TREATMENT OF A DYING PATIENT

JANICE NORTON, M.D. (Denver)

Case reports of dying patients are rare. In 1915 in "Thoughts for the Times on War and Death" Freud discussed our attitude toward death as being "far from straightforward. To anyone who listened to us we were of course prepared to maintain that death was the necessary outcome of life, that everyone owes nature a death and must expect to pay the debt—in short, that death was natural, undeniable and unavoidable. In reality, however, we were accustomed to behave as if it were otherwise. We showed an unmistakable tendency to put death on one side, to eliminate it from life. We tried to hush it up" (p. 289). Considering the universality of the experience of dying, the relative rarity of case material dealing with dying patients would suggest a continued reluctance to deal with dying. Nearly all authors writing of dying patients remark on this (Aronson, 1959; Brodsky, 1959; Eissler, 1955; Feifel, 1959; L. and E. LeShan, 1951; Sandford, 1957; Saul, 1959; Weisman and Hackett, 1961). At the same time they also make a plea for more thorough study of the psychology of dying and insist that the psychiatrist may have a psychotherapeutic role with the dying. Freud (1915, 1916) and Eissler (1955) deal most adequately with both conscious and unconscious reasons for avoiding the dying, and I do not propose to repeat their discussions here.

What follows is a detailed case summary of the last three and a half months of life of a gallant and articulate woman. The case report owes its existence to the fact that all those on whom we usually rely to spare us the necessity of listening to dying patients, family, clergy, friends, other physicians, had already relinquished

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Assistant Professor, Department of Psychiatry, University of Colorado School of Medicine.

I would like to express my indebtedness to René Spitz whose ideas and encouragement were invaluable in this case.

their roles and could not be induced to resume them. I was faced with the choice of allowing this patient to die a miserable and lonely death, possibly by suicide, or of trying to relieve her suffering in so far as I could.

CASE REPORT

Mrs. B., the thirty-two-year-old married mother of two sons, five and three, reluctantly came to see me at the urging of her sister, a social worker from a distant city. Her sister had been visiting and had become alarmed at Mrs. B.'s increasing depression and her hints at suicidal thoughts. While the patient frankly told me both were present, she herself felt no need to see a psychiatrist as both depression and a wish to commit suicide seemed to her to be entirely reasonable under the circumstances. She had substantial pain, cough, hemorrhagic tendencies, anemia, and increasing fatigue from metastatic breast cancer; she was losing weight and strength rapidly, had little appetite, slept poorly, and it was apparent to her that X-ray therapy, hormones, and repeated transfusions were having increasingly little effect in controlling the relentless progression of the disease toward her death. She was using very small doses of morphine, mostly at night, in a partial attempt to control the pain and in order to sleep, but had been told to use narcotics very sparingly because of the possibility of addiction. She felt it quite reasonable to wish to stop her suffering by suicide and also felt her suicide would considerably lessen the burden she was imposing on her parents, her sons, and her husband. She told me all this in a quite matter-of-fact way, underscoring the idea that she felt no need to see a psychiatrist and was only coming in once in order to please her sister. She felt she had the right to die as she pleased, had drugs readily available to her, and that her suicide could be made to look like death due to the disease if she took an overdose of morphine at some time when she was unusually sick. She had not confided this plan to anyone, although her statements about her wish to die without a prolonged terminal phase of pain and increasing incapacitation had alarmed her sister; the rest of the family had taken these to mean that she was sick and in pain but "just talking" at times when she felt most uncomfortable.

The breast cancer had been diagnosed very late in the pregnancy with the younger son and a radical mastectomy was performed immediately; following delivery she had bilateral oophorectomy and irradiation to the breast area. She was initially worried about recurrence or spread of the disease, but as several months passed without symptoms she felt encouraged, and except for occasional feelings of regret about the imposed limitation on the size of her family, she was pleased with her life: her husband was enthusiastically beginning his career; her sons were doing well and gave her much pleasure; and she herself was engrossed with her life. Eight months before she came to see me, she had begun to suffer with chest pain and X-ray immediately demonstrated metastases to the ribs, spine, and pelvis. Both her husband and surgeon had frankly discussed this with her at her request, and although for about two months she tried to convince herself that X-ray and hormones might either cure her or give her "years" yet to live, the steady accumulation of symptoms was more than she could deny. She became very conscious of the fact that death was imminent in the immediately foreseeable future.

