

Issues in psychotherapy with terminally ill patients

S. TZIPORAH COHEN, M.D.,¹ AND SUSAN BLOCK, M.D.²

¹Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, Massachusetts

²The Dana Farber Cancer Institute, Harvard Medical School, Boston, Massachusetts

(RECEIVED March 7, 2004; ACCEPTED May 2, 2004)

ABSTRACT

Psychotherapy with the terminally ill poses special challenges for clinicians and in return offers unique rewards. As a time limited therapy, acceptance, rather than change is a primary goal; yet, patients can be strongly motivated to change. Patients may need to struggle with how to disengage while also maintaining connection. Unique transference and countertransference issues arise. The psychological tasks of dying include grieving, saying goodbye, constructing a meaningful context to one's life, and letting go. The therapist can serve as a companion and guide to the dying person as she or he negotiates these tasks. Through the use of a case example, these issues are explored from the perspectives of patient and therapist. The therapist must address the following issues: attending to physical suffering, differentiating between grieving and depression, addressing fears, facilitating the life review, and assisting in decision making. A dying patient's need to leave a legacy, complete relationships, grapple with spiritual and religious issues, and attend to his or her family, are often important themes. Therapists must work productively with denial, maintain flexible yet appropriate boundaries, grapple with their own anxiety about death, and grieve the loss of their patients. Psychotherapy with dying patients can help reduce their psychological pain, relieving psychosocial distress and providing opportunities for personal growth in the last stage of life. Such work is often draining yet immensely rewarding for the patient and therapist alike.

KEYWORDS: Palliative care, Psychotherapy, Psychooncology, Transference, Countertransference

INTRODUCTION

Psychotherapy with the terminally ill poses special challenges for clinicians and in return offers unique rewards. The process of dying is often considered a journey with the therapist serving as a travel companion. This journey has a beginning (learning one is dying), middle (processing this information and living one's remaining life), and end (dying), with many landmarks along the way, all of which inform the therapy process. Patients and therapists con-

front common issues during this journey and appreciation of these common experiences helps guide action.

A good death has been described as peaceful and as "dying easily and without pain" (Schwartz & Karasu, 1977). From a patient's perspective, elements of a good death include minimizing physical discomfort, empowering decision making, maintaining a sense of control, strengthening relationships, and making meaning of one's existence while preparing for death (Emanuel & Emanuel, 1998; Singer et al., 1999; Steinhauer et al., 2000). Psychological pain is inherent in the dying process, but mental health clinicians who work with the terminally ill believe that psychological pain can often be re-

Corresponding author: Tziporah Cohen, MD, Rabb 2, 330 Brookline Avenue, Boston, MA 02215, USA. E-mail: tcohen@bidmc.harvard.edu

duced, while efforts to achieve emotional peace can be enhanced. Thus, this work includes relieving psychosocial distress and providing opportunities for personal growth in the last stage of life. This article will review the common landmarks that arise throughout this journey, and how the therapist can accompany the patient along this difficult path, using the example of one of our patients. Although we draw primarily from our work with cancer patients, we believe that these concepts can be generalized to other populations of dying patients.

Therapy with the dying differs from therapy with the nondying in several critical ways. First, for dying patients, time is clearly more limited. Changes that might have unfolded over years with nondying patients are impossible. Acceptance, rather than change, often must be the primary goal. At the same time, both the patient and therapist often feel a pressing motivation to achieve changes because they recognize time is short. Thus, remarkable emotional maturation sometimes can occur in the context of a heightened awareness of a shortened life trajectory. Second, whereas the focus with nondying patients is often on how to help them engage more fully in life, with the dying the focus is simultaneously on disengagement or letting go (Hacker, 1977) *and* maintaining connection. Third, the fact that the therapist will live on after the patient's death is unique to this special relationship, where the therapist serves as "survivor, preserver of continuity, messenger" (Hacker, 1977). As such, a major role of the terminally ill individual's therapist is to bear witness, to both the individual's life and death. A key goal of the therapist is to help the patient construct a narrative of his or her life, looking for positive aspects and strengths that then can support the patient as she or he goes through the dying process. Fourth, feelings of the patient for the therapist (traditionally termed transference) may be unique and may be handled differently, with emphasis on the real relationship rather than analysis of the transference. Fifth, the therapist must address his or her own feelings that arise during the therapy, such as survivor guilt, grief, burnout, and feelings of helplessness. While keeping the above differences in mind, it is important to recognize that therapy with the dying also consists of "business as usual" (Kastenbaum, 1977). There are still everyday tasks to attend to, as well as issues and conflicts whose roots have preceded the terminal illness. Many of these issues in patients' lives do not disappear because they are dying.

