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Families facing a loved one's illness

Living with illness in the couple: *Clinical reflections from a Special Interest Group*

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Summary

This paper presents clinical insights and theoretical reflections from a Special Interest Group (SIG) on Illness, Couples, and Couple Therapy, founded by Christopher Vincent in 2019. Through the contributions of four members, the paper explores how serious illness disrupts couple functioning and evokes powerful emotional dynamics in therapists. Drawing on psychoanalytic thinking, particularly object relations theory, and reflecting on personal and clinical experiences, the paper highlights the unique role of the SIG as a space for containment, creativity, and the integration of personal and professional meaning. We have

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chosen 4 topics for this paper including dementia, suicide, therapist vulnerability, societal context, and the interface of clinical and personal experience.

Keywords: illness, couple functioning, the group as container, dementia, suicide, therapist vulnerability, intervision, an ethic of presence.

Résumé. *Vivre avec la maladie dans le couple:* réflexions cliniques d'un Groupe d'Intérêt Spécial

Cet article présente les perspectives cliniques et les réflexions théoriques d'un Groupe d'intérêt spécial (GIS) sur la maladie, les couples et la thérapie de couple, fondé par Christopher Vincent en 2019. À travers les contributions de quatre membres de ce groupe, l'article explore comment la maladie grave perturbe le fonctionnement du couple et évoque de puissantes dynamiques émotionnelles chez les thérapeutes. S'appuyant sur la pensée psychanalytique, en particulier la théorie des relations d'objet, et réfléchissant sur les expériences personnelles et cliniques, le document met en évidence le rôle unique du GIS en tant qu'espace de contenance, de créativité et d'intégration du sens personnel et professionnel. Nous avons choisi quatre thèmes pour cet article : la démence, le suicide, la vulnérabilité du thérapeute, le contexte sociétal et l'interface entre l'expérience clinique et l'expérience personnelle.

Mots-clés: maladie, fonctionnement du couple, le groupe comme contenant, démence, suicide, vulnérabilité du thérapeute, intervision, éthique de la présence.

Resumen. *Vivir con la Enfermedad en la Pareja:* Reflexiones Clínicas de un Grupo de Interés Especial

Este artículo presenta reflexiones clínicas y teóricas de un Grupo de Interés Especial (GIE) sobre Enfermedad, Parejas y Terapia de Pareja, fundado por Christopher Vincent en 2019. A través de las contribuciones de cuatro miembros, el documento explora cómo la enfermedad grave altera el funcionamiento de la pareja y evoca poderosas dinámicas emocionales en los terapeutas. Basándose en el pensamiento psicoanalítico, en particular en la teoría de las relaciones objetales, y reflexionando sobre experiencias personales y clínicas, el documento destaca el papel único del GIS como espacio de contención, creatividad e integración del significado personal y profesional. Hemos elegido cuatro temas para esta ponencia: la demencia, el suicidio, la vulnerabilidad del terapeuta, el contexto social y la interfaz entre la experiencia clínica y la personal.

Palabras clave: enfermedad, funcionamiento de la pareja, el grupo como contenedor, demencia, suicidio, vulnerabilidad del terapeuta, intervisión, una ética de la presencia.

Introduction

Christopher Vincent is a Consultant Psychoanalytical Psychotherapist who founded this Special Interest Group in 2019. The SIG is an international online forum that fosters discussion and collaboration among mental health professionals working with couples and families affected by severe medical conditions. Its aim is to expand our understanding of how serious illnesses interact with couple functioning and to provide a setting where clinical work can be shared.

The group emerged from a growing recognition that serious illness affects not only individuals but also couple and family relationships Since its inception the SIG has provided a space for clinicians to reflect on the interface between illness and couple functioning, to share clinical material, and to build a theoretical and emotional understanding of the complexities involved. Now, with over fifty meetings held and a broad range of topics explored, the group continues to offer a container for rich and often difficult discussions that lie at the heart of human vulnerability.

