

ISOLATION, LONELINESS AND ALONENESS IN THE AGE OF COVID-19: REFLECTIONS ON CLINICAL EXPERIENCES

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The Covid-19 pandemic brought a heightened fear of death and illness, and increased experiences of isolation, loneliness and aloneness. In this article we describe clinical experiences of psychotherapists in Argentina, the UK and Germany in order to explore how the impacts of the pandemic are variously felt and mediated by inner resources. We explore the capacity to relate internally to good experiences of infancy and a secure internal world, and the risks of loneliness, and interpersonal and intrapsychic withdrawal, that lead to vulnerability in patients and therapists. We contrast instances where psychotherapy in response to increased fears of death, infection and isolation is facilitative of change and growth, with situations where perverse, destructive or defensive relating predominate. We ask if we are witnessing and, through our therapeutic activities, contributing to the emergence of new ways of understanding the internal conflicts of this Covid-19 age, and tentatively identify some key emerging themes; the capacity for facilitative interactions and change; identifications with the powerful virus; an increase in paranoid anxieties and the potential for a more considerate, ‘care-full’ way of relating.

KEYWORDS: COVID-19, ISOLATION, ALONENESS, ONLINE THERAPY, TRANSFERENCE, COUNTERTRANSFERENCE, SUICIDE

INTRODUCTION

The Covid-19 pandemic brought the immediate fear of death and illness, and through the effects of various social measures – lockdown, quarantine, social distancing – experiences of isolation, loneliness and aloneness.¹ In psychoanalysis, there are different understandings of the concepts of loneliness, isolation and aloneness across different languages, connecting with various psychoanalytic thinking about development. For Winnicott (1958) the capacity to be alone is a core developmental achievement, which depends on the attention and holding capacity of the mother; the capacity to be alone means having a sense of someone – the mother – being present. In contrast, to the capacity for aloneness (in the presence of another),

Melanie Klein's (1963) paper 'On the sense of loneliness' explored the state of internal loneliness arising from paranoid and depressive anxieties, and the pain of processes of internal integration, which involve 'facing one's own destructive impulses and hated parts of the self' (Klein, 1963, p. 304). Adler and Buie (1979) use the term 'aloneness' as marking a developmental failure. Intense painful aloneness arises from early developmental failure, and results in 'a relative or total inability to remember positive images or fantasies of sustaining people in the patient's present or past life or being overwhelmed by negative memories and images of these people' (Adler & Buie, 1979, p. 83). These different formulations have in common the central idea that the capacity to contend with external adversities depends on the reliability of early, infantile experiences that create a secure internal world. The melancholic predicament (Freud, 1917) acquires a specific meaning in the era of Covid-19 through the impact of sudden and dramatic losses of expected routines, and access to others in the social world.

The fear of death was a constant presence, and at the same time, a disavowed feature of the early days of the pandemic and continues to resonate on many levels. Freud's much quoted idea that 'our unconscious ... does not believe in its own death; it behaves as if it were immortal' (Freud, 1915, p. 296) suggests disavowal operating at a societal as well as an individual level. Freud (1923) also recognized the fear of death as appearing in reaction to external dangers and internal processes. He described the fear of death as a development of the fear of castration associated with the sense of guilt. The internal processes that we see illustrated in the Covid-19 experience draw on the realistic (and fantasized) fears of death as they are impacted by internal experiences of self-judgement and guilt.

Experiences of loss and mourning are impacted by the new context of the pandemic and lead to novel formulations, as for example, Massimo Recalcati's (2019) account of 'New Melancholies', adapted to the pandemic (Recalcati, 2020) which includes the idea of a cloistered safety drive, tending to closure and social phobia rather than openness and movement. How these factors affect clinical experiences in the era of Covid-19 is an important consideration for psychotherapy. Are we witnessing and, through our therapeutic activities, contributing to the emergence of new ways of understanding the internal conflicts of this Covid-19 age?

