

## Psychotherapy of the Dying Patient

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**SUMMARY** The psychotherapeutic aspects of the care of the 49 terminally ill patients described in the preceding paper are discussed. Their differing ways of coping with the stress of dying and the range of psychotherapeutic strategies used in treatment are described. The work suggests that the therapist's use of psychological insights can improve his understanding of the emotional pain of terminal illness, and well-aimed psychotherapy can contribute to its relief.

The role of the psychiatrist in a terminal care unit was described in general terms in the preceding paper by Stedeford and Bloch (1979). This paper focusses on the clinical experience gained while offering psychotherapy to the patients who were referred, and attempts to highlight the psychodynamics which they showed and the psychotherapeutic interventions which were used. Murray Parkes (1978) has reported that much of the physical pain in terminal illness goes unrelieved. Cartwright *et al* (1973) in their retrospective study of the symptoms suffered by patients in the last 12 months of their life, reported an incidence of 36 per cent for both depression and mental confusion. Our preceding paper confirms this in the cases referred to the psychiatrist, and in addition shows that family problems related to the terminal illness are even more common. Much of this suffering can be alleviated when the psychology of dying is understood and appropriate psychotherapy is provided.

### *The therapist's approach*

When considering the psychology of dying patients Kubler-Ross (1969) inevitably comes to mind. She described the stages through which they may pass during the course of their illness. Her work provides valuable guidelines for the therapist but he must avoid interpreting it too rigidly, or he may lose sight of the wide variety of ways in which terminally ill patients cope. There is obviously not one way which is ideal, and the therapist should approach

patients with an open mind, recognising that they are often more aware of their strength and limitations than is the therapist, and use coping mechanisms which they have learned to depend on during previous crises. Some have retained the flexibility that enables them to try new ways, and for them the experience of dying can be even one of growth. Others are frightened into withdrawal from the therapeutic relationship by anything other than support for their familiar pattern, coupled with the gentlest attempts to modify those aspects that are especially maladaptive. As the therapist explores with the patient the problems confronting him at that moment, he should ask himself about each one 'How is this patient coping with this? If his reaction is adaptive, can it be reinforced? If maladaptive, how much attempt at change will he tolerate?' The more secure a person feels the greater is his capacity for change. The relief of physical symptoms, the warmth of the therapeutic milieu, and a growing rapport with the therapist, may combine to transform a patient who is initially frightened and rigid to an open, more flexible person who will respond to a programme of psychotherapy. Then quite brief but precisely aimed intervention may bring about marked improvement, as case illustrations in this paper will show.

The dying patient should never be considered in isolation, because his interaction with those around him profoundly affects his own well-being and theirs. Therefore an adaptive reaction is here defined as one which brings

most relief or causes least suffering to the patient himself and also to his family and those patients and staff with whom he is in close contact. It is sometimes assumed that however difficult or destructive a patient's behaviour may be toward others it should be accepted just because he is dying. It is always appropriate to support those who are coping with the patient, giving them opportunities to ventilate their pain or frustration. But it may also be necessary to confront the patient himself with what he is doing and to explore with him the reasons for his behaviour. For example, hostility in dying patients is usually a mask for inner distress or fear, and where the psychotherapist can help the patient to cope with these, the resulting improvement is rewarding for everyone. Even if the patient does not change, discussion with relatives and staff about the causes of the behaviour enables them to tolerate it more easily.

#### *Establishing communication*

The dying person experiences many fears and often feels isolated because there is no-one with whom they can be shared. The basic aim in therapy is therefore to establish good rapport so that the patient feels free to talk and thus to discover the relief that comes from being understood and accepted. This interchange often leads the therapist to explore with the patient whether he wishes to share what has passed between them with a relative, friend or priest. Often he does, but is reluctant to begin. The therapist can offer to meet the other person and prepare the way, or suggest that a joint discussion takes place. Where the relationship was previously close, a single bridging interview may suffice. As soon as the patient begins to receive the emotional support he needs from his family and the regular staff, the therapist can withdraw. The main focus of attention will be on those patients who for one reason or another lack supports or are not able to use them.

