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# How Clinicians Feel about Working with Spouses of the Chronically Ill

Douglas H. Ingram

*Abstract:* Clinicians who provide psychotherapy to spouses or partners of the chronically ill were solicited through listserves of psychodynamic and other organizations. The current report excluded those therapists working with spouses of dementia patients. Interviews were conducted with clinicians who responded. The interviews highlight the challenges commonly encountered by psychotherapeutic work with this cohort of therapy patients. A comparison is drawn that shows both overlap and distinctions between the experiences of those therapists engaging with spouses of chronically ill patients without a dementing process and those working with spouses of chronically ill patients who do suffer from a dementing process.

Several years ago, I began working in psychodynamic therapy with two men facing the same overwhelming stress.\* They were referred separately and were unacquainted. Each man was successful in his life's work and each had an enduring lifelong marriage with children and grandchildren. Whatever other matters they were facing, they suffered a common life circumstance. The wife of each was suffering from dementia: the wife of one had Alzheimer's and the wife of the other had Parkinson's with severe impairment of motoric, affective, and cognitive functions.

I found professional fulfillment in offering a steadying presence for them when they were overcome with helplessness, fear, rage, guilt, and uncertainty. I felt keenly the poignancy of their circumstances. Discuss-

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\*Names and details have been changed to protect patient privacy.

The following is a partial list of those who helped make this project possible: Jean M. Baxendale, M.S.W.; Lynne Kwalwasser, Ph.D.; Patricia Brody, L.C.S.W.R.; Debbie Pausig, M.F.T., C.T., C.C.T.P.; John Stine, M.D., Nathan Horwitz, C.S.W., Jack Drescher, M.D., Richard Zuckerberg, Ph.D., Greg Mahr, M.D., and Robert Fenster, M.D.

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sions with colleagues proved helpful. Though I prescribed psychotropic medication (low-dose benzodiazepines), medication was decidedly beside the point.

I wondered whether other therapists working with caregivers of dementing spouses had experiences similar to mine. I posted an e-mail on numerous LISTSERVs soliciting clinicians who worked with persons who were caring for spouses or partners with dementia. I also solicited professional colleagues and recruited others who heard of this project by word-of-mouth. I found that some therapists reported occasional mild dissociative reactions in their sessions, not dissimilar from my own, and perhaps best described as awe and amazement. Some therapists experienced denial and the impulse to disengage, including the tendency to undervalue the spousal attachment bond, to prematurely recommend the hiring of aides, respites away from the ill spouse, and residential placement. I also found challenges to the therapist's value system, and, finally, difficulties these therapists encountered with the spousal caregiver's rage and potential violence (Ingram, 2014).

A commentary by Richard C. Friedman (2014) accompanied the report in publication. Friedman stated, "Most of the issues discussed in this article are not specific to patients with neurocognitive disorders... Therapists' empathic capacity toward caretakers of cancer or stroke patients for example, or those with a variety of terminal or chronic debilitating illnesses may be strained in a similar manner" (p. 305). While this is undeniable, I wondered about the extent of the overlap. How is the experience of therapists working with spouses of demented patients different from, or the same as, the experience of therapists working with spouses of the chronically ill but for whom dementia does not figure prominently? I decided to consider these questions using the same methodology as before (see Appendices A and B).

As in the prior exploration, my purpose in the current project was to use an open-ended psychodynamic orientation to interview therapists who have the experience I was seeking. The interviews were based on generally accepted psychodynamic paradigms of motivation and emphasized conscious and (inferred) unconscious attitudes, feelings, and beliefs of therapists. These were usually stimulated by unconsciously motivated behaviors of caregivers toward the ill spouse and/or were involved in coping with anxiety, anger, and/or depression mobilized by the caregiving situation. The interviews were not recorded and were 45–75 minutes' duration. I chose to exclude therapists treating spouses of those with primary psychiatric disorders, or those whose patients' spouses faced near-term mortality. My interest was in comparing the experiences of therapists working with caregivers whose spouses presented an ongoing chronic disorder where neither the immediacy of

death nor psychiatric disorder would be complicating variables. As in the prior exploration, this undertaking was focused on the experience of therapists, not the spousal caregivers or the ill patients.