The psychological tasks of dying are numerous. Grieving, constructing a meaningful context to one's life, letting go, and saying goodbye while maintaining connections to life are all essential to dying with

psychological peace. These tasks can be painful and lonely at times, whereas at others they can be gratifying and provide a sense of real accomplishment for the dying individual. The therapist can serve as a companion to the dying person as she or he grapples with these tasks, providing both a road map to help negotiate them and support to stay on course, and a vision of what can be achieved, and why it matters.

We divide the following discussion of these issues into three sections: (1) case presentation, (2) patient issues, and (3) therapist issues.

CASE

Mrs. R. is a 75-year-old Caucasian married mother of two children who was diagnosed with Stage III ovarian cancer a year previously. Her cancer did not respond to various chemotherapy agents, and she and her husband came to live with their daughter in order to pursue treatment at a major academic center. Despite further treatment, her cancer progressed, causing a small bowel obstruction that led to her hospitalization. She required moderate doses of opioids to keep her pain free, but these caused sedation, which was extremely distressing to both the patient and her husband. A psychiatry consult was requested when the patient started showing signs of depression and expressed a wish to die.

Mrs. R.'s first words to the psychiatrist were, "I hope you can help me." She related that she had always been strong and active and now felt like "a different person." She had no psychiatric history and had never seen a therapist before. Though she had coped well with her illness during the past year, for the past few weeks she had wondered whether life was worth it and had intermittently wanted to die. This wish to die was sometimes brought on by pain but now was related to a delay in discharge. She had been sleeping well and had relatively good concentration, but poor appetite.

Mrs. R. and her husband had been married for over 40 years. They had run a small business together until retirement. She had always been independent and active, and highly valued her role as wife and mother. Though they lived far away, they were in close contact with their two children, and enjoyed a great deal of pleasure from their grandchildren. Mrs. R.'s parents were no longer alive.

Mrs. R. coped with her illness by focusing on the full life she had had and through her faith. Though she accepted that she would die of her cancer, her husband avoided talking about her eventual death and sometimes intimated that she would get better.

In Mrs. R.'s initial meeting with the psychiatrist, Mrs. R. told stories about her family and expressed

her fears about dying. She was talkative and engageable, and made good eye contact. She described her mood as “down” and her affect was sad and tearful but she maintained her sense of humor and smiled when talking about happy memories. Though she wished to die, she did not have any thoughts of suicide. At the end of the visit she was no longer tearful and her mood had brightened considerably. She was amazed at this change, saying “If you had asked me when you came if I needed to talk, I would have said ‘no’.” The psychiatrist visited Mrs. R. four times during her 10-day hospitalization. At their second meeting, she brought up her biggest fear: that her death would be painful, as she had seen others die painfully from metastatic cancer, and she was visibly relieved to hear that with proper pain medication this did not have to be the case. She worried about her husband being on his own, and expressed a wish to return to her home to die.

After her discharge, Mrs. R. remained near the hospital for further treatment, and she and the psychiatrist continued to meet. At her first outpatient appointment she stated, “I’m having a crisis of faith,” and related that, though a religious person who prior to her illness had prayed daily and had had an ongoing inner dialogue with God, she had been unable to pray since her diagnosis 15 months before. This frightened her as she knew she “would need God even more now than before.” When encouraged to express some of her anger toward God she wondered whether that was “allowed.” A week later Mrs. R. related that she was relieved to be “talking to God again,” having been freed to do so by finally telling Him she was angry with Him for her illness.

Mrs. R. was hospitalized once more for a short time before returning home, and at their last meeting asked the psychiatrist to help her decide whether to write a letter to or to talk to each of her children individually to let them know of her love for them. She also talked about her wish that her husband would someday remarry and was surprised when encouraged to tell him so. At the end of the meeting, they said goodbye, and they exchanged hugs. She understood that she could call at any time and they could talk by phone.

