

VOLUME III, NUMBER 1 1984

AUSTRALIAN
[JOURNAL OF]
PSYCHOTHERAPY

Published by The Psychotherapy Association of Australia

Psychotherapy in the Dying and those with Incipient Bereavement

Paul Valent¹

With ever-increasing awareness of the dynamics and problems involved in the dying and grieving processes (1-8), the question may be asked whether psychotherapists may usefully contribute their skills to these processes in such a way as to make these processes meaningful, rather than the experiences of maladaptive suffering which they often turn out to be.

Much has been written on the stresses of bereavement, which may lead on to later physical and psychological illness (9-13). However, little seems to have been done in a preventative way to preempt such later dysfunctions (14, 15). There may be room for corrective interventions soon after bereavement, or even with anticipated bereavement. The concern of this paper is the latter possibility. Such treatment may be more useful than treatment relating to psychosomatic illnesses and unresolved grief reactions later on.

Communities are becoming more aware of the need for better dying and grieving. The growth of self-help grieving groups is a manifestation of this. It may be that more people will be asking for professional help toward a better death or better grief. Is this a field where psychotherapists may usefully contribute?

This paper contends that helping the dying and the families of the dying can be a valid psychotherapeutic endeavour. However, it is a difficult endeavour which needs to include the burgeoning knowledge relating to the processes of loss and grief. As well as this, the psychotherapist's usual skill will be taxed to the full with manifestations of basic, intense emotional communications which in ordinary therapy may come to light only over a period of time; and with very intense transference and particularly countertransference phenomena which need to be understood for proper treatment to progress.

1. Dr. Paul Valent, M.B., B.S., D.P.M., F.R.A.N.Z.C.P. In private practice, and Consultant Liaison Psychiatrist to the Casualty of Prince Henry's Hospital, Melbourne.

Though not psychotherapy in the orthodox sense, psychotherapeutic understanding is an extremely important element in treatment. The understanding may need to be exercised in a very disciplined way, though the structure of the therapeutic situation may need to be flexible and be adjusted to the needs of the situation.

A clinical case will now be presented in order to illustrate some of these points.

The case of Mr. Johnson and his family

Mr. Johnson was a 61-year-old widower with three daughters who was referred, a little sheepishly, by a gastroenterologist colleague. He stated that Mr. Johnson had carcinoma of the colon with liver metastases, and was now in the terminal stages of his disease. Mr. Johnson and his doctor daughter requested to see someone because of Mr. Johnson's "depression", and his "attitude to his condition".

Just prior to the session where Mr. Johnson and his daughter Rosemary were to come, the middle-daughter, Julie, rang to ask whether her father would not receive best treatment in a hospice. I suggested she come with her father and Rosemary to discuss the matter. She came with them but did not mention the hospice. The idea was used as a reason to be involved in the process with the others.

Mr. Johnson was a short man who did not look terminally ill, though his usual dignity seemed crushed by circumstances. However, it quickly asserted itself when given a chance. His daughters were in their twenties.

Mr. Johnson started by saying that he had been told that he had secondaries and his daughter Rosemary had talked to the doctors and she told him he had between three and six months left to live. In his perception he was given two tasks: one was to cope with a lot of pain up until his death; the other was to go through some stages until he accepted his death — according to a book he was given (Kübler-Ross's *On Death and Dying*). One could sense suppressed resentment to the doctors who handed out painful news and then expected him to "accept" this with good-humoured stoicism. His daughter and I were also among these doctors, though one sensed that he also clung to doctors for his intense needs. The blame on the doctors who "told me nothing and Rosemary had to inform me" turned out later to be unjustified, in that the information the doctors did impart soon after his surgery was too much for Mr. Johnson to assimilate at that time, and was mainly repressed.

The daughters complained that though their father had to die, he was not living the life remaining to him as happily and fully as he could. Thus he rejected holidays to Europe and even locally. He did not even seem to enjoy friends he liked. He seemed to have given up.

Mr. Johnson accepted the guilt implied in these remonstrations. He said he really did not feel like going on holidays, nor did he feel like seeing all his visitors. As the session progressed he also said he resented everything being done for him — his bed, cooking, etc. Finally, however, he expressed his greatest anguish — “I don’t feel I have any feelings for my daughters, and I never have had. Ever since my wife died, especially, I only performed my duty, and pretended.”