#### *Defences*

One obstacle to close relationships during the patient's illness may be his use of certain defences. Relatives do not know what to say, for instance, to a patient who is talking unrealistic-

ally about his future. They either collude or retreat from him by visiting infrequently or communicating at a superficial level, leaving him feeling lonely and isolated. But defences are an essential aspect of coping, and the therapist needs to know which are being used and whether they are maladaptive, before he plans his intervention. Some patients go through an initial crisis of adjustment, experiencing shock, anger, depression, and then acceptance followed by a period of relative calm. Then the various defences operate to enable him to cope with each new sign of the progress of the disease without re-evoking the fear of death. Few people can tolerate facing death for any length of time, and the therapist should be content simply to monitor the situation, intervening only if there is a resurgence of persistent anxiety and suffering. Forceful disclosure of the truth when a patient does not need to hear can be as harmful as evasion when he does.

The commonest defence is probably denial and this will be discussed in detail to illustrate how it may be dealt with in various circumstances. The use of other defence mechanisms such as displacement, projection, and regression will be mentioned more briefly.

#### *Denial*

Pattison (1977) has contributed to our understanding of denial by differentiating three forms: existential, psychological and non-attention denial. *Existential denial* refers to the universal capacity to suppress awareness of the hazards inherent in everyday life. It is necessary for a continuing sense of security that we should be able most of the time to ignore such threats as nuclear warfare or sudden accidental death. Persistent awareness of these possibilities would cause overwhelming anxiety and paralyse the individual's ability to respond selectively to those immediate threats that jeopardize his well being, and to which an effective response is possible.

*Psychological denial* is a defence against the anxiety evoked by danger or the threat of it. The dying patient who initially seems to accept the truth about his illness but then behaves as if he has never been told is using this defence. He shows anxiety at the non-verbal and physio-

logical levels, but denies it if questioned. He may repeatedly ask about his condition and respond to the answers he is given as if no such conversation had ever taken place before. This behaviour may indicate that he believes at an intellectual level that an honest approach is best, but at a deeper level is not prepared to know. If this is the case, he will continue to 'ask round' the staff until someone gives him a reassuring answer to which he can cling. More often this pattern gives the patient time to assimilate gradually information which would overwhelm him if he appreciated its full import at once. Over the passage of time he makes less use of denial and his behaviour indicates that he is making adjustments in his appraisal of his situation. No intervention other than sensitive support is necessary here.

I agree with Mansell-Pattison's observation that psychological denial is a problem only when it is the sole or prominent defence. It then blocks communication with family and friends and prevents the patient from making suitable plans for the future. It is often accompanied by severe anxiety, distressing dreams and either attention-seeking behaviour or withdrawal. The case of a farmer's wife with breast cancer illustrates this clearly. Her relatives reported that she had always been 'nervous and difficult to get on with' and that her habitual method of coping with stress had been a refusal to speak about it and an attempt to live as if nothing amiss had occurred. On admission she reacted angrily when she overheard a doctor talking with another patient about death. 'No one must ever talk to me like that' she declared. This request was respected until she reported a dream in which she had been trapped in a corner of an enclosure by a large herd of her husband's pigs. She had cried out for help, but although her husband could see her there was no way he could rescue her. Her readiness to talk about this dream seemed to indicate a change in attitude, and it led to her acknowledgement that she felt 'cornered' by her illness and afraid because there was no escape. Later she was able to talk with staff about the death of other patients she had come to know, and through this came to accept that she too was dying. She lost most of her fear and achieved

a peace which was remarkable for a woman whose lifestyle had always been one of anxiety and denial.

