Psychotherapy with Dying Patients

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Edith Weigert said, “The exclusion of death deprives life of its meaning, the personality of its wholeness and human relations of the depth of mutuality” (1, p. 192). Death is an existential fact, and it is more than likely the model for all human feelings of abandonment and separation. Is it, then, so difficult to understand why one should not feel anxious when faced with leaving the life he finds so rewarding and enriching? What we have in mind is the shared denial of death, in both the patient and the psychotherapist, and that the current thinking is overwhelming on the passionate, pleasurable, and sexual aspects of the human experience. After all, if we actually believe in the reality-principle, death is, or should be, as much a part of our discussions as life, else we deny something vital to our patients and, of course, to ourselves. If we are going to be able to offer a therapy for the dying person, then the psychotherapist must examine his own attitudes towards his very own death. It is the countertransference aspects that must first be understood. It has been our impression that psychotherapists are especially reluctant to face up to death in their personal lives and in their professional fields. For the most, the psychotherapist relegates matters of dying to other specialties or paramedical professions. It is only within the last decade that the psycho therapist has allowed himself some closeness with the dying person.

All professions, and especially the health sciences, have a very necessary mythology which helps and allows one to get on with more disagreeable portions of the work. It may be that the others, particularly theology, have a better myth. For the clergyman, his myth does not see death as necessarily an end. For the psychotherapist, this is not true. For him dead is dead and irrevocable, and consequently we can anticipate some of his resistances in dealing with a dying person. The selection of the material that the patient brings to the “talking-

treatment" is not always as random as we would have ourselves imagine. There exists a "patient empathy" whereby the patient tells us what he thinks we would like to hear. And, if his input senses our reluctance to deal with death, then it is very likely that we will not hear about his fears of death. There exists a discomfort in both parties in talking about death and, in a sense, that is the way it should be. It is no easy matter to tell a patient of his fatal illness, and even more difficult to tell of his coming death. We know that there are physicians for whom this represents no problem. Inured to death and untouched by it, they, of course, are no help for the suffering of the dying person. They might, conceivably, give rise to more suffering, psychosis or stimulation for a massive self-destructive act.

In the past, it was felt that one must not talk with patients about anything that might disturb or excite them; they had to be treated like children. Phrases like, "be brave and everything will be all right," were most commonplace. While we would not deny that in many instances this "suggestion"—a popular albeit frequently misunderstood word—had a magical feeling and did prove helpful, we must admit that the results were, at best, temporary and short-lived, requiring frequent reassurance. In this "psychotherapy," there are also elements of the confessional which tended to hide rather than reveal. While these methods restrict the function of secondary process reasoning and obtain their cure by attaching primary process thinking, there remain some individuals for whom this could be thought of as the method of choice. This is, and should be, an assessment that the psychotherapist would be making during the early phases of his relationship with the dying person.

The gratification for the psychotherapist in his work with patients is seeing and taking part in the resolution of intrapsychic conflict, reducing anxiety and consequently freeing energy for additional libidinal cathexis. There is no doubt of the gratification when we are dealing with a young person who comes to treatment in good physical health, who brings as his chief complaint a desire to establish more loving relationships and in whose growth and maturity we can play a part. But, what are the gratifications for the therapist when the patient's

life ends in death? For the therapist, the rewards, in part, can be in terms of trying to bring about a “euthanasia” (2, 3), which literally means the art of dying easily and without pain.

There would be little difficulty if the pain were restricted only to the physical. However, the mental anguish and fear of death, menaces from a punitive superego, are what we have to deal with. Also, as stated earlier, the pitfalls of the manifold countertransference feelings present difficulties. When faced with a hopelessly ill, dying person, the therapist is struggling with many conflicts. For example, is it really harder to die or witness death? The question has a justification when the relationship with the dying person has a closeness. Likewise, there exists a strong sense of embarrassment as one attempts to talk with encouragement when the future is death. Especially at those times when the patient’s denial becomes so massive that it goes beyond that of the therapist, and is consequently so unrealistic that the therapist feels removed from reality, a failure of the treatment could be a possibility. At those moments, if the therapist chooses to remain silent, his silence could be understood as accepting the patient’s denial as truth. Still another opportunity for failure exists if the therapist permits himself to become part of the real family-situation with all the feelings of guilt and hostility, as if he were really a family member.