Although the SIG primarily employs psychoanalytic perspectives, with a strong emphasis on object relations, there are also other theoretical perspectives, which add to the richness of our explorations. The SIG has engaged in diverse and clinically relevant discussions, reflecting the multifaceted impact of illness on couple relationships. Some of the central themes explored have included:

- Breast Cancer
- Chronic fatigue syndrome
- Couples and Early-Onset Alzheimer's Disease: *A case study on navigating relational shifts following a diagnosis at age 64*
- COVID-19 and Couples: *Early reflections on pandemic-related stressors in intimate partnerships (discussion dated January 14, 2021)*
- Death of a child
- Diverse patterns of partnering and their interface with health
- Daughters' Experiences of Maternal Dementia: *The psychological and relational implications of caregiving within families*
- Early and late onset Dementia and Caregiver Burden: *The impact of cognitive decline on couple relationships*
- Ethical and Emotional Dimensions of Assisted Suicide: *The relational dilemmas faced by couples in the context of end-of-life decisions*
- Facing terminal illness: illness, death and dying
- Feeling Apart: *how illness contributes towards dislocation and loneliness*

- Health Challenges for Older Women: *The unique experiences of aging women within intimate partnerships*
- Head injury and Stroke and Couple Functioning: *How sudden neurological changes redefine relational dynamics*
- Intersections of Illness and Domestic Abuse: *How health vulnerabilities influence power dynamics within relationships*
- Multiple Sclerosis
- Neurodiversity: Autism, ADHD and ASD
- Parkinson’s Disease and Relationship Adjustments: *The evolving roles and emotional struggles within couples*
- Rare Neurological Conditions and Genetic Counselling
- Sexual Intimacy and Illness: *The complexities of maintaining physical intimacy amid serious medical conditions*
- The Role of Grandmothers in Caregiving: *Intergenerational caregiving responsibilities and their impact on couple functioning*
- The Therapist’s Experience When a Client Commits Suicide: *The professional and personal impact on clinicians*

In this paper, four participants from the SIG share reflections and clinical insights. The voices are distinct but connected, each bringing a personal and professional lens to the work of the group. The paper weaves together personal experiences, theoretical perspectives, and case material to explore how illness shapes, challenges, and sometimes transforms intimate relationships. It also considers how such work affects us as therapists: how it stirs our own vulnerabilities, calls for robust containment, and invites moments of deep human connection.

The group as container: A personal view

I had been aware of the group’s existence but only joined during lockdown, when I was unable to participate in my usual activities and was therefore unexpectedly available at the time the SIG meetings took place. I always thought that once lockdown ended and life went “back to normal”, I would stop attending and go back to what I used to do pre- lockdown. I approached Chris Vincent tentatively, wondering if it would be all right to join the group on that basis. He responded in the warm, welcoming way which I subsequently learnt was so characteristic of him and which reflected the ethos of the group—open, inclusive, and deeply respectful.

So, what began as a tentative exploration turned into an enduring commitment. The word “special” in the group’s title doesn’t just describe the shared interest and focus on how couples are affected by illness. It also describes the unique nature and quality of the group, which is indeed special.

Why is this SIG so special? Working with long-term physical / neurological conditions that are sometimes chronic and sometimes terminal, poses particular challenges for the clinician. Illness puts us in touch with our own vulnerabilities and limitations. One could argue that illness is a narcissistic wound. There are similarities between illness and the ordinary process of ageing, when our body gradually begins to let us down and we are forced to face the reality of our own mortality and the inherent loss of our younger, stronger selves. As the actress Bette Davis once reportedly stated: "Getting old is not for sissies". But we could expand on Bette Davis' comment and say that illness and working with illness is also not for sissies. Perhaps what makes this kind of work particularly challenging is that the feelings that need thinking about, processing, understanding and containing sit at the interface of the personal and the professional.

Discussion in the group has always reflected this, with comments and exchanges moving easily between clinical and personal experiences, both past and present. This is not a collapse of appropriate boundaries, but rather, reflects an organic process that gathers momentum during the discussion of papers and clinical presentations; and not unlike the process of free association, results in a richness of material that reflects members' lived experiences of the clinical and the personal. We could describe it as personal experience within the clinical context; or, as a colleague suggested, "intra-vision" rather than supervision; an internal, inside look at what goes on for each of us when working in this challenging area; an inward gaze that explores what goes on within each of us as we engage with the suffering of our patients.

The organic nature of the SIG's process is illustrated by the way in which we often arrive at the next topic via the discussion that has just taken place. It is not unlike embarking on a journey without knowing its final destination point, which brings to mind Kafka's parable, "My Destination", quoted below.

I gave orders for my horse to be brought round from the stables. The servant did not understand me. I myself went to the stable, saddled my horse and mounted. In the distance I heard a bugle call, I asked him what this meant. He knew nothing and had heard nothing. At the gate he stopped me, asking: "Where are you riding to, master?"

