be projected by the client and what may belong to the therapist. Projective identification does not always mean that feelings are evoked in the therapist. There may be times when the therapist understands the unconscious phantasy of what he or she is meant to feel without being affected by those feelings.

The detailed understanding of this projective process helps further illuminate the establishment or reestablishment of loved ones in the internal world following bereavement. If there is a capacity to mourn and bear separateness, then there is a desire to restore the loved one in the mind out of love, not from a wish to possess and control. The projections will be withdrawn out of concern for the loved one. The mourner is thus able to allow the loved one to die and to install the loved one in a symbolical way in the mind. On the other hand in a frightened state of mind the bereaved person will be more likely to resort to projective identification to hold onto the loved one at all costs. The loved one may then be internalised in a concrete way that possesses and controls, and may be tormenting.

Fear of death

The fear of separateness and the use of projective identification to possess and control triggered by the bereavement of a loved one is associated with a fear for one's own survival following the sense of the devastation of the internal world in which all the loved ones are felt to be lost. The resulting concrete identification may then be an early response to bereavement which if it persists will obstruct mourning (Steiner, 1993). Paradoxically, in the resort to this use of projective identification the

fear of dying oneself is of course compounded by concretely identifying with the lost dead person. At its most extreme this form of identification can be seen in very severely depressed people who become mute, comatose and who would surely die if it were not for external intervention. A less extreme example can be seen in the following:

Mrs Foley, a woman in her early seventies, was admitted to hospital in a suicidal state. Her suicidal thoughts developed following the deteriorating physical condition of her husband who was ten years her senior. He was losing his mobility, becoming more and more dependent on her and feeling more and more hopeless about his physical state. Although Mrs Foley was herself physically fit, she became unable to leave the house on her own. She spent most of the time sitting with her husband, her arms folded in a worried state. Her recurring thoughts were of hanging herself and she associated these thoughts with stories of public hangings when she was a child. She acknowledged a sense of tragedy about her husband whom she loved but said she was unable to cry. She kept saying how very guilty she felt about her suicidal thoughts and about being in hospital. She also expressed guilt about an incident in her life many years earlier. When I tried to explore the nature of her suicidal thoughts she reproached me saying I was forcing these thoughts into her mind, whereas she didn't want to think about them. I felt very uncomfortable. With hindsight I can see she was giving me a taste of her experience of what it was like to feel helpless and guilty.

I think Mrs Foley found difficulty mourning the losses following her husband's severe physical decline, including the anticipation of his death. She became quite identified with him, immobilised and unable to do anything on her own. She expressed anger against herself in thoughts of hanging herself, as though like others she had observed in the public executions, she had committed a crime for which she must be punished. I think her unconscious crime was her anger and frustration with her husband who became disabled and might soon die and leave her. The identification with him kept him inside her, and at the same time indirectly expressed some of her anger towards him, for example by becoming something of an invalid herself and being unable to look after him. Her suicidal preoccupations may also have been a way of trying to manage her own fears of death, which were stirred by the anticipation of the loss of her husband. These fears were unconsciously communicated to others who feared for her life, admitted her to hospital and kept a close eye on her.

Another illustration of difficulties in mourning is Mr Powell, a 70 year-old man who, when he suffered a second stroke, had to be

admitted into long stay care because his wife could no longer look after him at home. Previously a pleasant natured and popular man, once in long stay he began punching staff and was often verbally abusive to them. He masturbated in public and made sexually provocative remarks to the female staff, admitting to taking pleasure in 'winding' them up. Over and over again he would insist on being taken to the toilet when he had no need of it.

Mr Powell could not bear his grief and sorrow about the dreadful consequences of his stroke. Instead he made the care staff feel his sense of outrage, disgust and helplessness by his aggressive and controlling behaviour. Mr Powell's strokes were undoubtedly a brush with death. Most of all he was unable to mourn the end of his own life.

Hanna Segal (1986) has written about psychoanalytic work with an elderly man which focussed on this man's unconscious fear of death. He was in treatment for 18 months which finished when he was 75. He led a healthy and vigorous life for another 11 years. Segal described events during the last evening of this man's life. The events were reported to her by the man's son. It seems this man had a long conversation with his wife during which he was concerned to establish the exact whereabouts of his family. Though his wife had told him before, he said 'it had never seemed real'. This time he said 'I know they are there and it is quite real to me'. Segal understands these events as part of this man preparing for his death by placing his family in reality, relinquishing of omnipotent control and allowing them to live on without him; and placing them in his internal world 'without coercion or control'. (p. 181)

Karina Codeco Barone described some therapeutic work with a five year-old girl who was suffering from a life threatening tumour (2005). In hospital the girl was forlorn and lifeless. When she was helped to play the girl soon portrayed scenarios in which a girl doll was going to die and nothing could be done to save her. The meaning of the child's play was not interpreted, but over some time the play changed. The girl introduced a story which she repeated and in which she encouraged her therapist to join her celebrating the girl doll's birthday. This is a touching example of how experiences of being able have someone take in and digest fears of death can lead to hope.