More specifically, when working with the dying person, affective empathy is the most effective—where it is understood that there exists an honesty, with very direct communications and without any semblance of value judgments. There must also be present an acceptance, without reservation, of the other person’s life story, at least for transitory moments. The empathizer must be able to allow himself to share in the reliving and living through of the dying person's experiences. From this, the dying person gains a sense of this experience and becomes aware of a fusion, which is brief but certainly realized. There seems to be much more difficulty for an observer to be aware of this state in the usual therapeutic situation; at times, however, the dying person’s response will make the affective empathy known.

In our personal experience of treatments with dying persons, there have been moments when the patient reversed the roles and became the comforter or caregiver. The fusion permitted and allowed identification and empathy with the therapist, thereby diminishing the sense of extreme loss for both. It is this state of feeling which removes the aloneness for all of us. The aversion to empathize with the dying person, to feel his helplessness and terror, can be most uncomfortable with our own built-in needs to avoid pain and anxiety. This affective empathy senses the person's real needs rather than waits until it is expressed in uncompromising terms. It is not just emotional closeness or identification with its narcissistic implications and possible failure of any real support but, rather, allowing oneself to enter into another's life experience fully and without reservation.

The affect of empathy does not mean to imply a mutual suffering along with the person. Olden (4) remarked that it is the interplay between mother and child with mutual sensitivity to the other's feelings that should be regarded as the starting point of empathy. She also stated that the mother needs satisfaction from the infant in order to accomplish the transition from physical gratification to mature empathy. She feels it may begin with the infant's searching of his mother's face. Beres (5) separated the process of identification from empathy. The feeling of identification is transitory and implies a temporary fusion with the object. Beres and Arlow (6) stated that empathy is not merely feeling with the patient or the object, but about him. Frequently, in the caring for and about the dying person, a bodily contact, i.e., holding or touching an arm or hand, will be meaningful and supportive.

The quality of empathy is the most significant affect a therapist can bring to the treatment of the dying person. It is a quality that requires a substantial degree of ego development, namely, memory, thinking, and good conceptualization; it is likewise much enhanced with age and experience. Greenson (7) also separates identification from empathy by virtue of its permanence and unconsciousness. It is meaningful in the therapy with the dying

person because its aim, as in childhood, is to overcome anxiety, guilt, and object loss. Our ubiquitous conscious fears of death are felt in the everyday life as fears of helplessness, injury or abandonment which, in turn, have their origins in the infantile anxiety due to separation from the protecting mother and in situations where the (go feels powerless. In this state of consciousness with which we are confronted in the interaction with the dying person, it will be the degree of affective empathy which will aid in removing the terror of death, and still permit us, as therapists, to maintain our individuality and perspective. At the conclusion of Greenson's paper, he suggests that "people with a tendency to depression make the best empathizers" (p. 422).

The problems of bringing the necessary degree of empathy to the treatment of the dying person are manifold: firstly, because we seem to live our lives deliberately ignoring the anticipation of our own death as well as the deaths of those we love; additionally, the confrontation with the dying person forces us to deny the truth of death to the point of aversion. Painters' and writers' works frequently confront us with the dirty, ugly realities of our existence, perhaps saving great energies which we often expend in avoiding and facing death. In his "Thoughts for the Times on War and Death," Freud (8) stated it thus: "Si vis vitam, para mortem"—"if you would endure life, be prepared for death" (p. 317).

We would like to report the treatment of two persons who came to "thanato-therapy" via two different routes.

Case 1

The first patient, a 26-year-old, moderately attractive, bright, keen, and mistrusting woman, developed a fatal illness during the course of analysis. When entering treatment, she was married and sought help because of difficulties within the marriage and obsessive thoughts of death and illness with accompanying anxiety. Also, she had an honest desire to spare her one-and-a-half-year-old adopted son her neurotic problems and conflicts. She had felt that her problems were destructive to herself and the family.

