

*Termination  
Death*

## ON FINAL TERMINATIONS: CONSULTATION WITH A DYING THERAPIST

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This is the report of the experience of four clinicians, friends and colleagues, as a consultation group for a colleague stricken with cancer. This colleague, Kayla, whose work had previously been unknown to us, sought our help in imparting to her patients, first the fact of her illness, and later the preparation for her impending death. Aware that there was little in the literature dealing with this situation, she tape recorded our sessions. It was her wish that her experience be shared with the profession.

Although the group members, long time friends and colleagues, have over the years had opportunities to work together in a variety of capacities, this was a unique period. None of us had previously had more than a somewhat distant professional relationship with Kayla, who was perhaps a half-generation younger. Approaching each of us in turn, she was almost apologetic. Yet each of us responded alike, with unquestioning readiness. Nor was there ever a question of fee. How do we understand this quick commitment on our part? Amongst ourselves, we speculated as to why her choice of us, and why the four of us? While in some measure there was the influence of identification with a professional colleague, more importantly each of us had experienced the threat of, or indeed the fact of, significant changes and losses in our own lives. Moreover we four were, are, of an age and time in life which occasions reflection on how we will deal with our own endings, our final terminations.

Kayla had worked, studied and trained as a clinician for many years, was psychoanalytic in orientation, and had a small private prac-

tice. Her strong professional commitment was reflected in her deep feelings of responsibility. Upon learning of her illness, her concern was about its impact on her patients. Our first meeting on December 19, 1986 established the purpose and format for our meetings. The frequency would depend on the course of the cancer treatment; the overall time period was indeterminate. On January 23, 1987, at our 4th meeting, we learned of the metastases and the rapid course of the illness, imposing time limits on our work together. In all, there were to be a total of twelve meetings. The last was held on March 27, 1987. Kayla died on April 2, 1987. Her work had ended, her client/patients either terminated or referred, or scattered. What remains is the record of its course: 1) of a courageous woman dealing with her illness and the ending of her professional life; 2) of her observations of self and client, and of individual client dynamics during this period; 3) of the progression of the consultation and its impact on us; 4) of our reflections and attempts to understand our role and its possible purpose in the process in which we all shared.

Our professional self represents a special aspect of the self. Its functioning may remain intact, its competence remarkably protected, despite what is ongoing in other parts of our life. It is here we can feel whole and here we stave off whatever private demons otherwise assail us. Above all, here we feel our aliveness, our effectiveness in performing our chosen tasks. It was in order to protect this space, to guard against the reality of her illness intruding inappropriately, thereby altering her professional stance, that the therapist sought the help of consultation. Although there is abundant literature about the termination phase of psychotherapy, there is very little written about how therapists work out those final terminations, which are not chosen but are necessitated by their own lives coming to a close. As it happened, one article appeared in the fall of 1986, and several of us "consultants" had read it and called the attention of the others to it. But we hesitated to bring it to Kayla's attention, perhaps because of its title, *The Seriously Ill or Dying Analyst and the Limits of Neutrality*. We did not yet know this colleague of ours well enough. The very next session after we had read it, Kayla provided us with copies! And together we discussed what Dr. Stanley Rosner (1986) had to say about it.

He began with confirming Kayla's impression, that there was sparse literature on this topic, and with a stated intent to explore the question: How much factual information should be revealed to patients concerning the illness and the prognosis? Although he dealt with the issues from the standpoint of psychoanalysis, much of what he had to say is applicable to any psychodynamic psychotherapy. He accused his colleagues of discussing disruptions from fatal illnesses as though they were equivalent to any other terminations. Since the frame of treatment is totally

changed under these conditions, he deemed such a stance *denial*. Our patients develop intense relationships with us; our serious illness would inevitably affect transference fantasies. And Rosner said, "The countertransference is in turmoil, and one is not clear about the reliability and validity of one's own conclusions and reactions" (p. 359). Kayla was most certainly aware of that. What she knew and feared was that the state of the therapist, as she imparts the bad news, is likely to be unstable.

If we assume that ideally the transference is a manifestation of that state which Winnicott calls "intermediate"—somewhere between the objective and the subjective, or between reality and fantasy—then, in the circumstances which Kayla faced, what was previously a metaphorical relationship becomes weighted toward the real. The delicate balance is thrown off, with "reality" weighing in disproportionately heavy. This inevitably affects the potential psychic space of the therapist, which in turn affects the field of the interrelationship with the patient, and, of course, the subsequent fantasies of patients.

