The American Journal of Psychoanalysis, ***2022, 82,*** *(456–479)*
© 2022 Association for the Advancement of Psychoanalysis 0002-9548/22
www.palgrave.com/journals

Article

THROUGH A GLASS DARKLY: A CLINICAL JOURNEY

Linda A. Chernus[1]

The use of the empathic mode for engaging and communicating with patients has become widely accepted by many psychoanalytic psychotherapists since Kohut's early formulations (Kohut, 1971; Atwood & Stolorow, 2014). However, diagnostic understanding based on ongoing empathic immersion with our patients is often complicated because it is continually being modified as we know them more deeply and as transference and countertransference factors influence our perceptions. To illustrate the complexity of diagnosis when it is grounded in ongoing empathic engagement with our patients, I describe in detail my treatment of an elderly woman who initially presented with severe and acute symptoms of psychological, cognitive, and physical impairment. As the treatment has progressed, my diagnostic understanding has been continually modified to include a combination of psychodynamic and organic factors including PTSD, intense unresolved grief, and extreme feelings of guilt and need for punishment. Adding further to this conundrum, I have been frequently challenged by my own responses to the fluctuations in her progress, especially to periods of hopefulness followed by periods of despair and regression.

KEY WORDS: complex diagnostic dilemma; empathic mode; countertransference; treatment of older adults; trauma

https://doi.org/10.1057/s11231-022-09371-w

For now we see through a glass darkly; but then face to face…
(1 Corinthians, 13:12 KJV)

INTRODUCTION

As we commemorate the 50th anniversary of Heinz Kohut's landmark publication, *The Analysis of the Self* (1971), the central role of empathy as a means of understanding the patient and promoting therapeutic change continues to be regarded by self psychologists as an essential foundation upon which the entire psychoanalytic treatment process rests (Chernus, 2017; Goldberg, 1983; Rowe & MacIsaac, 1989; Wolf, 1988). Furthermore,

Linda A. Chernus, MSW, BCD, DPNAP, Emerita Professor of Clinical Psychiatry, University of Cincinnati College of Medicine; author; full time private practice.

Address correspondence to Prof. Linda A. Chernus, 3093 West Mockingbird Lane, Tucson, AZ 85713, USA. E-mail: linda.chernus@gmail.com

subsequent schools of analytic thought such as intersubjectivity theory and object relations theory, originally emerging as outgrowths of more traditional self psychology, have continued to emphasize the importance of understanding the patient from the patient's subjective vantage point (see Greenberg & Mitchell, 1983; Stolorow, Brandschaft, & Atwood 1987; Mitchell, 1993; Atwood & Stolorow, 2014). Though these more recent paradigms may conceptualize what promotes therapeutic change somewhat differently from classical self psychology, their continued belief that empathic understanding is an essential bedrock for psychoanalytically informed psychotherapies suggests that empathy may in fact be Kohut's most enduring and clinically significant contribution to the evolution of psychoanalysis (Chernus, 1988).

When we consistently strive to understand our patients from an empathic vantage point, we generally find that our diagnostic understanding is continually modified over the course of treatment, as we come to know them more comprehensively and more deeply. Also, the ongoing interaction between patient and therapist continually affects our experience of the patient and the patient's experience of us on both conscious and unconscious levels (Atwood & Stolorow, 2014). On an unconscious level, our empathically based communications tend to promote the emergence and blossoming of a variety of self-object transferences, the analysis of which further deepens and modifies our understanding of the patient. With the gradual working through and internalization of these self-object functions served by the therapist in the transference, the structure of the patient's self is strengthened and his capacity for further therapeutic growth is enhanced.

The treatment of Eleanor powerfully illustrates how our diagnostic understanding is continually evolving when the patient is consistently "heard" from an empathic vantage point, as well as the many clinical and external factors, including new information about the patient's past, which have contributed to this evolution. I hope that sharing my internal experience working with this highly engaging, challenging patient will resonate with other clinicians needing to feel some professional connection or even twinship at a time when in-person sharing is so limited due to the COVID pandemic. I have subtitled this presentation "Through a Glass Darkly" because of the many lenses through which this treatment process can be understood. In addition to the lens of my own subjectivity, over time I have increasingly recognized the difficulty of trying to address and treat Eleanor's long-standing PTSD through the lens of her increasing neurocognitive impairment. And a third lens, of course, is the added challenge of doing psychotherapy with Eleanor during the COVID pandemic. Not only is it especially difficult to communicate remotely with her through FaceTime,

but it is also impossible to assess the degree to which the COVID pandemic has affected her psychologically and thereby contributed to her dramatic decline; it has served as fertile ground to trigger childhood traumas (see Harris, Csillag, Cutner, Freeman-Carroll, Mayson, & Rufino 2021).

THE TREATMENT PROCESS

Getting Acquainted

Eleanor is a 90-year-old Caucasian woman who was initially referred to me through one of her three adult sons, who had contacted Medicare seeking a therapist for her. When I called, as planned, to schedule the initial appointment, Eleanor seemed very confused but also eager to talk with me. She was quite insistent that she preferred FaceTime to simply talking on the phone, which I later understood in part as a means of maintaining object constancy and feeling reassured by my facial responses that I was not angry or frustrated with her. During our first session, in late July 2020, it was immediately apparent that Eleanor had considerable difficulty with both short-term and long-term memory, word finding, and activities of daily living. In response, she had become extremely distraught about her cognitive and physical impairments and continually tried to reassure me (and herself) that she used to be highly intelligent, though she now feels shame and self-loathing because she can no longer think clearly or verbally communicate her thoughts if or when she is aware of them. Her husband, David, sat close by during this and all subsequent sessions, though he was generally only visible to me on the FaceTime screen when he was responding directly to Eleanor's requests for help in communicating with me. I quickly noted that he seemed to be there for her when she really needed his help but encouraged her to think and speak for herself as much as possible.

During this initial session, Eleanor spontaneously described "feeling tired all the time." She then told me that she has "always been very articulate," but now feels continually confused, depressed, and anxious. She also reported a variety of OCD-like symptoms involving the need to constantly drink water in a ritualized way both day and night due to intense fears of choking on food or suffocating while sleeping. As a result of these concerns, she has recently "become obsessed with nutrition," but rather than allaying her fears of starving to death, this obsession has only intensified them.