This article discusses case material from three psychotherapists, working in different geographical settings – Argentina, the UK, and Germany – in the wake of the pandemic. Whilst on the one hand, in the global pandemic geographical and national differences were not in themselves significant, and social space – including psychotherapy – migrated to the online sphere, on the other hand, the timing of the pandemic, local differences in governmental responses and cultural expectations had a differential impact. In providing psychotherapy during the pandemic, the different traditions, schools of thought and practice impacted on the way psychotherapists responded. In the case material that follows, both the global and the local factors are important for understanding. The case material encompasses a wide age range; children, adolescents, adults and those in later life/old age. For clarity, we have retained the individual voices of the three psychotherapists in the following

accounts. These presentations draw on clinical experiences to explore the impacts of Covid-19 – how the fear of death and illness, isolation from others, and disconnection from the social world are variously felt and mediated by inner resources. The capacity to relate internally to good experiences of infancy and a secure internal world is contrasted with the risks of loneliness and interpersonal and intrapsychic withdrawal that lead to vulnerability in patients and therapists.

The adaptations, strengths and limitations, of working virtually online are increasingly being considered (e.g., Perelberg, 2021; Sayers, 2021; Isaacs Russell, 2020, 2021). Here we explore the vicissitudes of this work: on the one hand, patients who appear able to feel the sadness and loss brought about through being alone and separated from others, and be soothed/comforted either by evoking images and memories in their minds or by reaching out to others in real-time, via phone or video conferencing. In contrast, on the other hand, there are patients, and moments, where primordial, dissociative and unrepresented states of mind are stirred up, related to the helplessness and uncontained experiences in infancy, and for whom emotional connected psychotherapy is felt to be more difficult and threatening. We examine multiple aspects of the impact of the Covid-19 pandemic and the internal and social aspects of societal responses in different countries throughout the world, considering the potential dangers as well as the potential for growth from these extraordinary times that we find ourselves in.

FACILITATING WORKING THROUGH OF UNCONSCIOUS CONFLICTS, OR RELEASING PERVERSE OR SADISTIC FORCES (CCS)

I focus on two contrasting situations observed in my analytical practice. They were both remarkable because of the deep, significant emotions that were stirred up and the different outcomes that were reached. In the first instance, lively, introspective analytical work allowed child patients and, in some cases, their parents as well, to work through very difficult traumatic situations in their lives. On the other hand, for some patients, a perverse or sadistic aspect became apparent in their approach to the therapist, as they appeared to try to destroy the analyst's helpful, facilitative contact. In both cases, the processes were intense and appeared unusual in comparison with routine psychoanalytic work. These contrasting processes and outcomes are illustrated through the following clinical material.²

Isolation and Solitude as Facilitators of Introspective Unconscious Working Through the Subjective-Most-Important Conflicts

I found, to my surprise, that those child patients who had collaborative parents, and adolescents that were involved in their psychoanalysis, took the isolation through Covid-19 restrictions as an opportunity to work through and resolve long-term, very difficult problems that they had not been able to solve before. For patients who were seen in the traditional setting before the pandemic, the onset of the pandemic and the change of setting appeared to be a catalyst for change through unconscious processes. These changes led to a sense of relief, and it became clear that other family

members, and in some cases, the whole family, also benefitted from these changes. Another very important and surprising aspect for children of all ages was that they welcomed their online sessions. Although the presence of the assisting parent, for example, helping with the camera and technological preparations for the session, disturbed their analytic intimacy and could produce escalating excitement, experiencing this closeness with the parents allowed them to sort out many problems which had been postponed. This appeared to create the situation described by Winnicott (1958) of the capacity to be alone in the presence of another.

In the presence of the analyst, but isolated at home, in their own space, surrounded with their own belongings, I observed that children felt freer and more confident to report what was upsetting them with their parents or siblings compared with the consulting room environment. They stayed focused with no distractions from their need to solve their issues. In cases when they felt they were experiencing an unbearable situation, they asked their parents to call their analyst for help. In various cases, watching how their children asserted their views or rights made the parents think about their long-term problems. This status of family confinement at home and of excitement, despite being conflictual, was an agent of many important individual and family changes which I will illustrate with the following case.