She did not become depressed at this point, but instead turned to religion. Her father had been a minister until his recent retirement, and she had been brought up in a religious home. In college she had gradually become more and more intellectually doubting of her faith and had finally lost interest in religion. With the knowledge of her impending death, however, she attempted to return to religion through a Protestant minister whom she engaged in lengthy philosophic discussions, particularly on the subject of immortality. Unfortunately, he took her intellectual arguments at face value, agreed there was no scientific proof of an afterlife and that her doubts were well founded. He offered her faith as a substitute for logic, but this patient, although deeply religious, remained quite skeptical of standard religious doctrine. For several months, however, she continued to find talking with him comforting. Gradually their conversations became more personal and less religious, although occasionally when she was feeling unusually ill he would read to her from the Bible. She became increasingly involved with him and about two months before she came to see me, she had confided to him that she felt she might be falling in love with him. He responded by telling her that this was unrealistic, that she was sick, and by sharply curtailing their time together. In fact, he very shortly stopped seeing her entirely except in a superficial and perfunctory way. Her depression and suicidal preoccupation began at this time. She also became increasingly anxious and had several acute attacks of anxiety, which she attributed to bouts of increased pain and weakness.

Concurrent with this experience were other mounting difficulties in her relationships with important people. She presented everyone with a picture of a young woman visibly dying an early death who had a great need to come to terms with her feelings about this. As subsequent therapy with me bore out, listening had its problems as the entire situation was tragic. She was an appealing, attractive woman, warm, intelligent, well read, interested in many things, and capable of very intense feeling. One result of this was that all who loved her most and might have been expected to help her with her feelings about dying were intensely and understandably involved in grieving. Talking to others of her feelings about dying was virtually precluded by the intensity of the feelings she provoked in them. Her parents, both chronically ill and in their seventies, lived nearby and periodically cared for the children, but they could not bring themselves to see her because they "hated to cry" in her presence. Her husband, increasingly miserable at her impending death, busied himself with his work. Her doctors, increasingly frustrated at her lack of medical response to their various forms of treatment, became hearty and hollow; and her sister, frightened by the patient's obvious loneliness and despair, lived a great distance away and referred her to me. At the time I first saw her, her relationships with the two boys were about all that remained even relatively intact. She had not yet spent any protracted time in the hospital and was using what strength she had to continue to care for them as she always had, although this was becoming an increasing problem for her.

That this patient had remarkable ego strengths was immediately evident. She had faced surgery, pain, sickness, and the knowledge of her impending early death with impressive insistence on reality, and was doing her utmost to adapt to very adverse circumstances. She had continued her life as usual within the limits of her physical condition, did not resort to the drugs readily available to her, and the only demands she had made on those around her were that they allow her to share her experience with them. It was only when she became aware of their increasing withdrawal from her that she became suicidal. Her attitude toward her parents, her husband, and her doctors was essentially maternal, that she was protecting them from pain by not insisting that they listen and help her with her ever-increasing distress. At the same time she was well aware of her need for help and had done her utmost to find it.

Treatment: Early Phase

All of this became apparent in my initial interviews with the patient and despite her superficial objections to psychiatric treatment, it was possible to get her to continue to see me on a regular basis by agreeing that she had no serious, long-standing psychiatric problems, that she was facing an extraordinarily painful reality situation with admirable courage, but that it might be of some help to her if we were to talk over her feelings about this. In addition, with the relieved consent of her surgeon, I took over the management of her narcotics and sedation so that very soon she became relatively free of pain and began to sleep at night. I explained this to her as essential both for her comfort and for her ability to care for the children as she wished to. She never did agree very wholeheartedly to the idea of seeing a psychiatrist and even in the last week of her life teased me about what an "unpsychiatric psychiatrist" I had been in that I had never lived up to her stereotype of what a psychiatrist should be, a silent, remote interpreter of dreams and of the oedipal situation. The implication was that she had not really had psychiatric treatment but had found someone with whom she could talk, who fortunately happened to be a physician and was, almost by unhappy accident, a psychiatrist as well. My initial treatment plan was to help her with her depression, prevent her suicide if at all possible, and to see if I could help the family to deal with the situation somewhat more effectively. By this time, however, both her husband and her parents had so decathected their relationship with the patient that it proved impossible for them to help; to them, in many respects she was already dead or had in any event delayed her dying too long. Her sister lived too far away to be of any immediate help although she did come to stay with the patient and care for her during the last three weeks of her life. As a result of this, my treatment goal was very rapidly changed to that of trying to make this patient's death less lonely and frightening. To this end, I saw her daily in my office, the hospital, or at her home, depending on her physical condition, for the last three and a half months of her life. I made it explicit that I would be available to her at any time, and would be for as long as she needed me (see Eissler, 1955, pp. 126, 197).