When I gently inquired as to when these concerns first began, Eleanor was able to tell me, with considerable encouragement and some direct input from David, that her "breathing situation" had existed for most of her adult life, though in a much milder form. However, it suddenly worsened in

March 2020, concurrently with the acute onset of her other severe physical, cognitive, and psychological changes. I then learned what had precipitated this crisis. David had taken Eleanor to a local emergency room because she was having trouble breathing. She was initially misdiagnosed as having a collapsed lung, and although the correct diagnosis of fluid buildup around her heart and lungs was quickly made, and she was successfully treated and discharged, her sudden mental and physical decline began immediately thereafter. After I commented on how upsetting the misdiagnosis must have been to her, Eleanor was completely silent. But David explained to me that it was caused by scar tissue on her lungs secondary to having had a serious case of childhood pneumonia, which had apparently interfered with accurately reading the images on x-rays and CAT scans.

In retrospect, it was only later that I realized I had not paid sufficient attention to the impact of this traumatic childhood event during our initial session, partly because I was more focused on Eleanor's current decompensation and terror that she would die any moment. So, I simply assumed that being hospitalized and misdiagnosed just as the COVID pandemic was becoming critical had precipitated what she referred to as her "sickness." Unfortunately, however, her condition continued to worsen over the ensuing months. In June, her primary care physician had prescribed Buspar, but it did nothing to alleviate Eleanor's anxiety and instead caused insomnia. She was then switched to Sertraline and eventually to a small dose of Lexapro, which she was still taking though she didn't think it was helping. Sometimes her anxiety and depression are so intense that she spends almost the entire day in bed. Upon inquiry, I also learned that Eleanor had a history of other medical problems, including mild heart disease, Stage III kidney disease, and frequent UTIs, but when I asked, she denied having any anxiety about them or about COVID. Yet she was adamant that death was imminent and would be the result of suffocation or starvation.

As the session continued, Eleanor told me how narcissistically injured she felt because of both her severe cognitive impairment and her physical decline. She also feels shame about being "vain" for caring about not getting her hair cut or her nails done because of COVID. I became quite alarmed at the conclusion of the session when Eleanor began sharing her paranoid thoughts with me. She said, "I think my condition is punishment for things I've done wrong in the past, but I don't know what they were." She went on to say "Maybe I'm as bad a person as Donald Trump, sometimes I have dreams and I rely on them. I recently had a dream about how I have done bad things and now I'm afraid I'll spend an eternity in hell."

Not surprisingly, my clinical impressions during this initial session were quite confused and unclear. Harold Kelman (1955), in his seminal paper

describes his definition of diagnosis and prognosis. “Diagnosing is a process of evaluating growing possibilities”, which “concerns the feeling aspect of the process.” He states that “growing transcends sickness and/or health.” His definition of prognosis is this: “Prognosis is a process of predicting probabilities regarding immediate and future growing possibilities.” In Kelman’s view, this way of thinking about diagnosis and prognosis “conveys the tentativeness and ever-changing nature of this process” (p. 51). The main challenge is focusing on a continuing process of connecting to assets and liabilities in the patient’s past and present (pp. 55-60). One learns gradually that the process to evaluate and think about diagnosis and prognosis takes both time and empathy.

The suddenness and severity of Eleanor’s decline was shocking to me. As recently as February, she had been functioning quite competently for a woman of her age. She was still driving, cooking, working on the computer, and performing essentially the same daily activities as she did when she was younger. She had also derived considerable pleasure from her relationships with her three sons and their families, including her eight grandchildren. Her oldest son Robert had even relocated his family to Tucson in order to be closer to them as they were aging. Once or twice, she was able to express a sense of pride about her children’s personal and professional accomplishments, but immediately qualified this by saying she hoped she didn’t sound “too conceited.” When I inquired about her childhood, all Eleanor could say was that “my parents and older sister were good to me, and I loved school.”

Over the next few weekly sessions, I soon became aware of the extent of Eleanor’s cognitive impairment and the depth of her depression. She was unable to describe much about her earlier life and displayed a flatness of affect, poverty of thought, and sense of apathy in her responses to my gently encouraging her to tell me more about herself. During one session, when she repeatedly said, “now I worry about everything because I’ve been sick for a long time, I’m unorganized, I just want to sit around and do nothing,” I asked her to tell me more about the things that she worries about. But she became quite confused and unable to respond verbally. At that point, David joined our conversation to say he wondered if she worried about her other medical problems, to which Eleanor responded, “I’m not worried about the kidney disease or my heart because all of my heart and kidney doctors have been so excellent and so wonderful to me.” On another occasion, just after she told me more about her fears of leaving her house, I asked her if it was because she worried about catching COVID. She said “yes, of course,” but seemed very anxious, began to cry, and abruptly changed the subject.

Deepening My Understanding

As we entered the second month of treatment, Eleanor's despair and sense of hopelessness was palpable. She cried frequently while saying over and over "I just want to get better and be like I was before." With considerable help from David, I learned that Eleanor had an extensive and accomplished academic and professional career. Eleanor often described how active and gratifying their social life had been, how they enjoyed frequently traveling with friends and family, and how much she loved throwing parties. She once told me that she was an excellent cook and hostess, joking that David meant well but was not as good a cook as she!

When I inquired a little more about her childhood and adolescence, Eleanor was vague and essentially nonresponsive. At that point, David briefly joined in to say that although she was very attractive, intelligent, and athletically talented, Eleanor had always been critical of herself in general, and especially about her appearance. He then poignantly added that "when I met her, I quickly realized that what was most beautiful about her was that she didn't feel she was beautiful." I remember thinking to myself what a lovely and wonderful man David was, and how lucky Eleanor was to have him, especially at a time like this.

Unfortunately, the full extent of Eleanor's paranoia also manifested itself as the summer ended. She began making statements such as "my family is collecting evidence against me because I've done something very, very bad, and it will be found out, my children are trying to poison me, and I don't know what I've done wrong." Concerned, I recommended that Eleanor have a neurological evaluation for possible dementia and that they discuss with her primary care physician the possibility of trying either an antipsychotic or a dementia medication, whether or not any hard neurological evidence of dementia is found upon testing. Though in fact no anomalies were identified on her brain MRI and EEG, Eleanor performed poorly on assessments of her memory, language skills, and overall cognitive functioning. Following this consultation, her primary care doctor decided to prescribe Abilify, which of course I hoped might improve her cognitive functioning and related psychological distress. If the trial of Abilify wasn't helpful, her doctor next planned to try a medication such as Namenda or Aricept.