Rosemary burst into tears, saying, “You’ve been the most wonderful loving dad, it’s just that lately we have lost you.” Mr. Johnson went over to Rosemary, obviously emotional, and comforted her. Everyone noted silently how much emotion each one had, but did not acknowledge. It was confirmed how choking off of emotion left one with a sense of guilt for being abnormal and not loving.

Thus there was a shift from negation of the pain of loss through the approaching death. The book on dying was used as an intellectual defence where ready “acceptance” was “being together” and “being happy”, rather than being separated and depressed. The holidays were to be a symbol of this happy cohesiveness. Through the session, there was also a shift in authority. The father obviously came to lead the way, by expressing his feelings, whereas he was resentfully and despairingly passive in the beginning.

It was agreed in that session that the father would not be imposed on with holidays and excess visitors. The daughters would protect his privacy according to his desires. They would allow him to cook and make his bed. There was relief in the daughters that at last they could do something to please their father. It was agreed that the remaining, eldest daughter would be invited for next time. We also agreed that I would keep the same time each week available for the Johnson family.

In fact I saw Mr. Johnson in five consecutive weekly sessions, either alone or accompanied by family members.

Mr. Johnson came with all three daughters to the second session. He started by saying that he felt a whole lot better because he had cried. It was real heart-wrenching crying of the sort he did not know he had in him. It was a relief to know that he was not emotionally dead.

The eldest daughter Christine had some catching up to do. She started by attacking doctors. Doctors are often scapegoats for the anger associated with incipient loss. She said that the specialist suggested a blood transfusion, but the general practitioner did not favour this. Her father followed the latter’s advice. What right did doctors have taking away the enjoyment of life which the transfusion would enable her father to have? Again, enjoyment of life was to replace the inevitable loss of life.

But the attack on doctors had another meaning. Rosemary as a doctor had a greater piece of the paternal cake than the others. Yet whatever privileges with the father the power of being a doctor was used for, and whatever greed and envy were felt by the daughters, in a sense they were all defences against acknowledging loss. I suggested to Rosemary that it might be hard to be a doctor, because one had to be hard and callous. For instance it must have been difficult to tell dad that he had between three and six months to live. Rosemary started to say that it was not difficult as she had to do such jobs often, but she was overtaken by tears. The sisters were taken aback. The power of the favoured doctor-sister concealed just another grieving daughter like themselves.

They were able to deal with envy now that it was out in the open. Christine was resentful that because of her small children (whom father did not like) she could not see as much of father as the others. She was reassured that Mr. Johnson liked her children, but because of his condition could only take little of them. Two positive factors came out of this turn of conversation. Firstly, Mr. Johnson’s diminished self-esteem was given a boost when he saw himself as a valued object his daughters fought over. This re-established his past parental duty to help settle such matters of the children fighting for his attention. Secondly, it spurred the daughters to resolve their mutual envy, for as it was pointed out, they were all equally in the same boat. None of them would have father for long, and they would only have each other after his death. It would be a pity to build up mutual resentments for the future through unnecessary jockeying for father currently.

It was decided that the daughters would resolve among themselves a fair system of attending to father. Father would oversee any problems which might arise. In fact the daughters and their spouses arranged to mind Christine’s children so all daughters could have equal access to father.

Once loss became the central issue, clinging to father and fantasies of happy togetherness through blood transfusions and holidays lost their

importance.

Mr. Johnson directed that he alone attend the next session.

He needed to consolidate his situation and have an "adult to adult" conversation without his children. He explained that what others saw as him having "given up" to him just meant accepting the inevitable. He did not want prolongation of life which would be just pointless. That is why he did not want the blood transfusion. He explained how he found visitors a burden. They came to cheer him up when he did not want this, and they filled his valuable time with things like talk of golf which no longer had much meaning for him. He felt that he was on a path of no return. Actually he would not want to return even if a reprieve were offered him. His perceptions and desires were confirmed as valid, as was his right to determine how to run his life.

We discussed the parental role he was performing by teaching his daughters about an aspect of life which was dying and losing. He took some pride in this.

He said that his brothers had difficulty in coping with his dying. I suggested that he may bring them.