I interviewed 12 clinicians who broadly met the project criteria. One was excluded because of excessive guardedness and refusal or inability to report meaningful subjective experiences of his work in therapy. Four were social workers, four were psychiatrists, two were Ph.D.-level psychologists, and one was a marriage and family counselor. Of the group, nine were psychodynamically trained. Several stated they were certified in psychoanalysis. Often the respondents had substantial professional experience with spouses of chronically ill persons. One respondent, a psychiatrist with extensive experience in independent-living and assisted-living facilities, reported on his work with numerous spouses of the chronically ill. Afflictions reported of ill spouses by the therapists interviewed included Huntington's disease, multiple sclerosis, Parkinson's disease, amyotrophic lateral sclerosis, chronic fatigue syndrome, Crohn's disease, chronic obstructive pulmonary disease, cancer, heart disease with congestive heart failure, and multiple traumatic injuries with disabling sequelae. Although several of these illnesses may progress toward dementia, the respondents recognized that we were excluding dementia in the ill spouse. To meet the criteria I had established, dementia must not yet have become evident. The level of impairment and disability needed be continuously present and figuring prominently in the life of the marriage. That these criteria were met was established in my interviews with the respondents.

My interviews were by telephone and were aimed at eliciting therapists' subjective experiences that emerged in their work with spousal caregiver patients. Follow-up discussions and correspondence were conducted to verify accuracy of reports and to ensure sufficient disguise in order to protect patient privacy. The reports that follow below were each approved for possible publication by the interviewees. All subjects gave verbal consent and approval through e-mail for interview material to be published and discussed.

An unexpected finding was that three therapists whom I personally contacted simply had not registered that one or more of their patients were partnered with a chronically ill person. Of the three, two agreed to be interviewed. One declined for unstated reasons. It appeared that the therapeutic engagement for these therapists was not so intently focused on the burdens of spousal caregiving as to warrant special recognition. By this I mean that they were aware of the chronic illness in an intellectual sense, but viewed it as not being of particular significance from an emotional perspective. They did not assign weight to it in assessing their patients' subjective experience. These two therapists

acknowledged that they were more concerned with their patients' characterologic issues and regarded the stress of caring for a chronically ill spouse as simply another circumstance in which these issues were evident.

### **IMPACT OF THE THERAPISTS' PERSONAL EXPERIENCE ON THEIR WORK IN THERAPY WITH SPOUSES OF THE CHRONICALLY ILL**

Although most respondents reported no motivation to provide therapy with spouses of the chronically ill, 5 of the 11 indicated how their experience with their own chronically ill family members affected their work. One therapist stated:

*Report #1:* My father had heart attacks every year from my age of 13 until he died when I was 21. As a consequence, I think I understand my patient's terror of her husband's illness. I push it away sometimes. I don't want that terror triggered in me. The specter of death hung over me as a girl—I was very affected and frightened. My father said, as he was brought away on a gurney on one occasion, "You caused this!" He was right. I felt that I contributed to his illness—I would fight with him about things like coming home later at night than he demanded. I was rebellious and fought with him as teenagers will do with their parents. Maybe I was more rebellious than most. I called his doctor once and asked if I was making my father worse. The doctor agreed! Now, with my patient, I feel she contributes to her husband's illness insofar as she disappoints and angers him. When she tells me about upsetting him, I get angry (an internal state, only) at her lack of empathy. I guess that in this, I am identified with my father.

Another therapist also commented on how his personal history impacts his work with his patients:

*Report #2:* My mother was chronically depressed and hampered in her motherhood as a result. My wife has chronic back problems with psychological overlay. These experiences in my own life have attuned me to the psychological issues that often occur for a person who provides care to an ill spouse. It gives me a quicker sense of the dynamic operations in destructive codependent caregiving. I have experienced a sense of the profound tragedy in which one can spend much of one's life providing needless care for a mostly factitious illness. The hovering caregiver provides a necessary audience in these circumstances. Sometimes, a simple statement can work wonders: "You can get angry at her even though she is sick." That turns out for me to be the rewarding part of the work with

the caregivers. I have two women and one man who are caregivers of non-demented, chronically ill spouses. I regard the work I do as situationally focused dynamic therapy. To try to ameliorate disordered caregiving can be a challenge. Sometimes, delightedly, it succeeds.