After Mrs. R. and her husband returned home, she and the psychiatrist talked twice by telephone, with both calls being initiated by the psychiatrist after not hearing from her for several weeks. Both times, Mrs. R. said she had been thinking about calling and had specific issues she wanted to discuss, but didn’t want to “be a bother.” She mentioned her hurt that several close friends had not been to visit her. When the psychiatrist offered that it was possible they were uncomfortable with her

illness and impending death, rather than no longer caring about her, she responded by calling them and talking about their discomfort. In the second call, she told the psychiatrist that two of them had resumed visiting and had told her she was a good teacher to her elderly friends about dealing with death. She was quite surprised but pleased when the psychiatrist told her that she too was finding her a good teacher and was learning from her.

After her death, her husband sent an e-mail to the psychiatrist, saying how much he had admired his wife and how much he missed her. The psychiatrist responded in a condolence note, reassuring him that he had been a wonderful support for his wife and inviting him to be in contact if it were helpful.

PATIENT ISSUES

Physical Suffering

Psychotherapy is impossible for patients with poorly controlled physical symptoms such as pain and sedation. Therapists should assess these symptoms at the start of treatment both by observation and direct questioning. When necessary, therapists must advocate for patients and support the idea that these symptoms are controllable, ensuring that they are addressed by the medical team. This may include reviewing a patients’ medical charts and speaking with their medical providers, both of which might be considered a violation of boundaries in a traditional psychotherapy. In Mrs. R.’s case, the psychiatrist recommended beginning methylphenidate for treatment of Mrs. R.’s opioid-induced sedation.

Grieving and Depression

The distinction between grief and depression is an important one. Grief comprises the normal painful feelings and behaviors that result from a major loss (Osterweis et al., 1984) whereas depression is a pathological condition typified by depressed mood, decreased interest and enjoyment, physical symptoms such as appetite and sleep disturbance, loss of energy, and poor concentration, feelings of worthlessness or guilt, and thoughts of death or suicide (American Psychiatric Association, 1994). Grief is the central coping task faced by dying patients (Block, 2001). Dying patients must grieve the impending separation from loved ones, and come to terms with the fact that they will not realize their expected life trajectory (Viederman & Perry, 1980). The therapist helps the dying patient bear this grief by ensuring a safe, nonjudgmental place to

talk, by not becoming overwhelmed by the affect expressed, and by providing a place to practice saying goodbye. The relationship between the patient and therapist helps make the unbearable bearable. To facilitate grieving, we ask patients the following types of questions: Do you ever cry? What do you feel saddest about? What do you wish could be different? To whom or to what will it be the hardest to say goodbye?

Although sadness is a part of the grieving process and necessary for growth, clinical depression impairs quality of life and interferes with the patient's ability to attend to and work on psychological processes and to make informed decisions about end-of-life care. Clinical depression in the terminally ill is not normal and warrants psychopharmacological as well as psychotherapeutic intervention. Given the limited time available in the setting of terminal illness, psychostimulants are often preferred to SSRIs or other antidepressants (Block, 2000). In Mrs. R.'s case, the psychiatrist did not feel she had a clinical depression despite her intermittent wish to die, based on her ability to enjoy visits from her family, her use of humor, her ability to connect with and respond to the therapist, and the absence of many of the psychological symptoms of depression—hopelessness, guilt, worthlessness. Rather, she thought Mrs. R. was grieving appropriately and would benefit from further psychotherapy, though she did recommend methylphenidate to decrease her sedation.

Decision Making

Designating a health care proxy and formulating advance care directives (e.g., a living will), writing a will and addressing financial issues, and planning for the care of dependent relatives (elderly parents, young children, grown children with disabilities) are some of the practical tasks and decisions facing dying individuals. Some patients need to address these tasks before they can focus on psychological growth; other patients need to do some psychological work before they can make such decisions. These decisions are part of growth at the end of life, and the therapist helps the patient cycle between decision making and psychological work in the therapy. Therapists should introduce these topics if not brought up by patients. Ask directly: Have you thought about who will take care of your mother after you die? Have you spoken to a lawyer about guardianship for your children? What have you told your doctor about the use of breathing machines or cardiac resuscitation if you are unable to make these decisions yourself? It is not taboo for therapists to be directive, helping patients find commu-

nity resources, formulating how they will talk to family and lawyers, including rehearsing what words they will use in talking with a child, for example, and giving examples of how other patients have solved similar problems. Most patients will be relieved to be given permission to talk about such practical matters.