She was the older of two girls. Her sister had had training as a social worker, but was happily married and no longer working. Her parents were hardworking, well meaning, somewhat simple people with very clear-cut Fundamentalist ideas of right and wrong. Although the patient had rebelled considerably against her parents' religious beliefs during adolescence, she and her family had remained on good terms and quite close. She had been her father's favorite, had felt closer to him than to her mother, and they had shared many intellectual interests. She had repeated many aspects of her relationship with her father in the relationship with the minister, and subsequently repeated these early in treatment with me. She felt that she and her mother had never had very much in common and described her mother as timid, overanxious, and not much interested in anything outside of the home. This was in contrast to the patient who, although very interested in her husband and children, read a great deal and was active in local politics. The patient felt that her mother had been much less helpful than she might have been during her growing up. This particularly referred to adolescence when the patient had been quite rebellious and argumentative in her attempts to free herself from this somewhat close and restrictive family. The patient's mother had handled her rebellion by silent but visible worry and by impatiently telling the patient that she had to learn to think for herself. The patient felt let down by her mother's refusal to help. These were, of course, current complaints as well. This problem recurred in treatment in that she was very anxious about allowing herself any regression with me at first and felt that I, too, placed a high premium on her acting like an adult no matter how she felt.

Her childhood had been relatively unproblematic. She had done well in school, had had a series of best friends, been popular in high school, had begun to date then and had been "in love" with two different men before she met and married her husband. In late high school and college she had vague career plans of teaching English literature and of writing. She did teach for a while early in her marriage while her husband was still in school, and she had continued to write poetry for her own pleasure until the birth of their first child. She began again to write poetry in the months following the appearance of the metastases.

Her husband was a warm, sensitive, intelligent, ambitious young man who shared his life with her to her very great pleasure. Except for occasional arguments about his somewhat problematic and widowed mother who periodically decided she wanted to come to live with them, the marriage had presented no problems. Mrs. B. was basically a cheerful, optimistic, highly intelligent woman who had derived much pleasure from her marriage and her children. Her sexual life had been deeply satisfying to her and another contributing factor to her presenting depression was that pain and fatigue, combined with some reluctance on her husband's part, had sharply decreased the frequency of sexual intercourse in the months preceding my seeing her. She attributed falling in love with the minister to this. She was very worried that her husband no longer found her attractive now that she was ill.

The patient's relationships to her two sons were complex. Both were happy, spontaneous boys whom she enjoyed. It early became apparent that she at times identified with the older boy. As she became less and less well and more concerned about dying, she became fearful about his starting school without her and about how lonely she expected he might feel. A major goal for her became that she stay alive until he was safely started in school and not "by himself." In fact, she did accomplish this, became totally bed-ridden shortly after he started school, and died within three weeks. She had much less to say about her younger son. It was apparent that this relationship had been considerably more ambivalent from the start because the malignancy had been part of the pregnancy and the early months of his life. She struggled to fight off the irrational feeling that she might never have had cancer had it not been for this pregnancy. It felt to her increasingly that he was living at her expense and she was much troubled by her impatience with him. Talking about this helped substantially, but their relationship was never free from problems. It was this son about whom she most worried during a brief period in which she wondered if cancer might be either hereditary or contagious.

