The International Journal of Psychoanalysis

(1982). Int. J. Psychoanal., (63):149-155

On Loneliness and the Ageing Process

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Pearl King (1980), at the 31st International Congress, pointed out that it was the first time that a paper on the problems concerned with the psychoanalysis of elderly patients had been arranged. She indicated that researches in the theory and practice of psychoanalysis over the past few decades have necessitated a reevaluation of our attitudes, and the criteria we use for the selection of such patients.

Among such researches, I particularly refer to the changes in psychoanalytic understanding and technique that have facilitated clinical exploration of severe narcissistic disorders. These have emphasized the function of the defensive organization as a means of dealing with mental pain, and given us a deeper understanding of the transference relationships that can develop in such patients. Such studies detail the excessive amounts of envy and destructive feelings, and the use of early defence mechanisms such as splitting, projection, denial and omnipotence. This form of defensive organization is bound up with the inability to mourn, and the recognition of dependency, separation and death, features that are basic for the successful adaptation to ageing.

Psychoanalysts find themselves confronted with severe narcissistic patients frequently when patients are middle-aged and later, because, the very nature of their disorder has not allowed them to seek help earlier. It is only after their attempts at 'self cure' have failed that they reluctantly turn to therapy. Having built a precarious equilibrium around an omnipotent and idealized self, which hides excessive envious and destructive feelings, the onset of features of ageing such as the decline of both psychological and physical capacities, the loss of loved objects and the necessity of facing death as a reality, reinforces underlying envy and destructiveness and threatens the dissolution of whatever stability they have built up for themselves. Although they may approach treatment with a sense of urgency, it is also with a sense of failure, shame and humiliation. Their expectations of analysis present difficulties for themselves and the analyst, in that their conception of treatment is more in the realm of immediate relief of psychic distress rather than a need for internal change. If change is conceived of, it is more to do with a re-establishment of their previous narcissistic organization, rather than the promotion of psychic growth.

There is another feature that is present in severe psychological disturbance, that becomes significant in ageing, that is loneliness. By the sense of loneliness I am not referring to the condition of an external person being absent but to a painful internal state of mind that often results even when 'among friends or receiving love' (Klein, 1963). It is of interest to note that only two authors have, as far as I am aware, chosen loneliness as a major topic of discussion; they were both elderly when they wrote their papers and they were also the last papers that they wrote. I refer to papers by Fromm-Reichmann (1959) and Klein (1963).

The loneliness that I am referring to results from the failure of development of the capacity to be alone. I am not referring to the normal regressive episodes that often occur with physical illness, that may or may not be accompanied by a sense of loneliness. I am referring to the sense of being unable to communicate internally with part of oneself or one's objects. Fromm-Reichmann (1959) writes 'unlike other non-communicable emotional experiences it, i.e. the sense of loneliness, cannot even be shared empathically, perhaps because the other person's empathic abilities are obstructed by the anxiety arousing quality of the mere emanations of this profound loneliness'.

Winnicott (1958) points out that the capacity to be alone is a 'highly sophisticated phenomena

… closely related to emotional maturity'. It 'depends on the existence of a good object in the psychic reality of the individual', and implies a sufficiency of integration of the individual that allows for an awareness of dependency and trust in objects that are perceived as separate from oneself. Klein has described the infantile roots of such achievement in the 'depressive position' when through the infant's urge towards the integration of the life and death instincts and the capacity to perceive its mother as a whole person, there is a growing awareness of the infant's dependency. The fear of losing its mother on whom it is utterly dependent through its own destructiveness, stimulates the urge towards the object's restoration both internally and externally, and is the basis for the successful working through of mourning processes. If such a maturational stage does not come about through the failure of all those factors that interfere with the urge towards integration, such as excessive persecutory anxieties, then future development at different stages of an individual's life cycle are effected. When it comes to our assessment as to what help we may offer middle-aged and elderly patients, such as I am describing, then a careful understanding of their previous development, and the interplay of depressive and paranoid anxieties is essential if a reasonable assessment is to be made.

I want to illustrate these general points by reference to case material of an ageing patient, who presented with a traumatized history and severe narcissistic problems.