Story Telling

The life review is a mental process of reminiscing that offers patients an opportunity to reorganize and reintegrate past conflicts and achievements (Lewis & Butler, 1974). Viederman (Viederman & Perry, 1980; Viederman, 2000) defines the life narrative as a therapeutic process in which the therapist puts the patient's current experience into the context of their life history. In this process, the therapist's interest affirms the patient's value even while the patient may feel diminished by his or her illness and its attendant losses. Some patients choose to do this life review with friends and family, but for those who have become socially isolated, whose loved ones are emotionally unavailable to do this work with them, or who find it too overwhelming, the therapist can serve in this important role. The therapist becomes a witness to the patient's existence, contributions, and connections.

Patients can be encouraged to reminisce by asking them about their early adulthood: How did you decide to go into that type of work? What people have been important to you throughout your life? What are you most proud of and what do you wish you had done differently? Mrs. R. used the therapy for life review from the first session on, something she was unable to do with her husband because of his denial of her impending death. She related family stories that emphasized her pride in, as well as her perceived failings, in her role as a mother and wife. The therapist, by asking questions, laughing at anecdotes, appreciating past dilemmas, and presenting her understanding of her life trajectory, helped her to feel valuable and alive despite her increasing disability.

Addressing Fears

The fears of terminally ill patients are many: fear of the unknown, of loneliness and abandonment, of separation from family and friends, fear of pain, regression, dependency, and debilitation, and fear of becoming a burden to others. Fear of the loss of body, self-control, identity, dignity, and sense of personal integrity are also common (Hacker, 1977). Patients may have experienced traumatic deaths of

parents or other loved ones, and fear a similar experience.

Often fears can be addressed directly and mitigated in therapy. Things that seem unspeakable seem less so when talked about and said “out loud.” Reporting back to the oncologist about the patient’s fears can help the medical team address them directly with the patient. Educating patients about palliative care options, including hospice, can help address the fear of dying in an unfamiliar environment with little control over the decisions surrounding one’s death. Many patients, especially those with cancer, are afraid of dying in pain, and can be reassured by their medical doctor’s commitment to providing adequate pain medication as their disease progresses. Individuals with terminal illness often fear dying alone, and are afraid that the people around them, including their doctors, will abandon them at the end. An important role of the therapist is to provide reassurance that she or he will not abandon the patient as death approaches. This commitment, by necessity, often means making home visits or telephone calls when the patient is no longer able to come in to the office. The therapist must be realistic about what is possible for him or her, so as not to overcommit and be unable to follow through.

Mrs. R. was very afraid of dying in pain, and reassurance from the therapist and her oncologist allayed this fear considerably, enabling her to focus energy on other tasks of dying. Her fear of dying in the hospital was addressed by helping her arrange hospice care in her hometown, and a joint meeting with her and her husband began to address her fear that he wouldn’t be able to manage without her.

The most effective way to explore patients’ fears is simply to ask about them: “What are your fears about dying? What are you most afraid of?” Asking about how parents died (if applicable) can jumpstart discussion. For patients who have more trouble talking about their fears, the therapist may be more direct: “Some patients I work with have told me they are afraid that they will have severe pain (hate the thought of being dependent on their family, worry that their friends will stop coming to see them, etc.). Is this something that you worry about?”

Spiritual and Religious Issues

Dying patients often grapple with their relationship with God and beliefs about what happens after death, even if they have not been particularly religious during life. A spiritual crisis can also occur in patients who identify themselves as spiritual without connection to formal religion. A patient’s relationship with God can be considered a personal

relationship in need of exploration, just as their many other relationships require (Cassem, 2000).

Spiritual pain can manifest as physical or psychological symptoms, such as intractable pain, anxiety, depression, or despair (Kearney, 2000). Feelings of anger at God may give rise to a crisis of faith, shame, and a sense of being abandoned by God. For some patients, talking to familiar clergy can help relieve some of this suffering, though others may feel too ashamed or alienated or afraid of judgment to talk about a crisis of faith even with the more anonymous hospital chaplain. For these patients, the therapist can provide a nonjudgmental ear and help the patient to identify and overcome the feelings that are blocking their reliance on their faith as a comfort and support. Mrs. R.’s inability to connect with God since becoming ill was explored in the therapy and led to a resolution, enabling her to turn once again to her faith to help support her through the dying process.

To help patients with these issues, therapists must start by obtaining a religious and spiritual history. We ask every patient whether they have a spiritual or religious belief system and how that informs their life and their facing death. Helpful questions include: “Is religion or spirituality something that you draw on to cope? What do you believe happens after we die?” How does your faith help you manage the stress of your illness? What would help you make more use of this faith to help you through these hard times? Patients should be encouraged to be in contact with their personal chaplain (many will visit their congregants in the hospital) or to meet with hospital chaplain if they would like.