During early September, I finally recognized that Eleanor's inability to be separate from David was severely incapacitating. She could not tolerate his leaving the house even for a few moments to water the garden or get the mail and followed him wherever he went. She was especially terrified for him to run errands by himself, not only because she felt unsafe alone at home, but also, because he could have a car accident or some other medical emergency, and she would not be there with him. I noted to myself

that although David has generally accommodated Eleanor's desperate need for constant contact and her extreme dependency on him, he was careful not to enable it and would sometimes even gently encourage her to try tolerating very brief separations within their house, just as he encouraged her to try doing things for herself before he would assist her. Compounding her separation anxiety was a profound sense of guilt and shame over this dependency on David and about the physical and psychological toll she imagined it was taking on him. She felt especially guilty about his health because he was getting up during the night to comfort her when she would invariably awaken in a panic believing she had stopped breathing.

As our September sessions progressed, I began to understand how Eleanor's severe depression was not only related to organic factors but was also fueled by profound grief over her many enormous losses. Each week she would repeat in a sorrowful and trembling voice "I've lost my real self my old self." It was painful to stay empathically connected to her as she mourned the loss of her previous sense of physical and psychological well-being, her personal autonomy, and the self-esteem she had always derived from her relationships, accomplishments, and activities. She felt extremely alone, except of course for her bond with David, and often said she "knew" she would never again have the physical or psychological stamina to resume her former, highly gratifying life. An ominous warning sign of what was to come, I also noted at this time that Eleanor was frequently describing not only feeling that life had somehow "slipped away" from her, but also that it was a "punishment" for some unknown and unspoken transgression.

At the same time, Eleanor revealed to me more about her extreme preoccupation with rituals related to her two primordial fears, not being able to breathe and being abandoned. She had developed an obsession with fluids going in and out of her body, manifested symptomatically by elaborate water drinking and urinating rituals. When I expressed some interest in knowing more about them, she talked vaguely about how she performs certain routines "in order to make my urine come out in a certain way." She first stands on one side of the bathroom, but then moves to the other side in order to prevent the possibility of being contaminated by germs. She worries that "if the urine doesn't come out in the right way, something terrible will happen to me." Eleanor's fear of choking to death while eating has caused her to take a sip of water after each bite, though this ritual, like her others, has not been very successful in reducing her anxiety.

She is also fearful of suffocating to death in her sleep, so she has developed a nighttime ritual in which 3 cups of water are arranged in a certain sequence on the night table beside her bed. She described this to me as being "all part of the formula that I have to use in order to get the certain drool that I want." With my encouraging her to continue, Eleanor added that

"there will be two different outcomes and one will be the drooling that I want. But I don't have the nerve to do what I need to do to get the outcome I want." And finally, when she awakens at night in a panic, believing that she has stopped breathing, a pattern has developed in which David checks her vitals and reassures her that both her respiration and her oxygen level are normal.

After 10 weekly psychotherapy sessions, my overall diagnostic impressions remained confused and unclear, though I was now more appreciative of how much Eleanor's profound grief was contributing to the clinical picture. Because of her age and overall presentation, I initially assumed that she probably had some form of primary dementia, or possibly dementia secondary to a medical problem and/or medication. Both were preliminarily ruled out through testing, but because I was aware of the limitations of neuropsychological testing in accurately diagnosing different kinds of dementias, I continued to trust my clinical impression of apparent neurodegenerative disease. Though early on I also considered that Eleanor might have a psychotic disorder or a major depressive disorder with psychotic features, her symptoms could simply be indicative of organic changes occurring in her brain. Adding to my uncertainty at this time none of these differential diagnoses seemed to account for the suddenness and severity of her cognitive and physical decline.

My concerns about the increasing bizarreness of Eleanor's presentation escalated during October. She described feeling that "there is a line that I have to cross to get to the sputum." She also began referring to "a project which you and I must complete, or else" and was distressed because she didn't know what it was. Magical thinking, such as "special numbers with special powers," was also beginning to enter our dialogue more regularly, though Eleanor had difficulty explaining what they meant to her. During several sessions she spontaneously reported nightmares involving separation and death. In some of them she was physically lost and unable to find her way home, and in others she was searching unsuccessfully for water.

Eleanor's water rituals were also becoming more highly elaborated, rigid, and compulsive. She now needed to be positioned in a certain way in bed in addition to having her glasses of water lined up in a specific manner. In one memorable session in late October, as she was describing more about her fear of choking because of not having enough water, Eleanor hesitantly began to explain to me about what she called her "two throats." When she quickly became frustrated, David clarified her words by telling me that she had always insisted that she had two openings at the bottom of her throat and could somehow choke to death as a result. But this belief had been under control until it suddenly intensified last March with the onset of her "sickness," as did her other long-standing, though previously mild phobias

and rituals. She told me with some irritation that they had discussed her "two throats" with several physicians over the years, but none of them took it very seriously because no anomalies were noted on a cursory visual inspection. Unfortunately, however, this didn't ameliorate Eleanor's anxiety about her "two throats," and instead reinforced her feeling that "everybody thought it was in my head and I was crazy."

My association to this was that Eleanor's separation anxiety had also been long-standing, though mild enough until now to not significantly affect her independent functioning. Suddenly I recalled their telling me during our first session that Eleanor had almost died from double pneumonia when she was seven years of age. When she was hospitalized, she "freaked out" because parents were only allowed to visit during limited hours, and never overnight. But her mother spoke to the hospital administration and received permission to visit throughout the day and even stay with her overnight.

But then my mind then began to race with thoughts that perhaps the acute onset of Eleanor's "condition" last March, after being misdiagnosed with pneumonia and briefly hospitalized, was symptomatic of a powerful reactivation and reexperiencing of this childhood trauma, coincidental with the escalation of the COVID-19 pandemic. Maybe she was once again that small child who was fearful of suffocating to death and being abandoned by those who could protect and save her? Compounding the trauma even further, just as her parents were initially restricted in being with her, so too David was not permitted to be with her in the hospital due to COVID restrictions. Unlike her mother, however, David did not have the power to override the official regulations! I was excited by these thoughts. Understanding from this perspective how her recent, traumatic hospital experience had reactivated long-standing, unresolved PTSD from childhood could account for both Eleanor's current state of severe regression and her lifelong, milder anxieties about death through abandonment or suffocation.