Tina: A 4-Year-Old Girl

Tina was the only child of highly educated parents who was brought for consultation because, from her parents' point of view, she presented disruptive behaviour whenever she was opposed to their wishes. She screamed loudly or threw herself to the floor kicking, punching, spitting, biting or cursing. Mother experienced her daughter as a little rebellious monster and felt exhausted and at her wits' end. Father had a mobility disability since childhood which affected his ability to walk and for which he had repeated surgery. He seemed more tolerant and playful when these events took place. Tina still needed her diaper to defecate because she was afraid of her faeces. She still used diapers at night even though she was able to control urination during the day.

I saw Tina before the pandemic, beginning with two assessment sessions in the consulting room. She was an intelligent, energetic, tiny girl who could clearly communicate her concerns. Tina could not be separated from her mother, who always stayed with her in the consulting room. Her play was always about the idea of carrying heavy burdens, and this seemed to imply an excessive self-demand (Lacan, 1967). She was very self-demanding, trying to show perfect skills in everything, such as climbing, running, speaking, painting and so on, until she felt exhausted. She made me feel tired as well. When I playfully commented on this, she found a tiny baby doll with broken limbs to play with and started walking or sliding on her knees while she played. She then confronted her image in the large mirror in the room in order to check that she was not broken.

I spoke with the parents about the huge responsibilities the girl thought she had, such as having the idealistic motion skills her father lacked, or the obsessive

perfection her mother was looking for. I wondered what would be the scary ‘filth’ or ‘shit’ that they were not able to see and that had to be covered by the diapers. I also wondered why the mother felt impotent when having to contain her child. I asked her how it could be that she unrealistically felt that her cute and tiny daughter was like an uncontrollable monster. Was she projecting something else on to her? After thinking about this, the mother disclosed sensitive information concerning her own father. He had been a sexual abuser with her two elder siblings, but not with her. He always found imperfections to complain about when he arrived home. The children stood still and frightened at the dinner table until he found an excuse to take the elder ones to the bathroom and he either spanked them or abused them, while her mother turned a blind eye and kept making conversation with her as if nothing was happening.

After discovering the uncontrollable monster was in fact her grandfather, during the first year of her once-weekly treatment, the girl felt relieved and her tantrums stopped, although she could still not be separated from her mother. The mother was relieved as well because she felt that she had proven herself to be a better mother than her own mother had been. She was still very sensitive concerning her own issues and Tina’s father was concerned about his own parents’ ongoing over-protectiveness, due to his past disability and suffering. At this point, the girl was the only one in the family in therapy.

There were two very significant moments in Tina’s therapy prior to the pandemic. The first of these was when she was painting with water colours and modelling – trying to solve her faeces problem – and she suddenly stopped and approached her mother who was sitting on a distant armchair. Sitting on the floor and looking at her, Tina asked, ‘Mummy, do you really want me to be Tina, Tina?’ Her mother immediately understood this concern reflecting her daughter’s wish to be allowed to be herself.

The second moment occurred when Tina was enthusiastically driving a train, with all her beloved people, going to a ‘lovely place’. As she placed the dolls inside the wagons, she named them: ‘Mum, dad, granny, doggie, cousins, aunties, Casilda’. There was someone missing, so I asked: ‘And what about grandpa?’

‘Oh! We’ll throw him into the river!’ she answered.

‘And does he know how to swim?’ I asked.

‘No!’ She happily answered and went on playing.

These two moments eloquently revealed her two crucial wishes: to be allowed to be herself, and her need to be rid of the burden of her grandfather’s ominous presence in the family’s history.

Despite the pandemic restrictions I was able to continue working remotely, with the child’s parents helping with the camera. I was surprised how facilitative these remote sessions appeared to be. Tina stopped using diapers at night and was proud to become an independent 5-year-old girl who got up at night and wasn’t scared to go to the bathroom by herself. At home, she also practised many female

identifications by dressing up in different costumes including a cook, Wonder Woman, mother, dancer, skater, her teacher as well as a number of female cartoon characters. She carefully showed every character, or her concerns, to me during her sessions. She became very fond of her father. She also began investigating her own body and sexuality with great enthusiasm. All of Tina's changes made her parents feel more confident in terms of their parenting abilities and this served as a model for their own need to change. Mother decided to continue her previous personal therapy to solve her fears about the abuse, and the father decided that he too needed psychotherapeutic help.