Our experience includes three parallel processes—that of the clinician, Kayla, that of the patients, and that of the consultation group.

## PHASE I

The first phase lasted from December 12, 1986 through January 23, 1987. It was, of necessity, filled with some trepidation but remarkably little confusion or divergence of positions. In our first session it was clear that Kayla felt a great need to continue her work and to be "professionally productive."

In the beginning, the prognosis of her illness was not fully known; it was clearly serious, and predictable that there would be bad times—both from the cancer itself and from the treatments—times when there would need to be sudden cancellations. Kayla recognized, "I'm not the same person that I was." Even before the diagnosis was made, there were clues that her patients might be noticing. One day when she was drowsy from medication, a couple said, "We're losing, you, Kayla." She told them that she was having a back problem, that she hoped it was not serious. Another patient had asked if she was wearing a wig and if that meant she was in chemotherapy. She was not in a wig; her neat hair was part of her characteristic orderliness.

Although she denied to us that she was thinking, "Why me?" but instead "Why not me?" there was some manifest incredulity at the diagnosis. She had always been "incredibly healthy," never had regular chest x-rays. She had asked her doctor, "Can I record this?" when he discussed the malignancy with her "because I'm not an accurate listener to

stuff like this." There was a human impulse to deny, but it was quickly countered by a stoic "Let's face the reality" attitude. There was also guilt: "Is this my fault?" (There is a popular notion around that if we fall victim to cancer, we just may be somehow responsible.) Her realistic concern, over how long she could function at a level sufficient to meet her own high expectations, created apprehension. It led to the major question of what her clients needed to know and how best to handle that issue.

Our conviction was that patients should be told. They already sensed that Kayla was indeed different; and Kayla would be more comfortable should she have to cancel or change appointments, or appear unreliable.

We quickly developed consensus on two points—1) that Kayla needed to be clear, unequivocal and honest with her patients, about her illness and its impact on their work together; 2) that the information be used insofar as possible to increase patients' growth, for example by working with separation and loss, anger, fears of death, abandonment, autonomy, etc. Sharing honestly such devastating information could signify trust, afford patients a chance to work through old materials and to assume responsibility for themselves. We believed the process could be producing if the patient were genuinely allowed freedom of choice in deciding whether or not to continue in treatment with Kayla.

These consensual premises were more readily arrived at than acted upon. The early tapes show just how much ambivalence there was on the part of the therapist and the consultative group. Kayla's focus centered on her professional commitment to patients. Her concern was that she maintain a professional balance, that her personal anxiety not intrude. She wanted to facilitate her patients' use of her illness as a growth experience, at the best, and at the least, wished to ensure that it not be destructive. The consultants' initial impressions were that Kayla was a very private person, somewhat distancing in her self-control. Perhaps this feature of personality heightened the concern in her repeated question of "what would be the best possible way" to prepare her patients for termination and referral. On February 6th, (prior to her oncologists' advising her that the chemotherapy was not effective), it may have been some prescience of what lay ahead which led her to exclaim, "Now wouldn't it be terrible, just terrible if I get into some trouble where I have to let them (her patients) down."

She wanted to do better than had three of the four analysts described in the Rosner article. They had had their secretaries phone their patients to tell them they were in the hospital, thus using "denial defenses," placing patients on temporary hold. Once they knew they would be out for a long while, they had to deal differently with patients. One questioned how much information should be given, lest it contaminate

the transference; he did not suggest consultation with someone else. One unequivocally preferred not to give factual information, saying it would inhibit feelings of hostility toward the ill analyst—and this could be fraught with anxiety should the latter die. Rosner, however, pointed out that by the therapist's not providing factual information, the patient would be confronted with an ambiguous unstructured situation and could feel like a child who "shouldn't know such things," abandoned and betrayed. (The result would be iatrogenically induced negative transference.) We agreed that to attempt to shield the relationship from either transference or countertransference reactions would be impossible. As we well know, patients have their ways of finding out such news and then therapists never know what exactly they were told or about its accuracy.