A third respondent joined in his patient's denial as a result of his personal experience:

*Report #3:* A patient came to see me because of anxiety and depressed mood triggered by his wife's condition. His wife's Parkinsonism was characterized by muscle rigidity and impairment in walking. I found myself less focused on his wife's condition than on his communication style which inexplicably concerned me. In the early phase of treatment, my patient often became excited about what seemed like minor bureaucratic side benefits of his wife's disability. I'd feel alienated from him at those times. I saw this enthusiasm as a manic defense against underlying depression. He would move about almost hyperactively while he talked, his hands flying as if to illustrate his words. I saw him every other week and he focused on successful activities they had shared. I was waiting around for him to talk about himself rather than about her management of her disability, but he preferred not to.

There was a personal component in my response to this patient. At the time, my wife's uncle had advanced Parkinson's. My patient's happy-go-lucky mannerisms put me off. They felt off-base. Through my wife's uncle's deterioration, I felt I could see what the future held. I saw the horror of my uncle's condition, and I had that in mind when I saw my patient. His apparent denial of what was likely to happen in the future was alienating for me. I found myself taking a parental posture in this, thinking—better that you don't see what's coming down the pike. In protecting him from the future, I joined him in his manic denial. Once I became aware of this countertransference I was able to appreciate the importance of his defenses. I was less reactive, more supportive, and my patient, in turn was less strident in repressing depressed feelings.

Another therapist, a former caregiver to a husband with Huntington's disease (HD) offered the following:

*Report #4:* I come from 25 years of police work. I have a different skin because of that professional history. It may be thicker than the average therapist. Nothing surprises me. Caregiving was and is exhaustive. My husband was ill for 17 years with HD. The last 7 years of his life were unbearable. I was a police officer, the parent of two young children, and my husband's caregiver. I had no time for self-care. I suffered from acute major depression, a result of caregiver burnout. I had depleted my internal resources. It took one year of antidepressant medication and psychotherapy to stabilize

me. But even with that help there was still only slight relief. I was starved for self-care. I had a career-ending injury in 2005 that led to forced retirement as an officer from the police department. In retrospect, that injury and numerous surgeries plus recuperation gave me the gift of time with my husband in his final years. My husband died in February 2008. Because of HD, I am now a Marriage and Family Therapist and Certified Thanatologist. I run bereavement groups around the state of Connecticut and I am the Huntington's Disease Society of America-CT Affiliate Caregiver support group leader for four support groups within the state. I work with my HD support groups as a spouse/caregiver/widow/survivor who had a husband who died with HD. I see spouses and family members struggling with caregiving for their loved ones with HD in all stages. I see examples of destructive codependent caregiving in both HD support groups and some of my bereavement groups.

Another therapist, working with a man whose wife has Parkinson's disease reports that her own husband has had multiple sclerosis for 20 years, as well as cardiac problems:

*Report #5:* My husband's condition had gotten worse. He had not worked for the past decade. He walked with difficulty. We used a scooter or a wheelchair. As a result, I had quite a lot of empathy for my patient who was a caregiver to his chronically ill wife. It was a feeling of love and entrapment, both, he said. He was physically turned off to his wife and acknowledged fantasies about me and other women, and he felt guilty about it (my slip!—he didn't actually say that. My thing? I suppose so.). *Interviewer:* Had you asked him if he feels guilty? I did not ask him—that might strike awfully close to home. This was an area that was not explored because—this situation, my treatment of him, hit closer to home than my usual work with patients. Earlier, I tried to reassure him that his fantasies about me and other women were ways of thinking about matters that would not come to pass, so the fantasies—because they would not be enacted—were very understandable and, in our therapy sessions, acceptable to disclose. He responded by missing his appointment the following week. He claimed illness. Also, he explained that fantasies were preludes to behavior. *Interviewer:* For him they are rehearsals for performance. Imagine telling a performer that he is rehearsing for a performance that will never go on?! We can regard my statement about fantasies as a way to reassure him—and to reassure me—that nothing will happen. I suppose this should be counted as a countertransference enactment.

## HOW DO THERAPISTS COPE WITH THEIR REACTIONS IN WORKING WITH SPOUSAL CAREGIVERS?

Effective psychodynamic therapy relies in some measure on identification with the patient (Racker, 1968). In two reports (#1 and #12, to be presented below), the therapist has an experience akin to that of the ill spouse. Regardless, the effective psychic metabolizing of matters that impinge on the therapist is necessary for therapy to proceed. We may ask, what are the adaptive defensive operations that enable therapists to maintain psychic stability in order to apply their skills? More specifically for the purposes of this exploration, what are the adaptive operations that are brought to bear by therapists in work with spouses of chronically ill, non-demented persons?