Treatment can perhaps most easily be summarized in terms of her relationship to me. The very fact of her prospective death had seriously disturbed her relationships with those who meant most to her but had in no way impaired her need for people, had in fact increased it. She very quickly became intensely involved with me. My statement that she was entitled to help and comfort and my intervention regarding the drugs undoubtedly facilitated this. In the second hour she questioned me about my training and my professional life and made it clear that she was worried that I might feel as defeated about her dying as her other doctors seemed to. I assured her that I was willing to help her in any way that I could and that this certainly included helping her with her feelings about dying. When she asked if this might not make me uncomfortable, I replied that I would try to help her in any event. She then began to discuss religion and philosophy with me, in large part I think to see whether I was really willing to help her with her feelings or would, like her parents and the minister, succumb to religious platitudes or withdraw out of my own discomfort. I did neither, and out of these discussions emerged several problems. She was afraid of dying alone, of becoming less and less attractive, "sick," and having people lose interest in her, a fear which was partially substantiated by the way her family had turned away from her. She also feared the gradually increasing sense of helplessness that her physical incapacitation was giving rise to and was in part using her intelligence to help to master this difficult situation. She was also using the philosophic discussions in an attempt to gain my approval of how "adult" she was being. Discussion of these problems gradually led to a diminution of her depression, complete absence of any talk of suicide, impressive absence of anxiety, and an increased sense of well-being and of hope which was quite at odds with her deteriorating physical condition. She was physically more comfortable during this period because of adequate medication. At this same time she asked to borrow some books of mine, which I loaned her, and she began to bring me poetry which she had written earlier. I quote one poem to illustrate her preoccupation with separation.

> To die is such a lonely thing,
> We cannot take one friend along.
> To hold a hand would make it
> Far less a frightening song.

With this she began to share with me her grief over dying, which to her essentially meant leaving those she loved best. Despite occasional interruptions by her worsening physical condition, mourning continued in one form or another until her final coma. She began by talking about the relationship to the minister and how hurt and angry she had been at his misunderstanding her need for him and his present avoidance of her. She told me in detail how they had met, the discussions they had had about her illness, and what they discussed during the times she was discouraged. She wept over his leaving her when she needed him most. She was very scornful of this kind of "religion," but also felt that he was to be pitied as he apparently did not have the strength to remain with her to help.

This led to her feelings about her husband's withdrawing from her. She understood that he was grieving himself, was hurt by his inability to help her with her feelings, but for the most part was protective about his feelings. Except for occasionally talking of feeling irritated by the lengthy hours he worked, she expressed little anger about him. She gradually told me about her marriage and relationship to her husband, of their courtship, honeymoon, the earlier happy times that they had had, his hopes and aspirations about his profession, and how she shared these. She was deeply grieved by the fact that she would not be around to continue to share his life with him; she hoped he would marry again, but preferred not to think about this. She discussed both pregnancies and her relationships with both sons in equal detail, again with emphasis on how sorely she would miss future participation in their lives. She allowed herself some daydreaming as to what she hoped their futures would be like. All of this seemed very much like working through in mourning, was accompanied by appropriate crying and by occasional denial, although the denial was almost always in the form of giving herself an extra year or so of life, not of being cured. Her ego never permitted her any convincing fantasies of a hereafter in which she might continue to be aware of the lives of those she loved. Death to her meant the end of these relationships and a separation from those she loved best. She was angry at the unfairness of her early death and talked with intense feeling of the impending loss of those she loved most and the experiences she would never have with them. She tried to console herself by reminding herself of the things she had already had, but until she was much sicker physically, she found little comfort in this.

She was both angry about and defeated by her parents' current minimal participation in her life. For the most part, however, she viewed her parents protectively and felt she was saving them pain by not insisting they spend time with her. This seemed to repeat aspects of her adolescent emancipation from her parents. Memories of earlier aspects of her relationship to them never appeared directly except for the nostalgia for the intellectual relationship she had shared with her father, which was now precluded by his age and illness as well as by his feelings about her death.

Her pain and insomnia during this six-week period were well controlled by drugs, but her weakness and weight loss were increasing, and she had had several hemorrhages from minor bruises. Her surgeon decided to hospitalize her for another course of X-ray and for transfusions. By this time she was beginning to look grotesque because of skull metastases, and shortly after hospitalization she became comatose, presumably from increased intracranial pressure. She was promptly treated and regained consciousness gradually over a period of three days.