Tina's mother was not very keen on being separated from her daughter when schools reopened, especially since they had created a solid, pleasurable bond within the family. She thought that Tina would prefer staying at home with her because of the newness of starting primary school. This issue of separation was the focus of an in-person session following one year of isolation and remote therapy.

On arrival at my consulting room, Tina hid behind her mother. I interpreted this as her performance of what she felt in her out-of-home world. Then she decided to pop out from her hiding place to greet the cat which had sometimes represented a transitional object (Winnicott, 1953) to cope with separation. As we entered the consulting room with her mother, she immediately ran and held her favourite toy puppy tightly, and then they both dived into a huge mattress-style cushion and pretended to rest, like babies inside the mother's womb. I told her this represented what she had experienced at home and wished to preserve. Then, she looked at herself in the mirror smiling and showing all her brand-new teeth. She had lost all her upper and lower front baby teeth very quickly and the adult teeth had grown during the last months. We spoke about her fear of destabilization because of the many changes she was going through, including a new school and new friends.

She got up to check the shelf, noticing some new plush toys. She took them one by one and, laughing and seeking complicity, she made each one break wind. Then, I mentioned that she might have felt protected like a little baby when she was isolated with mum and dad at home, but she had also felt uncomfortable, with excessive pressure on her shoulders and her body. Therefore, meeting new pals, in a new school, would be a relaxing experience not only for her but also for all children. She was happy about this project. She embraced my views and then she held a toy bear and gave it to her mother. We agreed that she was concerned about her mother staying alone at home without her and that she was giving her the teddy bear to comfort her now that she didn't need to be comforted herself. They both understood: the situation had shifted, and Tina was happy to enter her first grade of primary school.

Renée: Fantasies of Horror

The example of Renée, a 50-year-old woman, illustrates a more sinister and destructive way of relating. Renée called the Argentine Psychoanalytic Associations (APA)'s COVID online Help Centre, telling the psychiatrist who took the phone

call that she needed to know how to help her son who lived far away from his mother in a different province. I was then informed that the time she wanted to talk was after her afternoon nap, so I called her that evening. Renée seemed calm, but competitive, taking an academic tone in her speech. She informed me that she had been an experienced teacher. She spoke about her concerns regarding her son and how she wanted to pay him a visit because she felt that he was deeply depressed, but this was not allowed under the current restrictions. I asked about her fears, and I also asked if there was anybody staying with her son, or if they could arrange an urgent medical assessment for him. I strongly recommended her to follow these protective steps. She said that she was going to talk to him, and I said I would get back to her the next day after she had spoken with him, and we would see how to sort things out.

When I called her the following evening she said: 'It's too late, my son has already committed suicide'. She blamed me for not calling her in the morning because she insisted that an early call with assertive instructions would have prevented her son's suicide. I tried to help her cope with the situation, in every possible therapeutic way, over a very long phone call. Eventually she said that she had lied about her son committing suicide. Her son was alive, and she had invented this weird story because she was angry with me for not having called her immediately after our first telephone interview. She continued, in an angry tone, to urge me to sign a referral for her to be able to attend other well-known free therapeutic services. Renée said then that she had been turned down by several services before. I recommended that she request psychiatric help from her medical insurance service.

The similarity in both cases was the feeling that death was just around the corner, and could reach anyone, anywhere. In her panicky response, indicating a lack of internal resources, Renée appears to convey her utter helplessness in the face of something inexplicable, as perhaps is implied by Freud in his discussion of castration anxiety, as discussed in the introduction, above. The quality of Renée's isolation from the everyday three-dimensional world thus seemed to produce a dream-like state, and an illusory or mnemonic regression, as if to the womb. This kind of deprivation can lead to poor sensual feedback and tends to frustrate the network of erogenous satisfactions that in-person relationships bring to our lives. The inability to tolerate these anxieties led to increased use of defences of splitting and projection in order to get rid of the stirring and ongoing 'real' (Lacan, 1953–54), or the sense of a disturbing/disturbed presence or object inside them (Freud, 1917, 1920). Renée's disturbed response to the fear of death, isolation and disconnection from others, the key theme of this paper, appears to show an angry rebellion against the intolerable sense of confinement and separation from her son, as well as her reaction to feeling dismissed by the various social services before she called the APA service. Whilst from this brief contact it is not possible to accurately analyse her experiences of infancy, we can however suggest that an absence of a truthful, containing parental presence might have affected her capacity to think about overwhelming anxieties.