The following categories of adaptive operations are somewhat arbitrary.

### Obsessional Defensive Operations

As defined here, obsessional defensive operations include the broad array of both pathological and healthy psychic means to engage and manage anxiety arising from threats that have their origins in both external reality and inner conflict. Obsessional operations may range from, say, reliance on thought with isolation of affect on the pathological end of the spectrum to mindfulness and deliberate self-analysis on the healthier end of the spectrum (cf. A. Freud, 1937; Salzman, 1968; Vaillant, 1992).

In the following, the therapist decides to turn to an explicit code, the Caregiver's Bill of Rights (Horne, 1985). In brief, this code affirms the right of the caregiver to care for oneself, seek help, experience difficult feelings such as anger, receive consideration from loved ones, and to appreciate one's own courage in the face of adversity.

*Report #6:* My patient's husband had Huntington's disease and she regarded herself as needing to help. If only she tried harder, she would succeed. I saw her as having a major anxiety disorder. She cancelled appointments with me. Sometimes, she frustrated me but I did like her a lot. Yet I was unable to get her to see that this disorder will not get better. I was a gentle confronter. My frustrations, which I felt with her, came under control. I gave her the Caregiver's Bill of Rights and this was a new concept for her. It helped her and it helped me. Gradually she began to see her husband's diagnosis more accurately and to better understand the chronicity



and eventual outcome of this devastating illness. Though she continued to over-function, she appeared to understand that her efforts would not result in his improvement. She was increasingly able to self-care, spending more time doing what she enjoys and spending more time with her children and grandchildren.

## Humor

Although humor may endorse defensive denial, humor may also serve the humanizing supportive engagement between patient and therapist, diminishing the immediacy and threat evoked in the therapist by the patient's situational difficulties.

*Report #7:* I worked with a woman whose husband fell off a ladder and sustained severe head trauma and spinal injury. She blamed herself and struggled with the conflict of whether to leave him or stay. I was drawn into the depths of her conflict. I could not know what direction to support. She had run a business that supported the household and which she gave up to care for him. She became obsessively concerned that he would get an infection from caregivers. She could be very funny, mostly through self-deprecation. Sometimes, I joined her in laughter. Our use of humor did not especially lead to a loss of focus. Rather, it was often a way to encourage her continued self-exploration. I never initiated a humorous aside, but would react to hers spontaneously. I found that our shared humor advanced the therapeutic process. Eventually, she left her husband.

## Projective Identification

In its broadest interpretation, projective identification refers to the therapist's intense experience of affective matter, which is primarily experienced by the patient who however is not aware of this. First described by the child psychoanalyst Melanie Klein (1946), projective identification refers to the infant's unconsciously externalizing to another person hostile internal objects with their associated affects, impulses, and cognitive content. These hostile objects had been internalized into the ego, but actually threaten the unity of the ego. Hence, they are projected outward and are no longer part of the infant's self-experience. Many clinicians have come to regard this process as occurring in people of all ages. When this defense mechanism does occur in therapy, a patient projects aspects of core feelings and conflicts into a therapist. The patient is not aware that this unconscious process is occurring. As

illustrated in the clinical reports below, the therapist then experiences and is tempted to behave in a fashion similar to the conflictual object that the patient had internalized. Put differently, the therapist comes to identify with the projected part (Grotstein, 1994; Meissner, 1980; Ogden, 1979). The recognition by the therapist that this transpersonal process is occurring can lead to enhanced understanding of the patient. The effectiveness of therapeutic work may then be informed by forbearance, compassion, and interpretive effectiveness.

In the following instance, projective identification is recognized by the therapist but does not lead immediately to interpretive effectiveness:

*Report #8:* I was working with a woman in her 50s. Her husband was diagnosed with MS a few years before. She felt completely responsible for her husband and I could not get her to take care of herself. She supported his denial. The husband had issues beyond the MS. One time, she fell and broke her knee cap. He was not willing to help her. She could not express or experience her anger. I felt anger in myself, interpreting it as a proxy for her anger that was repressed. I said, "That must make you angry." That proved of little value. She continued to deny feeling angry.