There was one analyst, (Caron 1984, cited in Meloche, 1984), who, knowing he had a progressive and terminal illness, did tell his patients, and reported that they had reacted with shock, disbelief, subsequent reactions of protest, despair, and mourning. The fantasies emerged nevertheless, and there were displacements and "off-target" transferences (which Kayla was later to encounter too). And of course there was the hatred at being abandoned. Rosner said that it would seem that the more information given to patients, the more hostility will the therapist be subjected to, and he wondered whether the decision not to give it may represent a means of avoiding that.

Caron was, of the four analysts described by Rosner, the one who subsequently died. That he elected the "least orthodox" approach with his patients may have been prompted by his sense that his illness would be fatal. But we might guess that crucial to our understanding of the mode chosen would be the relationship between therapist and patient prior to this, the nature of the transference and countertransference. Kayla felt guilty toward patients whom she would have to "let down." However, although she thought it was going to be "drenching and wrenching" to level with them about her condition, she was resolved to do it. She affirmed, "I want to stay with them as long as I can." She acknowledged uncertainties about how her strengths would hold up, and this was particularly difficult for this woman who was used to feeling herself in control.

Our part in this was to support her intent to be honest with her patients, and to respect her own inclinations from moment to moment. Kayla told us that what she got out of her first several preparatory sessions with us was, "I should not have preconceived ideas, but should feel my way with each patient." But under the circumstances, she had also to stay close to where she was, physically and emotionally. To share the facts of her cancer she had to be ready to cope with them herself, and she admitted reluctances to imagining the dialogue in which she would

have to say her lines. She dreaded what felt to her the imposition of her own problems into the therapeutic milieu.

Our hypotheses is that Kayla wanted us to enable her to preserve enough "potential space" to inform her patients in as therapeutic a way as possible, and to cope with the inevitable sense of diminished and ever-diminishing space. We could guess that her contact with us was intended to increase, at least for a while, the sense of some room in which she could constructively maneuver. Her patient load was a small one and several cases, like the couple who found Kayla dozing, were effectively and appropriately terminated or referred without disclosure of the illness. Our work then centered primarily on four women patients who chose to continue: "A" was in her mid 40's, needy, overly dependent, she came primarily regarding her child who was in treatment elsewhere. Her major pattern was that she did for others—then felt deprived and misused by them; "B" was in her early 30's, with primary concerns over relationships with men in which she felt rejected, empty, and blamed herself for testing, and not trusting. Many of her issues were related to disappointing her parents—never quite meeting their expectations. "C" was in her late 20's; she had been in psychotherapy previously with her unmeshed family. She had recently married and her concerns centered on coping with every day problems of interaction, based on fears about predictability and trusting others; "D" was in her early 40's. Her highly disturbed son, placed in a residential treatment facility, was the focus of attention between the divorced parents. Her mother had died of cancer some years previously, and her father, who was seen as the withholding unaccepting parent had had successful cancer surgery. She longed for closeness with her father, and blamed herself for "failure" with husband, son and father because of her "deficits."

These four patients were informed early in January—each according to Kayla's sense of when it was appropriate and dictated by her own comfort, always with care to provide reaction time in the disclosure session. She used our group to rehearse how she would present her news. She moved quickly from a hesitant, "I have something unpleasant to discuss" to "I am ill and it will affect our work together. I believe you should know in order to have freedom to plan effectively how to proceed." All patients were given what amounted to open ended opportunity to be helped to make other treatment arrangements or to continue, knowing the lack of predictability. Each patient had her unique initial reaction. "A" seemed numbed, controlled, but attempted to redefine the therapist/patient relationship. "B" correctly "interpreted" Kayla's difficulty; that her problem in sharing the personal was her fervent wish to be able to maintain a *professional* stance. "You're such a private person." Only belatedly did Kayla understand what this patient meant when she reiterated how difficult it must be for Kayla to have to tell her.

Kayla said, "I feel as though you've left your seat and come over into my chair!" "C" began to try to fix everything, so predictability might ensue. "D's" major reaction was to jump up, hug and comfort Kayla.

These responses were used in the ensuing therapeutic process with what we believed were insight producing results.

By the consultation group's third meeting, each patient had been told of Kayla's diagnosis and illness. She meantime had begun to have a good (unfortunately short term) response to chemo and felt perhaps she had unnecessarily burdened, "dumped on" the patients. She was conflicted over having met her needs in the disclosing, at the same time continuing to express fears of deterioration and of her ability to go on. We saw a parallel process with the patients, the therapist and the consultation group.