Family Issues

Terminally ill patients are influenced by their family relationships, as well as the converse (Wellisch, 2000), and dying patients should never be considered in isolation (Stedeford, 1979). Terminally ill patients may identify family members about whom they are worried for a variety of reasons. They may have practical concerns (“I worry that my husband won’t be able to manage the finances alone, or that my daughter will be overwhelmed by selling the house.”) They may feel that a loved one’s denial prevents them from planning for their death or expressing their fears, or even their love, for that person. Parents of young children often request guidance about how to talk with their children about their illness, and have many concerns about the psychological effects of a parent’s death.

Therapists can help address these issues in several ways: by helping with problem solving, by help-

ing the patient learn new ways of approaching and talking to family members, or by inviting the patient to bring family members into the therapy sessions. Inviting patients and family members to voice their concerns and feelings in each other's presence, with the therapist present to assist, often facilitates communication. Separate sessions with family members, with the patient's permission, may help them to voice feelings and fears they feel they need to protect the patient from hearing. Mrs. R. was concerned about her husband's denial, both because she worried he would be unprepared for her death and because it prevented her from saying certain things to him, such as her hope that he would someday remarry. On her request, the therapist and her husband met for a separate session, where he felt more comfortable voicing his fears and sadness.

Before death, during the last days or hours, our focus begins to shift to the survivors: helping family members understand how their loved one will die, addressing their fears and answering their questions, assessing their coping and providing extra support as needed. Our responsibility for our patients' care does not end at their death (Bedell et al., 2001). Making contact with the deceased's loved ones, whether in a meeting, a condolence card, or attending the patient's funeral, can be of immeasurable benefit to relatives, as well as achieve closure for both the therapist and the family (Bedell et al., 2001). Being able to process the death with someone who knew the patient and is not afraid of intense grief can alleviate guilt and doubt and facilitate healthy bereavement in family members. Some patients' family members will benefit from brief contact with the therapist after their loved one's death, as in Mr. R.'s e-mail to his wife's psychiatrist. Others will request ongoing bereavement counseling, feeling more comfortable with someone who knew their relative than with a new therapist.

Relationship Completion

Byock (1997), Kubler-Ross (1969), and others conceptualize certain tasks inherent in completing relationships with others before one dies. Byock (1997) lists these tasks as saying: "I forgive you," "forgive me," "thank you," "I love you," and "good-bye." These tasks affirm the importance of connections with others and help the patient reflect on their meaning. In one study of terminally ill cancer patients, 92–97% of patients rated "expressing my feelings to my family" and "saying goodbye to people closest to me" as extremely or very important to them (Greisinger et al., 1997). Tying up loose ends in relationships may lead to a more accepting and peaceful

death for the dying individual, and may help those remaining to have a less conflicted bereavement. Because our culture is so silent about death, many patients and family members don't see opportunities for doing meaningful work on relationships during the dying process. Yet such a focus can often serve as an antidote to hopelessness and can provide a positive focus for the patient's and family's energies. With careful attention to the patient's agenda, patients can be encouraged to talk with their loved ones in a different way and thereby attain some resolution before death.

The therapist can model some of these tasks, saying goodbye to the patient and expressing appreciation for what she or he has learned from him or her, enabling the patient to practice these skills within the context of the therapeutic relationship. Although Mrs. R. decided on her own to address some of these tasks with her children, other patients may be less able to identify their need to address unfinished business in their relationships and may need permission and encouragement to do so. Some patients may need road maps showing them how to say what they want to, and need to be reassured that they and their loved ones can tolerate it. Role playing can be helpful: "If I were your brother, what would you say to me? Tell me what you wish you could say to your wife." Some patients may be more able to write letters to family members, as this may feel less threatening and give them a chance to rewrite it until it feels "right." Other patients may need specific suggestions, such as "I think you would feel more at peace if you could tell your husband that you have forgiven him for ...".

Legacy

Many dying patients wish to leave a legacy, not only to their children if they have them, but to a larger collective, an issue that is unique to this type of therapy. Leaving a legacy reassures patients that their life was worth living and that they will not be forgotten after their death. Many patients struggle to come to terms with the meaning of their lives: What have I contributed? What will I leave behind after I am gone? This contribution can take many forms, from having raised children, writing or recording one's life story for future generations, contributing to one's work during a career, leaving scrapbooks or photo albums for loved ones, to donating money to a favorite cause. By asking open-ended questions, remaining nonjudgmental, and helping patients recognize heretofore unappreciated contributions, the therapist plays a critical role in allowing the patient to broach and explore

these questions without premature, and inhibiting, reassurance.