Recalcati (2020) described this as a new kind of melancholia, a cloistered drive tending to closure and social phobia, as opposed to openness and movement.

The new melancholia tends to social distance and isolation, with the main aim of obtaining security. It is an anti-drive driven drive which, in the name of radical boundaries, immunity and security is mainly a death-driven drive dominated by the obedience to the superego's commands. It tends to Nirvana and would work inside us as the pleasure principle, just like drug intake inhibition does. Under these melancholic circumstances, Recalcati proposes that the analyst should be mainly focused on the transference and the countertransference, as a witness of life or liveliness, mainly surviving the anxiety existing within the encounter with the other.

Tina and her parents were able to access the possibilities and make use of the analyst to facilitate working through of unconscious conflicts. Disturbed or perverse patients, such as Renée, were incapable of tolerating or addressing their problems of self-destructiveness by themselves and were unable to transform them. Therefore, they found new ways of getting rid of them by means of projection and denial mechanisms (Ahumada, Olagaray & Richards, 1997; Casado Sastre, 2019). Although the manipulation of the analyst and attempts to exert power were to some degree conscious, it appeared they unconsciously identified with the powerful virus.

SHARING SPACE WITH THE VIRUS CONTENDING WITH THE AMBIVALENT 'COVID INTERNAL OBJECT' (SB)

The need to get rid of overwhelming anxieties, through increasing use of splitting and projection, impacts powerfully in the therapeutic relationship, and in these circumstances holding ambivalence becomes intolerable. The following case example (Briggs, 2021) illustrates and develops further the idea of identification with the powerful virus such that the fear of the powerful virus was played out in the transference and countertransference relationship. This vignette took place at the beginning of the pandemic when the requirement to stay at home, in lockdown, was quite suddenly implemented. At this point in time, the fear of death and infection was in the air everywhere, appearing to be beyond comprehension.

Sally, as I will call her, was a woman in her 20s. Over some months in her once weekly therapy, she had developed – not easily – a sense of having a place safe enough to help explore her difficulties. At the start of the pandemic, she became suddenly overtaken by fear of the virus. She said she had not thought about it at all until travelling to her session with me that day, and when she did recognize the threat, she became terrified. Internal and external anxieties became confused and amplified; these included not being able to sleep, conflicts in her family relationships, and those in her workplace, about others making demands on her. These now merged with the fear of the threat she felt in the streets and on public transport. After speaking about these anxieties, she withdrew, taking flight, not, it seemed, from the virus, but from her objects, including me. As she stared out of the window of the consulting room, out on the streets she had felt were so dangerous, she seemed helpless and immobilized. She conveyed wishing to be outside, to get away, but also transfixed by the danger of the streets. I had the thought she seemed to be trying to see the virus.

It seemed that she felt she had brought the dangerous, virus-permeated world into the room, and it was out of her control, and, alongside this, it seemed the source of the danger became located in me. This was not expressed directly as the idea that I might be infected, knowingly, or unknowingly, and therefore could infect her. I started to feel very uncomfortably that I was the virus or at least its transporter. As I thought about this, I felt strongly that I wanted to disown and repudiate the idea that I could be a harmful object, in this way; I felt pulled away from my therapeutic position. After an internal struggle with these thoughts, I said to her that it felt as though the virus might have got into this room. I spoke about her sudden realization of the threat of the virus, and she did not know what or who was safe, so all her anxieties, internal and external, felt merged and confused. It was hard to try to differentiate between the different sources of these, I added. This intervention did seem to provide some temporary respite, perhaps for both of us; some space to think about how to manage the external situation of threat, and the problem between us, of how to deal with an invasive factor that impacted immediately and profoundly on our relating.

However, there was an immediate problem, of how to separate from me and manage her return home after the session. From her side it was a question of how she could manage a journey she did not want to make and of which she was very fearful. For me, it was a question of what care I could provide for her, recognizing her anxieties and the realities of viral infection. As the end of the session approached, she was palpably overwhelmed, both wanting to get away and fearing returning to the terror provoking streets.