1. The consultation group, possibly to gain control over our own emotions, often seemed quite directive. This competed with avoidance, i.e., running after details in the cases which may have been insignificant and overly intellectualized discussions. We also relied heavily on mutual support, reassurance, nurturance and praise for Kayla and ourselves.
2. The therapist struggled with ambivalence about what was necessary and what was fair. Whose needs should be met? A wish to avoid and deny her illness was offset by commitment to honesty and effort to use all material for therapeutic growth. She gradually relinquished some need to "be professionally productive," could confront her fears of deterioration, her denial diminished.
3. All patients showed some ambivalence, i.e., should they leave, would it be disloyal? Or could they do productive work? Empathy for Kayla and acknowledgment of a gift given was a common verbalization by each.

At first, in every instance, Kayla attempted to remove the focus from herself to enable the patients to get on with their own troubles. They were not finding that easy, often declaring that their problems seemed petty by comparison with hers. We consultants felt, and Kayla quickly recognized, that she must seem to her patients insufficiently concerned about herself. Thus her urging them to get back to their personal matters was having a result opposite to her aim. As we grappled with the enormity of the situation, we reduced the amount of reassurance given to Kayla. We began to zero in on something we heard as concerns from her patients—that Kayla somehow had to back away from being the giving, nurturing therapist and begin to take care of herself. We thought this important in itself but also an important theme for patients to hear. Kayla responded to our emphasis with less stoicism and

more concern for herself. This shift in emphasis seemed to make her better able to free the patients to move on and to give them permission to see their own needs as valid and important.

During this time, another major question had been, how can you possibly care about my trivial problem? Yet, by the fourth session after the disclosure, each patient had returned to focus on her own issues while showing interest and appropriate concern about Kayla's condition.

## PHASE II

As our unusual mission developed, we found ourselves drawing on various aspects of ourselves. In part, this was as therapists, but it touched on our own deepest feelings, ideals and vulnerabilities as well.

It was a struggle for all of us to keep Kayla's illness in focus and not to rampanly deny. She was still robust, with minor cues that something was amiss. She maintained her high level of involvement, caring and interest in her patients, and in her own reactions. Her paramount wish was that other therapists would learn and benefit from her experience.

Our meetings with her became a focal point for us as well as for her. Facing her, her mortality, and inferentially our own, had a compelling quality. We drew strength from each other to face this, and she drew strength from our being a group as well. At times, she was concerned that she was imposing on our time, but in actuality the meetings became a compelling part of the rhythm of our lives. Indeed, we had to remind ourselves and her that there might be times she would rather we *didn't* come, and she needed to feel free to let us know that. This is one example of parallel process that repeatedly emerged, for this same issue existed between Kayla and her patients. These needed preparation for times when she might not have the psychic or physical energy to see them, and they needed her to be able to respect that in herself. By the same token, there was explicit ambivalence expressed in varying degrees by her patients. There was not surety they all wanted to continue this difficult road, dealing with their own problems, and squarely facing the impact of her illness as well.

We were concerned that she pay attention to her own level of strength. One of the consultants had experienced serious illness and realized there were times it would have served her patients better had she not worked when her energies were needed for herself. We understood and empathized with Kayla's commitment to do the necessary work, but we wanted her to consider as well her own weakened condition. Kayla worried about a sudden loss of ability to function. In our group meeting,

she could anticipate her worst fears, talk about them, and together we could do some option planning. The preparation came in good stead, for in her next session with one patient, her foot had gone to sleep and she was comfortable in saying, "You go ahead," and to remain seated at the end of the hour.

Understandably, the issue of having some sense of control was important to her and she was sensitive to this with her patients. She took the opportunity to let one patient take charge about an appointment time. With another, Kayla brought her patient a glass of water as a non verbal message that she could still give to her. A turning point occurred when she eased off on her "business as usual" approach and began to attend to her own needs—as by calling her doctor and making him see her, saying, "I feel abandoned, sick," and by arranging for some therapeutic counseling help for herself. It seemed to us that her patients were then enabled to balance their concern for her with contemplating their own problems, and to regard the inevitable interrelationship between the two.

We all struggled with feelings of abandonment. Kayla did not want to abandon her patients, nor they her. We did not want to abandon Kayla or be abandoned by her. Kayla was able to use this therapeutically with one patient who always saw herself as a loser and interpreted Kayla's illness as another example of losing out and being abandoned. Kayla was able to help her see this in another way, not as an example of the patients inadequacy, and to see that Kayla could still give to her.