Following the summer vacation, she returned to analysis and reported that she had been able to enjoy being with her son and husband on brief holidays at beach resorts and on short trips. However, in keeping with her basic character structure, which was predominantly masochistic, she had sought out a situation during the vacation that would make for guilt and anxiety by entering into an extramarital affair. The material following her return was occupied with efforts to understand the meaning of the acting out. It was during this time that she began to complain of intermenstrual bleeding with painful gums and teeth, all of which she viewed as punishment for her indiscretions.

She had consultations with a dentist and her gynecologist; her dentist encouraged her to have more extensive blood examinations. At this point, she contacted her uncle, a physician, who had functioned as the family doctor through most of the early years. Following a preliminary examination, he phoned the therapist without knowledge of the patient, informing him that everything pointed to acute myelogenous leukemia. He did not comply with the therapist's demand to discontinue the telephone conversation, stating that the emotional shock—a feeling shared by the therapist—made him incapable of providing any further help He implored the therapist to take over and make any arrangements that he felt necessary.

The therapist informed the patient of the uncle's phone call, but did not disclose the exact nature of the findings other than to say that the uncle would like the therapist to suggest an internist. The patient was most willing to accept the recommendation of the internist who suggested hospitalization for a more complete examination. While hospitalized, she phoned the therapist's office asking if he would be coming to the hospital, since she knew that it was the hospital where the therapist taught psychiatric residents. Her phone call was regarded as a request and the therapist visited her.

There was a quietness about her mood; she was seemingly satisfied with the diagnosis which was said to be infectious mononucleosis. She was free from anxiety and did not appear depressed. There was a distinct sense of well-being about her affect. She was free of symptoms and it was the feeling of the therapist that the illness represented the fulfillment of some unconscious childhood wishes that had the effect of appeasing an underlying harsh and critical conscience, thus causing the neurosis seemingly to vanish.

After this visit, the therapist was button-holed by various family members —the physician-uncle, mother, and husband. The father was present, but chose to remain out of the conversation. The mother and uncle immediately raised the issue of the diagnosis, and both agreed that, at all costs, the truth would be kept from the patient. The husband was not as firm that this should be the course of action, as he would be the one with the patient most often, and having to fend off her ever-present suspicions would be nothing less than formidable. The family, following the patterns of her early childhood, exerted great pressure that the truth be hidden.

Bowing reluctantly to family pressure, the therapist agreed to continue in the deception for the time being. However, he insisted on reserving the right to disclose the nature of her illness to the patient, should he feel that this would alleviate her anxiety, guilt, and despair, when assured at the same time that she would never be abandoned, but rather that the therapist would try to share her

experience. He explained to the family that the denial would foster mistrust and the feeling of being set apart, both of which should be avoided if the patient were to have any real opportunity for an “easy death.”

The patient returned to the “analysis,” where no changes were suggested in the way treatment was to be conducted. The manifest content of her first dream had themes of punishment and death. For the most part, the time that followed was filled with similar material. She would talk about death, diagnosis, punishment and guilt. At no time did she directly question the diagnosis of her illness. The game of hiding the reality and reinforcing the denial continued. She wondered how one goes about explaining death to a child and said that her own mother always shielded her from the realistic details of death. Then she added, “When you die, you are put out of the house and separated from the family.” The therapist’s formulation, in part, was that it was this separation anxiety with which she had struggled most of her life. She developed an interest in, and fascination with, perpetual motion machines and would fantasize about inventing one.

About two weeks before her death, she decided to write her will, mentioning that she had somewhat less money than when she first married. Four days before her death, she called, saying that she felt too weak to keep her appointment. She had fever, a sore throat and a cough, and asked directly what she should do. The recommendation was that she call her internist and follow his advice. She was hospitalized, but it could not be certain whether this episode represented an upper respiratory infection or perhaps the terminal part of her illness. The following day she called the therapist from the hospital, saying that she did not want to see him, and if he had made plans to visit, it would not be necessary. He was quite aware of her rage, her disappointment with him and his magic. She was experiencing the most intense despair and helplessness, so the therapist decided to visit in spite of her conscious contrary verbalizations. He was cognizant that his insistence on the visit could confirm the seriousness of the illness and give additional proof that he would never abandon her. His

formulation and attitude would be reality testing dependent on the assessment of her ego strengths with preserved hope and magical thinking.