When I caught my own breath, I casually said to Eleanor that I wondered if maybe what's happened to her since they briefly misdiagnosed her with pneumonia last March had brought up the terror she felt as child when she was away from home, in the hospital, and struggling to breathe. Though she had considerable cognitive difficulty following what I was saying, David joined in to say that he had just had the same thought. This would explain both her chronic separation problems and her anxieties about choking or suffocating. However, I felt that understanding her decompensation as a form of reactivated PTSD didn't really explain her delusions, cognitive impairment, paranoia, and escalating feelings of intense and unremitting guilt. Yet I tried to remain hopeful that interpreting Eleanor's symptoms as in part a reactivation of severe childhood trauma and subsequent PTSD would contribute to a more comprehensive understanding of what had happened

to her, and that helping her to see and accept this might contribute to her psychological recovery.

The Plot Thickens

Towards the end of October, Eleanor's anxiety and paranoia were both rapidly escalating. I initially attributed this to her preoccupation with growing fears that Donald Trump might be reelected on November 3rd. Though such fears were in my opinion quite rational, they quickly became delusional. For example, she was afraid that the grocery store clerk who loaded their pickup order into their car might know she was a liberal Democrat and deliberately poison their food. She was also paranoid about going to the doctor, and in general felt mistrustful towards everyone, including her own family members. David was the only exception. Eleanor trusted him completely and relied almost solely on him for protection, validation, and emotional support. She also began to talk more about her fears of choking while swallowing not only solid food, but even liquids, adding that ever since childhood she has never really liked or cared about food anyway. During one particular session, Eleanor associated from this to her belief about her two throats, saying "what if the food goes down the second hole and just stays there, because it has no opening to my stomach?" But avoiding food because of these fears has created an additional source of anxiety, because she is terrified that if she doesn't consume enough calories, she will lose weight, become weaker, and eventually die. These terrors have increasingly become incorporated into delusions such as one in which "my teeth are no longer sharp enough to chew foods that I was previously able to eat, especially vegetables, and they will probably go down the wrong throat and I will die."

Despite this escalation of Eleanor's subjective distress, during the month of November she began to hesitantly share with me that she could "now do a few new things," which encouraged her somewhat that she might eventually recover after all. I silently wondered if these improvements might indeed be related to our growing understanding of how her illness and brief misdiagnosis last Spring had reactivated her childhood trauma of fearing that she would suffocate to death alone, with nobody there to save her. A pattern began to emerge in which Eleanor would proudly report her new accomplishments to me each week. For the first time since last March, she was enjoying sitting out in the sun with David and was pleased with herself that she was able to fold some laundry and even help David cook dinner. She was also trying harder to eat vegetables, despite her fears of choking, not only because she didn't want to die of malnutrition, but also because

she felt very guilty about being "unappreciative" of David's continual efforts to prepare foods she would enjoy. I struggled to make sense of how and why these slight improvements in Eleanor's daily functioning were occurring just when her terrifying delusions and related rituals were escalating. Shortly before Thanksgiving, however, David informed me that Eleanor had recently been prescribed CBD (Cannabidiol), which he felt was helping her energy level. Perhaps this explained the notable discrepancy between her current levels of physical and psychological/cognitive functioning.

Following the Thanksgiving holiday, Eleanor's bizarre delusions continued to escalate, and she frequently said she was afraid she was "going crazy." Her separation anxiety was so severe that she became quite agitated before a scheduled dental appointment, terrified that they would not let David be with her in the exam room despite his repeatedly reassuring her that there would be no problem since he had already okayed it with the dentist's staff. She cried during our sessions, mournfully repeating, "I don't want to go to a looney bin for the rest of my life." Eleanor's distress seemed to peak during our first few December sessions, when she shared with me more of her water rituals and described an image of a castle where it was difficult to reach water. She referred to it as the "Golden Castle," but it was transformed into a "Black Castle" if she and David both went to sleep at the same time and had no access to water. At times she would refer to "a tractor with no wheels and also seven tractors with seven people, all of whom have throats."

When I would ask her to tell me more about the castles or the tractors, Eleanor would become extremely frustrated, saying either that she didn't know anything more about them or that she couldn't describe them to me in words. Towards the end of one session, she sobbed while begging me to save her, saying "please help me and make me not be crazy. I don't want to go to a looney bin and not be with David ever again." This was painful to hear precisely because I could not "save her," no matter how hard I was trying.

Yet Eleanor continued to idealize both me and David despite our inability to magically heal her. During this period of treatment, David's selfobject functions as both a mirror of her progress and an idealized, calming figure became even more important. By casually and nonjudgmentally adding more of the details of her delusions and rituals as she verbalized them, he was able to both calm her agitation and convey important information that further contributed to my understanding of her. Eleanor's increasing idealization of me became quite apparent when she reported a dream in which "David has an appointment on Friday, our appointment day, but he leaves me with someone else to take care of me, so, it was okay." I suggested that perhaps talking with me has made her feel safer and

taken care of, to which she responded, "yes and it's because I can tell that you really understand me." She then added that "having you here is like being with my mama, she's in heaven but I know she still looks after me and loves me."

It was clear that Eleanor had always regarded David as her protector, and now seemed to experience David and me as an idealized team working together to help her. I remember asking her if she saw herself as also part of the team. She immediately said "no, it's all up to you two," which I interpreted to mean not only that she idealized us, but also that she felt totally powerless to help herself and was fully dependent on us for her physical and psychological survival. Concomitant with this increasing idealization, Eleanor's separation anxiety at the end of each session seemed to be worsening. She would sob at the end of our sessions, saying she knew she wouldn't be alive to see me again the next week, though my empathizing with her terror about imminent death seemed to temporarily soothe her.

A New Development

A few days later, I received a lengthy email message from David saying that Eleanor had just seen a new pulmonologist for her yearly respiratory checkup and told him about her "two throats." Though other doctors had consistently disregarded this seemingly strange claim for lack of evidence, this physician took her complaint more seriously and used a newly developed, highly specialized scope to investigate it further. Much to his surprise, he was able to identify a small opening in Eleanor's throat that was completely insignificant medically, though she had apparently always sensed it physically. I think that David and I were both cautiously optimistic that maybe if Eleanor could fully understand and accept this, she might at least feel a little bit less "crazy." However, given how our earlier understanding of the reactivation of her childhood trauma hadn't significantly improved her symptoms, this validation that she was not delusional after all about her "two throats" might also have no therapeutic effect because of her degree of cognitive impairment. I was also beginning to more fully grasp the extent to which Eleanor's neurological impairments were seriously complicating our efforts to process and hopefully ameliorate both her long-standing PTSD and her current intense feelings of guilt, shame, and grief. In a sense, we were processing these feelings through the metaphoric "language" of her delusional and paranoid ideation.