In addition to the life review (Lewis & Butler, 1974), where a patient can reflect on contributions and contextualize perceived failures, the therapist can help the patient create new legacies even as she or he is dying. We find ourselves using our ingenuity to consider possible roles and contributions for our patients, something that might be considered a boundary violation in a more traditional therapy. Some of our patients choose to participate in a medical school course where they are interviewed about their experience living with and dying of a serious illness, and take pride in being teachers to the next generation of doctors. Feeling that they still have an opportunity to contribute, even as they are becoming increasingly dependent on others, helps patients maintain a sense of psychological intactness.

Related to the concept of legacy is the way in which we say goodbye to our patients as they approach death. We look for opportunities to reflect and share with the patient what we have learned from them, to comment on their strengths, and to express appreciation for having been allowed to know them. These are the elements of termination in any psychotherapy, but for dying patients this acknowledgment by the therapist often has great importance and can be a source of comfort and strength.

Feelings about the Therapist

Dying patients may develop a variety of feelings (or transferences) toward the therapist, some of which are unique to this special situation. Patients may have envy for the therapist who is healthy and will go on enjoying life after they die. This may be accentuated in patients who are younger and for whom life is being cut unfairly short. One of our patients, a 35-year-old woman with metastatic breast cancer, reacted angrily to her therapist becoming engaged, and canceled several appointments. When the therapist pointed out the connection between these events, the patient was able to talk about her yearning to marry and have children and her grief at not having the time to do so. Patients may wish for the therapist to be omnipotent and fantasize that the therapist will be able to change the course of their illness. They may become angry with the therapist for his or her limitations. Feelings may also be positive, and include feelings of love, as with Mrs. R. This real relationship between therapist and patient should not be ignored. Seeing someone through the dying process is intensely emotional for both parties, who may develop strong feelings

for each other in short periods of time. Within proper boundaries, expressions of caring are entirely appropriate, and help patients to feel less alone in their struggle.

THERAPIST ISSUES

Working with Denial

Denial is a psychological defense that helps us manage the anxiety inherent in day-to-day life. Denial allows patients to keep living while facing the painfulness of their inevitable death. Denial can take several forms, and generally should not be confronted unless causing problems for the patient or family (Maguire, 2000). Rarely, a patient may completely disregard the fact that she or he is dying and continue on as if nothing had changed. This form of denial is used when the individual is not able to assimilate the information because of overwhelming anxiety. Although adaptive in that sense, if not resolved, it may block communication with family, friends, and caregivers and prevent the individual from making plans for the future (Pattison, 1977). More commonly, a patient acknowledges she or he is dying and makes appropriate arrangements but at other times carries on as if nothing has changed. This form of denial helps patients to maintain quality of life in the present and is partly conscious (Pattison, 1977). Although usually adaptive, it may cause patients to refuse needed treatment or undermedicate their pain. One of our patients prepared for his death by updating his will, writing an autobiography for his grandchildren, and saying goodbye to friends and family. At the same time he adamantly refused all prescription pain medication, despite his obvious pain. Exploration of this issue revealed his association of the need for prescription medication with progression of his cancer, and revealed that, for him, refusing pain medication represented an effort to deny his imminent death. His eventual understanding of this allowed him to accept the medication and be much more comfortable.

If a patient's denial is maladaptive, the therapist must nonetheless respect the patient's position and proceed slowly to avoid causing overwhelming anxiety. It is usually more useful to explore related topics than to confront the patient's denial head on. For a patient who demands further treatment of an incurable disease, it is more helpful to begin by asking what his or her experience with treatment has been so far, and what his or her hopes are for the future. Good questions include: What was your worst fear at the start of treat-

ment? What is it now? Did you ever imagine you might die from your illness? What has your doctor told you about it? What does your family think is happening? Patients may express alternately fears and concerns about dying and hopes for cure or remission. This affords the therapist the opportunity to juxtapose them for the patient, helping him or her make sense of these seemingly contradictory feelings. This helps patients locate the struggle within themselves, rather than engage in a struggle with their caregivers. These techniques are also useful in working with a family member's denial, as in the case of Mrs. R.'s husband, who believed she would get better even after she accepted she was dying.