The laboratory reports were very unfavorable, disclosing an overwhelming process. Upon first seeing her, there was little doubt in the therapist's mind that she was nearing the end of her life. She was outspoken towards him with her rage, wished for enough strength to toss the water pitcher at him, and advised him that he was lucky she was so weak. But, the ambivalence quickly revealed itself when she thanked him for coming to see her and for sensing that this was really what she wanted. After a while, her father came into the room. She introduced the therapist, asking her father to leave and return later. The remainder of the visit concerned the new medication, her fever, and the weakness she felt. As the therapist was leaving, she repeated that it would not be necessary for him to return the next day, since it was Saturday and should be spent with his family. He said he would return, because he felt she needed him more

Departing from the hospital, the therapist reviewed the hour just spent in the hope of gleaning what, perhaps, was uppermost in her unconscious. The intuitive response was that she felt he was failing her in the moments of her greatest need. In reality, she felt his performance was very similar to all others in her past and present life. He was making a pretense, keeping secret the truth and not acknowledging that she was dying. He was, for all purposes, allowing her to die alone (9), without comfort, without expression of his grief or compassion, merely continuing a hoax, the nature of which had long since been known to her.

For the following visit, the therapist formulated a tentative plan: to listen, wait for the appropriate moment and disclose the nature of the illness. His hope was to allay or appease the conflict of ambivalence by giving her the feeling that somehow that part of him was dying with her. In his paper, "Dying Together," Ernest Jones (10) pointed to this fantasy and noted that it also contained the wish to be impregnated by, or fused with, the partner. The previous material gave

strong evidence for this feeling. At one point during the past months, her desire to adopt another child was so strong that she brought her husband to the office specifically to discuss this possibility. In this psychotherapy, the therapist would be accepting her on one level as a mature woman, giving her the feeling of intense sublimated love or, better called, fondness, and at another level accepting her as a helpless child, but being truthful and refusing to be caught up in the performance of her past family experience.

The next morning the clinical state was somewhat improved, giving hope that a remission might possibly be in the offing. Of course, the therapist's own ambivalence was revived. If this were to be true remission, perhaps the course now would be to withhold the facts and continue the game of making strong the ever-present archaic belief of her own immortality. His decision had to be guided by the expression of her overt anxiety and what he felt she was asking to know. Her greeting was friendlier than the previous day, and she reiterated that this visit was undoubtedly inconveniencing him additionally as, for the most part, she did not feel it was necessary. Her denial was still active and her testing the transference was manifest. She was anxious, tearful and mildly agitated. At the moment the hematologist was preparing to leave the room, and upon his leaving, she expressed relief that the "clown" was gone. She could no longer stand his silly jokes and the talk about infectious mononucleosis; certainly now, she was more aware than at any other time of her impending death.

The therapist sat at her bedside and she continued to talk. She was clear and lucid, giving no evidence of any alteration in her state of consciousness. She spoke about the illness—her doubts about the diagnosis, the trouble she was putting the family through. She was bothered by the loneliness her young son must be feeling; just talking with him by telephone must have helped some. "Why is it taking me so long to get well? Why don't they tell me the truth?"

The therapist reminded her that in all the previous months she never once asked him the diagnosis. She continued to talk, generally performing like a

person without the benefit of hearing. After a silence, she turned toward him and asked, “What do I have?” With knowing hesitation, he told her. For the first time in many days, she sat up in bed, reached for his arm, held it tightly, and rested backwards on the pillow. She looked for his hand and clasped it in hers. Speaking softly, haltingly, and with a seriousness of which more would be heard, she asked, “What will I do now?” He replied that they would continue as they had during the past months and that he would give all possible help. She admitted that she had suspected this for a long time, but would never ask him, knowing that he, of all people, would tell her the truth. She remarked that she felt strange and that things appeared unreal to her. She thought and spoke of suicide but felt that there is a difference to a child as to how a parent dies, and she would not leave her son with this other burden.