An academic, he first contacted me in his late forties. His reason for doing so was that his therapist had died, after his having been in treatment over a few years. He was not at all sure why he had come to see me, or whether he wanted to start treatment. He expressed no real regret at the loss of his therapist or of his treatment. Indeed he was not quite sure why he had come to see me, except that this had been suggested to him. He did not pursue the question of treatment at the time. He came to see me years later when he was in his middle fifties. This time he was extremely anxious, and expressed himself in urgent need of help. The change from when I had seen him on the first occasion was dramatic. It seemed apparent that the reasons for his seeking help now were to do with the death of his father who had been ill for a long time, and the threat that a homosexual affair he had been having during this time was about to break up.

His main complaint was that he had suffered from loneliness for as long as he could remember. He also had vague ideas about 'death' from an early age. As an only child he was never very close to either of his parents, or the few friends he did have. Later in his therapy he told me that a baby brother was born when he was 3-years-old and died suddenly when the patient was 6 or 7. His mother had become quite disturbed at the time and her attempts to turn to her young son for consolation had been very disturbing and confusing for him. He feared he was being intruded upon by a very frightening mother. At the same time he clearly felt no support from an indifferent father who suffered from uncontrollable outbursts of temper. My patient apparently had been pliable and passive in his puberty and adolescence, but essentially lonely. Mother 'organized' his life style, and added to his growing conviction that any closeness was a danger and a burden. He married in his late twenties in the hope that his fears, particularly of loneliness and sense of death, might be alleviated. he found that he was impotent, and in particular could not tolerate the attempts of his wife to get close to him emotionally. It was after the failure of his marriage that he had his first homosexual affair.

When my patient came to see me for the second time to commence therapy, he was very anxious and distracted, with a strong sense of urgency. He saw the analyst in a very idealized way with great hopes that he would soon be cured. Indeed his distress quickly disappeared, and with this his attitude changed. He now appeared very controlled with a sense of restrained familiarity, which hardly hid a sense of tolerant superiority. He spoke about himself in a very careful exact way, that made me aware of the one area of his life that he stressed he was very good at, namely that of a lecturer; however his sense of estrangement was all too clear. He did not complain about his loneliness, but the analyst was made acutely conscious of it. Empathizing with him was painful not only because of the loneliness of the analytic atmosphere that prevailed, but also because of the nature and form of his associations. The featureless

way that he spoke not only made him boring to listen to, but made it difficult to be sure what he was conveying. This was not an atmosphere of reflection or contemplation; memories as such were conspicuous by their absence. The impeccable pedantry of his associations was such that the analyst found it difficult at times to see the point of his remarks.

It became evident that his concern was related to his feeling that his first therapist had been continually trying to make him give up his homosexual companion, so that he would be more reliant on the therapist. He was fearful that his present therapist would do the same, and in so doing the possibility of exposure to death (of the analyst) would again result. But such expressions of anxieties were not only denied but produced an increased sense of dissociation, confusion and contemptuous attacks on the analyst because of the implied suggestion of his being dependent on the analyst.