All along, the patients dealt with their confusion of feelings, a wish to leave and not watch her deteriorate, but not wanting to desert her either. Caring and concern were expressed by each patient in her own way, but each was also able to continue some work on her own problems. Their concern about intruding on Kayla's need to attend to her life-threatening illness could be laid aside, as she encouraged freedom to express a full range of feelings. There was more to her than her cancer. She had a spectrum of rich responses for them, untouched by her cancer.

As Bruce Lackie (1983) has told us, a high proportion of clinical social workers have been "parentified children." We were early socialized into the role of caretakers. So it is not only our professional training but our whole personal way of being in the world that results in "empathy for others taking precedence over empathy for the self." When a critical illness hits, as Kayla was to discover, we may be forced to put to rest the impossible strivings, at last to make peace with inevitable feelings of powerlessness, and assume a more manageable caretaking—one that includes the self.

Kayla was ambivalent about these changes. She described working on herself as "unlocking the tears." And she told us, "I didn't visualize doing all this with a lot of emotions—or I wouldn't have done it." On

the day she was most emotional with us, she said, "When we finish today, I'm going to feel simply terrible!" (i.e., for giving in to her own feelings). But she was able to use our comments to the effect that we felt her generous to be willing to share her sadness with us. She mused that when she first told patients of her cancer, they had drawn her in—as by physical demonstrativeness, but that when the time limits were set, "I was not sharing the patients' pain. I had never thought of that." And we all concluded that grieving in these circumstances is a two-way process. We too were able to grieve as she increasingly could acknowledge her own grief.

### PHASE III

On our 8th meeting, Kayla told us that the chemotherapy was not working. Death was now a certainty in a matter of weeks or months at best. This shook us all. It was difficult and painful to face the reality, and at the same time to think in terms of the impact on her and her patients. Until now, her goal had been to continue the work, focusing on patients' needs despite the dramatic changes in her circumstances. There had been a fine line between what in this ambitious goal was strengthening, enabling her to continue functioning at high level, and what was unreasonable expectation. Now she was aware that her reality brought fears about how long and how well she could function. It became clear a time limit needed to be set.

The therapist's psychodynamic orientation had shaped her habitual psychotherapeutic style of "staying where the client is." It had been the patient/client who set the pace and direction of treatment. However, confronted by the constraints of her illness, she moved with a sense of urgency into a "time limited" psychotherapy mode, demonstrating her increasing therapeutic flexibility. Her pace quickened to move the treatment forward. For example, reporting on Patient "A" in a session following the setting of the time limit, Kayla told us, "A" spoke of how hard it was to come (to the therapy sessions). She continued to feel very distressed about the whole thing. She cannot visualize focusing on herself. We both agreed that it (these feelings) reflected a life-long parental message of "you are not that all important, you know." Then I said, "We don't have time to track this all down. What we have to do is push it aside to maximize the limited time we have left. I urged her to allow herself, or to force herself, to focus on what she needs now. It was interesting to watch because it sort of started out slowly, and then with more conviction coming into her, she was able to address her current issues: her recently acquired understanding of the ways her projection of feelings of abandonment interfered with her developing relationships."

As our work together progressed, the therapist became increasingly relaxed and open during consultation meetings. She spoke of her illness and the discomfort of the endless testing procedures. Should there be no hope of a remission, she wanted to maintain control over the length of her illness and we talked together of attitudes about euthanasia. She felt good about changes in the more personal aspects of her life and had a perspective about her need to be in control, which she was able to view with both some self humor and self acceptance. Overall she was permitting herself more softness and "humanness." She moved from questioning us, "Are you sure?" with respect to our recommending leveling with patients, to acknowledging the importance of doing so. She told us, "I was saying to my husband the other day that one of the big disadvantages of trying to wind things up with clients is what happens with this group, because this has become so enormously meaningful!" But meeting to "just talk" was not allowable for her. She added, "We can be writing this paper, too."

She explored with us what it was going to feel like to break the news about termination. She worried about the tears her patients would have and her own reaction to the tears. She wished to protect them from their inevitable sorrow and inferentially herself from her own sorrow.