She began crying, and the intensity of her emotional response brought tears to the therapist’s eyes. His first impulse was to attempt to conceal this from her. Would his crying forfeit the omnipotent role she so heavily demanded? His own feelings of compassion and sorrow were uppermost. No one else previously had permitted himself the freedom of crying with her, and his behavior might give additional strength to the formulation that he was empathic with her feelings and that perhaps he, too, was “dying.” For the most part, others were bent on playing the game of denial without truly acknowledging her illness. She said, “I’m feeling a little better now. I think it took a lot of guts for you to tell me. Aren’t you afraid that I might go crazy? Maybe I’ll have a delayed reaction?” The therapist was beginning to feel reassured and his own doubts were assuaged. There was the feeling of a shift in their roles, with her identifying herself as the therapist. Realistically, it was a “gift situation,” giving her part of his life—like “dying together.” Her unconsciously incorporating the therapist thereby insured the mutual death. This fantasy of mutual death has been called “Liebestod Fantasies” by J. C. Flugel (12) and is further documented and elaborated on in a recent paper by Bernard Brodsky (11).

She spoke about her pregnancy that had occurred during the second year of

treatment and, in spite of the fact that it had ended in a spontaneous abortion, she said, “I was happy to know that I could at least almost have a baby.” Soon after, her husband arrived. She promptly in formed him that there was no longer any need for pretense. It appeared that this knowledge of her illness made her unique and imparted a feeling of strength. Her affect became more elated and she phoned the hematologist, informing him that he, too, could stop playing the hoax She asked for a drink of liquor—this had been restricted during the past, four months—quickly assuring the therapist that it was not to be dead drunk, because she loved life too much, but merely to feel somewhat mellow. At her invitation, the therapist joined her and her husband with a drink. Leaving her with her husband, the therapist mentioned that he would return later that day. She replied that she would be looking forward to the visit, and to talking more. This last verbalization gave dramatic proof that in some way her ambivalence had gained some resolution.

The therapist’s second visit that same day was shorter, and for most of it her husband was present. She was quite eager to relate her fantasies, especially about the future. She had a great interest in travel and wanted to go to far-off lands, but only by airplane. Her husband, who owned a small plane, joined in by saying that he would fly all of us to Europe. It appeared that he, too, had entered the fantasy of “dying together,” since his plane had a very limited range and would carry all of us to a watery grave. In this fantasy, the therapist was to be her personal physician, again giving affirmation, I felt, of the theme of “dying together.” Before leaving, he suggested that arrangements could be made to bring an extra bed in the room so that the husband, who was most eager to be of honest help, might spend the night at her bedside. Their marriage had been estranged and his guilts were being rather strongly felt. Her final words to the therapist, when leaving, were, “I want to see you for many more hours, and I hope you make lots of money from us.”

The therapist visited the following morning to find the patient unconscious, breathing in a labored manner, and moribund. Her husband related the events of

the evening leading to the coma. She began to feel anxious, and became talkative, having concern about the enlarged nodes in her neck. The resident physician was called and ordered a mild sedative for the night. Shortly thereafter, quietly and without a struggle, she lapsed into a deep coma. Most fitting, and quite appropriate at this point, are the words of Lewin (13): "In the desired sleep state related to ecstasy, we meet the quality of immortality, the unending heavenly bliss…union with the immortal superego forms a prominent feature and the sense of immortality is a function of the fusion"—as he emphasizes, "the good death with the good sleep" (pp. 1551-1552). She fulfilled a long sought goal. There was some harmony, some lessening of fear and trepidation, with little mention of resentment about her coming death.

At various moments since her death, the therapist's speculations concerning the specific event itself, and the time it occurred have been most provocative. One cannot help but feel that what we call the human person represents a tremendous interaction of many various and diversified psychobiological forces, and that when we refer to the realities of life giving the appearance of being the only dynamic forces, perhaps we might be putting aside the totality of the human organism. It is suggested that her death, this most decisive event, final and ultimate, may very well have come by her own choice. Without anxiety or despair, she saw her death as a solution to her problem rather than as a source of conflict.