When we met for the next session, Eleanor did immediately tell me the news, but in a somewhat matter of fact tone. When I asked her specifically

how she felt about it, she said "I'm relieved that I'm not completely crazy after all, but they all made me think I was crazy." I recall being disappointed that she either couldn't express, or perhaps even feel, any strong emotion about decades of being discounted by doctors. Instead, her terror about choking to death if the food went down the wrong throat was intensifying, as was both her separation anxiety and her bizarre delusions, such as having "special connections" to certain numbers. Yet, I sensed that Eleanor was progressing with grieving her many losses, culminating with the tragic, profound loss of the fully gratifying and meaningful life she had until only months ago. She began to report dreams about her former life, which "make me sad because they take me back to times not very long ago when I could drive, cook, have company, do everything I wanted." While processing this deep pain, I commented that maybe these dreams also expressed her hope to get better and be able to have those experiences again. Eleanor responded by recalling a recent dream in which "there was a party and there were lots of people there and I was the hostess, and everyone was having a good time." Following this dream, she was excited to tell me about an experience she and David had the other night. They were sitting together on their porch, and she suddenly realized "I feel fine, there is nothing wrong with me, I can think clearly again and I'm happy for the first time in a while." She began crying with joy about this, but then suddenly became anxious and upset, saying she was afraid that the experience would never happen again.

Making Progress

Despite her continued delusional and paranoid thinking, Eleanor did not become severely traumatized or further disorganized by the January 6 insurrection. In fact, she continued to give me a "progress report" in each of our weekly sessions. She was pleased with herself for her new accomplishments, but also worried I would be disappointed if she didn't report steady progress each week. She was excited to tell me that she had finally figured out how to draw a diagram of the inside of her house, and was once again doing her sudoku puzzles, though only the easier ones. But I was most astounded by the noticeable improvement in both her short-term and long-term memory, her clarity of thought, and her capacity to verbalize her thoughts effectively. For example, during one session in late January, she recalled in detail being in a beauty contest in sixth grade, for which her mother allowed her to get her first permanent. She remembered feeling "embarrassed because I didn't think I was pretty enough to be in it," As her memory began to improve, Eleanor talked more fluidly and seemed less

impoverished in both her thought processes and the contents of her inner world.

During our last January session, I was encouraged when Eleanor said "I finally believe both of you that I'm getting better. And my attitude about getting better has become more positive now." She could now answer the phone and even initiate phone calls to her sons, though it still made her a little anxious. When I asked, she also hesitantly told me that her sleep rituals were decreasing in both frequency and intensity. But what she was most excited to share with me was that she could now tolerate David going outside by himself to feed the hummingbirds or get the mail! Towards the end of the session, I suggested to Eleanor that her "believing" us might mean she herself is experiencing internally that feeling of actually getting better. She responded very positively, saying "yes, you hit the nail on the head."

As we entered our seventh month of treatment, Eleanor continued grieving her many losses. She missed her cleaning lady, whom she hadn't seen since the beginning of COVID, and wasn't sure if she will ever feel safe enough to have her return. She cried about feeling she will never again be capable of driving a car or interacting socially with friends. It was only when she narrated her academic and professional accomplishments that she seemed to feel a momentary sense of relief. After earning a bachelor's degree in business and teaching business courses to high school students, she soon realized that she enjoyed their coming to her more with personal than academic problems, so she subsequently returned to graduate school and earned a master's degree in counseling. She even told me in a confident tone that she had gone back to school in her 50s for her PhD, all the while commuting daily from home 45 miles each way.

During one memorable session, Eleanor described "feeling all along that counseling was my true calling, like I think it is for you also." I recall thinking about how this emerging "twinship" transference, as well as her ongoing idealization of me, were helping to strengthen Eleanor's sense of self and subsequent hopefulness about being able to "return to a more normal life again." However, alongside these slight but significant improvements in her daily functioning, I had to continually remind myself that she was still being tortured by paranoid thoughts, delusions of persecution, and overwhelming feelings of intense guilt, all of which I now realized were at least in part related to a progressive and probably irreversible neurological disorder.

When we met for our last session in February, I was surprised to see that Eleanor was dressed in a beautiful outfit rather than her usual bathrobe or shawl. She seemed fully alert, happy, and more communicative, describing in detail, even with some humor, the sequence of events they had just endured in order to finally get their microwave repaired. She also reported

for the first time that she has recently been a little less fearful of choking or suffocating. I suggested in response that perhaps her water rituals might soon be diminishing. If so, maybe she wouldn't need to take a sip of water between each bite of food, would consequently feel less full, and could then eat a little more food.

A few hours later, I happened to recall my own experience, only two years earlier, when I developed a mild case of hyponatremia, an abnormally low level of sodium electrolytes in the blood. Elderly persons living in hot climates are particularly vulnerable to hyponatremia, especially if they are taking a diuretic and drinking large quantities of water, both of which have the effect of diluting the concentration of sodium electrolytes. Though it is readily treated with IV saline solutions, left untreated it can cause convulsions and eventual death. And the primary symptoms of hyponatremia are physical weakness and tiredness, cognitive impairment, confusion, anxiety, and depression! Could this be another reason for Eleanor's condition? Could it help to explain her physical and cognitive decline, her delusions and paranoia, and perhaps even her severe depression? And what about my countertransference in not considering the possibility of hyponatremia until now? How and why did I overlook what would have been a benign explanation for her condition? Though I knew it was probably wishful thinking, I even began to fantasize that perhaps Eleanor did not suffer from an organically based dementia after all, but instead had severe hyponatremia and could be "cured" in reality.