One way of helping patients to work through denial is by taking the stance of "hope for the best, prepare for the worst." Patients may feel that preparing for death by writing a will, planning a funeral, or talking to providers about end-of-life care preferences means that they have given up, and may avoid these topics. With the "hope for the best, prepare for the worst" approach, the therapist can remind patients that these are not contradictory tasks and can help them prepare for death without robbing them of the hope that sustains them while they live. Moreover, it can be pointed out that such advance preparations allow them to control decisions that are important to them, and that completing these tasks can lead to a sense of relief and security, as well as a sense of completion.

Boundaries

Working with dying patients both requires and permits a flexibility of both physical and emotional boundaries less common in psychotherapy with non-dying patients. Therapist-initiated telephone calls, e-mails, and home visits may be part of the work. Session length may be shortened or lengthened, and family members may be included in sessions with the permission of the patient. We may share stories about ourselves and our experiences with death in our own lives. Physical contact, such as patient-initiated hugs, or reaching to touch a crying patient's hand, is not inappropriate. Such physical contact helps patients to feel less repulsive as their bodies fail them and our emotional openness reminds them that we still see them as connected humans even while they are dying. It is important, of course, that therapists manage their own feelings through supervision, discussions with colleagues, or their own therapy so as to maintain appropriate boundaries while remaining emotionally available to their patients.

Therapist Attitudes about Death

Kubler-Ross (1969) states that, as therapists, we must "take a good hard look at our own attitudes towards death and dying before we can sit quietly and without anxiety next to a terminally ill patient." Our reluctance to face death in our personal lives (i.e., our own denial) may be the single most important stumbling block in our work with dying patients. Many of us have not written wills, advance directives, or designated a healthcare proxy. Therapists' own experiences with loss have a great influence on how they relate to dying patients, and need to be processed in their own personal work or therapy.

Kubler-Ross' (1969) well-known stages in coping with terminal illness—denial and isolation, anger, bargaining, depression, acceptance—are not limited to the dying individual or his or her family's experience. Therapists also may find themselves experiencing these stages in conjunction with the patient. To remain emotionally available to our patients we must come to an acceptance of their deaths and learn to say goodbye. Death is rarely part of the curriculum in the training of mental health professionals and as a result therapists may not confront these issues until faced with them clinically.

Countertransference

Countertransference is the term given to the therapist's unconscious feelings about and his or her patient. Our unconscious feelings as therapists are amplified by the special stresses this work entails. As therapists, we are invested in our patient's welfare and therefore vulnerable as they die (Schneidman, 1978). In addition to sadness, we may experience intense anger at a patient for dying, because it is hard for us to bear the loss of this person to whom we have become attached. We may harbor a fantasy of "rescuing" the patient from death. We may feel relieved that it is not we who are dying or we may experience survivor guilt. One of us recalls intense feelings of guilt experienced while bicycling shortly after visiting a patient dying of metastatic cancer: guilt at having a strong, healthy body while the patient was too weak to stand. We must tolerate helplessness while avoiding therapeutic nihilism ("There's nothing I can do.") There are also positive countertransferences that emerge: inspiration and amazement at human strength and capacity for adaptation, gratitude for our own lives, and intense appreciation for the opportunity to help patients and to learn from them.

Grief

As therapists to dying patients, we are partners in an intensely emotional experience and as such cannot help but come to care about, even love, our patients, and to grieve for them when they die. It is our loss too when a patient dies and we must give ourselves permission to mourn. Going to a patient's funeral or sending a condolence card to relatives, although done primarily for survivors' benefit, also helps the therapist acknowledge his or her loss and attain closure. Acknowledging our sadness helps us to renew ourselves and avoid burnout, helping us remain receptive to our future patients' experiences and pain.

With all the difficulties this work entails, and the often high emotional cost, why is working with the terminally ill so gratifying? Undoubtedly there is satisfaction in working with a population that others view as painful to be with and try to avoid. Meeting the needs of these "underserved" patients fulfills our altruistic needs; addressing the many emotional challenges these patients bring to us helps us feel competent. There is no doubt that our patients and their families are grateful to us for our work. It is said that for physicians, death represents failure, and is a blow to their narcissism (Schwartz & Karasu, 1977). Perhaps for some of us, helping someone "die well" is a way of transforming some of this failure into success.