"I don't know", I said, "Only away from here, away from here. Always away from here, only by doing so can I reach my destination."

"And so you know your destination?" he asked.

"Yes," I answered, "didn't I say so? Away-From-Here, that is my destination."

"You have no provisions with you," he said.

"I need none", I said, "The journey is so long that I must die of hunger if I don't get anything on the way. No provisions can save me. For it is, fortunately, a truly immense journey."

The SIG has been such a journey – without a clear destination, but full of discovery. It has helped me understand not only my patients but myself, as a person and as a clinician.

Like all meaningful conversations, the SIG's evolution has been driven less by agenda than by appetite – by what lingered after the silence, what someone couldn't quite let go of. It reminds us that psychoanalytic inquiry is always provisional, always becoming. We don't so much decide where to go next as find ourselves there, compelled by what speaks to us. From this open-ended process emerges our next exploration: the bond between daughters and their mothers in the disorienting landscape of dementia, where loss is never just loss, and remembering is not always the point.

Daughters and mothers: The challenge of dementia

In this section we turn to the contribution of a SIG members who undertook research into the experiences of daughters whose mothers have dementia. This small qualitative study revealed profound emotional complexities: grief, confusion, and a yearning for connection. For many daughters, dementia was not only a loss of the mother they knew but a confrontation with societal fear and silence around ageing and cognitive decline.

This qualitative study strikingly highlights the way in which societal narratives infiltrate the personal experience. Dementia is often portrayed as a loss of self, a void. But for some daughters, there were unexpected moments of tenderness and renewal – a new way of relating that did not depend on memory or language. Therapy can help daughters make meaning of these experiences and support them in forging new emotional bonds with their mothers.

These insights have direct implications for clinical practice. Therapists need to be alert to the cultural framing of dementia and its impact on clients. They must also advocate for services that support not only individuals with dementia but their families. As Maciejewski (2001) argued, we must "communicate the value of psychological perspectives in dementia care."

How do daughters experience having a mother with dementia?

Seven daughters who were not living with their mothers were interviewed, their ages ranged from 50 to 66.

The mothers' ages were from 78 to 90, they had a range of dementia diagnoses and time since they had been diagnosed. Interviews were audio recorded and conducted using a schedule of 20 guiding questions, which included "open" questions. The research questions were broad to allow topics or themes to emerge during the interviews and analysis (Smith, 2004).

The following are two examples from the interview schedule

- "Can you tell me how your mother's dementia has affected your life?"
- "Can you tell me how your mother's dementia has affected your relationship with her?"

Main themes and sub themes emerged during the analysis (see table below).

Main themes	
Bewilderment and Fear	**Transformed Relationships**
Sub themes	**Sub themes**
Resisting Knowing	Contrasts
Confusing Behaviour	Feelings Regarding the Transformed Relationship
Uncertainty	Lost Connections
Professional Help; Absent and Disengaged	New connections

Table of Themes

Examples from the theme of Bewilderment and Fear

The extracts below were taken from an article outlining the research. [For further themes and the research, see the full article (Finill & Tribe, 2017)]

Resisting knowing

Four of the daughters talked about the different ways they resisted knowing that their mother's difficulties were symptoms of dementia. Susan and Natalie's bewilderment, fear, and resistance is evident in the following extracts. Susan noticed how her mother asked the same questions four or five times. Instead of thinking that there may be a difficulty that needed acknowledging, she says:

> *At first, I didn't sort of pick up on it… I mean, it's at the back of your mind, but you don't want to really think… (Susan)*

Natalie commented on her mother's confusion as follows:

> *We were all in denial. (Natalie)*

Balfour commented as follows, «In a sense, we may all share a tendency to wish to deny something felt to be so unbearable» (Balfour, 2007, p. 225). This may explain, at least in part, why some daughters resisted acknowledging changes in their mothers.

Uncertainty

Daughters gave examples of their uncertainty around their mothers' dementia. Maggie, Natalie, and Carol anticipated a fearful future in which they would not be able to manage situations around their mothers' dementia and they expressed the extent of their anxiety in the following way, "worry terribly", "constant worry", and "dread the phone ringing".