I immediately inquired about this at our next session and learned that Eleanor had indeed been prescribed a diuretic last March, but it was discontinued two months ago. I eagerly shared with them my thought that perhaps low sodium electrolytes had played a significant role in her sudden and severe decline. David called an hour later to tell me that he just went online to check Eleanor's labs. And yes indeed, her sodium electrolytes were very low throughout the summer and autumn months but had returned to normal on her December blood draw. This would correspond with the unexplained improvement in Eleanor's daily functioning over the past few months! Despite my immediate reaction of anger about her physician apparently overlooking her lab results, I was excited by this news and hoped that my fantasy might indeed become reality. David was also encouraged and planned to discuss this at Eleanor's next doctor's appointment, though Eleanor did not overtly display much of a reaction to this new information.

As we approached the one-year anniversary of the inception of Eleanor's so-called "sickness," I was struck with how different she seemed from the severely impaired, bedridden woman I had met only eight months ago. She began one session saying, "I'm beginning to feel inside that I'm getting a little bit better, and I'm also having some dreams about that." They have

been playing board games and have also been enjoying watching "ridiculous and absurd shows," on TV, "the more absurd the better because they take me away from my reality and I'm happier." She described how "we find ourselves giggling and having a great time doing these activities together." I also noted that the intensity of her grief seemed to be diminishing slightly, partly, I hoped, because of the therapeutic grief work we had been doing and partly because of her increasing hopefulness that more of her "normal" life could be recovered.

These improvements in Eleanor's daily functioning continued through March and into April. She still had severe anxiety about going back out into the world now that she was fully vaccinated, but eventually was able, with David's encouragement, to go clothes shopping and get her hair done. During one session, she was wearing another new outfit and told me without guilt how much she loved it and how well it fit. Besides her remarkable physical progress, I noticed that she could now discuss her fears about not being able to breathe in a more rational and less delusional manner and was even beginning to understand how they might be connected to her childhood experience with double pneumonia.

The following week, Eleanor spontaneously recalled that while she was hospitalized at age 7, a doctor other than her regular attending examined her one day, and then turned to the nurse saying, "give that baby a drink of water." When the nurse protested because it was not in the patient's chart, this doctor ordered the nurse to give her the water anyway, which she did. Eleanor concluded the story by saying that the doctor had saved her life, and I remember feeling that I now more deeply understood her lifelong preoccupation with water, and why it had become more bizarre, intense, and ritualistic since the reactivation of her childhood trauma last March.

Plunging into Despair

Once again, my recently reawakened optimism about the possible extent of Eleanor's recovery was suddenly and rather traumatically shattered during our final session in April. She was in her bathrobe, looked quite disheveled, and was almost incoherent as she tried to tell me that David's sister Marsha had passed away peacefully three days earlier. Most of the session was spent with Eleanor sobbing and struggling to find words to describe what this loss meant to her. Marsha was David's "surrogate mother" when he was very young, and their sibling relationship had remained close ever since, with mutual admiration and respect for one another's personal qualities and professional accomplishments. Eleanor and Marsha had also loved one

another, and Eleanor felt comfortable with her despite Eleanor's history of anxiety concerning relationships with other women.

As this session continued, Eleanor began to express delusional and magical thinking related to Marsha's death, including extreme guilt for somehow causing Marsha's death because she herself was still alive. She then started crying and told me she was also terrified that "something bad" had happened to her neighbor, Judy, and that this too was her fault. When I encouraged her to tell me more about Judy, Eleanor was initially too distraught to respond, so David spoke for her. I learned that Judy had been successfully treated for melanoma two years ago and had once told Eleanor that she feared a possible recurrence. Eleanor abruptly interrupted David to say that "one of us has to die in order for the other to live, and because I am the guilty one it has to be me." She then began crying so hard that she could not speak and insisted on ending the session early. But despite the alarming nature of Eleanor's presentation, I did feel slightly more hopeful once again when David informed me that Eleanor had tested positive for a urinary tract infection and was currently being treated for it. Perhaps this explained the recent, dramatic change and Eleanor would soon return to her previously improved condition?

Unfortunately, this was not to be. Instead, as we entered the month of May, Eleanor became increasingly agitated, confused, and conflicted about everything. She was terrified she would starve to death unless she ate more but was equally terrified of choking to death with each bite she struggled to swallow. She and David described how she was waking up more frequently in the middle of the night terrified that she was not breathing. David would immediately get up and try to verbally reassure her that her breathing was fine, but sometimes she was unable to calm down even after he also checked her pulse and her oxygen level. At my suggestion, they began to regularly do breathing exercises to lower Eleanor's anxiety, which helped a bit temporarily, but did nothing to mitigate the complex network of delusional thoughts related to guilt and punishment that was torturing her. She was so terrified that she would not live through each day that when she awoke every morning, she needed David to reassure her over and over that she would survive "at least until tomorrow." She frequently spoke about her "horrible sins," and how death was a fitting punishment for having committed them and continued to despair even further because she still did not know what they were.

The origins of this seemingly primitive, all-consuming feeling of sinfulness and subsequent fear of punishment began to emerge as we entered the month of June, when Eleanor began to hesitantly share with me more about her guilt related to competition with other women. I already knew that she had never been comfortable with her physical attractiveness

as a young woman, but now learned that she had also carried intense guilt because a male cousin, with whom she was raised, admired her so much that he would tell people he wanted to find someone just like her to be his wife. After this cousin eventually married, Eleanor always felt uncomfortable around his wife, though on the surface they were good friends. Each week she would tell me over and over how she hated her cousin's attention and never encouraged it, but this did not seem to assuage her profound sense of guilt.

Little did I know that I would soon understand the meaning of Eleanor's guilt more fully. With intense emotion, she began to describe in detail having been in a long-term, abusive relationship with a boyfriend during her mid-adolescent years. Ricky was several years older than she, but because he came from a prominent, wealthy family, her parents were comfortable with her dating him and assumed he was a good person who would treat Eleanor well. Not only did she feel totally psychologically and physically controlled by Ricky in all aspects of her life, but she was also sometimes "taken advantage of by him sexually."

To make matters worse, she was terrified to tell her extremely religious, conservative parents about the abuse, despite feeling desperate for their help, because she knew they would not only be shocked and horrified but would also be extremely disappointed in her and maybe even morally condemn her for it. Eleanor also feared that rumors about her relationship with Ricky would spread through their small town, bringing shame upon both herself and her parents. She would frequently cry uncontrollably while referring to herself as a "Jezebel," and would then ask me for reassurance that she was "a good girl" but was so terrified by Ricky's threats of harm that she passively went along with his sexual abuse. She also tearfully repeated how naïve she was about sexuality and how she was constantly fearful of getting pregnant. Adding to Eleanor's guilt, she felt she had lied to her parents by not telling them about the abusive relationship. And just as her lifelong anxieties and related rituals had intensified and become more delusional since last March, so too this moral guilt had reached psychotic-like proportions as it was experienced through the lens of what appeared to be Eleanor's increasing neurocognitive impairment.

