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Working with the unworkable – a trainee's case of maternal mourning and ulcerative colitis

Dr. Julianna Challenor

Counselling Psychologist

9 Lyncroft Gardens

Ealing, W13 9PU

Tel: 0208 566 4421

Mob: 07549 499 591

Email: jchallenor@gmail.com

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Abstract

In this paper I describe a time-limited piece of work that I undertook as a trainee with a mother whose child had died. The client had developed serious ulcerative colitis and was referred to counselling because she was refusing an operation to treat it. I have conceptualised her illness as the embodiment of her experience of disintegration in grief. As a trainee, I found working in the transference difficult in this case, as though I was betraying the client in some way. The client's failure to make herself better both from her disease and from mourning her daughter made her continue to feel like a victim. Understanding this as transference and drawing on relational psychoanalytic theory was key to being able to work with her and to begin to make links.

Keywords: Maternal mourning; ulcerative colitis; relational model; supervision; suicide.

Introduction

This paper is a reflection on one of the most emotionally demanding pieces of therapeutic work undertaken during my Counselling Psychology training. The client was a middle-aged woman suffering with an auto-immune disease, ulcerative colitis. She was also a bereaved mother, whose only child had died. Here I present an account of my struggle with the feelings evoked in me that were sometimes expressed in the counselling relationship; how I tried to make sense of these feelings, and contain them through supervision.

Brice (1991) suggests that maternal mourning is essentially paradoxical – the mother wishes to recover from her child's death but by completing the work of mourning she faces losing connection with her entirely, describing the utter psychic devastation of this: "…as an attack she can only conflictedly fight; as the death of her world, as the destruction of her past, present, and future, and as an identity and reality crisis" (p17).

The case

The client, Jane[1], had a diagnosis of acute ulcerative colitis for which drug treatment had been unsuccessful and for which the only remaining medical option was surgery to remove her colon. She had been referred for NHS primary care counselling by a hospital Psychiatrist because of the difficulty she was experiencing in deciding whether to undergo surgery. The Psychiatrist had decided that she was not suitable for intensive psychotherapy because she was "pre-occupied with her physical illness" and would instead benefit from a more "supportive arrangement". There was no mention of her bereavement. This was Jane's third psychotherapy referral in under than a year and I imagined that she might be feeling angry, rejected and bewildered

[1] All names and some biographical/personal identifying details have been changed throughout in order to preserve confidentiality.

at having to begin again with yet another counsellor. I also felt a twinge of narcissistic irritation, as though the "supportive" therapy that I could offer was somehow less important than the Psychiatrist's. It became clear in the first session that she had by this stage become unable to contemplate the surgery at all. What she wanted to talk about, and to understand, was her inability to come to terms in any way at all with the death of her child and her despair at her failing health.

When I collected Jane from the waiting room for our first session I met a tired looking, slight, fair-haired woman. She took her seat in the therapy room, and told me was how difficult it was for her to attend appointments because of the severity of her symptoms. She seemed anxious that I understand this.

Her disease was intensely painful and distressing. She told me how she bled internally, and was prone to infection, anaemia and exhaustion. She described how ashamed she felt about these symptoms, which made her feel dirty and depressed. she could not bear the thought of an operation to remove her colon, even though this would effectively cure the disease, because it would leave her with a stoma, an opening from her small intestine to the outside of her abdomen, and a bag to collect waste.

She told me how her colitis had begun suddenly, nearly six years previously, almost the same number of years after the death of her only child, when she had attempted to visit her daughter's grave. She said that she had been afraid that she would "lose control" at the graveside. My sense as she described this was of her fear of total disintegration and how her symptoms represented this. Her internal bleeding was like a hidden physical representation of her grief. She vehemently rejected the operation that would relieve her of her crippling symptoms but would leave her alone with her grief, which felt shameful and awful. Our first task was to find a way to stay in the room together and to think about how it felt to mourn for her lost child and her own lost life.

Her daughter had been thirteen when she had killed herself. At the time of her death she had been staying with her father, a man from whom Jane was divorced after an extremely violent and abusive marriage. She described her ex-husband as paranoid and how she was often afraid during their relationship that he might kill her. She felt that her parents and siblings had been unwilling to help get her daughter away from her ex-husband and she could not forgive them for this, believing she would not have killed herself if she had been with Jane. She described her own childhood with a distant, authoritarian father, and a passive mother. She could not remember much of this part of her life. Her memories seemed to begin with her marriage at a relatively young age.