Three patients who persisted in using denial as a defence were found to have suppressed their grief over the death of close relatives in the past. One who was referred because of vomiting which was thought to be psychogenic, could not recall experiencing grief when either of her parents died, and appeared unconcerned over her own malignant disease. The other two were referred for chronic anxiety and depression and had never mourned the death of a husband, and a daughter. It seems likely that successful grief work in the past prepares people to approach their own death with more equanimity. Conversely, a history of previously unexpressed grief should alert the therapist to the problems he may encounter when he treats such patients.

*Non-attention denial* differs from psychological denial in that it is at least partly conscious and not usually accompanied by undue anxiety. It occurs in those patients who, having accepted that they are terminally ill and made necessary practical arrangements, pretend to themselves and others that they will recover. The purpose of this form of denial is not to escape the truth, but to prevent the pain of it from spoiling the quality of life in the present. It enables patients to live as normally as possible for as long as possible, and is adaptive unless it reaches a level where they deny the severity of the illness to such an extent that they refuse further treatment and endure unnecessary pain.

#### *Displacement*

Patients use the defence of displacement as a means of coping with powerful emotions which would be most appropriately felt about themselves or their predicament. By directing their feelings on to others they remain relatively calm except when thinking about those who have become the focus. This defence may be adaptive in some respects for the patient, but causes suffering to the person who has become the target. A man who showed considerable non-verbal anxiety denied that he was at all worried about himself. He declared that he had witnessed death in the Army Medical Corps and had learned to accept it. Now his sole concern was

for his wife. He remained calm for most of the day with a detached attitude to this illness, but became increasingly apprehensive as visiting time approached and quite agitated if his wife was a few minutes late. When she did arrive, his reproachful attitude and his anxious questioning about her activities distressed her so much that she curtailed her visits and consequently felt guilty. Psychotherapy aimed at allowing him to experience appropriate anxiety about himself corrected this displacement. Temporarily he was more disturbed as he worked this through, but his relationship with his wife improved so much that she was able to sit for hours by his bedside, knitting and keeping him company as she would have done at home.

Anger about the terminal illness is often displaced on to doctors, who are blamed inappropriately for making the diagnosis too late or giving wrong or ineffective treatment. Relatives are sometimes blamed for not showing sufficient concern, and nurses may become the butt of innumerable petty complaints. A patient who displaces anger in this way can disrupt relationships with those on whom he depends for his care, and psychotherapy which allows him to express the anger and frustration he feels because he is dying, often changes the situation for the better.

#### *Projection*

Paranoid states in terminally ill patients can often be understood in terms of projection. The unconscious recognition that a man is soon to die is turned into a belief that someone is trying to kill him, and may result in frightened or aggressive behaviour, in apparent self-defence. I have described elsewhere (Stedeford, 1978) how this happens most often in acute confusional states in which impaired consciousness can result in disinhibition and the release of florid psychotic material. Guilt about events in the patient's past may appear as ideas of persecution and accusatory auditory hallucinations. Although it may be necessary to control the resulting disturbed behaviour with major tranquillizers, it is also worth attempting psychotherapy with these patients. They usually retain some capacity to relate to a sympathetic person

and may—during or after the acute episode—be able to perceive the relationship between their psychotic experience and their real guilt or fears. When this occurs, the abnormal experiences usually cease.

#### *Counterdependency, dependency and regression*

There is an appropriate level of dependency for each stage of the illness and the psychiatrist may be able to help his patient to achieve this. In the terminal phase, a patient's heroic attempts to maintain his independence can cause suffering both to himself and to his relatives. The person who is determined to walk unaided despite frequent falls often needs help to recognise that it is not shameful to 'give in' at this stage and accept assistance. The man or woman who 'has always been a fighter' needs permission to stop struggling and, having received it, often experiences great relief when able to let go.