One especially difficult session in early June began with Eleanor crying and saying "I think I'm going to die today. I'm dying now and I know that I'm not going to heaven because I'm going to hell." When I responded by saying "you're living in hell right now, constantly feeling you are about to die," she said "yes," suddenly became agitated, and began relating dreams about her guilt and fear of punishment by death. In one dream "there was something I wasn't supposed to tell anyone about, and if I did it meant I was a Jezebel." Other dreams related to the cousin who wanted to find a woman

just like her. I learned that his wife had recently died, but she and David were unable to attend the funeral in person. Eleanor feared that people might interpret this as related to her discomfort around her and was extremely upset about this. She even dreamt that a voice said, "what a shameful, bad girl you are, because your cousin is in love with you."

A few days later, I received a phone message from David saying Eleanor was requesting an "emergency session," which of course we scheduled. She immediately plunged back into the details of her abusive relationship with Ricky. In a remarkably lucid manner, and through her tears, she said "He controlled everything I did in high school. I was damaged by this young man when I was very young, you have to help me tell you that." And she then added "I was like imprisoned for a long time and I wasn't even aware of it." During the next few sessions, Eleanor continued to describe details of the abuse, saying over and over that "he had total control over me, he assaulted me, and I couldn't go anywhere or see my friends." On one occasion, "he said if he couldn't have me, nobody else would, and then he made me do things to him." When I would comment at times on how she was reliving being that "scared little girl who was trapped and couldn't get help and protection," Eleanor would sob and repeatedly say "I still feel I need to be punished, even though I would say he really did rape me."

On a more positive note, just before the close of one session, Eleanor reported a dream in which "I was dying in David's arms, and it was very beautiful." She associated from this to having eventually told her father about the abusive relationship with Ricky. He responded by saying "are you ever going to marry this boy?" And then, when she said, "definitely not," her previously uninvolved father took out a restraining order against Ricky, which made Eleanor feel very nurtured, protected, and loved, just as she has always felt with David.

The months of July and August were challenging for all of us. Eleanor remained highly delusional and disoriented and showed no improvement when olanzapine was added to her medication regimen. Furthermore, she frequently referred to "the project which we need to complete or else I will die and go to hell." At times she would say "when I try to complete it something pulls me back, and the project involves drinking chicken broth, like my mother gave me as a child when I was sick." Sometimes she would cry about how she didn't even know what the project was, and during one session she told me "I'm afraid we'll never complete the project because they took the chicken broth away. They changed the menu."

Eleanor also continued to be plagued by intense guilt over both her relationship with Ricky and issues of competition with other women, which were initially triggered by her male cousin's idealization of her. She told me repeatedly how "Ricky used me and harmed me, he ruined my reputation

and everything else, he forced me to do things that scared me." But despite her progress in being able to verbalize these feelings, Eleanor's guilt and shame for having "participated" in their relationship remained unabated. Believing that death was a fitting punishment, she awoke each morning afraid to open her eyes "because if I open my eyes I will find out if I'm dead or alive." She continued to ask David every morning if she were going to die that day, but his reassurances to the contrary didn't seem to make any difference. In one dream, Eleanor saw bright lights and had a profound sense of peace, which she spontaneously interpreted as "a practice for when I die." Because of my growing awareness of how Eleanor's cognitive impairment was complicating the therapeutic work, I was beginning to feel discouraged about what *I* regarded as our project, namely, to heal Eleanor's recently reactivated PTSD and concomitant intense feelings of guilt, shame, and need for punishment.

A real-life situation further intensified these fears. I learned that her friend Judy had recently noticed a new lesion and was now being tested for a possible recurrence of her melanoma. Eleanor sobbed while saying "We are vying for the same position. I don't want her to die, and I don't want to die." She also reported hallucinations of helicopters flying over their two houses, which meant to her that "we are competing for who goes to heaven, I have to go to hell so she can go to heaven." And in one particularly ominous session, Eleanor repeatedly said "I smell embalming fluid."

Remarkably, however, as the summer ended, I noticed some softening in the intensity of Eleanor's guilt. She began to report more positive dreams, such as one in which "there were children, they were playing together in the yard, and they were all happy." We continued to focus on her ongoing frustration with completing the unknown "project," to which I once casually suggested that "maybe you have already completed the project." She hesitated a bit, and then said "maybe, but if I did, I don't remember doing it." But much to my amazement, when we met the next week, I immediately noticed that Eleanor's physical appearance was remarkably improved and that she seemed much calmer. She even said "I no longer feel I'm guilty and going to hell, but I'm not sure if we completed the project. Maybe I need to accept that we never will."

Fearing that this was just a temporary fluke, probably related to my offhand comment about possibly having already completed the project, I was anxious about how our next sessions would go. The following week, however, Eleanor's anxiety continued to be much milder, and she also seemed to be sharper cognitively. During one session she told me that "I now think I'm going to heaven, not hell, but sometimes I feel like I am in hell right now and sometimes I'm not." Since then, Eleanor has continued to address her guilt and fear of punishment, though in a much more rational

and less delusional manner. She has also been able to make excellent use of me as a mirroring self-object to strengthen her sense of self, proudly telling me each week about her new physical and cognitive achievements, such as consistently beating David at their favorite game, Aggravation!

It has been very rewarding to witness how Eleanor's guilt and fear are gradually attenuating. Her punitive dreams, hallucinations, and delusions are less frequent and intense, she is sleeping better, and she is even able to separate from David for very brief periods of time. Furthermore, and much to my pleasant surprise, it appears that these positive physical and emotional changes have also contributed to a modest improvement in Eleanor's cognitive functioning, despite the limits imposed by her neurological impairment.

CLOSING THOUGHTS

I believe that the treatment of Eleanor illustrates the complexity of diagnostic understanding when it is grounded in the use of the empathic mode. It also demonstrates how transference and countertransference factors enter the treatment process, both facilitating and at times temporarily impeding therapeutic progress. Because Eleanor felt consistently understood, she experienced me as serving a mirroring, validating function for her, which I believe helped to stabilize her sense of self. In addition, she gradually developed an idealization of me, which further contributed to her improvement. I, like David, could protect her from death and eventually be able to "bring her back to life." I was the good mother who could magically cure her, and she frequently told me that she loved me. Interestingly, she was able to maintain this idealization despite plaintively begging me over and over to "make me well, fix me" and the obvious limits of my ability to fully do so (see Hoffer & Buie, 2016).