Professional help; Absent and disengaged

Almost all the daughters found NHS professionals to be absent and disengaged for their mothers and they themselves were not offered support. A possible reason for the difficulties regarding mothers being inadequately supported might be one that Balfour (2006, p. 341) proposes in that «Without containment and support, they [the staff in institutions] can find themselves acting in ways that echo the difficulties of their patients». It may be that the staff were not supported and contained adequately and this led them to experience a fear of dementia and a lack of capacity to adequately support many of the mothers in this study. A greater understanding of the difficulties that professionals experience when working with people with dementia and their families may also lead to improvements in the quality of care offered.

Although the focus of this research is on individual daughters, it seems likely that if psychological therapy was widely available for those with dementia, the experience may be less distressing for both mothers and daughters. In terms of therapy for people with dementia, Ng (2009, p. 202) puts forward the disappointing view that, «Despite the scale of the problem, provision of psychological support to this group [people with dementia] is diminutive in comparison with other illnesses». Kitwood (1997, p. 14) offers a suggestion for the possible fear in psychologists and other health professionals:

«There is no real consolation in saying ‘It won’t happen to me’. In being close to a person with dementia we may be seeing some terrifying anticipation of how we may become».

A persuasive argument for the provision of therapeutic services for people with dementia, highlighted by Ng, (2009) is that, although it affects cognitive abilities, it does not mean a loss of emotions, and therapists could concentrate on working with the person’s emotions.

Although daughters and their mothers in this study did not have access to psychological help, there have been some innovative initiatives from psychologists and other professionals. The British Psychological Society and Department of Clinical Psychology (2006) produced a briefing paper providing information about the role and function of Clinical Psychologists working with older people, their families, and other carers. The British Psychological Society and Department of Clinical Psychology also produced a useful summary of documents – Dementia Pathways (2013) outlining services that could inform dementia treatment.

Examples from the theme of Transformed Relationships

Lost connections

Some daughters tried to connect in old, previously established, ways which were no longer successful. For example, daughters tried to laugh with their mothers, discuss politics, and have a conversation.

Carol portrays sadness when she talks of the things her mother used to do that she is unable to do now. She uses the words “all gone” to stress how her mother has lost interest in her hobbies and, by implication, this makes it hard for Carol to have a connection with her mother.

New connections

Some daughters described seeing positive aspects of the changes. Daughters made the following comments about their present mothers: “she [‘s] still can be enormous fun”, “she had this amazing bit of insight”, “emotionally really accessible” and “being less inhibited than she was”. Four daughters described thinking of imaginative new ways of achieving intimacy with their mothers, such as, cuddling, singing, looking at art and photographs together, and discussing the distant past.

Martha described how she achieved intimacy with her mother as follows:

...but this kind of intimacy of the last year... a real sense of what she might have been like as a young woman…some of that shines through. So I think overall it would have

been better for her not to suffer this… in some ways I have got something from it which I didn't have before. (Martha)

Conclusions and clinical implications

This research used a small number of participants, and any conclusions are tentative. It seems as though it is particularly important for counselling psychologists, other therapists, and health professionals to be aware of the possible challenges of having a mother with dementia when working with clients. This could be on an individual basis with daughters, for example, giving them an opportunity to express their feelings about loss but also to help with understanding angry or confusing behaviour in their mothers. This could help daughters to move towards their mothers emotionally, rather than away from them, and subsequently assist them towards forging new and meaningful connections with their mothers. In addition, if mothers were offered psychological therapy in the early stages of dementia, this may be helpful for reducing anxiety and distress in mothers and subsequently lead to reduced anxiety in daughters. Although the focus of this research is mothers and daughters, it is likely that a consideration of the difficulties that anyone close to someone with dementia could be experiencing may be helpful.

The research highlighted a complex fear from professionals and society at large that seemed to impact on the individual experience of the daughters. This seemed to be an example of the way in which societal context encroaches on individuals and, in this case, the experiences for the daughters. So, although the focus of this research is on individual experience, and more individual help would be appropriate, implications for clinical practice seems to be wider than this. These may include considering how the experience of having a relative with dementia is embedded within, and shaped by, the broader socio-political context. This could influence not only how services are set up and funded but how dementia is spoken about and portrayed. This fits well into the ethos of counselling psychology as it «places a commitment to understanding social context and socio-political processes at the heart of its mission» (Raflin, 2010, p. 49). In addition, counselling psychologists and other therapists could contribute to reducing the fear around dementia by addressing the issues rather than neglecting them. Maciejewski (2001, p. 26) makes an important point; she suggests that the challenge is to «communicate the value of psychological perspectives in dementia care». It seems that there have been initiatives resulting in progress in this area over the last few years. There are now excellent services available to some people with dementia and their families. For services and support to continue to increase there needs to be a strong motivation and commitment to argue for services along with a willingness to work in them.