On the other hand the regression which accompanies dependency may be maladaptive in terminal illness, as it deprives the patient of independence which he could still enjoy and makes him expect more attention from others than he needs. A patient who became breathless on walking a few yards claimed that he was too ill to walk at all, and thus denied himself the freedom to move about the unit at will. During psychotherapy he revealed that while he was taken everywhere in a chair, he could sit and imagine he was still able to walk well if he chose. The last attempt he had made had forced him to recognise how ill he was, and he would rather stay put than be made aware, day by day, that his strength was waning. When he understood why he had taken to his wheelchair prematurely and had accepted that he would gradually be able to do less, he resumed walking and was pleasantly surprised at how much he could still do.

Later in the illness regression is appropriate, and allows the patient to accept without loss of dignity the personal help and attention which he needs. The closeness that results from the giving and receiving of tender care can be one of the compensations for the suffering of terminal illness, for both patient and family, and for nursing staff too. Adaptive regression can be an

enriching experience as a dying psychoanalyst discovered. She asked for psychotherapeutic help to ensure that her defences did not deprive her of full awareness of what she was experiencing. When she gave up her vigorous attempts to be independent, she became almost childlike in her attachment to the therapist, and the new intimacy that followed gave her intense joy. This emotional regression in no way impaired her ability to ponder about the philosophical and spiritual aspects of her dying, which led to deep and stimulating conversations almost to the end.

### *Hope*

This discussion of defences and their management leads on to the subject of hope, particularly because some clinicians maintain that it is cruel to remove defences and confront patients with the truth about their illness as this will inevitably undermine some of their hope. The idea that truth destroys hope is often used as a justification for keeping patients in ignorance. Some doctors with such a view may well have seen patients in a stage of shock, anger, or despair after news has been awkwardly imparted, and not be aware that their emotional state can change considerably over a few days. Dying patients have a great facility for holding two incompatible ideas without feeling that they are incongruous. They make appropriate preparations for imminent death, and at the same time can plan for a splendid holiday a year hence. As death approaches, it is not that hope gets lost, but that its object changes. At first a patient hopes that the doctors are wrong and that he will recover. Later he accepts limits, and sets his sights on an event such as a wedding, which he hopes to attend before he dies. Later still, he speaks of his aspirations for members of his family who will survive (as if he envisages himself living on in them) and for himself he asks only for a peaceful death. If he is religious, his hopes turn to eternal life, and perhaps to reunion with beloved relatives who have already died. Only the patient who knows he is dying can make these natural adjustments. To withhold information about prognosis when a patient is seeking it is therefore to deny him something which is essential if he is to do the work of rounding off his life in a fulfilling way.

### *Depression*

As the preceding paper indicates, depression is common in dying patients who have many losses to mourn. Some staff and relatives find it hard to accept that depression is appropriate and inevitable, and their well meaning attempts to cheer a patient may jar, and make him feel that he is not understood. There may be pressure on the psychiatrist to prescribe antidepressant drugs, motivated by the need to feel that something is being done for the patient. It should be recognised that giving support and understanding, together with the facilitation of the expression of anger where necessary, is in itself active treatment. Patients who have always had a positive attitude to life emerge from this kind of depression with a new appreciation of the good things that are left. Once they accept that their time is limited, they begin to make the most of every opportunity that presents itself, and outsiders are often surprised by their capacity to experience so much happiness. Other patients who are naturally of a gloomy disposition do not change much. But even they may respond to the staff's friendly individual attention, and this together with freedom from customary responsibilities, may bring about improvement in mood.

The only patient in this series with completely intractable depression believed that an intrathecal block done for the relief of severe pain had caused her paraplegia. When seen by the psychiatrist, she began to reveal her feelings and it soon became clear that she had suppressed a considerable amount of resentment. The display of any negative feelings was taboo for her, and she refused to discuss the matter further or to see the psychiatrist again. She remained most unhappy until her death.