Case 2

The second case presents some different problems related to the psychotherapy with the dying person. This patient made a request to the internist for psychiatric assistance after she had been told of the discovery of an abdominal malignancy. The discovery of two metastic lesions in her lungs was not revealed to her. The therapist visited her in the hospital six days following her surgery, and the remainder of his visits occurred within the hospital. They met for a total of ten sessions during a three-week period. As the course of illness came closer to her death, the visits were more frequent. Several unexpected and unannounced visits were made at what might be thought of as "odd" times, for which she expressed great pleasure. Their first meeting had been seven years earlier at the funeral of her older son whom the therapist had seen for five months of psychotherapy before his sudden and, in a sense, unexpected death. The son had had a session with the therapist at the office two days before he suffered a massive intracerebral hemorrhage.

Though at the first meeting with the mother in the hospital, neither she nor the therapist recognized each other, the transference had a "ready made" component, as did the therapist's feelings about this patient. Her son had been a talented and distinguished scholar with an international reputation, about whose early life the therapist was very curious. To have the opportunity to meet his mother was an added dimension for the therapist.

At the time of the first session, the room was bright and cheerful, with full sunshine streaming through the blinds. The patient was out of bed, standing in front of the wall mirror, grooming herself with care. She looked her age of 77, but certainly not like a woman who was preparing for her death. After the introduction, there was little necessity for him to ask questions. She mentioned how much she had enjoyed the changes in her son during his visits with the therapist, and hoped the same could be done for her. "I know that I have a

malignancy and that I probably will die from it," she said, touching the area of her wound as she talked. She added, "I have made out a 'living-will' (4), so please see that the other doctors do not use any heroic measures." He said that he understood these feelings and would try to see that her wishes were respected.

After this prologue—this contract between them—she launched into a list of complaints about the nursing staff and some physicians. Getting enough medication for her pain and for sleeping was uppermost in her mind. She felt that medication for pain should be given before the pain returned—"it makes it more difficult, and then I have to wait almost 45 minutes before there's help." She was unhappy about the fact that the staff did not reveal to her the names of the various medications as well as her temperature. This woman had been a scientist, working at a full-time job until before the surgery, and had been independent since her husband's death two years previously. It was difficult for her to accept a position of passivity in merely being a patient. She spoke quite openly about her death, but found it most difficult really to accept the idea. She did not express any feelings of "why me?" or any significant anger other than the complaints about staff. She wanted to have more talks with the therapist and hoped he could help her arrange her life.

The therapist was taken by this woman, and there was no difficulty in his mind about his full commitment for the remainder of her life. He completely enjoyed her stories about her early education in a small Central European town and her later university studies. When she spoke in scientific jargon about her field of interest, there was complete seduction. She was a most extraordinary and unforgettable person, and now he also had some additional documentation for her son's character. Tentatively, he felt that the current evidence led toward thinking of her coming death as a most peaceful, if not a happy one.

During the next visit, it appeared that much had changed. She was more disturbed about the staff and blamed the breakdown in her wound on faulty technique. The wound drainage became the reality which did not allow adequate

denial to take place, as did the continued pain. The therapist felt that she "knew" more of her was dying, but did not really understand that she would be dead. It was made clear that he would improve the arrangements for the medication, both for pain and sleeping. The nursing staff was instructed to tell her the names of all drugs, to give her some sense of control. This was done, of course, with the realization that this desire to know might represent some feeling that the staff was being less than honest. She was encouraged to feel that the therapist's position was to be utilized for her welfare.

The draining wound prevented the denial and the symbolic displacement from incurable illness to curable. The focus on the wound was an expression of the symbolic fear of death for her. Her trusted "friend," her body, was beginning to fail and desert her; she was feeling "attacked" and becoming somewhat more angry and depressed. Nine days following the first visit, she was eating less, and she was beginning to permit some assistance from the therapist at mealtime (some visits were especially made to coincide with meals).