The next time I saw her – on the screen in a video call – she was less anxious; she said she felt safer indoors. However, I was now in the role of an intruder on this refuge, and, as she put it, a reminder of how bad it was outside. Her temporary solution was to be alone, rather than to feel invaded and overwhelmed by others, a withdrawal that was inevitably very limited and limiting, and one which increased her fear of being alone, not as Winnicott (1958) described being alone in the presence of another, but as loneliness, achieved at the cost of the loss of the integration of internal good or benign relatedness. For Sally, the intense confusion could only be resolved, for now, as a retreat from the external world, but at the cost also of a retreat from her objects. The overriding need was felt to be the reduction of her paranoid anxieties.

The anxiety about Covid and its effect on changing the quality of relationships takes some shape in this vignette. We are contending with the fear of infecting and being infected, changing how we share space (Britton, 2003). There is a real danger, for which anxiety – signal anxiety (Freud, 1926) – is a realistic response. However, at another level, there ensues a struggle to make sense of the new experience and to find a position. There is a pressure to defend, disavow, hold on to the way things were and, alternatively, to completely run away. Sally seemed unable to draw on internal objects that could protect her, and they became questionable as a source of help. She was less overwhelmed when she had retreated to stay at home, and to repudiate being in the world of others, but this incurred losses, including the

re-evaluation of her therapeutic space with me, the safety it previously provided, and its protectiveness, and her trust in this. The fragility of her trust in good objects, and the quality of her defences, appear to be factors that limited her capacity to relate to others when anxiety is high, as here, faced by fear of infection and death, and suggests a limitation of her internal resources.

Responding to the pandemic changed the way we share space with others, both literally, physically, and in our inner worlds. Ron Britton discussed the issues involved in sharing space with another. 'We live and move in physical space', Britton (2003, p. 165) wrote, 'yet it is also psychic space; its perceived shape and size is an extension of our state of mind'. Britton was thinking primarily of how internal states impact the way we see the physical world; here we need to add that physical space, its characteristics, especially at extreme moments, influences psychic space, changes its shape and features. There is always a muddle of material and mental space, 'mental mixing', which is experienced as 'phantasy rich perceptions of physical space' (Britton, 2003, p. 165). In the pandemic, psychic spaces were changed by the qualities of the 'Covid-object', introducing a new kind of ambivalence characterized by the contradictory pull away from others, to create social distances, and yet also towards others, to seek comfort and containment for anxious states. Thus, there arose a new dimension to the problem of sharing space, where mental mixing becomes a new confusion of good and bad, of loving and protecting versus infecting and being infected, or, as in the case of solitariness, an intense internal relatedness to absent objects, mitigated to an extent by online contacts.

How we share space with each other socially in the pandemic has been – and remains – of fundamental importance. Recognizing the capacity to infect and be infected, social distancing excludes physical closeness, touching and being touched, both in the closure of the social world in lockdown and in the complex arrangement for reopening the social world. The turn to virtual space as a way of mitigating the dangers of social contact has led to different norms for sharing space, through the cinematic, *not*-embodied qualities of the screen. Not only has our way of sharing space with each other changed, we all share space with the virus, this invisible, deadly and unrepresentable ever-present; it is Covid that invests all of us with the contents of its 'talismanic significance', to use Britton's phrase, referring to sharing space with others and applying it to this different context: 'that territory imbued with another's ideas, that room invested with someone else's good intentions, that couch or bed saturated with the other's desires, that domestic arrangement requiring acquiescence' (Britton, 2003, p. 165).

The first characteristic of the new, Covid-influenced internal object is that it is a paranoid object that recognizes, responds to, and defends against the dangerous ways in which we can infect others, and be infected by them. As online or remote therapy became established, some new kinds of interactions emerged. Patients began to ask how I was at the beginning of sessions, and this involved both a relaxing of the frame, and a genuine communication of a shared experience. Was I alive? Well? Or infected? Rosine Perelberg (2021) records something similar in her work. This seems to shape a new 'care-full' way of relating, which I suggest is the second

aspect of the 'Covid object' in the internal world. Perhaps uniquely in this regard, in the pandemic patient and therapist were on equal terms; the fact is out there and known, and cannot be shielded from the patient; the patient knows we are living through it too. The configuration of paranoid and 'care-full' aspects produces a range of outcomes. Patients were grateful for the continuity of their therapy, when the capacity to bear and face the losses incurred led to discovering new ways of being and relating.