The following example also shows the capacity for the therapist to recognize projective identification, and likewise shows that doing so does not assure success in therapeutic work:

*Report #9:* I will describe one of my least satisfying cases, that of a physician who in her compliance was quietly difficult. I saw her once weekly for about a year. She came because her husband, a brilliant professor of mathematics, had developed a progressively debilitating neurological disease which was gradually rendering him physically disabled. Their life had become limited in all respects, and she felt guilty about her resentment of his dependency on her and the way it limited her living a full life. She expressed her distaste for his drooling and "eating in a way that looked disgusting." There were few ways he could help with all the tasks that were now on her shoulders, and she was violently angry about how little help there was from anyone in his family. She felt I wasn't helpful: I was just telling her what she already knew. I wondered if she felt competitive with me, resentful of what I appeared to have and needed to defeat me. It was never clear what she wanted from me. When she came, she had said she wanted to talk, but talking wasn't making her feel better. I believed that I was feeling what she was unable to feel—helpless and inadequate. I regarded this as a projective identification that I do not believe I identified for her clearly enough. It seemed impossible to bring it to a surface so that it could be explored. After a summer break, she didn't come back, saying therapy wasn't helping her.

The successful recognition of projective identification leads in the next example to the determined decision of the therapist to content himself with the role of bearing witness:

*Report #10:* My patient was skeptical that his wife had chronic fatigue syndrome. He regarded that diagnosis as buttressing her huge complaints about him and the world. He tended to regard her illness as a passive-aggressive adaptation. I experienced him as afraid of her, as weak and fearful, yet tenacious about the marriage. When I'd point out that perhaps he could stand up to her, he'd say, "You don't get it!" I was frustrated in my therapeutic ambition, a frustration in the countertransference that I believed paralleled his frustration with his wife. Like him, I felt defeated. I did ask him why he was coming to therapy since my counsel was off target. He said that he would feel it a defeat if he left therapy, an attitude that also described why he would not leave his marriage.

It seemed to me that the best I could do, at least for now, was to bear witness to his suffering. Cynicism had become his adaptive attitude. Comments or therapeutic moves that assaulted this cynical attitude were threatening to him. My bearing witness served to provide an external auditor. By my willingness to continue as this man's therapist, I may be regarded as endorsing my patient's cynical worldview. Yet, there seemed little alternative and it did provide a level of stability for him.

When projective identification is adequately appreciated, the sense of mutual engagement is more patently evident. The experience of the therapist may parallel that of the patient. The identification is concordant with the self experience of the patient (Racker, 1968):

*Report #11:* He had come to accept his wife's problem and yet he was afraid that she would die and he would be left alone. He did love his wife. At times, he seemed to be in some denial about her illness. At those times, he tended not to talk about it. He tried to get her to try doing things. When he talked about it, I sometimes had this visceral feeling that part of him was "leaving"—suddenly he seemed so young and vulnerable. When I expressed this, he said, yes, that was how he felt. Mostly, at those times, I felt bad about his feeling helpless, and I also felt helpless. I think there was a parallel process there.

As in report #1 above, the therapist may identify with the ill spouse:

*Report #12:* In the course of treating a couple in marriage therapy, I held several individual sessions with the 50-year-old husband whose wife had been diagnosed with metastatic breast cancer. In the couple's sessions, she

expressed ongoing concerns that her husband was not attentive or responsive to her feelings of anxiety and pessimism. The husband was a highly anxious, obsessional individual, perfectionistic—and with a harsh superego. With his wife he was in persistent denial and always explicitly positive, much like a football coach rallying his team. In response, she would feel unrecognized and unsupported. He loved her dearly and she knew it. I saw his defensive denial as a consequence of his own early history of abandonment and of his helplessness in the face of her diagnosis. I tried to help him see the defenses at work within him. Sometimes it became frustrating. His capacity for empathy was impaired by his fear of losing her. As a result, I could empathically engage with his wife more effectively than he could. I was aware that there may have been a competitive edge to it for me—an acting-in. And, I felt some toward him in my identification with her. Since his empathic engagement with her was impaired and mine was not, it was not surprising that I found myself thinking, “I could be a better partner to his wife.”

Soon after, I discovered that I could put this realization of my own countertransference in the service of my work with him. I could better appreciate how his denial was functioning and empathically join with him to gain a realistic sense of just how ill she was.