In *Making Death Thinkable* the author Franco De Masi (2004) maintains that our own death is essentially unthinkable. He points out that when we think of our death it is often from the perspective implicitly of still being present, for example of looking on at our own funeral.

Unconsciously too, however painful or tormenting death may be portrayed in dreams, the dreamer is usually present. What is unimaginable is nothingness. De Masi describes our death as an excessive trauma for our mind, he says:

'our death as individuals is an experience of separation unlike any other form of mourning, and therefore it triggers a specific anxiety which cannot be worked through easily or assimilated to other partings.' (p. 112)

De Masi concludes that 'Reparation can only be achieved *through the past*, through the projection of our past into the future, *in the future of others*' (author's italics). But he adds 'The real tragedy, unthinkable and beyond every possible reparation, is not so much the death of any one individual self, but the destruction of humanity and the universe which has given us a home and allows us to experience a sense of continuity; the irreparable damage is the total destruction of the world and its future memory.' (p. 124)

De Masi helps us understand why anticipation of one's own death may have become particularly terrifying since the development and amassing of enough nuclear weapons to destroy our entire civilisation. As Robert Hinshelwood (2002) has written:

'We each have methods of coping with a desire for immortality, by means of institutionalised religion, family descendants or physical or academic achievements. But (in a nuclear war) none of these will remain, so unlike death in ordinary war, we know there will be no-one left to glorify the war and the sacrifice or to keep us and our achievements in their hearts.' (p. 253)

Elliot Jaques (1965) has written of how the awareness of death precipitates a mid-life crisis. He has examined the effects of this awareness in the differences between creativity in early and in later life. He describes how achieving an acceptance of hatred, destructiveness and the inevitability of death lead to a mature creativity which reflects a 'constructive resignation to the imperfections of men and to shortcomings in one's own work'. This constructive resignation 'then imparts serenity to life and work' (p. 232). Thus being able to mourn in old age, which means accepting the inevitability of death and acknowledging hatred and human destructiveness, can bring a serenity to our final years.

Summary

Mourning is central to therapeutic work with older people because it recognises in loss the loves, passions, achievements and attachments in life. In the internal world mourning establishes who and what have been loved and lost externally, in a way that they may continue to sustain and nourish one's life. Psychoanalytic studies of grief and bereavement provide an insight into the mourning process and why it is so very painful and may endure for a long time. Each loss revives earlier ones and our unconscious internal world is felt to be bereft of all the loved and loving internal figures. Unconscious hatred, fears of separateness and fears of death create particular obstacles and can lead to depression and a denial of loss in a concrete identification with the lost loved person through the use of projective identification. Mourning means coming to accept the limitations of our loved one and life itself. Reestablishing the lost one internally comes through reparation from bearing hatred, aggression, destructiveness, guilt and sorrow. It also means bearing separateness, retrieving projected aspects of the self that are used to possess and control, and thus being able to establish the loved one internally in a symbolical way that recognises loss.

In therapy to enable mourning means providing the kind of holding and containment the mother provides for her infant. Just as the mother's reliable and consistent presence helps the infant accommodate early experiences of absence and loss, so the therapist's maintaining a reliable and consistent therapeutic frame helps the mourning process. Within the security of the therapeutic frame the therapist offers receptiveness for the bereaved's unmanageable feelings. It is particularly the therapist's capacity to bear what is most unbearable, unconscious and projected, and gradually help the client retrieve these projections that enables the client to work through the grieving process. In many respects these elements of mourning are central to the aims of psychodynamic therapy to help the client regain lost projected parts of him- or herself. These aims are manifest in the work of addressing the transference and counter-transference, and the underlying projective processes by which a client is depleted of emotional resources (Steiner, 1989).

The challenge for the therapist is to remain receptive to the projections which can mean that the client unconsciously may mobilise the therapist's own fears, and perhaps most difficult the fear of death, which in our contemporary society has become especially terrifying because of the nuclear threat to civilisation. Crucial elements in the therapeutic work will be absences, breaks, and the ending of the thera-

peutic relationship, because each loss of the therapist is an opportunity to address the very difficulties of grieving and letting go for which the client is in need of help.

If we can help our older clients mourn then they may be less depleted by projective processes and thus have a more complete and integrated sense of themselves. They may gain enrichment from an internal sense of what has disappeared externally, and be strengthened to pursue creative possibilities of later life. At the very least they may achieve serenity in this last phase of life.

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