Some patients whose pain is disproportionately severe and unresponsive to analgesics are suffering from *atypical depression*. One such woman with severe facial pain had a personality disorder, characterized among other features by a belief that the only acceptable way to respond to trouble was to treat it as a joke. Her attempts to laugh her way through her illness did not evoke the sympathy and support she needed, and the only way she could obtain concerned attention was through pain. Psycho-

therapy enabled her to begin to express her distress more directly, especially to her husband, who in his turn learned to support her. Her depression lessened, and although her pain never left her, it receded into the background so much that she could return to her home and her role as housewife, and her requirement for analgesics diminished.

#### *Anxiety*

Anxiety too is common in the dying and the defences discussed above are used in an attempt to cope with it. When a patient expresses anxiety directly about himself and his condition, it is often helpful to explore it by breaking it down into its various components. Existential anxiety, the fear of non-being, was seldom in evidence in our patients. More common were fears about the suffering which the process of dying might entail; pain, loss of control, dependency, and abandonment. Some fears were groundless, and disappeared when they had been spoken about. Others were realistic, and here patients responded to reassurance that their fears were understood and were not shameful. They needed to know that their symptoms would continue to be treated as they arose, and that they would never be left alone to cope. We have noted that the presence of a familiar person does much to allay anxiety, and relatives sitting quietly by the bedside contribute greatly to a peaceful death. Anxiolytics are a valuable adjunct to psychotherapy, but no substitute for care and support.

#### *Organic brain disease*

The following case history illustrates the management of a variety of problems which one patient presented, and in particular shows how the distress of organic brain disease can be ameliorated.

Mrs G., a 52-year-old widow whose husband had failed to return from the war, had lived with, and cared for her 86-year-old mother until she became too disabled by her illness. At the time of admission she had a severe hemiplegia and some dysphasia, the result of a cerebral tumour. The first problem arose when she convinced her relatives that the nurses had strapped her in her chair all day and prevented her from walking. Her use of this mechanism of projection enabled her to avoid the distress of accepting the full extent of her disability, and to blame

the staff instead. Attempts to help Mrs G. withdraw this pattern of projection were not successful at this stage, but explanation of it to the nurses helped them to cope with her allegations and handle the relatives' complaints with understanding.

She also presented with depression, provoked in part by the loss of her role as head of the household. On her admission to hospital, relatives had abruptly stopped consulting her about the future care of her mother in the belief that she had enough to worry about. When it was explained to them that she was still very much concerned, and that all she had left to offer was her interest and advice, they readily agreed to involve her in their deliberations. Her depression then diminished.

Later, the patient experienced temporal and spatial disorientation and thought that she was in Germany searching for her husband. This was associated with great distress. Staff were instructed on how to talk her back to reality and to separate past and present; their efforts usually brought temporary relief. On one occasion when Mrs G. was disorientated in time, she angrily blamed her watch for being wrong; it became apparent that she believed 'they' had decimalized time. With reassurance that this was not the case, she reflected for a long interval and then said 'it is only a matter of time'. This led to conversation about her impending death and her difficulty in tolerating the uncertainty of how much time she had left.

In spite of her confusion, she did have lucid periods. In one of these, she complained that some nurses thought she was mad, and discussion with them led to greater understanding on their part. Through talking about her condition with the psychiatrist, she lost her fear of insanity and slipped in and out of confusion without being distressed. She learned to separate 'myself' from 'my illness' and summed up her acceptance by saying on one occasion 'I think it is perfectly logical that I should be confused'.

#### *Psychotherapy with the family*

The patient's admission to a terminal care unit confronts the family with the seriousness of his illness. Practical decisions about who shall be told, who shall visit, and how dependent members should be cared for, immediately arise. In this crisis the united family shows its strength, but the problems of a divided family are painfully exposed. In the latter case, the patient is often distressed at visiting time, and family feuds may erupt in a way that disturbs others in the unit. In almost half the cases in this series, the dying patient was so affected by family problems that psychotherapy was indicated in an attempt to alleviate them. Relatives were usually invited to see the therapist alone at first. This often led to conjoint or family interviews.