First Regression: Externalization of Superego and Identification

However, this sudden severe clinical change brought about a striking change in our relationship, the first obvious regression, and from this point on there was no question that she was repeating with me aspects of her earlier relationship with her mother. She herself perceived the regression and was briefly apologetic "for being such a baby," but as I explained this as an expected part of her illness, she became less ashamed. My manifest response to her underwent a change at this time, too, in that she was obviously much sicker, and communication was no longer on an exclusively verbal level. She frequently needed physical care during the time I spent with her, and I made her bed comfortable, fed her at times, and at other times simply sat quietly with her. She often asked me to stay with her while she fell asleep. Essentially I responded to her regression by assuming certain necessary kinds of ego functions for her, in effect began to function as an external ego in much the same sense that the mother's ego functions as an external ego for that of the developing child. Clinically, the patient's affective response made it easily possible to judge the amount of this that was necessary: too little help made her ashamed about the regression, whereas too much made her impatient and angry with me.

As she became more alert, she reported the only dreams she told me during therapy. These were a series of dream fragments having to do with physical activity: she was a child again and running happily; she was swimming at the country club to which she belonged; she was jumping rope as a young girl; she was playing tennis as she had done the previous summer. All of these dreams seemed essentially to represent the wish to be well and active; they also illustrate regression to the simple wish-fulfillment dreams of childhood. They were reported with sadness, but, as she associated to them, she began to be irritated with me. Discussion of the irritation brought into focus her intense envy of me which had been present but unverbalized from the beginning. She envied my relative youth, my health, my activity, the fact that I was not sick and helpless as she was. She also was jealous of me, said she had recently become very troubled by a recurring idea that I might marry her husband and care for her children after her death. She also reported that she was even more worried that her mother-in-law would replace her with her children and had made her husband promise that he would not permit his mother to move in with him after her death. Her jealousy and envy of the minister's wife had also been intense, but she had been too ashamed of this to tell me earlier. As she spoke of these feelings about me she first apologized but gradually became very angry and demanded that I stop seeing her because the comparison between our relative states of health and attractiveness was more than she could bear. I told her that these feelings were certainly understandable in these circumstances, that I understood how angry she was at me, but that I did not feel that this precluded our continuing to work together, that I really wanted to help her. I also made the only transference interpretation I ever made to her, vague and incomplete though it was: that part of what troubled her was that because she was sick, she was refeeling with me some of the feelings she had had as a child about being a child and not able to do what her mother did. She seemed relieved by this, smiled, and said she had changed her mind about firing me. Both of these issues came up several times again but never with the same intensity, and were more often apparent in attempts to identify with me. She knew my schedule of teaching activities, for instance, and would imagine herself in my role at various times of the day, spent considerable time imagining what I was doing and where I was. The oedipal transference was readily apparent and the ambivalence apparently solved by her childlike identification with the positive side of the ambivalence. In essence I allowed her to externalize her punitive superego and gave her an ego ideal she could live up to when I accepted the jealousy and envy as part of her illness.

Her strength partially returned and she again went home and resumed some care of the children. The older boy's starting school increasingly became a focus of worry and, for her, a compelling reason to husband her energies. She made repeated references to the hope he would not have to do this without her as she was sure this would be terrifying for him. Initially this was a puzzling preoccupation, especially so in that her own first days at school had not been in any way disturbing, a fact confirmed by the patient's mother as well as by the patient. Continued discussion of this, however, indicated that she was equating his starting school with her own approaching death and that she was quite troubled by the idea that she "knew no one there," would in effect be a stranger among strangers as she expected her son to feel in his early days at school. That this patient had had no deaths in those closest to her may have contributed to this preoccupation as she had no one to "join in death" in fantasy (Brodsky, 1954; Jones, 1911).

After a brief period at home she again became so weak that hospitalization was necessary for rest and for transfusions. She had been complaining of periodic visual difficulties for several weeks and feared she was losing her sight, although she had hopefully attributed this to bouts of weakness. While in the hospital she gradually became intermittently blind. She showed more severe anxiety about this than she had about any previous symptom. It was a concrete sign of the nearness of her death, of course, but to her this meant that she was about to be completely cut off from the people around her, by this time especially from me, and she was terrified of what she envisioned as a life in which she was mentally alert but remote from contact with people.