The SIG offered a forum for exploring these themes in depth. Hearing about this work facilitated a connection between the personal, the clinical, and the societal, thus enabling group members to feel supported in thinking about the wider implications of individual experience. And individual experience is what we turn to in the next part of our paper.

If the work on dementia has shown how individual grief can be shaped by cultural fears, then what follows brings us closer to grief that resists such influence – grief that remains private even when shared, and unspeakable even in therapy. Just as dementia unsettles our assumptions about personhood and continuity, suicide ruptures the fantasy that understanding is always possible, or that therapeutic presence guarantees survival. In both, the therapist is left listening for what was never said – and perhaps never sayable – while wondering how much they ever really knew. It is with these echoes that we now turn to the next section.

Echoes of silence: Therapist reflections on suicide in couple therapy

One of the most haunting experiences of my clinical life was the suicide of a male partner in a couple I was working with. The work had been intense and emotionally charged, full of unspoken pain and fractured communication. After his death, I was left with fragments – words, gestures, silences – that echoed in my mind like the voice of Echo in the Greek myth: repeating, haunting, unanswered.

This event challenged me not only as a therapist but as a person. It raised questions about responsibility, about what had been missed, about the limits of our listening. It also highlighted the power of transference and countertransference in couple work, especially when desire, betrayal, and despair collide.

Introduction

This case study explores my psychoanalytic work with a couple whose long-standing relationship was destabilized by a complex web of desire, loss, and betrayal. The process unfolded within the emotional intensities of transference and countertransference and culminated in the tragic suicide of the male partner. While the paper focuses primarily on the emotional impact of this event on me as the therapist, (Bateman & Holmes, 1995). I also attempt to evoke the atmosphere of the sessions and the couple's shared psychic life.

The Greek myth of Echo – condemned to repeat only the words of others –has resonated deeply with me in the aftermath of this suicide. Like Echo, I found myself left with fragments: the patient's words, expressions, gestures, and silences echoing in my mind. These remnants remain unanswered and perhaps unanswerable, suspended in the analytic frame. After his death, I was haunted by what had been said, what remained unsaid, and what I may never have been able to hear in time.

Presenting problem

The couple, both in their fifties, came to therapy following a rupture in their marriage. They were both always very polite, softly spoken, and well dressed. The wife, a schoolteacher, revealed she had fallen in love with a 22-year-old undocumented North African man. Though she insisted the relationship was not sexual, she described it as emotionally profound and had begun giving him €500 a month. The husband, visibly shaken, tried to rationalize this as a generous, even altruistic act.

I remember sitting with them during those early sessions, feeling a rising bewilderment as they spoke. It was as if a fog hung in the room—not just from their denial, but from mine too, a collusive mist in which we all temporarily accepted the idea that everything was somehow still "OK." Their calm, even resigned way of narrating events belied the turmoil I sensed underneath. I recall asking myself how both of them could appear so detached from what, to me, felt like a seismic shift in their lives.

The husband’s insistence that he understood her choices seemed to reflect a kind of dissociative defence. I began to think of Klein’s paranoid-schizoid position (Klein, 1946) – he appeared to split his internal world to avoid overwhelming feelings of humiliation and abandonment. His idealization of her remained curiously intact, even as her affections turned elsewhere.

Escalating marital strain

Over time, the cracks deepened. The wife withdrew emotionally and sexually. “I love him, but I don’t want him,” she told me—words that left her husband sitting in stunned silence. I remember the long pauses in the room, the tension that neither of them could name. He looked at me, as if seeking confirmation that this situation made any kind of sense.

This emotional dissonance brought to mind Bion’s *uncontained beta elements (*Bion, 1962), raw, unprocessed affects that flooded the room and could not yet be thought about. Their apartment, I later learned, was cramped, offering no space for privacy. It became a metaphor for their psychic entrapment. She sought escape, while he became increasingly cornered –emotionally, spatially, existentially.