As she told me the details of her daughter's death in that first session she cried, and I could not stop myself from crying too. I felt panic, unable to think, concerned that she might experience me as unable to contain her grief. I struggled to reflect on whom my tears were for, Jane or myself. The image of her child's body in the ground felt almost overwhelming to me at that moment and I was distracted by the thought of a child so distressed that they would want to kill themselves.

Jane brought to our sessions the work of loss and endings – the ending of the life of her only child, the ending of her health and hopes for the future, those with previous therapists, and since this was taking place in an NHS setting that only allowed for time-limited therapy, looming over us, the end of our own relationship. After consulting with my supervisor, we both felt that the standard six sessions felt withholding in the context of Jane's grief. Twelve sessions, although still short, felt better, and we hoped might offer a more containing experience while we worked out what this client needed to be able to go on with her life. The twelve sessions were extremely hard for Jane to attend and it took nearly six months for her to be able to complete them or perhaps she was spreading them out, to make the therapy last longer.

Resisting links between physical illness and grief

In the first session I asked Jane tentatively whether she felt there might be any link between her illness and her grief, but she resisted this fiercely, angrily saying that it would either be like blaming her child, which was intolerable for her, or it felt like criticism of herself, which was only slightly more bearable. Contained in Jane's rejection of a psycho-somatic link was the idea that if she was doing making herself ill, then she ought to be able to make herself better. She experienced her inability to effect change in herself as a personal failure and therefore had to reject any connection between her grief and her symptoms. Her illness continued to connect her to unprocessed traumatic memories and she spoke of still feeling like a victim of her abusive husband. In the fourth session she told me angrily; "I get worse and worse", and how she "hated" herself for this. She refused to believe that her daughter had meant to kill herself, asking why she would have come home that day and made herself something to eat if she was really intending to die? She blamed her ex-husband, convinced that he had somehow made her do it by putting the idea of suicide in her daughter's head.

Therapy took on a pattern of Jane attending for one or two sessions and then missing the next one or two. She never managed to come to more than two consecutive appointments but would always telephone to cancel. I felt that she was letting me know that she needed me even when she could not face coming. Often the reason given was that she felt too unwell, or had clashing medical appointments. I thought that she needed me to see how ill she was. Towards the end of counselling Jane told me that some of the times she had been unable to come because she had felt too ashamed.

Jane complained angrily about her medical treatment, describing how she had to wait too long, or attend multiple appointments. I felt that she was also furious

with me for failing to help her. In the fifth session, she related to me an incident with a doctor who had seemed to her to be refusing to give her an iron infusion for anaemia. I felt as though I was the one being attacked. I found Winnicott's (1971) theory of object use to be helpful here. In addition to having their own subjectivity recognised, Winnicott says that an individual needs to be able to recognise that of another and understand the object as outside omnipotent control. The therapist has to be able to survive destructive attacks by the client, and only when the client experiences the therapist as an object 'out there', having survived destruction and existing separately from projection, can change occur (Winnicott, 1971).

Using supervision - containment

At first, I needed to use supervision as a container for my feelings of helplessness. After the first three or four sessions, facing what felt like an onslaught of grief, I was overwhelmed and deskilled by the level of distress that Jane brought. I could not imagine how the counselling might be able to help her, unable to trust the therapeutic relationship (Herman, 1992). Gradually, I was able to think about Jane's grief as belonging (mostly) to her. By working through this process alone and in supervision, in later sessions when tears came to my eyes I was less afraid to show her how she affected me.

Later, helplessness was replaced with what was certainly counter-transferential anger. Through sensitive supervision, I was able to observe to Jane this anger at both her ill health and her feelings of utter hopelessness that she would ever be able to live with her grief.

In the fifth session, Jane told me that although I "might not believe" her, she had not slept the previous night and in spite of feeling exhausted she had still come. I felt that she wanted me to see that she desperately wanted to get better, but I was struck that she thought that I would not "believe" her. Jane was telling me not to interpret her the way a previous therapist had interpreted her non-attendance.