Weissman writes of the ideal of an "appropriate" death, one in which there is a reduction of conflict, continuity of significant relationships, and consummation of prevailing wishes and instincts (Weissman, 1972). We believe, along with others, that psychotherapy helps dying patients die a more appropriate death, much as psychotherapy with non-dying patients helps them live a more appropriate life (Hacker, 1977). Being a part of this growth, though often draining, is immensely rewarding for those who dare to undertake it.

ACKNOWLEDGMENT

Dr. Cohen thanks the Leaves of Grass Fund for financial support while writing this article.

REFERENCES

- American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. Washington, DC: American Psychiatric Association.
- Bedell, S.E., Cadenhead, K., & Graboys, T.B. (2001). The doctor's letter of condolence. *New England Journal of Medicine*, 344, 162–164.
- Block, S.D. (2000). Assessing and managing depression in the terminally ill patient. *Annals of Internal Medicine*, 132, 209–218.
- Block, S.D. (2001). Psychological considerations, growth, and transcendence at the end of life: The art of the possible. *JAMA*, 285, 2898–2905.
- Byock, I. (1997). *Dying Well*. New York: Riverhead Books.
- Cassem, E.H. (2000). Care and management of the patient at the end of life. In *Handbook of Psychiatry in Palliative Medicine*, Chochinov, H.M. & Breitbart, W. (eds.), pp. 13–24. Oxford: Oxford University Press.
- Emanuel, E.J. & Emanuel, L.L. (1998). The promise of a good death. *Lancet*, 352S, 1121–1129.
- Greisinger, A.J., Lorimor, R.J., Aday, L.A., et al. (1997). Terminally ill cancer patients: Their most important concerns. *Cancer Practice*, 5, 147–154.
- Hacker, T.A. (1977). Some aspects of transference and countertransference in therapy with dying and non-dying patients. *Suicide and Life-Threatening Behavior*, 7, 189–198.
- Kastenbaum, R. (1977). *Death, Society, and Human Experience*. St. Louis: Mosby.
- Kearney, M. (2000). Spiritual care of the dying patient. In *Handbook of Psychiatry in Palliative Medicine*, Chochinov, H.M. & Breitbart, W. (eds.), pp. 357–373. Oxford: Oxford University Press.
- Kubler-Ross, E. (1969). *On Death and Dying*. New York: Macmillan Publishing Company.
- Lewis, M.I. & Butler, R.N. (1974). Life review therapy. *Geriatrics*, 29, 165–173.
- Maguire, P. (2000). Communication with terminally ill patients and their relatives. In *Handbook of Psychiatry in Palliative Medicine*, Chochinov, H.M. & Breitbart, W. (eds.), pp. 291–301. Oxford: Oxford University Press.
- Osterweis, M., Solomon, F., & Green, M. (eds.). (1984). *Bereavement: Reactions, Consequences, and Care*. Washington, DC: National Academy Press.
- Pattison, E.M. (1977). *The Experience of Dying*. Upper Saddle River, NJ: Prentice Hall.
- Schneidman, E.S. (1978). Some aspects of psychotherapy with dying patients. In *Psychosocial Care of the Dying Patient*, Garfield, C. (ed.), pp. 201–218. New York: McGraw Hill Co.
- Schwartz, A.M. & Karasu, T.B. (1977). Psychotherapy with the dying patient. *American Journal of Psychotherapy*, 31, 19–33.
- Singer, P.A., Martin, D.K., & Kelner, M. (1999). Quality end-of-life care: Patient's perspectives. *JAMA*, 281, 163–168.
- Stedford, A. (1979). Psychotherapy of the dying patient. *British Journal of Psychiatry*, 135, 7–14.
- Steinhauser, K.E., Clipp, E.C., McNeilly, M., et al. (2000). In search of a good death: Observations of patient's families, and providers. *Annals of Internal Medicine*, 132, 825–832.
- Viederman, M. (2000). The supportive relationship, the psychodynamic life narrative, and the dying patient. In *Handbook of Psychiatry in Palliative Medicine*, Chochinov, H.M. & Breitbart, W. (eds.), pp. 215–222. Oxford: Oxford University Press.
- Viederman, M. & Perry, S. (1980). Use of a psychodynamic life narrative in the treatment of depression in the physically ill. *General Hospital Psychiatry*, 2, 177–185.
- Weissman, A. (1972). *On Dying and Denying*. New York: Behavioral Publications.
- Wellisch, D. (2000). Family issues and palliative care. In *Handbook of Psychiatry in Palliative Medicine*, Chochinov, H.M. & Breitbart, W. (eds.), pp. 275–289. Oxford: Oxford University Press.