When the young man failed his exams and left the country, the wife continued to support him and made plans to follow him abroad. This “why now” moment struck me as particularly poignant. Her sudden attraction to this younger man seemed to erupt from a deeper yearning –for vitality, for meaning, for a reawakening from the emotional deadness of her long marriage. Perhaps the young man represented something she felt she had lost or never had. But why at this point in her life? I wondered if his presence – his foreignness, his youth, his dependency – had touched a dissociated part of herself, long buried under domestic duty and compromise. (Bowlby, 1980)

I don’t have all the answers to that question. And although there is much more that could be said about her projective identification, the couple fit, and the psychic system they co-created, that is beyond the scope of this paper. My central focus here remains on the psychic reverberations of the husband’s suicide, his attempt to hold onto the relationship, a false self, (Winnicott, 1960) and the clinical and ethical dilemmas it raised for me.

Occupational crisis and the erosion of self

Around the same time, the husband suffered a blow to his professional identity. After two decades of reliable work in an institutional kitchen, he was passed over for a promotion in favor of a younger colleague he had mentored. This betrayal mirrored what he was experiencing at home. He began to speak of himself as obsolete, used up.

His job had provided structure and dignity – what Menzies Lyth described as a system that defends against anxiety (Menzies Lyth, 1960). Now, stripped of both love and purpose, he began to unravel. In a one-to-one session, he spoke quietly of insomnia, hopelessness, and suicidal thoughts. He described buying rope, scouting a wooded area. I felt a heavy dread. The detail in his account was chilling. The imagery of hanging, often associated with deep unconscious fantasies of reparation and punishment, suggested an unbearable sense of guilt and self-recrimination, perhaps linked to both perceived failures as a husband and professional (Ogden, 2004).

He was referred immediately for psychiatric evaluation, and for a time, it seemed like the crisis had passed. He appeared calmer, less anxious. But in hindsight, I wonder whether this was what Freud called the calm before the storm (Freud, 1917).

The final act

A few weeks into the autumn term, I received a message from the wife. Her husband had taken his own life. He had gone to his workplace, left farewell notes for his colleagues, and hanged himself. In a long letter to his wife, he seemed to both release her and accuse her. There was no mention of his work, only of her betrayal.

This final act felt like a communication from a place beyond words – what Bion might call an unprocessed projection of unbearable affect. His suicide was not just a personal act; it was an expression of the couple's psychic collapse, a last message hurled into the silence. An unprocessed projection of unbearable affect, (Bion 1962)

My emotional response

The news hit me like a wave. I felt sadness, guilt, disbelief. I was tormented by the thought: had I missed something crucial? A colleague in the SIG group recommended *Working in the Dark* (Campbell & Hale, 2017). Reading the accounts of other therapists' experiences of patient suicide helped me begin to process what had happened. The numbness, the self-reproach, the sense of having failed – these were not mine alone. Another colleague sent me a powerful article that stated: *no one is to blame for anyone else's death by suicide. However, to achieve this, we must begin with ourselves* (Gibbons, 2025). That line stayed with me.

Due to strict confidentiality laws, I was unable to share clinical details with authorities, even posthumously. This legal silence mirrored the psychic silence I was left with. In supervision, I began to explore the many strands of this experience – the loss, the ethical complexities, the transferential echoes (Gabbard, 2001).

The couple as a system

Though much of my attention understandably focused on the man's psychological deterioration, I have come to see the importance of thinking about the couple as a shared psychic system. Their relationship had long been sustained by what I now understand as a collusive dynamic: a mutual avoidance of painful truths. His idealization of her allowed him to maintain a fragile sense of order. Her reliance on his passivity gave her space to seek other sources of desire.

This mutual projective system held them together – until it didn't. As Bollas, (1987) wrote, couples may choose each other for their mutual tolerance of each other's voids. But when those voids can no longer be ignored, the couple fit can unravel. Their shared defences, denial, idealization, the refusal to mourn – left them ill-equipped to process the grief of their relationship's disintegration.

Mary Morgan's concept of the "couple state of mind" (2018) was illuminating. They had shared a psychic space that buffered them from inner chaos. When it collapsed, each was left exposed and alone. In some ways, the husband's suicide felt like the voice of this collapsed couple system—a final, irreversible communication.

It is my first experience of a patient suicide in more than thirty years of clinical practice and raised vital questions about managing risk, assessing psychic reality, and understanding the meaning of despair within a relational context. The countertransference evoked – a mix of helplessness, frustration, and identification with the patient's exclusion – demanded careful reflection.

Concluding reflections

This case left me with more questions than answers. It forced me to confront the limits of therapeutic power. However skilled or attuned we may be, we cannot always prevent catastrophe. What remains essential is a commitment to reflection, supervision, and honesty –with ourselves and our colleagues.