He asked why it was that though he always loved the flute he could not listen to it now, especially his favourite Mozart *Flute Concerto*. I suggested that it might be painful to listen to something he loved, possibly for the last time. There were many things to which to say goodbye, each painful. He nodded assent. I later learnt that he then played his favourite records at home.

Mr. Johnson took leave saying he would call me if he needed me. Mr. Johnson liked to feel that he was in charge of his therapy. Yet throughout our brief encounter he attended punctiliously, and regularly.

After duly calling me, Mr. Johnson came for his fourth session with his two older brothers. As usual, they started by being angry with the doctors who gave addictive narcotics which placed Mr. Johnson in an unnatural happy but distant frame of mind and he was not amenable for discussions of an ordinary nature. Would he not get addicted to these drugs? Is it not more natural, even if painful, to suffer pain rather than suppress it? Mr. Johnson seemed crushed with this onslaught like he was when he came to the first session with his daughters. With mild encouragement, however, he was able to defend his right to not feel pain. I reassured the brothers about the addiction, and Mr. Johnson said that when he appeared distant it

was not due to the drugs, but because he was either tired or had thinking to do. He could not be bothered with much of the conversations which were a burden to him. The brothers were hurt, but it was explained that Mr. Johnson would like to talk to the brothers, but they always veered the conversation away from what was meaningful to Mr. Johnson in his dying condition. His being "away from them" when due to tiredness or need for introspection was like a partial death by him already, and was very difficult to take.

The word death was a shock. I suggested that it was hard to accept that their brother was dying. It was indeed, and should he not keep fighting and hope for a miracle? Mr. Johnson explained he accepted that he would die, and did not wish it otherwise. Nor did he wish for the hypocrisy of invoking miracles. Again there was painful relief that the forbidden subject of death could be talked about. In fact in the past the brothers felt at a loss as to what to do for the best. It was gratifying to know that the best was to be truthful. There was a thawing of emotions and interrelating just like there was in the earlier sessions with the daughters.

One brother, after struggling within himself, eventually asked what Mr. Johnson thought about the painting which the brother had given him recently and which was opposite Mr. Johnson's bed. The importance of the picture was clarified as one of the brother's best, a special gift to the patient, and also a means to be symbolically always there with him. Mr. Johnson replied that the picture gave him much pleasure, except for one part which was artificial and had been done for reasons of convention.

Returning to hypocrisy, Mr. Johnson mentioned that he hoped his funeral would be free of it. For instance, he did not want glorified speeches about himself. It was resolved that the brothers would discuss the funeral arrangements with Mr. Johnson further, and inform the daughters of Mr. Johnson's wishes. There was a lively exchange of feelings now. Some were warm, others painful, yet others conflicting. For instance, the eldest brother argued in favour of some religious faith. The brothers were brothers again. In the end the two brothers agreed to differ on religious outlook. Mr. Johnson had set the pace again. He was now obviously physically deteriorating.

Mr. Johnson came alone for his fifth and last session. He looked worse. He started telling me that he had severe chest pains the day before, reminding him of his heart attack a year prior. Then, as on the day before the session, he had felt panic but then settled down in bed and expected calmly whatever might happen. He then recounted two

other times he nearly died — with a gangrenous appendix as a young adult, and diphtheria as a child. He recalled his father's long and painful illness. It was actually that illness which had made him believe he would also suffer much pain over a prolonged period before he died. We discussed how this was not inevitable, and that he was a different man from his father.

Mr. Johnson described some strange phenomena which he had experienced and not understood. Sometimes he felt outside his own body, and looking down on himself he felt it was someone else dying. At other times he felt that his right side was sick but he existed in his healthy left side. It was explained that the mind had tricks which could allow him to imagine that there was nothing to fear. He described how indeed at other times he felt scared and small in face of the overpowering force of fate against which he could do nothing.

Mr. Johnson asked me how I thought he would be at the time of his actual death. It worried him that he might not handle it well. I pointed out that he had rehearsed his dying the day before and he re-experienced his near death from the previous year. Possibly he would be quite scared with the advent of death again, but would quite likely settle as before, and expect what had to be, calmly. I even thought that there was a possibility that he might have some power to influence his actual dying.