Second Regression: Externalization of Ego

During the first few days of her blindness I spent extra time with her and at her request visually described and identified for her hospital personnel and the details of her room; she was particularly interested in knowing what clothing I was wearing and was pleased when it was something familiar to her. I also did my utmost to demonstrate that while visual communication was seriously interfered with, we retained the equally important avenues of communication of talking and of touch. She likened these to the way a baby must feel, that feeling physical closeness and hearing the sound of mother's voice might be of as basic importance as seeing. I read to her—she particularly liked the 23rd and 121st Psalms—and I sat close enough that she could touch me or I her at any time. She often drowsed or fell asleep during these hours, and I had the impression that my physical presence and the tone of my voice were almost more important than the verbal content of what I said.

This outbreak of acute anxiety, in fact the only such outbreak during treatment, at a time when her relationship to me was threatened by blindness is an impressive illustration of the level of ego regression. By this time I had assumed for her many aspects of ego functioning. Her anxiety signaled the danger of ego disruption at the threatened loss of my supporting ego. This is, of course, an infantile form of separation anxiety. I responded to her anxiety with a marked increase in my availability to her and by "loaning" her my sight as well as by reassuring her that her loss of sight did not mean a disruption of our relationship. Her anxiety diminished with this.

Third Regression: Introjection

Further ego regression assured continuation of the relationship, for soon thereafter she began to talk of an all-pervasive sense of peace and contentment which was quite at odds with the clinical picture but was related to what she described as her "silly illogical imagination." Instead of imagining me in the various aspects of my life, she now felt I was with her twenty-four hours a day and she began to carry on imaginary conversations with me. Most of these that she reported at this time dealt with discussions of her feelings, but increasingly she felt as if I were always there comforting her, assuaging pain or physical discomfort and telling her she need not be afraid, that she was not alone.

She felt that her death was quickly approaching, asked that she be allowed to die at home, and I encouraged her sister to come and care for her there. At home she rallied briefly to get her older son started in school and then became partially bedridden. Her sister cared for her physical needs, and we both continued to talk with her, read to her, and to keep her as comfortable as we could. She drowsed frequently but remained very much alert and interested in the lives of her family when she was awake. The blindness was intermittent during these weeks. She began occasionally to call her sister by my first name and at the same time to me made several uncorrected slips of calling me "mother" (Saul, 1959). She questioned me closely about the time of my last visit and the length of my current visit (I was seeing her twice a day at this point) and always expressed surprise at my answers as she now "almost" had the conviction that I was always there. Occasionally she would wake in pain and be surprised to find me absent.

Eissler, in *The Psychiatrist and the Dying Patient,* says, "It is conceivable that through the establishment of transference, through an approach which mobilizes the archaic trust in the world and reawakens the primordial feelings of being protected by a mother, the suffering of the dying can be reduced to a minimum even in case of extreme physical pain" (1955, p. 119). Freud also mentions this as a possibility (1926, p. 171). The psychological suffering of the patient is also reduced to a minimum; in fact, this sense of peace and contentment seemed massively to protect against all affects of unpleasure. It was only at times of severe physical pain that the protection of this "hallucination" failed and then only briefly and without anxiety; the expectation was that I would "soon" arrive and provide relief. Here the regressive level is to that developmental stage in which the object is clearly perceived as an object, felt as continuously present, and the borders between external and internal are at times hazy. This not only had the effect of minimizing physical pain and psychological suffering but also seemed to prevent the narcissistic, hypochondriacal preoccupation that is so frequently a part of serious illness. That this level of regression in object relations coexisted with nonregressed ego functioning in other areas indicates only the complexity of the concept of regression.

She remained troubled by the conflict between this feeling of my continuous presence and the reality of the situation, however, and began to talk of her unhappiness that I would not be with her when she died. I at first thought she was referring to my physical presence and tried to reassure her, but it turned out that she had long since taken my presence during her death as an established fact. What she meant was that I would not be dying with her, that this we could not share.