Though much more could be explored – about the projective dynamics, the couple's collusion, the unconscious choice of their fit, and the question of "why now" – these lie beyond the scope of this paper. My focus here is on the emotional and ethical aftermath of suicide in the consulting room: the echoes it leaves in its wake and the therapist's task of making meaning from the silence.

The SIG provided a space where I could bring these reflections and be met with empathy and understanding. It allowed me to articulate the unspeakable, to begin to metabolise the trauma, and to find language for the inchoate feelings that lingered.

In some ways, the group mirrored the analytic frame: a containing environment where the unconscious can unfold, where we can bear witness to each other's pain. It reminded me that we do not work alone, even when we feel isolated. The echoes remain, but they are no longer silent.

If the SIG offered a space to hear what had previously gone unheard, then what follows is a reflection on what it means to listen when the other is fading before us. The work of mourning does not begin when a life ends, but often in those slow, cumulative losses that make up the experience of dementia. It is in these moments – when language falters, when presence becomes the only response – that the therapist, like the carer, is called to be both witness and container. Here, the personal and the professional are not so much in conflict as in conversation.

Therapist containment and the work of mourning

My interest in working with couples with dementia developed several years after my father died after living with dementia for 10 years. Witnessing his decline was an intense and extraordinary experience. Whilst often shocking, heartbreaking and disturbing it also opened up new experiences. As his defences and executive functioning declined, I encountered more openness, spontaneity and trust with him, and found this experience moving, exhausting and meaningful.

To be alongside such painful experiences requires layers of support and containment. Patients with dementia require the interested attention of the carer to counter the bewilderment and to feel accompanied. For carers to be responsive in this way, they need their experiences taken in and understood. Similarly, therapists, to be open and receptive in their work need thoughtful supervision, paying close attention to their countertransference.

The impact of dementia and relevance of psychoanalytic thinking

Throughout my practice, psychoanalytic thinking has informed and supported my training, clinical work and personal experience of working and being alongside individuals and couples affected by serious illness and those facing death, including couples with dementia. Couples are emotionally interdependent especially in later years and their experience of dementia is impacted by the preexisting quality and experience of their relationship and their individual histories. Hence the value of a relational approach to include partners as the 'unit of care', to meet the needs of those diagnosed with dementia.

Whatever the type of dementia, the experience is unique and can present couples with huge and potentially overwhelming anxieties and intense feelings of isolation. In addition, the couple may be feeling the loss of their relationship that provided them both with containment. The quality of these experiences can be helped to be understood by attending to the couple's internal worlds as well as the external realities.

Becoming ill, feeling out of control and dependent on others to take care of us, can understandably stir up primitive anxieties and fears around dependency akin to our earliest experiences, and potentially a loss of trust in what may have felt to be a predictable world.

Those with dementia become increasingly unable to orientate themselves which can stir up fears of loss, separation and insecurity. These fragmented experiences can lead to an increase in attachment seeking behaviour as a way of trying to feel secure. However, if there is no real contact, no 'object' in whom these experiences can be contained, depression and withdrawal will emerge. This experience resonates with the children seen in the seminal Robertson and Robertson (1967-71) films, where uncontained feelings give way to depression and despair.

Yet, sustaining contact with fragmented experience is challenging for partners whose own attachment style may interfere with their ability to respond sensitively.

Klein (1975/1946) and Bion (1962) have contributed to the psychoanalytic understanding of dementia and fragmented states of mind. The anxiety associated with early dementia has been likened to Bion's 'nameless dread' (Martindale 1989) akin to the infant's primitive experience of discomfort and need. The carer's role is to offer containment (Bion's alpha function) in order to transform the dread and fragmented experience into thinking capacity. Yet containment in this context is complicated, as it is often impossible to give back the digested experience to the person with dementia with a deteriorated mind. In some instances, creative therapies, that do not rely on words, such as music, singing and dance can offer alternative potentially rich and transforming, soothing experiences.

I have witnessed remarkable moments when a couple's emotional experience is fully taken in and the person with dementia suddenly becomes more fluent verbally. It is as if the experience of feeling really listened to can unlock the attack on thinking and linking.

However, at the heart of the work with couples and dementia is the tension between the need and space to mourn versus the desire to turn away out of fear and helplessness. Thus, understanding the significance of mental defence mechanisms, especially denial and repression can aid therapists' capacity to come alongside and gauge the timing of what losses might be possible to face.