The 47th birthday of her deceased son was close at hand. She spoke again about his untimely death, and also about her mother's grave remaining unmarked. She made a request that her mother's name be inscribed along with her own on the new tombstone. Here the therapist felt that the material revealed some sense of guilt towards her mother and that the knowledge of her impending death was an atonement for same; likewise, there was the theme of "dying together" (16) and fusion. In other words, freedom from guilt is derived from the conscious recognition of death. During this visit, she spoke somewhat about the difficulty of being alone at night. The therapist's next visit, unscheduled, was on a Sunday morning, and she questioned the reason for his coming to see her unannounced. He responded that on Friday he had sensed a feeling that she was fearful of being left alone. Then she said, "I'm pleased to have a chance to talk more with you."

Four days before her death, she requested that her phone be turned off; she

no longer had the patience to speak, even with old friends. This was the first striking evidence of a desire for the beginning of cutting her ties and decathecting old subjects. The odor from the wound was a continuous concern and source of much displeasure. She was embarrassed, and said that her death would be easier if she did not have that added burden. She requested that the therapist prescribe a tranquilizer for her anxiety, and mentioned her regret that she had not brought her own medication. He agreed to order the additional medication.

On the same day, her younger son came from another city and, during his visit, told her that, when discharged from the hospital, she would come and live at his home. She spoke of dying in this other city. Then, by administrative decision, and unbeknown to the therapist, she was transferred to another part of the hospital. Briefly, she was moved from an acute active service to the more chronic part of the hospital where beds are also utilized for convalescence. From this point on, her course was rapidly downhill. The therapist sensed and felt that she regarded the move as a signal that staff had despaired of her recovery. She stopped eating completely, talked little and left her bed only for bathroom needs. The nights, with darkness and the quietness about the hospital, became more frightening. She accepted fluids from the therapist in the form of ice water and tea.

Visiting with her about 12 hours before her death, he found her silent, lying in bed staring straight ahead, but not actually acknowledging his presence. The silence was complete without any verbal response even to colloquial questions. She did not appear to be in any severe pain; her face was not tense, but she was perspiring. After about half an hour, when asked whether she might wish him to leave, she shook her head negatively. He remained longer, but they never spoke again. Some relatives who came received the same silence; her only responses were displayed by head-nodding. The silence possibly was part of an acceptance and her way of saying, “Nothing more need be said.” She died the following morning.

In this psychotherapy, there was no conspiracy which would have tended to isolate the patient. None of her questions were ever considered irrelevant and all were answered in a very direct manner. However, she was never told directly that she was dying, nor was she told about the metastases. The therapist felt honest with her, despite his withholding some of the truth. They talked about death often and she was aware of her diagnosis. In their first visit, she informed him that she was in fact dying—it was after she knew the diagnosis that she requested his visit. In addition, there existed this "ready-made" transference as the person who had treated her son before his death, and the transference had the appearance that the therapist was the bridge for her to the dead son and mother. But even this "reconciliation" was not sufficient to make her death positively a happy one. The transfer to the more chronic division of the hospital seemed to hasten the course of her death. Her ego must have felt that the "game" was up. There was no way out except through a flight into "psychosis," manifesting itself in withdrawal, feelings of unreality, negativism, and becoming completely mute. When the body was threatened—and with this patient the constant draining wound was felt as a continuous threat—there was the gradual withdrawal from objects and great intensification of her feeling of narcissistic injury. This aggression against her was felt, perhaps, as a punishment. Early in the treatment she fought back and directed complaints against the staff. During the last few days the therapist speculated that there existed some, perhaps masochistic, albeit pleasurable, suffering. All visiting relatives were made to feel guilty and helpless by her negativism. The guilt was especially strong with her former daughter-in-law, who was a constant and devoted visitor at her bedside, and who found it difficult to accept the patient's behavior in spite of the therapist's explanations.

The dynamics in this case, indeed, are complicated further with the time of her dead son's birthday and her wish that her mother's name be inscribed on her tombstone. We are all quite familiar with the anxiety that many women suffer before parturition, and how this often becomes fear of death. While there is no

actual strong data to support the speculation that the thought of being in childbirth was active within her (i.e., abdominal mass), it remains a thought for consideration. Also, perhaps, the wish for reunion with her mother might have been another possibility—the headlines of the material were present. Additional support for these speculations centers on the meaning of the mass growing within her. Candidly, the therapist could not say that her death was a complete euthanasia (2) in spite of his original feelings following the first meeting. Perhaps the death might have been happier, if the transfer had not occurred, but that will remain her secret. However, the case does show the investment of time and torment that the physician who commits himself to the treatment of the dying person must be prepared to make. In such instances, he must sustain some sense of medical failure and, not least of all, at times a poor psychological death. No matter the degree of honesty, each person has his death in his appropriate setting, based on the concept that all of us will have our own private style of dying, an outgrowth of our previous life cycle.