My joining with him clearly enabled the patient to be more self-reflective about the essence of his defensive reactions to his wife. This was probably related to a lessening of his needing to unconsciously defend himself against my own unwitting communication of negative and competitive reactions.

## Supervisory Assistance

Turning to a colleague or supervisor to help deal effectively with therapeutic challenges was the approach followed in a problem arising in an erotic transference and countertransference:

*Report #13:* I had been working with a vigorous elderly man whose wife had developed Parkinson's several years earlier. Incorporating magical thinking, he imagined his wife's condition to be psychological. He presented with neck pain that, in the absence of medical findings he believed to be related to unconscious material. He denied it had anything to do with his wife's condition. He was educated and successful in his professional life. When he first came to see me, he was emotionally very volatile. He cried and said, “What if I fell in love with you—I can see that happening?” I said that we'd talk about it. The erotic transference continued and entered into every session. He felt sexually very robust. Though I wondered if there were frontal lobe problems, I also knew his entire life was replete with sexualized issues involving women.

He and his wife had been married 50 years or more. He had had no sexual relations with her for 10 years. He masturbated sometimes and had a prostitute some months before his work began with me. He found his wife's body repellent. *Interviewer: How did his erotic transference affect you?* I was nonplussed and contacted a supervisor wanting help in containing the patient's sexual desires toward me yet doing it so as not to shame the patient. I contained it. At the same time, I found myself thinking a lot more than usual about what I would wear on the days of my sessions with him. I felt flattered. He was distinguished and successful. For me, his attraction to me was frankly seductive. I contained it successfully...I think.

### HOW DO THERAPISTS FEEL ABOUT WORKING WITH SPOUSES OF THE NON-DEMENTED CHRONICALLY ILL?

In this exploration, I considered therapists' experiences in their work with patients whose spouses were afflicted with chronic illnesses that were neither psychiatric, neurocognitive, nor near-term fatal. An early finding during the selection process was the relative non-salience of the caregiving burdens in the experience of therapists' work with spousal caregivers. Therapists who were personally addressed by the author or whose relationship with the author led to review of their practice rolls with these questions in mind discovered that indeed they were working with patients married to chronically ill persons. This may reflect a denial or minimization of the impact of chronic illness that both the spousal caregiver and the therapist share.

This relative lack of salience is noted (report #3) by the clinician who found himself "waiting around for [my patient] to talk about himself rather than [his wife's] disability." Although his patient spoke incessantly about his wife's Parkinsonism, the locus of concern for the clinician is his patient's manic denial and his own willingness to support that denial as a consequence of the clinician's personal family experience with Parkinson's. Similarly, the clinician who recognized that his patient's cynicism was paramount (#10) and whose therapeutic plan moved toward "bearing witness" regarded the matter as characterologic, not situational.

Focus on patient character structure rather than the painful circumstance of that patient's chronically ill spouse is likewise observed in reports #2 and #4. Both clinicians offer supportive help and attend to what the clinician of report #2 describes as "situationally focused dynamic therapy," but both are concerned about what they refer to as "destructive codependence." Codependency is a concept arising from

within the self-help movement and understood in the self psychology literature as counterdependency. In the present context, the caregiver is understood as suffering from profound object hunger and relies desperately on the ill spouse to provide archaic self-selfobject needs (Cooper, 1992; Kohut, 1971). Mahr has applied the term "pathological caregiving" to this disordered pairing of ill spouse and caregiver (2014, personal communication). The therapists of reports #2 and #4 address situational concerns in order to mitigate the expression of underlying character pathology. Of note is that these two clinicians appear to have occupied through many years of their lives the role of caregiver to chronically ill spouses. They expressed more strongly than others in the project a concern about what they refer to as destructive codependence.

The voluntary willingness of therapists to be interviewed, as in any similar methodology, raises the question, Why would they? What is salient about the project that a clinician would be prompted to participate? Of the 11 participants, five had personal experiences with chronically ill relatives. These experiences rendered their feelings with their patients more compelling. Of note is of the five, three clinicians arguably felt a more immediate compassion for their spousal caregiver patients (reports #3, #4, and #5). The therapy provided by the author of report #3 was shaped by his relative's deteriorating Parkinsonism. Marriage to a man with Huntington's disease and a caregiver, herself, shaped the life of the author of report #4 leading to professional work as a counselor to support groups. Likewise, the author of report #5 is the caregiver of a husband with multiple sclerosis.