Listening to these concerns about interpreting the transference, my supervisor reflected to me that it seemed as though I felt that by working in the transference, making links, I would be betraying Jane, and suggested that my role was to do exactly what she could not and use the transference to be able to think. Hoffman (1983) suggests that the therapist strives to let the client know that they are not so threatened by the counter-transference that they cannot work, and are able to provide a relationship that departs from the client's usual transference-countertransference interaction.

Allowing links

And it seemed to work, because in the next session we were able to experience for the first time together the full weight of guilt and regret that Jane felt about her daughter's suicide. Until this point, it was as though she had been rationing her distress, unsure of how much I would be able to tolerate. She sobbed violently, and said that for six years she had been telling herself that it was not her fault that her daughter had died, but that she did not really believe this. She said that she still felt like a victim of her ex-husband and wanted to know how to forgive herself. I said that it seemed as though she was never going to find a way to think about this in a way that was bearable for her. At this, she became calmer and thoughtful, leaving long pauses between speaking. I said to Jane that she seemed to be blaming herself both for what had happened and also for continuing to feel guilty about it. I hoped that this might offer her a tolerable way to experience a link between her grief and her illness, something I had struggled with up to that point. I said that she felt sorry for herself but also angry with herself for being ill. She said that she did not want to be a victim any more but didn't know how to get rid of the feelings of self-blame, hatred and regret because her daughter was gone.

After a long pause, she said sadly that she felt as though all her life she had been waiting for something that might bring her hope, but that when she looked at it,

she saw there was no hope. She was thinking about her abusive marriage. She sat silently for a minute or two, thinking hard and I thought about how sad this jettisoning of hope was for her. After a long pause, she looked up and laughed sadly, and told me that she had been in the waiting room when I had arrived that afternoon and that she had felt sorry for me because she was my first client. I wondered how to respond to this, and decided not to interpret it but said instead that it was difficult to see how much pain she was in, but that I was glad that she came. She said, "thank you", and I had the sense that it was as though something had shifted for her.

Bringing anger and shame into the sessions

The content of our sessions changed. Jane began to bring feelings of disappointment at her current life situation, referring much less frequently to her ulcerative colitis symptoms. She had married again but she and her husband were financially insecure and he was now also physically unwell. She felt that once again any promise of happiness that she might have dared hope for had been lost. She said that when she was sad, people assumed that it must only be for her daughter, but it wasn't always about that, she said, she also felt sad for her own life, her feeling that she had been denied the opportunity to be happy. She said that she had been waiting for her whole life for things to get better, but they never did, and she asked me whether I thought she was unrealistic to want this. As we were approaching the last two sessions, I reflected that it felt to her that I had also failed her, the therapy would end and nothing would have changed.

The ending

At the end, we were left with the certain knowledge that Jane's grief work will go on through the rest of her life. The task of coming to terms with her daughter's death can never be completed (Brice, 1991). We made it to the last session, and this felt like an

achievement in itself. I felt that I did not want to let her go and she declined the offer of an onward referral.

In the last session Jane arrived with photographs of her daughter to show me. My initial response was one of horror at the thought of having to see her dead child but it felt important that we look at her together. She sobbed violently and said that she missed her. Klein (1940) describes how crying in mourning is a way of expelling bad feelings and objects, creating a greater feeling of internal freedom and the experience of internalising a lost good object. After about thirty minutes, she put them on the table between us, where they remained for the rest of the session, like a symbol of the loss that had shaped our work. Jane said that it was difficult for her to say goodbye, and remembered sorrowfully that she had never had the chance to say goodbye to her daughter. She apologised for giving me such a sad and difficult piece of work. Howard describes how developing therapists struggle to come to terms with their "power and significance" for clients and I certainly experienced this struggle acutely with Jane (2010, p92). In the final minutes of the last session, as we were saying goodbye, she asked me whether I was a mother. I felt grateful to her for having spared me from this question earlier in the therapy, as it had been one that I had dreaded having to answer. I told her that I was, because it seemed important as we said goodbye to acknowledge this aspect of our "real" relationship. The work with Jane, although extremely brief, represents some of the most important training I received. She showed me that it is possible to survive almost total psychic destruction, and how to think about another person's seemingly interminable pain.

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