OLD AGE, PANDEMIC ISOLATION AND SOLITUDE AND THE RECOGNITION
OF SEPARATION AND CONNECTEDNESS (RL)

The elderly have been particularly affected by the general restrictions on social activities to combat the Covid-19 pandemic that include quarantine measures, requests to stay at home, restrictions on direct social contact, and wearing protective masks. These measures often lead to an experience of isolation, solitude, and feeling abandoned. An intrapsychic state of disconnectedness even to the point of absence of internal objects can occur under certain conditions, which may provoke suicidal defensive thoughts and actions. In the case example that follows, I will explore how a more 'care-full' way of relating arose through negotiating the impacts of Covid-19 on the therapeutic dyad. In this, I ask whether the hypothesis named by Casilda Casado Sastre can also apply to psychotherapy with old people, namely that isolation and feeling left alone can serve as facilitators of introspective unconscious working through of subjectively significant conflicts?

On Tuesday, 17 November 2020, I had a test for SARS-CoV 2 because I suddenly developed a significant cold the day before. The following day, I received the positive test result and an order from the health department to quarantine for 14 days all of my patients and supervisees that I had been in contact with during the past 48 hours. Among the patients and supervisees, I had seen the previous day was Mr H., a 90-year-old man whom I had visited in his home for 50 minutes in his large living room without a mask. The fact that I visited him at home perhaps needs some explanation. Firstly, it was a compassionate way to provide therapeutic help for someone who would not be able to visit a clinic, and, secondly, at this point in the pandemic, in the country where I worked, Germany, these visits were allowed in these circumstances of the patient's manifest and many vulnerabilities.

Mr H. is severely disabled with multiple medical conditions. He lives alone, but usually gets together with some friends of the same age during the week. I have been working with him for seven years in fortnightly visiting and supportive psychodynamic psychotherapy. In this long period of time, we have approached the recognition of an early experience of loss by his father shortly after World War II, and thus, very slowly, of his lifelong warded off neediness, especially of a massive experience of early childhood loss. Just in the session before I fell ill, he told me he had thought a lot in the last weeks and realized that 'I am traumatized, dragging a severe psychological problem through life with me, myself, and can't always just think of others (his daughter-in-law) who are sick'.

I was unable to contact Mr H. for two days because he did not pick up my calls. During this time, I developed a great fear about possibly having infected him and felt guilty for not having protected him. I imagined he could already be seriously ill in the hospital or even suddenly deceased. I finally reached him after two days of trying and told him of the need for a 14-day period of quarantine. When I contacted him again a week later, he reported that he was healthy, had no symptoms and said, very empathetically, that he had also wanted to call me to find out how I was doing.

The transference about caring for the sick therapist became more explicit in the following months. Mr H. had been involved in a decades-long family conflict with his eldest son, who he saw as taking the 'wrong wife', a woman he felt did not fit into the family, who drew his son away from the family orbit. With the lockdown that started in March 2020, he became increasingly isolated, his health deteriorated with incontinence, a leg vein thrombosis and an increase of an itching urticaria that interfered in his ability to sleep at night. The conflict with his son worsened. He felt he needed his son more and more and resented and verbally attacked his daughter-in-law to the point of causing his son to break off contact.

On the other hand, in his attitude towards me, the 'transference son', he was able to show interest and even caring, in addition to the increased neediness which was also present. I learned that he had thoughts of suicide when his son broke off contact, initially as a fantasy of punishing the son by his death. However, a few weeks later, his brother-in-law died by suicide in an old people's home, and Mr H. told me that he would not kill himself because his principle of life was his own independence and that of others. He said that if he killed himself neither he nor his son would be independent. He would pass on his misery to his son and destroy his son's independence as he would remain bound to him in his ongoing self-reproaches.