The Carer partner may need to take on new roles and responsibilities in the relationship and so this transition from partner to carer can be multilayered. Changes to couple's communication accompany cognitive decline. In the later stages of dependency, projective identification may become a common form of communication. And understanding this phenomenon assists clinicians and carers to manage unbearable states of mind.

The 'Living Together with Dementia' Project (LTwD)

The 'Living Together with Dementia' innovation project was developed by Andrew Balfour (2014) at Tavistock Relationships with the aim to support the protective aspects of the couple relationship, which research indicates is to do with emotional contact, shared involvement and understanding. It draws on psychoanalytic thinking and video-based approaches, involving filming the couple engaging in everyday tasks that can be replayed to allow the couple to observe themselves. Replaying vignettes allows a vantage point for partners to observe and be curious and question why things are happening in a particular way as well as capturing moments of emotional connection, thus helping to reduce the tendency for partners to withdraw and the accompanying isolation.

In this structured intervention comprising 10 fortnightly home visits, dementia is considered as a shared difficulty. The experience is unique depending on relationship dynamics and shared histories. There is also separate time to meet with partners on their own, especially to address the needs of the carer who may increasingly be required to be the 'container' in the relationship but may be overwhelmed with their own feelings. These need to be taken in before being able to be responsive and able to tune in to their partner.

LTwD case example (Balfour & Salter 2019)

Mary had been able to gloss over her husband John's dementia and carried on as usual. She rarely mentioned it to family or friends until he sustained a fall. Mary started to become anxious and not sleeping well. She was irritated by the limitations his condition imposed on her and he seemed to miss her more when she went out. She tried to manage things by keeping a daily timetable of instructions and timings of when she was out. But he was unable to hold events in his mind and this infuriated her as she felt he was doing it deliberately to spoil her plans.

The first video we recorded was of them washing up. On viewing the recording, Mary was disappointed as she'd hoped she would see him in charge like he always used to be. The video exposed just how much had changed since his diagnosis and how self-reliant she now had to be. A later video involved them looking at some old photographs together. Mary grew irritated as she showed him photos in quick succession but he could not keep up. When we replayed the video and asked her what she noticed, she was able to say 'John looks really lost' and became upset. This visual moment allowed her to tune into John and see his vulnerability, softening her irritation towards him.

Mary in her individual meeting spoke about how embarrassed she felt sometimes to be in public with John. He no longer drove and she couldn't rely on him as before. They had swapped places and she too felt lost.

Later in a moving individual session John mentioned his fears for Mary after he dies. He felt his ending was close. When later we spoke about this together Mary was very touched by John's consideration of her and this emotional connection helped her feel more in contact with the John she knew. He also seemed less anxious as her irritation towards him reduced.

Visits continued and Mary was more open to making emotional contact with her family who became more involved and helpful. She enlisted practical help and support enabling her to spend time with John and continue with some of her interests.

At the end of the sessions, she expressed less guilt and resentment towards John and was more realistic about their situation.

To my mind, the SIG group has added an additional layer of containment to my practice, adding a rich humanity, intellectual stimulation and thought-provoking discussion. Sharing clinical work within a diverse and experienced group has helped me to explore both personally and professionally at greater depth, the challenges of our ageing, dependency and human vulnerability.

If containment is what makes thought possible, then the SIG has been a kind of thinking-with—where uncertainty is not resolved but respected. The unfolding of Mary’s story, and of those shared within the group, reminds us that clinical work is never simply about making things better, but about staying close enough to what is difficult so that something new might emerge. Before we conclude, we might ask: what kind of presence makes this possible—not only for our patients, but for ourselves?

Conclusion: Towards an ethic of presence

The work of the SIG over the past five years has created a unique space in the landscape of psychoanalytic couple and family therapy. It has allowed clinicians to explore the impact of illness not only on couples but on themselves. It has supported the development of theory, the articulation of personal and professional experience, and the sharing of clinical insight.

What emerges from these reflections is a sense of the centrality of presence: being with, staying with, bearing with. Illness, loss, and vulnerability call for an ethic of presence, one that is rooted in openness, curiosity, and compassion.

The journey of the SIG continues. Like Kafka’s traveller, we may not know our destination, but we trust the process. And in doing so, we learn to accompany others – patients, couples, colleagues – on their own journeys through illness, towards meaning, and perhaps, towards transformation.

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