Three days before her death and a few hours before she became terminally comatose, we had a long conversation about her dying. She told me her only remaining fear was that dying was strange and unknown to her, that she had never done it before. Like birth, it was something that only happened once to any individual, and that similarly one might not remember what it was really like, only know that it had once happened. She no longer worried about what was to happen to her after death any more than an infant being born could worry about what his future life might be; she felt that she might be unnecessarily concerned with the actual process of death itself. She then asked me if I had been with other patients when they died and seemed relieved by my affirmative answer. One very comforting recurring thought to her was that throughout the centuries many people had died before her; more importantly, it had occurred to her that I would share this experience with her, although not at this time. I agreed that this was certainly so and added that I hoped I might equal her courage. She was pleased by this, and she then reminisced about our relationship. She recalled our first meeting and smiled in retrospect at her needless reluctance at seeing a psychiatrist. She thanked me for having helped her, particularly not to commit suicide, which she now felt would have been most difficult for her family, especially her sons. I was obviously moved by the finality of all this, and she chided me about being much more involved with her than doctors should be with their patients, and abruptly cried. Her regret was that we had known each other so briefly, that she was dying without ever knowing me really well. I said she had known me rather better than she might think, that I felt it a great privilege that she had shared this experience with me and that I, too, wished we had had more time together. She asked me if after her death I would wear for her a red dress she had bought just before she became too sick to have any fun—she wanted "the dress to have some fun." I agreed, thanked her, asked whether there was anything else I might do for her, and she asked that I again read the 23rd Psalm. In the midst of this she interrupted me by crying. She said she would miss me terribly but somehow knew I was "always there" and asked that I hold her hand while she fell asleep. I did, and this was the last time the patient was conscious except for very brief periods that afternoon. She became comatose later on in the day and died three days later without regaining consciousness.

Eissler feels that mourning would ease the plight of the dying patient by accomplishing a decathexis of objects prior to death and that therefore death could be accepted as a "natural consequence of an energic constellation in that moment." But he feels that this is not likely while "perception conveys the fact of the existence of the love objects" (1955, p. 181). Mourning was a very prominent feature of this patient's last few months of life; although part of this seemed to have resulted from the emotional withdrawal of those around her, part was also related to her knowledge of her death, its meaning to her of separation, and to the physical changes in herself. It is worth noting that the order in which she grieved was chronologically significant. She began with the most recent relationship, the minister, and followed this by mourning the loss of her husband, and her parents. The grief about her two sons was a relatively continuous process in that mourning them was very intimately related to mourning the loss of her health, her productivity, and her own future. What seemed to happen was that libido detached from objects through mourning gradually found a transference substitute in me. However, at the end she was presented with the impending conclusion of our relationship by her death. During the last hour she mourned this but also solved the problem by extending her own life through me through the gift of the red dress, and by taking me with her in death "although not at this time."

DISCUSSION

This case has been presented in considerable detail because of the relative rarity of such cases in the literature and because of its theoretical and therapeutic implications. The patient's presenting despair and grief about dying are far from unusual; that family, friends, physicians, and clergy often turn from the dying in one way or another need not surprise us. As Eissler points out, many factors have tended to exclude the psychiatrist or the analyst from the bedside of the dying patient, not the least of which are the unusual demands on time (1955, pp. 240-253).

Eissler says that the technique of the treatment of the dying patient must center around what he calls "the gift situation" in which the psychiatrist must create the proper time to make the right gift. The gift is experienced by the patient as "an unusual . . . favor of destiny" (p. 126). This case would suggest that the really crucial gift the therapist can give is that of himself as an available object. The treatment of this patient can be simply summarized as a process in which I helped the patient to defend herself against object loss by facilitating the development of a regressive relationship to me which precluded object loss.

The patient came into treatment with me anxious, depressed, and contemplating suicide in her despair over the failure of those around her to respond to her need for them. Once she established my willingness to be with her and to try to help she quickly agreed to psychiatric treatment. She initially tested my willingness to help her by engaging me in religious and philosophic discussions of the meaning of death, as if to make certain that I would not be driven away by the mention of death as an abstraction. In retrospect I think she was also exploring my own attitudes about death. Satisfied that

I could listen and remain with her, she then allowed herself to grieve with me the actual and potential losses she was facing—her husband, children, family, her health, and her future.