I will now give some details of a session that conveys these points. It is a session before a holiday break and on a Monday. The patient asks me if I know someone called 'X'—then quickly adds 'never mind, don't tell me, I will explain it all to you later'. Such a remark was highly unusual for this patient. He went on to complain that his homosexual companion was looking worried and distracted, and 'does not seem to know what is going on'. He had asked him a question and he complained bitterly that his companion was impossible, because the reply he received suggested five different possibilities. The patient immediately added that he had been to see a doctor about a complaint in a particular area of his body, but the doctor had said that the cause of the complaint was elsewhere. As an aside he added that this doctor had rooms in the area of my previous consulting room, where the patient used to see me. On impulse he had gone there, because he thought he remembered that a certain friend who practised homeopathy had lived there. He explained in a rambling fashion that the bells indicating the various consulting rooms in the building were not working. By chance a man who worked in the building came along and told him that his homeopathic friend was no longer there. This man turned out to be working in my old consulting room as a psychotherapist. My patient was amazed and said 'this is the man "X"', he added 'he was dressed most informally, seemed very disorganized … not like you, very professional and organized in the way you put things to me'. It is of course difficult to convey a rather long series of ideas such as this and the atmosphere of it. The analyst's reaction was an awareness of a change in that for this patient this was a lively exchange of ideas, that left the analyst somewhat bemused. He was drawing my attention to a number of related events. He was aware of a companion looking worried and distracted, who gives five different possibilities to an apparently simple question; a doctor who when confronted with one problem suggests the trouble is elsewhere; his memory of a homeopathic friend who seemed to have 'self cures' or one for each separate aspect of the body and finally a rather disorganized and informal psychotherapist. A great deal of work had been done on his sense of distraction and worry, that he could only feel fleetingly, which gave him the feeling he did not know what was going on. In this state of mind he had the greatest difficulty in being able to concentrate and get to the point of a situation. My patient was not aware that the 'worry and distraction' that he described in this situation were his, and this caused difficulties in his appreciating the nature of his anxieties about the coming holiday break. He had told me that he could not believe he was so worried. He located such events in the analyst by projective identification. What he feels confronted by then are those aspects of himself that break up connexions between events and are disorganized, so he is not sure what is going on. He broke up the previous week of analytic work that had been related to his anxieties about separation, so that he felt that he was presented with five separate possibilities. He found difficulty also in understanding his doctor's advice that one area of his bodily complaint could be related to another. He was able to tell me that what he feared most was that he confused everyone around him, i.e. he felt that he had done this to his doctor and to the analyst causing them to appear confused, and what they said to be unrelated. His thoughts do not 'ring a bell', he cannot make contact with parts of himself or the analyst. He does however feel that an organized aspect of the analyst and his self remain, that allow him to continue the analytic work.

These attacks occurred continually whenever the question of his sense of dependency, and with it the recognition of the analyst as being separate, were approached. He omnipotently sought to take over, by projective identification, the analyst's

functions, particularly of integrating his experiences and associations. In so doing he feels he enviously spoils and confuses the analyst's capacities. He finds himself faced with those aspects of himself that seek to 'cure himself' but are not capable of doing so. The severe splitting and projective identification increases his sense of internal loneliness in that he is unable to make contact with aspects of himself, and increases his sense of external isolation in that he destroys the very linking that might provide him with the sense of understanding and belonging (Bion, 1959).

His sense of internal poverty is intensified through the force of his projections and the envious spoiling of those people whom he needs to turn to for help. This makes him vulnerable, and makes him feel continually intruded and taken over by the analyst's remarks that he fears have the same force as his own projections.

For instance, he returned from a holiday break with his usual complaints of mistakes by someone or other, that had spoilt his holiday. But on this occasion he reluctantly admitted that he had had a good time, significantly having had a dream, which was an extremely rare occurrence for him. In the dream *he had affectionate feelings in a situation which was clearly related to the analyst and parents*. In the next session he talked about how difficult it was to hold on to his feelings, then remarked that he had noticed someone near the consulting room searching through the rubbish bin, he added 'presumably looking for valuables'. Later in the session the patient referred to his awareness that he is always giving people the impression that he is so rich that he does not really need anything, because he does not ask for help. In the next session the patient was very worried because he was making some inexplicable slips of the tongue, which for someone as pedantic as himself was very alarming; he was extremely frightened that something had gone wrong with his brain, like a stroke, 'something one gets when one gets old'. He then said that he was furious with his companion who lazes around the house and does nothing. I indicated to him that the slip of the tongue, the mistake that he was worried about, is his partial admission to the analyst of his internal poverty and with it his growing awareness of his sense of need. The patient was now reminded of a famous missionary who he felt acts like a benevolent benefactor towards the natives, but who really is a despot for he treats them with contempt, like slaves. That is, as soon as my patient does ask for help which also means a closer relationship, he feels that his benefactor, the analyst, to whom he turns, becomes through projective identification someone who attacks him, tries to intrude on him, and influences him like a missionary, acting like a despot, and treating him contemptuously like a 'native'; this increases his sense of humiliation and shame, and it kills off his desire to ask for help.