The changes in her body as it began to fail her readied the therapist for her final task. Although throughout we consultants had again and again supported her giving herself permission to listen to her own needs, to not be so totally "responsible," this would have been out of character. Her rigorous self-demands to do her very best, her utmost, had always been a way of life. But the delicate balance between objective and subjective began to tip under the weight of her rapidly deteriorating health. Acknowledging and accepting the dictates of her fading energies she began to let go, to alter and amend her self expectation. She told her patients of the changed timetable dictated by her illness. Without hesitation, she set about limiting the number of remaining sessions. There were to be two. For therapist and for each patient in turn, this was a highly charged, enormously rewarding termination. She had become comfortable in acknowledging weaknesses. She moved one client a little closer to self acceptance, and another, in looking at changes and gains that had been achieved, began to trust her own strength. There was an honest sharing of grieving as, in closure, the therapeutic relationship moved in the direction of a person to person acknowledgment. In one instance, the patient said, "I'm sad for you, I'm sad for me, I'm so sad about the whole situation." Kayla thought, "that makes two of a kind." She told us "I didn't say that, but it was true enough."

Thus she told each one and worked out with each the number of remaining visits. And now she began to feel an urgency to get the visits in, and for the first time began to consider the relief it might be to be

able to say good-bye, and not to continue carrying such awesome responsibilities. She could accept her patients' need to keep in touch, reporting "Each one of them has said, in effect, I can't just now know what is happening" . . . and to us she added, "The final closure is the death."

Her intention and her plan for two final sessions had to be amended. She could manage only one, the second needing to be a telephone call. One of the latter was initiated by the client/patient. The therapist reported, "She was calling because she had the feeling that I might be feeling I had left her in limbo. She wanted me to know she was not feeling that way because our process had been going on long enough and well enough that if we had to stop prematurely, it wasn't premature. We really had completed something."

This affirmation that indeed she had achieved her goal of successful termination was repeated again and again as patients said their final good-byes, telling her of the profound meaning of their work with her. There were moving testimonials, both verbal and written. Perhaps one of the most significant was that of patient "A", scarred by inadequate parenting in her capacity to trust. Her struggle with repeated feelings of abandonment had been the focus in her psychotherapy. In her final office session, which followed a weekend away with her lover, she spoke of having been flooded with feelings of abandonment. Examining her over-all feelings, she told the therapist, "I know you are not abandoning me in the sense that you've had enough, but one feels left behind. It seems that however much you are putting into it, that doesn't insure anything either." The therapist responded with, "Neither of us chose this or wanted it, but there it is." Then in reflecting on her feelings of abandonment, she distinguished her current distress from earlier feelings of "how can I burden you with this when you are so burdened with your own stuff."

The therapist gleefully reported, "She came up with what I thought was really fabulous, and that was the idea that maybe this had something to do with the preparation for separation." She described the patient's struggle to give up the fantasy of the power of the "bad self," and with it the fantasy of control. This patient did not want an immediate referral, saying, "I need to test out for myself if a lot of these things you and I have been working on have become as much a part of me as I think they have."

Upon completion of her self assigned task, the therapist described, "I had this profound feeling of relief. It didn't go quite as I'd visualized, but it was near enough and I'm finished."

The last consultation meeting was on March 20th in the therapist's bedroom. A meeting that had originally been scheduled for the previous week had had to be cancelled and we were all dismayed by the rapidity of change for the worse which was now so clearly visible. In bed, oxygen

available, breathing labored, the therapist acknowledged that she might not have sufficient strength to proceed. Earlier in the day she had considered canceling out. But we began, and indeed she seemed to rally. At the end, she expressed her surprise at how much better she felt. We planned our next meeting, all of us knowing it might not come about. "It really is a fact that we don't know how much time there is, and it is limited. . . ." Nevertheless, the date was set. In considering that its agenda would focus on how to go about writing up this total experience, the therapist with her old spirit volunteered, "We'll try to do a rough draft. You know what? I'll make myself undertake it." Time robbed her of that opportunity. The meeting was cancelled. She died on April 2, 1987. For us consultants, grieving for her was made even more poignant by the very personal loss brought on by the unexpected death of the husband of one of the consultants—the day before our group was to have met. Paradoxically, the memorial services for the two coincided.