It seems that an internal process was developing along with the social lockdown. Mr H. had begun to be aware of his own neediness, and felt he could begin to turn to me, for relief, through the therapeutic relationship. Due to the pandemic, my own illness and the fact that he had to be quarantined because of seeing me face-to-face, an inner process began in which Mr. H. could recognize a mutual dependency without having to give up his ideal of independence. These events surrounding the pandemic, as well as the trauma of his brother-in-law's suicide enabled him to tolerate an ambivalent state between striving for independence and the recognition of commonality and connection to others in life.

Mr H.'s physical health deteriorated further. He was ever more frail, and that increased his sense of neediness. On the one hand, he projectively warded off these feelings through his resentment and rejection of his son. At the same time, his altruistic caring and connection-sensing feelings aroused in his experience of his therapist's illness, thwarted his narcissistic suicidal regression, and produced a compromise that allowed him to survive. He acknowledged his neediness by describing himself as traumatized, while at the same time, he remained bound to an autonomy ideal of wanting to live and die independently. He found a tolerable compromise. He would not kill himself out of revenge in order to harm his son. In so doing he preserved both his own and his son's sense of independency. By not

killing himself he would not be placing the burden of his feelings on his son and on his therapist. Instead, he got help. He went to his doctor, received a remedy for the nighttime skin itch, was able to sleep better and coped better during the day, feeling more awake and stronger. He also continued contact and exchange with his therapist and experienced the positive therapeutic connection.

The isolation and the common danger to which patient and therapist were exposed led to a compromise solution with a partial recognition of his attachment to other people: He felt empathy with the therapist, and in fantasy also with his daughter-in-law and son: 'that we are all traumatized'. He was thus able to transform excessive necessity of autonomy into a healthier separateness. Out of it, he was able to let go of the suicidal revenge fantasy and, rejected the phantasy of fusion in feelings of revenge and guilt. He refrained from suicide and took care of himself. The positive therapeutic alliance developed over many years protected his autonomy as well as his vulnerability.

Psychotherapy takes place in real contexts, which naturally activate the neurotic conflicts and relational patterns. We cannot hide the reality of the external world, but we can try to understand its meaning in the context of its influence on the inner world of the patients and support the patients to deal with this reality, as well as the reality of interdependency and existential separateness from each other.

CONCLUDING COMMENTS

The Covid-19 pandemic created intense anxieties, driven by the fear of infection and death, following the wide-scale disruption to the routines of the global social world leading to isolation, aloneness and loneliness. In this paper we describe the experiences of three psychotherapists working in three different countries and illustrate this work with case material across the life cycle.

There was clear commonality across the different geographical settings; all were involved in the same global pandemic. At the same time, we show some differences in the contexts, the disparities of local practices which nevertheless shared the common aim of reaching out to patients in difficult times, and adapting new ways of working. We set out to illustrate the different – even disparate – ways that patients and their therapists encountered, addressed and managed the onset of the pandemic. We thought that the fear of death and illness, isolation from others, and disconnection from the social world during the pandemic would be experienced in different ways and organized by the qualities of inner resources. We worked on the psychoanalytic premise that these would have a strong relation to, and be rooted in experiences of infancy. In effect, we found this was true of the cases presented here; the anxieties and fears of death, illness, isolation and disconnection appeared to stir up very different kinds of anxieties and defences, which strongly indicated underlying, internal structures in these patients.

We have also shown that it is possible to work with the constructive aspects of patients' inner worlds to facilitate change and growth in the new circumstances of the pandemic, including the online setting. In contrast, we highlight the potential for

destructive, perverse or defensive ways of relating to the psychoanalytic setting. There are connections between the material generated by these psychotherapists working separately in different parts of the world; the capacity for facilitative interactions and change in response to the fears of death, infection and isolation; identifications with the powerful virus; an increase in paranoid anxieties and the potential for a more considerate, 'care-full' way of relating. We witness and, through our therapeutic activities, contribute to the emergence of new ways of understanding the internal conflicts of this age of Covid-19 age and follow Recalcati in suggesting that some of these characteristics are likely to endure.

NOTES

1. This paper was initially presented as a Panel discussion at the International Psychoanalytical Association Online Congress 2021 (originally scheduled to take place in Vancouver, Canada).
2. All clinical material in this paper has been fully disguised.

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