However, for the therapist having experience as a caregiver to the chronically ill does not necessarily confer concordant identifications and associated compassionate regard for patients who are spousal caregivers. The author of report #1 states that her adolescent rebelliousness worsened her father's chronic cardiac condition leading in her report of the clinical relationship to feel angry with a patient who upsets the patient's ill husband. The author of report #2 had a depressed mother and a wife with back problems. He is keenly aware of "the profound tragedy" of needless caregiving.

Adaptive defensive operations are a ubiquitous constant of psychic operations. For the author of report #6, reliance on an external code, the Caregiver's Bill of Rights (Horne, 1985) provided authority beyond that conferred transferentially in the therapeutic relationship. Other reporters did not turn to an external code relying instead on the transference to provide the necessary authority to say, for example, "It is acceptable for you to feel anger, here." The communion provided by the enjoyment of shared humor was central to the clinician in her report #7. Recogni-

tion that projective identification was utilized as a defensive operation by the patient, that the therapist was a recipient of repressed and projected affect and associated cognition, proved helpful for the authors of reports #8, #9, and #10. The conscious experience of helplessness, experienced symmetrically between patient and therapist characterized the reported aspect of the work of the author in report #11.

As is likely the case with each patient who consults us, our own life experiences impinge significantly in our understanding and approach to our work. The recognition that this is inevitable, that neutrality is a problematic concept, has been a source of consternation and contention within psychoanalytic circles (Greenberg, 2001; Hoffer, 1985; Zachrisson, 2008). The impact of the therapist's past is evident in most of the reports. The therapists fully own that this is the case. The therapists who voluntarily participated had done so largely because its focus touched them. As a consequence, the lessons to be drawn are uncertain. As psychodynamic therapists, we bring who we are to the work we do. So, too, do the therapists who participated. Beyond that tired cliché, a commonality mostly endorsed through a review of the vignettes is the tendency among these therapists to regard their patients' characterological matters as deserving attention, the illness of the spouse serving as a substrate or medium through which these characterological features are highlighted and become the object of therapeutic attention.

### **WORKING WITH SPOUSES OF DEMENTIA PATIENTS COMPARED WITH WORKING WITH SPOUSES OF CHRONICALLY ILL PATIENTS WITHOUT DEMENTIA**

Those patients whose spouses suffer from dementia, regardless of the etiology of the dementia, share a specific commonality: the loss of the psychic integrity of a life partner. The loss is gradual and progressive in most instances. The therapist who accompanies the patient through the decline of the patient's partner likewise endures in concordant identifications with the patient an intensity of painful subjective experiences (Ingram, 2014). The therapist may be struck that the bond between his or her patient and dementing partner can be so profound that the therapist may experience mildly dissociative reactions or denial that the bond could possibly be as strong as it seems. The therapist, seeking to mitigate his or her own subjective distress, may prematurely recommend residential placement for the ill spouse, the introduction of a health care aide, and social outreach. In other words, unable to empathically tolerate the patient's struggle with the anguish of caring



for the demented partner, the therapist too quickly engages in problem solving. Also, the therapist's personal values may be affronted by the well spouse's use of "white lies" or the quest for intimate personal and sexual relations outside the marital union. The most economical theoretical formulation for these difficulties is found in attachment theory. The threat to the bond of attachment occasioned by the dementing process can trigger a protest in the spousal caregiver so intense that it may threaten to become violent.

Where chronic illness occurs, and dementia is specifically excluded, the issues encountered by the spousal caregiver are far more varied than is found among spousal caregivers of demented partners. Similarly, the impact of these patients' caregiving burdens on the therapist is also more varied. The outcome in each instance of that vast array of chronic illnesses further impacts how that illness will be experienced by the ill spouse, the spousal caregiver (who is the patient in therapy), and the therapist. Is the patient on a downhill course leading to psychiatric and neurocognitive difficulties as in Huntington's disease and often multiple sclerosis? Is the course unlikely to be accompanied by significant cognitive decline as in diabetes, ALS, congestive heart failure, or COPD? Is mortality lurking as with metastatic cancer? Put differently, the heterogeneity entailed by non-dementing chronic illness is so much greater than that of a neurocognitive-based dementia that to compare the two groups is troublesome, comparing a basket of apples with a basket containing not only apples, but also oranges, pears, and grapes.