He agreed that he had arranged all his affairs. He was pleased with the state of his daughters, except he worried about how Julie would take his death. He felt he had achieved his aims with me. 'I understand my feelings and so I am armed for the path to death. The black hole about me has disappeared, I don't want to stop now.' He estimated that he would die somewhere between two weeks and two months from then.

Mr. Johnson then acknowledged the work I had done with him, and the process of therapy which he found interesting and helpful. I acknowledged my respect for the style of his living, working and teaching his family and me. There was some surprise at the latter assertion but pride and dignified acceptance of what I said.

Characteristically, just when it was time to end the session he said, 'I want to chuck it in now, I've had enough. I had no drugs before I came today. You see me as I am, without props.' He said goodbye.

By chance I had feedback on what happened thereafter. Mr. Johnson died exactly one month after our last session. He had much communication with his daughters before he died. Much of it was not through

talking. For instance one daughter rubbed his feet for hours on end to keep the pain out of them. All three daughters were present when he died. His last act was a long meaningful look at Julie. He died looking at her. All the daughters were content about this. Julie had been the rebel in the family. All felt that the last look signified final rapprochement between father and daughter. All the daughters were now equal in their griefs. The funeral was a particularly poignant secular one, and Mr. Johnson's favourite Mozart flute concerto was played as he was lowered into his grave.

Discussion

We see that unresolved grief reactions may start before bereavement, and that useful interventions may help their prevention both for the dying person and for his family. If normal progress can proceed, incipient death and bereavement may be crises like others in life from which the participants can gain increased maturity and growth and meaningful relationships. The crisis of incipient death is perhaps more insistent than others, with a specific time urgency. This may make the crisis more intense and compelling, with participants wishing dearly to resolve their problems. Interventions therefore may be more acceptable and rewarding.

If one views dying and incipient bereavement as a crisis, the focus of the crisis is loss, and the focus of therapy the facilitation of normal grieving. The grieving may be shared for a time by the dying person and his family, to the mutual comfort of both parties.

Severance of attachments and reactions to loss have been described by Freud (1), Bowlby (3), Parkes (4) and Kübler-Ross (5). The dying and the bereaved show us acute manifestations of reactions to loss which may otherwise only be observed in babies or other major traumatic situations like disasters. In therapy with the dying and the bereaved or incipiently bereaved it is imperative to be aware of the biological, psychological and social manifestations of the dying or grieving processes, and their evolution over time. The psychological aspects include the affects, and defences against painful affects. Evolution of the dying or grieving processes over time does not imply a mechanistic passage over "stages". For instance, we saw that Mr. Johnson experienced denial, bargaining, panic, depression and acceptance, all within the time of his last session. The somatic, psychological, defensive, and social aspects of grieving in its different phases, the meaning of these phases and treatment appropriate to them has been described by the author elsewhere. (8)

Treatment in this family focused on bringing the already existing loss

and the greater incipient loss to consciousness, so that the affects in relation to the losses could be dealt with and shared. The therapist gave permission and helped to shed the burdensome defences each person had (e.g. of denial). This then facilitated expression and sharing of the affects, with much relief. Grieving could then proceed.

Observation of the grieving process "in vivo" raises some interesting questions. For instance we have seen the guilt expressed by Mr. Johnson for not feeling towards his daughters, as a result of suppressed emotions. We wonder how much guilt subsequent to bereavement is due to similar experiences of subjective callousness towards the dying person. Such guilt among survivors has been described among concentration camp and atom bomb survivors (16) and has led to unresolved grief. Certainly denial, here unlocked before the death, is known to enhance unresolved grief reactions. Similarly, anger toward the person who refuses to stay alive (not enjoying holidays offered, not participating vivaciously in conversations, refusing blood transfusions) may not be dealt with at the time and may remain as anger, and guilt for the anger, after bereavement.

Therapy of this type is intense and involving. There is no emotion or defence against it which the therapist does not feel himself. The author felt along with the family members the temptation to isolate affect and on his part to see Mr. Johnson as "a case of dying". It would have been easy to go along with the intellectualisation of the dying stages. The actual experience of them, similar to the family's experience, was quite another matter.