The empathic attunement to Eleanor included having David present in the sessions and collaborating with him to help her. This "elasticity of technique" (Ferenczi, 1928) is crucial when working with older patients, or those who have cognitive and/or physical impairments (see Dal Molin, 2022). It also created the opportunity for Eleanor to experience two benign, attentive people who bore witness (Mészáros, 2010) and assisted her in processing formerly unmetabolized traumatic experiences.

In reflecting upon my countertransference toward Eleanor, I am aware of admiring her greatly and feeling deep affection for her. I also feel a sense of kinship and connection to her, perhaps in response to her twinship transference to me. Both factors have fueled my need to believe that she will get better cognitively, which has been both a motivating factor in working

with her and a complicating factor in gradually accepting that her cognitive functioning will probably never significantly improve, despite considerable improvement in her PTSD related symptoms. I have also developed a deep respect for David. He has constantly been fully devoted and extremely nurturing to Eleanor, has taken excellent care of her and their home, and has remained positive and encouraging with her, despite his own fears for her and his struggles to accept the limits of his power to help her with either her cognitive functioning or her emotional despair.

I now recognize that I also idealize them as a couple because of the strength, love, and mutual commitment in their 65 years of marriage, even fantasizing that my husband and I will be as devoted to one another when we are their age or even older. I have also had thoughts about where Eleanor would be if not for David. Given how she was almost completely unable to care for herself, she would probably have been forced to live with one of her sons or in a residential facility, either of which would have been a severe narcissistic injury to her. And where will David be if or when he loses her?

In closing, while reflecting on our therapeutic relationship, the depth of my unconscious connection with Eleanor has become more apparent by my reference to the biblical quote "Through a Glass Darkly." Though I initially and consciously intended it to refer to what I conceptualized as "three lenses" through which this treatment has been filtered, I recently recalled that "Through a Glass Darkly" is also the title of a surrealistic film by my favorite foreign director, Ingmar Bergman (Bergman & Ekelund, 1961). It tells the story of a young schizophrenic woman who experienced delusions about meeting God. When she eventually does so, God appears to her in the form of a terrifying spider, punishment for having just engaged in incestuous activity with her brother. Being in the complex process took both time and empathy, the opposite of the punitive presence in Berman's film. The clinical process is tentative and ever-changing, and the challenge was to focus on a continuing process of empathically connecting to assets and liabilities in the patient's past and present (Kelman, 1955, pp. 55-60).

NOTE

1. Linda A. Chernus, MSW, BCD, DPNAP, is a Professor Emerita of Psychiatry and Behavioral Neuroscience at the University of Cincinnati College of Medicine, where she was a faculty member for 40 years, and is currently in full time private practice. The author of more than 50 publications in refereed journals, she is the Book Review Editor of

Psychoanalytic Social Work and serves on the Editorial Boards of *Clinical Social Work Journal* and *Smith College Studies in Social Work*. In 1992, she was elected by the National Academies of Practice as a "Distinguished Practitioner and Member, National Academy of Practice in Social Work.

REFERENCES

Atwood, G. E., & Stolorow, R. D. (2014). *Structures of subjectivity: Explorations in psychoanalytic phenomenology and contextualism. Second edition*. London and New York: Routledge Press.

Bergman, I. (Director) & Ekelund, A. (Producer) (1961). *Through a glass darkly.* [Motion Picture]. Janus Films. Sweden.

Chernus, L. A. (1988). Why Kohut endures. *Clinical Social Work Journal, 16*(4), 336–354.

Chernus, L. A. (2017). Intersubjectivity theory revisited: A 30-year retrospective. *Psychoanalytic Social Work, 24*(2), 163–170.

Dal Molin, E. C. (2022). The tailor-made analysis: The analyst's adaptation to the patient and the question of time. *American Journal of Psychoanalysis, 8*(2), 281–294.

Ferenczi S. (1928). The elasticity of psychoanalytic technique. In *Final contribution to the problems and methods of psychoanalysis*. (pp. 87–101). London: Karnac Books. 1994.

Goldberg, A. (1983). On the scientific status of empathy. *Annual of Psychoanalysis, 11*, 155–169.

Greenberg, J., & Mitchell, S. (1983). *Object relations in psychoanalytic theory*. Cambridge: Harvard University Press.

Harris, A., Csillag, V., Cutner, N., Freeman-Carroll, N., Mayson, S. J., & Rufino, M. (2021). Clinical life in the context of the pandemic. *American Journal of Psychoanalysis, 81*(3), 361–394.

Hoffer, A., & Buie, D. H. (2016). Helplessness and the analyst's war against feeling it. *American Journal of Psychoanalysis, 76*(1), 1–17.

Holy Bible. (2021). King James version. Retrieved from: https://www.932kingjamesbibleonline.org

Kelman, H. (1955). Diagnosing and prognosing in psychoanalysis. *American Journal of Psychoanalysis, 15*, 49–70.

Kohut, H. (1971). *The analysis of the self. A systematic approach to the psychoanalytic treatment of narcissistic personality disorders*. New York: International Universities Press.

Mészáros, J. (2010). Building blocks toward contemporary trauma theory: Ferenczi 's paradigm shift. *American Journal of Psychoanalysis, 70*(4), 328–340.

Mitchell, S. A. (1993). *Hope and dread in psychoanalysis*. New York: Basic Books.

Rowe, C., & MacIsaac, D. (1989). *Empathic attunement: The "technique" of psychoanalytic self psychology*. Lanham, MD: Jason Aronson.

Stolorow, R., Brandschaft, B., & Atwood, G. (1987). *Psychoanalytic treatment: An intersubjective approach*. Hillsdale: The Analytic Press.

Wolf, E. (1988). *Treating the self: Elements of clinical self psychology*. (*Second edition*). New York: The Guilford Press. 2002.

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

Springer Nature or its licensor holds exclusive rights to this article under a publishing agreement with the author(s) or other rightsholder(s); author self-archiving of the accepted manuscript version of this article is solely governed by the terms of such publishing agreement and applicable law.