Briefly put, there are areas of overlap in the subjective experience of the two groups of therapists, as Friedman (2014) points out. However, therapists of spouses of the chronically ill non-demented are more likely to be directed toward characterologic issues exacerbated by situational stress. Therapists of the spouses of those afflicted with a dementing process are impacted far more by the circumstances arising from the threat to a primal attachment bond. Whereas counterdependency (so-called codependency) or pathological caregiving (Mahr, 2014, personal communication) is noted to be a finding by the therapists of the spouses of the chronically ill non-demented, this concern never arose among therapists of spouses in the dementia group. In general, the salience or penetrating immediacy of the therapists' experiences in the dementia group is far greater than that of the non-demented chronically ill.



## CONCLUSION

The current exploration is an attempt to elaborate on Friedman's commentary to a prior report (Ingram, 2014). In that earlier exploration, I considered how therapists feel in their work with patients whose spouses were afflicted with neurocognitive disorders leading to progressive dementia. Friedman (2014) noted that the observations in that report may also apply at times to therapists of spouses of the non-demented chronically ill. This follow-up project sought to focus on the extent of overlap. I interviewed therapists of patients whose spouses are chronically ill, but where dementia is absent.

Both explorations depended on the willingness of therapists' responding to listserv solicitations to be interviewed about their work with partners of the chronically ill, each considering respectively partners with and without dementia. The methodology was the same for both. The bias created by the process of self-selection and the limited number of respondents need to be considered in evaluating the validity of both reports.

Nevertheless, these explorations suggest that in general the salience for therapists of patients whose spouses are suffering from dementia is qualitatively different from and greater than the salience for therapists of patients whose spouses suffer from chronic illness without dementia. Whereas therapists in the first group responded with considerable intensity to the attachment threat in their patients to dementia in their partners, the therapists of the second group showed greater interest in characterologic issues that render their patients susceptible to the burden of caregiving. In fact, for this latter group of therapists the burden of caregiving may seem to be yet another expression of life's difficulties that call on the susceptible individual to develop adaptive strategies. By contrast, the existential threat arising as a life partner fades through dementia is the primary factor that animates the therapist's experience in the first group.

To paraphrase a comment of one of the two men I described in the introduction of this article, pushing an otherwise healthy spouse in a wheelchair is altogether different from the sorrowful frustration of a spouse's vacant gaze and from the wracking grief of a loved one's di-

minishment. For the therapist, too, the treatment of the spouse who is pushing the wheelchair is likely to feel different from the treatment of the spouse whose partner is cognitively fading.

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## APPENDIX A

The following is the basic letter soliciting therapists for the project, modified to suit the LISTSERV where it would be appear:

Dear Colleague:

I am researching the experience of psychodynamically oriented clinicians who have worked in therapy with the husbands, wives, or longtime partners of those with significant chronic illness.

My interest is in learning about the experiences that working with "spousal caregivers" can produce for the therapist. What is the impact of the caregiving dimension in the patient's life for the therapist?

This inquiry is directed to therapists working with caregivers whose ill spouses do not suffer from a dementing process. The current research is a companion to a study that considered therapists' experiences with patients whose spouses suffer from neurocognitive impairment. The current study asks for therapists' experiences of patients whose spouses are chronically ill, but with disorders in which dementia is absent. This research is methodologically the same as in the prior study and is drawn from interviews with clinicians. Confidentiality is assured.

In this study, chronic illness is defined as a persistent, possibly progressive, non-psychiatric disorder accompanied by pain, personal, social, or occupational limitation of no less than 2 years' duration. Included is the full spectrum of medical disorders in which neurocognitive impairment is absent.

If you have worked with a patient whose spouse suffers from chronic illness without dementia, I would like to speak with you. Please contact me at [contact information]. Thank you.

## APPENDIX B

The letter soliciting therapists was posted on the LISTSERVs of the following:

American Institute for Psychoanalysis of the Karen Horney Institute and Center, American Psychoanalytic Association, New York Medical College Department of Psychiatry, American Academy of Psychoanalysis and Dynamic Psychiatry, Jack Drescher's LISTSERV, William Alanson White Institute, New York University Postdoctoral Program in Psychotherapy and Psychoanalysis, American College of Psychoanalysts, the Metropolitan Institute for Training in Psychoanalytic Psychotherapy, the New York Psychodynamic Psychiatry Study Group, The National MS Society, and the ALS Association.

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