Success in helping such patients to appreciate their needs and dependence is easily felt by them as a way of triumphing over them and crushing them, because of the projection of the sense of envy, triumph and omnipotence that the child previously felt to their parental figures (Riviere, 1936); (Rosenfeld, 1964).

His frustration, and with it his envy and greed, not only reduces his good feelings to rubbish, but the confusion that he feels between libidinal and aggressive feelings leads to a situation in which he cannot tell what is valuable or what is rubbish. He empties himself into the analyst's rubbish bin as a means of getting rid of his confusing feelings, increasing again his sense of emptiness. His feeling 'better' is a consequence of his using the analyst as a means of relieving himself of his anxieties and reinforced the idealization of the analyst as a defence against the continual underlying persecutory intrusiveness that he feared.

I have previously stressed how difficult and painful it was to empathize with this patient. The sense of confusion, the feeling of being blocked out and the pervading sense of loneliness in the transference leads to a constant sense of futility. The analyst may feel particularly frustrated and tantalized, in that the very sense of closeness leads to this frustration. It is important to see this as an expression of the futility that the patient feels. Rosenfeld (1978) points out that the over-whelming helpless rage that this situation creates, causes a feeling of 'emptiness, ego weakness, lack of desire to do anything and consequently excessive passivity, which is often related to a

desire to die or disappear into nothing'. In this weakened state the patient feels even more prey to those projected aspects of himself that he feared most, his envy and greed, so that invariably he would feel depleted, robbed and confused.

The patient's air of self sufficiency, based on the omnipotent possession of an idealized mother, helped him to deny any dependence on his objects, and thus avoid his fear of separation and death. However this was very precarious because he feared his ideal object constantly liable to envious attacks. A way of dealing with this was by establishing the analyst and his financial advisor as the containers of this ideal part of himself. He put his wealth into the hands of his financial advisor and operated a special bank account which 'was the analyst's', although of course the patient retained control. He completely denied any anxiety that either his financial advisor or his analyst could make any 'mistakes'–and this patient had a remarkable facility in finding mistakes. He never really felt he 'paid' for his help. It was all done automatically. He avoided any recognition of guilt, and need for recognition of help. His associations clearly revealed that it was not only a question of preserving a part of himself from his own internal destructiveness, but the motive that underlies such a procedure was to rob the analyst of any parental function. The underlying sense of despair and hopelessness towards his primary objects together with the feeling of not being able to alleviate the painful sense of loneliness would reinforce the sense of self sufficiency, and his turning towards his homosexual companion.

The narcissistic type of homosexuality where the patient is attracted to a younger man, who represents the patient himself, was described by Freud (1910). He described an identification with the mother. The sort of mother with whom this patient identified himself was, through the nature of his projective identificatory mechanisms, very intrusive, manipulative and persecutory. This was complicated by the birth of the brother and his death at an early age. The enormous envy and destructiveness, the inability to deal with the guilt, and a depressed mother who could not contain her son's difficulties, confirmed his feelings of being intruded into by anyone he attempted to get close to, increasing his confusion and sense of being burdened.

My patient maintained a manipulative control over his homosexual companion, that obviated any question of him leading a separate existence. He had complete disdain for him on the grounds that he was utterly dependent, a state of mind that he completely repudiated in himself. Together with the sense of dependency he included his companion's envy, greed and exploiting nature. However it was not only parts of himself that he felt to be bad that were projected into his companion, but also good parts of himself, such as the sense of liveliness and youthfulness. He did not feel that he really had a mind of his own, in that there was little that he could undertake in his general life without his companion, but denied that he was being helped by someone other than himself. As soon as anything his companion said or did emphasized a degree of separateness between them, he attacked him contemptuously for making 'mistakes', for being ridiculous and being inconsistent.

Through his own behaviour he encouraged and promoted those very aspects of his companion that he hated, through a form of pseudo-generosity that gave the impression that he was very tolerant. He thus lived vicariously. His protestations of being generous hid a pseudo-reparation of a manic quality; this 'false reparation' has been noted by Segal (1973); it is not directed at the primary object, nor is there any sense of real concern for the object, and there is no sense of loss or guilt. What he effectively prevented was a possibility of growth in himself in that he could not integrate those projected parts of himself or allow growth toward independence in his companion. What he did achieve was the illusion of having a situation in which he could communicate in a projected way with parts of himself, as a way of dealing with the overwhelming sense of internal loneliness. He effectively removed from the analytic scene the possibility of getting into contact with those parts of himself which could put him in touch with those areas which might afford a focus for growth and integration, and thus alleviate his sense of loneliness.