An Approach to Helping a Dying Person

The material presented from the history and course of treatment of these two particular dying people can be helpful in delineating various essential psychotherapeutic tools which could be comforting for the dying person. However, in both these situations there was a "ready-made" transference, an advantage that does not exist in all instances. In the first case, the fatal illness became part of an ongoing treatment. With the second case, it was clear at the first session that the therapist was to be the bridge between her dead son and her death (2). In numerous situations of consultation the goals, of necessity, will have imposed limitations, and the time needed does not exist. Often, the assessment must be quite rapid and, hopefully, gets to the heart of the matter. Consequently, the considerations should be 1) to help the patient; 2) to give assistance to the staff, including paramedical helpers; 3) to provide time to be spent with the family. In dealing with these categories, the matter of the individual and collective *grief* must be realized and treated. Most usually, this involves management of their guilt and feelings of *helplessness* referable to themselves and towards the dying person as well. The referring physician, with his sense of medical *failure* and damage to his *narcissism,* cannot be forgotten or neglected.

The therapist who decides to involve himself in the treatment of a dying person must commit himself 1) to utilize all his efforts in behalf of the patient's welfare. The patient must understand this clearly, and also know that the therapist will be a constant, available, and reliable figure for the patient. The psychodynamic evidence is that the fear of abandonment occupies a central position in the mind of the dying person. The therapist should have knowledge of the various pharmacological agents that can allay anxiety, counter depression and, at times, handle more malignant symptoms, namely paranoid thinking. Superficial optimism is usually opposed, since it can encourage suspicion and mistrust. However, in certain instances of persons with character traits of being

chronic optimists, the denial should not be challenged; it should be viewed as homeostatic and as ego-syntonic for maintaining self-esteem; 2) to try to respond appropriately to the patient's needs by listening carefully to the complaints and the words used to express them. It is especially important to watch for *displacements* of the symbolic representation of the fear of death, namely, "the room is dark, please open the blinds,"…"the room is stuffy." Making minor, or seemingly minor, physical changes often has a remarkable way of making the patient more comfortable, reducing anxiety and lifting depression; 3) to be fully prepared to accept his own countertransference, as *doubts*, *guilts* and *damage* to his narcissism are encountered. He must be fully prepared to have his own death *wishes* from earlier years reactivated and, of course, to be reminded constantly of his own *death* and *mortality.*

From this, it remains an easy step to see why we have left in the past and continue now to leave the dying person alone. We know that the pain of death is made more intense, if the journey is embarked upon alone. Without a partner, the fear quickly escalates to panic and dread. Here, then, is the role for the therapist —an empathy—an affective one which provides a fusion with the patient's unconscious and transmits the feeling that a part of the therapist will die with that person. Superficial optimism which is so removed from the reality can oppose this fusion and empathy.

The ability to transmit this feeling quite naturally transgresses individual capacities in therapists and is not accessible to all. The therapist must be aware that his own defenses cannot be rigidly adhered to, since they tend only to widen the gap in communication between himself and the patient. The treatment must permit a guilt-free regression in the patient; this will go a long way to preclude object-loss.

It is not too difficult to know and realize a "bad" death, but to be able to sort out a "good" death presents more difficulty. The therapist must work for relief of pain, and counter the arguments of "addiction" as often, reflecting, in part, some

of the staff's inability to give up control, even though they require that the patient do so. It may also express their denial and false hope or, at best, indicate an example of awkward thinking. Above all, the therapist must understand that this personal presence remains all that is available against the fear of abandonment (15)—the journey to death remains an illusion that must have some allies. The struggle and torment for the therapist with the dying person is always the battle of David and Goliath, but we must recognize beforehand that Goliath, in all instances, will be the winner.

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Note

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