In one such family, the patient was an elderly

man who had always been independent. He had expected to care for his invalid sister until her death, and refused to accept that he would die before her. He obstructed any arrangements that were suggested for her management, and consequently the family were forced to attempt to decide amongst themselves what should be done. The patient then complained that 'things were going on behind his back' and became increasingly angry. In this crisis, several interviews were held with the patient, his sister, and various family members, over three days. These resulted in an acknowledgement by the patient that he was dying, and the recognition that his anger and frustration about his illness had become displaced on to his family. A partial reconciliation was effected, sufficient for them to agree on plans for the care of his sister. The patient was also anxious that, because his sister had not made a will, her vulnerable situation after his death might be exploited by various family members who wanted to gain access to the money he planned to leave her. Delicate negotiations continued until the will was made, and she was placed in a nursing home. The old man then became less irascible, both with his family and with nursing staff, and he died peacefully a few weeks later.

Terminal illness puts a strain on any marriage, particularly on one in which there are underlying problems. In eight instances in the series an important focus of intervention was the couple: the following vignette illustrates the kind of therapeutic approach used. A man of 53 was admitted primarily because he had become so morose and irritable at home that his wife could no longer cope. Theirs was a marriage in which she was dominant while he could only assert his masculinity sexually and as a skilled labourer. When prostatic carcinoma made him weak and partially impotent he lost all self-esteem and suffered from depression punctuated by angry outbursts against his wife and sons. Psychotherapy with the couple helped the wife to understand her husband's difficult behaviour and to respond more appropriately to his emotional and sexual needs. He found a new role, taking increased interest in his adolescent boys whose care and discipline he had previously left almost entirely to his wife. Com-

munication between the couple improved, serious quarrels ceased and both saw the last months of their relationship as the most intimate of any period of their marriage.

In terminal care there is a tendency to underestimate the ability of the dying patient to give. Relatives may feel that a dying person should not be troubled about other problems arising in the family, and may try to conceal them. This often depresses the patient who senses that something is amiss, and feels deprived of his role as parent or spouse. It is appropriate for the therapist to point out to the family that the sick person still wants to give, and that he can continue to offer his concern and advice. They soon appreciate that he is likely to feel more alive if involved in family affairs, even when they are an additional source of anxiety.

Although the spouse of a dying patient may be painfully aware of the lack of communication between them, he is often reluctant to talk about the impending separation. This may be because he is trying to avoid facing the situation himself, and pointing this out to him gently may be helpful. If the spouse accepts this insight he may still be unwilling to talk, fearing that he might break down in the course of the conversation and further upset the patient. A knowledge of the marital history is important here. If the dying partner has been a source of strength and encouragement to the spouse in previous crises, he is likely to want to do so again, and he can only act in this role when the couple are facing the separation together. Discussion about the future and planning how the surviving spouse will cope helps the patient to work through guilt he or she feels about abandoning a loved partner. In the days and weeks that follow death, there is comfort for the newly widowed in the knowledge that they are carrying out those things which the couple planned together.

### Conclusion

The psychiatrist who provides psychotherapy for the terminally ill needs to be something of a jack-of-all-trades, and the prospect might seem daunting. However, sophisticated psychotherapy is not as necessary as are sensitivity, a willingness to follow the patient rather than lead him,

some knowledge of the psychology of dying, and the ability to accept the inevitability of death. In the relief of pain physicians have moved from the era of aspirin and morphine to a wide variety of analgesics, each with its specific indications. To use them well the causes of pain must be accurately diagnosed and the drugs given in the optimum way. The relief of the emotional pain of dying has traditionally been achieved with tender loving care, and spiritual measures for those patients who are religious. Both still play an essential part, but the experience described in these two papers suggests that a better understanding of the causes of emotional pain, and the use of psychotherapeutic strategies

aimed at specific areas of distress may be more effective than devoted care alone.

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(Received 23 November 1978; revised 11 January 1979)