There were more subtle countertransference problems. It was a little disconcerting to keep appointments open for Mr. Johnson and not know if he would take them up. In fact he always informed me with utmost courtesy and in good time prior to each appointment time that he would come, and he informed me with whom. To have insisted on regular commitment of appointments would have denied the actual uncertainty about his ability to come, and taken away the sense of control which was so important to Mr. Johnson. I offered to see Mr. Johnson at home if he could not come to me. It was important for Mr. Johnson to not accept this offer, and to press it would have been akin to the relatives demanding their time with him. In fact Mr. Johnson and I developed a relationship of mutual respect. It was a real loss to lose him and this had to be worked through by the therapist separately. It could have been tempting to act out the therapist's grief (or denial of its parts) in therapy, or to see Mr. Johnson in place of people the therapist had lost in the past, and try to work through some of the

difficult feelings left over from those bereavements. These aspects, too, had to be resisted. Mr. Johnson's unique individuality and unique working through were paramount, as were those of his family members.

In this short synopsis not every emotion and interaction and technique could be covered. For instance, the representation of the therapist as the doctors who allowed the death to happen, the blame and guilt of the dying and the bereaved for not stopping the killing process, the envy by the dying of the living (including the therapist) and by the bereaved of the non-bereaved therapist, all are examples of the intense feelings not covered, but very much a part of this type of therapy. However, the thread on which most attention was focused in this paper, as indeed it was in the therapy itself, was on facilitation of the acceptance of loss.

Summary

A case is presented which raises the possibility of psychotherapeutic help with dying patients and those around them with incipient bereavement. If possible, intervention at this stage may be more profitable and preventive, than later work on unresolved grief reactions. Work in this stage is very intensive and involving. The challenge may be very rewarding. To be armed for this challenge one needs a clear understanding of the framework of object loss in its biological, psychological and social aspects; and a grasp of the intricacies of the psychotherapeutic process including transference and countertransference phenomena. Interactions between the dying person, those incipiently bereaved and the therapist must be understood and dealt with. The therapy must be adapted structurally to the needs of the patient. The focus of therapy is the acceptance of loss, and thereby facilitation of normal grief processes in all.

More research is needed into the applicability of various psychotherapeutic interventions to the dying and to their relatives with incipient bereavement.

References

- (1) Freud, S. "Mourning and melancholia", XIV, pp.243-258, *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, tr. James Strachey, The Hogarth Press, London, 1961.

- (2) Engel, G. "Is grief a disease?" in *Psychosomatic Medicine*, 23: 18-22, 1961.
- (3) Bowlby, J. *Separation: Anxiety and Anger*, Pelican Books, London, 1975.
- (4) Parkes, C.M. *Bereavement. Studies of grief in adult life*, Tavistock Publications, London, 1972.
- (5) Kübler-Ross, E. *On death and dying*, Social Science Paperback, London, 1973.
- (6) Valent, P. "Issues with dying patients", *Med. J. Aust.*, 1:433-437, 1978.
- (7) Valent, P. "Management of the dying patient", *Patient Management*, 3:7-9, 1979.
- (8) Valent, P. "Death and the Family", *Patient Management*, 9:11-24, 1980.
- (9) Petrich, J. & Holmes, T.H. "Life change and onset of illness", *Medical Clinics of North America*, 61:825-837, 1977.
- (10) Cohen, F. "Stress and bodily illness", *Psychiatric Clinics of North America*, 4:269-286, 1981.
- (11) Weiner, H. *Psychobiology and human disease*, pp.612-618, Elsevier North Holland, New York, 1977.
- (12) Steptoe, A. *Psychological factors in cardiovascular disorders*, pp. 190,195, Academic Press, New York, 1981.
- (13) Barrett, J.E. (Ed.) *Stress and mental disorder*, Parts I and II, American Psychopathological Association Series, The Raven Press, New York, 1979.
- (14) Lindemann, E. "Symptomatology and management of acute grief", *Am. J. Psychiatry*, 101:141, 1944.
- (15) Raphael, B. & Maddison, D. "The care of bereaved adults", in Hill (Ed.) *Modern trends in psychosomatic medicine*, Butterworths, London, 1976.
- (16) Lifton, R.J. *Death in life. Survivors of Hiroshima*, Touchstone, New York, 1967.