This patient had always attempted to maintain his academic career as an area of stability. Discretion does not allow me to mention the nature of his subject, but it depended on detailed exact memory. There is no doubt that he was a

brilliant lecturer. He achieved his effects by making what is a practical subject abstract; he had the capacity to empty it, divorce it from its base and embellish it in such a way that he gave it a semblance of originality. His brilliance as a lecturer followed the almost manic quality of his performance that was meant to arouse the envy of his audience; during periods of the analysis when, as he put it, he took over the analysis, he developed what he came to call his 'paraphernalia' of talk. This sort of talk, and with it what he considered to be his area of stability, were constantly being threatened by the analytic work. It was the fear of loss of his academic stability which he later realized had in fact tipped the scales in favour of his seeking treatment when he did. The imminence of mandatory retirement was impossible for him to contemplate.

What I have tried to emphasize in this presentation is a vicious circle, in that the awareness of his dependency, and with it the awareness of separation, increases his narcissistic defences; but his pathological narcissistic defences increase his loneliness making him unable to achieve a sense of belonging. It is this which makes it difficult for him to approach mourning and thus facilitate adaptation to the problem of ageing.

The possibility of psychoanalytic therapy helping to provide a new experience for such a severely traumatized patient depends on a number of considerations, some of which I have indicated, particularly with regard to his sense of being able to tolerate dependency. The increased understanding of psychoanalytic researches in recent years (Rosenfeld, 1978); (Kernberg, 1980), whilst acting as a spur to further clinical experience, also indicates those areas where specific features have to be considered, such as ageing. Both these previously mentioned authors have indicated the possibility of the emergence of psychotic manifestations in previously non-psychotic patients (transference psychosis). This may pose specific problems in ageing patients. At the other end of the scale there is always the danger that excessive idealization may lead to a situation that makes treatment interminable.

It is important however in ageing to retain the capacity to recognize and seek environmental help that often becomes a necessity, and this means recognizing ones sense of dependency. The working through of paranoid and depressive anxieties that go on throughout life can be facilitated by psychoanalytic work, even in such severely traumatized patients as this. Psychoanalysis cannot replace quality of experiences that a patient has never had. I think it was Genet who wrote somewhere 'that the problem of growing old, is that we are young, not that we are old'. If we can to some extent mitigate excessive envy and rivalry, this diminishes the sense of loneliness, which is such a painful accompaniment of ageing. It allows vicarious satisfaction of other people's achievements, both young and old. Depressive anxieties never fully supersede the paranoid schizoid anxieties, integration is never complete and defences against the depressive conflict bring about regression to paranoid schizoid phenomena. Nearly all psychoanalytical writers on the subject of ageing have emphasized that the ageing process itself focuses the individual's attention on death, and faces a reexamination of their attitudes towards it (Jaques, 1965); (Kernberg, 1980). If paranoid schizoid anxieties predominate then death is felt in an extremely persecutory way. Eissler (1975) wrote 'I presume that George Bernard Shaw would have said that ageing is the only deadly sin for which the Lord has stipulated no other retribution but capital punishment'. What I am urging is that the criteria that we use in coming to our decisions be based, as indeed clinical psychoanalysis has always been, on our experiences of individual treatments. No matter what theoretical approach we may take, collective evaluations of this nature, we hope will modify and enhance both our expectations and our theoretical understanding.

SUMMARY

In this paper I have focused attention on a particular group of patients who by the very nature of their narcissistic disorder often do not seek help until they are elderly. I have indicated through clinical material the nature of intrapsychic conflicts, a failure to achieve and work through depressive anxieties that interfere with the successful resolution of problems related to mourning; this does not allow for adequate adaptation to ageing and poses problems with regard to the evaluation and prognosis of such patients for psychoanalytic therapy.

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