While the mourning was still in progress, she became temporarily physically very ill, briefly comatose, and from this point on she was consciously very preoccupied with her relationship to me. One of her first worries on regaining consciousness and perceiving her regression was that she might have become "too much of a baby" for me to continue to help. When I reassured her about this, she for the first time began to express the envious, hostile competitiveness of the oedipal transference, which was also a threat to the relationship. My interpretation of this combined with her intense need for a relatively unambivalent relationship with me allowed her to re-externalize her superego and to identify with the positive side of the oedipal ambivalence.

Later on, when blindness intervened, the anxiety was again that this seriously threatened her relationship to me. She solved this by a further regression to a level of object relationship in which she hallucinated my presence and the boundaries of external and internal were at times blurred. The tenacity with which she clung to this object relationship despite all vicissitudes was extremely impressive. In the last hour she solved the problem of threatened loss of me by feeling that I would be with her in death, "although not at this time." In the course of dying this patient's ego permitted massive regression in many areas, all of which was apparently in the service of maintaining an intensely cathected object relationship with me.

The protection this relationship provided her against anxiety and depression was extremely impressive. Although she grieved throughout treatment, depression was never a serious problem, and the only massive anxiety occurred briefly at the time of her blindness. In addition, despite both pulmonary and bone metastases, she was relatively free from pain on comparatively small amounts of morphine. Freud remarks in *Inhibitions, Symptoms and Anxiety* that "when there is a psychical diversion brought about by some other interest, even the most intense physical pains fail to arise" (1926, p. 171). This case amply bears this out. Interestingly enough, the intensity of the relationship also precluded the increased narcissism and bodily preoccupation that are so frequently associated with severe illness. It would certainly suggest that such symptoms, often assumed to be an inevitable part of the chronic or fatal illness, can be obviated by a therapeutic approach such as the one presented here. It is tempting to speculate that at least in certain patients many problems frequently met with in dying patients, i.e., denial, anxiety, depression, increased narcissism and apathy, may be a result of actual or anticipated object loss and are by no means intrinsic to the psychological response to death. Certainly there is no question that a therapeutic approach such as I have outlined could be expected substantially to ease the suffering of many dying patients and add greatly to our knowledge of the metapsychology of dying.

In summary, the essential therapeutic tools in the treatment of the dying patient are the therapist's constant availability as an object, his reliability, his empathy, and his ability to respond appropriately to the patient's needs. Once Mrs. B. was truly convinced I meant it when I said I would be with her until her death, she made few demands for extra time; I did, however, offer this unasked at crucial times for her, such as during the early days of her blindness.

An essential prerequisite of therapy with the dying is consciously accepted countertransference. The dying patient specifically confronts the analyst with guilt and with an injury to his narcissism; that the patient is actually dying inevitably mobilizes the analyst's childhood death wishes and at the same time serves as a painful reminder of his own mortality. Defenses against either or both countertransferences in large part explain why dying patients are so often left to die alone. The analyst's defenses against these will distance him from the patient in one way or another and inevitably seriously interfere with his ability to respond appropriately to the patient's needs. The last hour illustrates this well. Both the patient and I knew she was very close to death; she solved the problem of our separation by taking me with her in death. She generously provided me with a partial defense by adding "although not at this time." She also relinquished to me the oedipal struggle by bequeathing me her favorite dress, the one she had bought "for fun." I was aware of grief, guilt, anxiety, and anger during this hour, but I am sure it is apparent that defenses against any of these countertransference responses, whether denial, reassurance, repression, overprotectiveness, false optimism, or intellectualization, would have markedly interfered with my usefulness to the patient as the object she needed. My conscious awareness of the sources of these responses was what made it possible for me to respond appropriately in terms of her needs. In essence, the dying patient inevitably provokes countertransference responses in the analyst, but acceptance and utilization of these can be most therapeutic for the patient.

SUMMARY

A case report of the treatment of a patient during the last three and a half months of her life has been presented. The case suggests that a major psychological problem of the dying patient is that of both actual and threatened object loss. A method of treatment has been described which provides massive protection against both physical pain and psychological unpleasure, and certain theoretical conclusions about the psychological problems of the dying have been drawn.

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