## EPILOGUE

In coming to terms with the imminence of Kayla's death, one of us commented that a certain patient was expressing the "tragic view." Kayla herself associated to Schafer's (1970, 1976) "Psychoanalytic Vision of Reality." In reflecting on the totality of our experience together, we seem to have gyrated around the specter of human mortality, moving spirally from the comic vision, through the romantic, into the tragic and even the ironic, not always in that sequence, for ultimately they were all aspects of the vision which we gained from living Kayla's death with her.

In referring to the *comic*, we do not speak of the humorous, although that was manifest until the very end. Rather we mean the "melioristic" orientation shared by all participants in this drama. It was manifest in a degree of denial, an initial hopefulness, even perhaps a belief, if not in medicine, then in the "power of positive thinking" (Schafer, p. 26). Our protagonist, Kayla, would pursue with clients their therapeutic goals, and her powerful mastery of personal reactions would enable patients to master their own. She would, by her own efforts and resolve, turn this crisis into a triumph. Unlike those analysts in the Rosner article, she would level with her patients, pioneer for us all a new way of dealing with ultimate adversity. She would proceed as though time were not a consideration; in her ending she would make a "new beginning" (Balint, 1952).

The *romantic* vision was evident in the element of quest to acknowledge individual needs and wishes as they conflicted with Kayla's image of the ideal professional. She told us at the start that she felt "like a

nervous student," and she appointed us as her teachers and guides. Her quest was begun with "I'm not the same person that I was," and it ended with each of us consultants saying the same words, having each embarked on a quest of her own in this vicarious sharing of Kayla's experiences. Schafer tells us that a "persistent nostalgia for a golden age in time or space" is the "prize for the counter-phobic victor" (p. 32). There was no choice for any of us but to behave counterphobically as we tried to make our way over relatively uncharted domains. The "prize" wanted was the sense of *personhood* integrated with a sense of professional *being*. The process was a continued search—within self, sometimes alone, sometimes with clients, sometimes with us—for understandings and insights. Kayla constantly demanded that we be honest with her if ever we thought what she was doing with clients was out of line. Her courage gave us the courage to level with her.

The process led inevitably into the realm of the *tragic*, as all of us adventurers confronted the unwelcome fact that time is linear, that life leads inexorably to death. From the beginning, Kayla eschewed the melodramatic and the pathetic; she could not bear a feeling that she was burdening others with her plight. Her tragedy, as she portrayed it, was not just that she might die, but that she might let her clients down. This prospect gave her intolerable guilt. She cross examined herself and us as to whether she was warranted in imparting the bad news to those she wanted to help. It was an aspect of our task to enable her to accept the role of tragic heroine. In the treatment situation this meant not "personal intervention or inaction, but . . . empathy, reflection, and inquiry" (ibid, p. 40). When Kayla could diminish her exhorting of patients to bypass their reactions to her illness and to her, and could share with them the terrible grief and mourning of unwelcome terminations, she could, paradoxically, only then safeguard the ethic of *neutrality* at its best.

Overlapping the tragic, says Schafer, is the *ironic*. While the tragic aims at full contemplation of crises with their momentous implications, the ironic aims at detachment, at perspective, at taking nothing for granted. Kayla's irony was often manifest in a self-deprecatory attitude—not one that was self debasing; it was rather that she safeguarded her good judgement by not taking herself too seriously. It was that irony that let her conclude that although she had been helpful to those who had reached for her services, there were limits to the changes they had been able to make. And although she could enjoy the note of praise which one woman sent to her, she also saw it as "too much, too pat . . . what we would write if we were asked to write what we would like to hear . . . like a final exam." In that last session with us she joked, "If you had called that you weren't coming after all, that you'd found a better movie, I might have felt relief," but she added that she

had learned one more valuable thing! It was that "the final closure is death, and finally you just walk off into the sunset and don't know . . ."

Kayla had come to know "the renunciations that are intermingled with the conditions of gratification; the necessity to act in ignorance and bear the fear and guilt of action; the burden of unanswerable questions and incomprehensible afflictions; the probability of suffering while learning or changing; and the frequency with which it is true that only in the greatest adversity do people realize themselves most fully" (Schafer, 1976, p. 35).

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## Further Considerations

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The story "Consultation with a Dying Therapist" is illustrative of one way of working with the particularly hard and often poignant issues of termination. The consultants were in agreement that such terminations, precipitated by the serious, possibly life-threatening illness of the therapist, are of a different order than those initiated by other life events. The grim unforeseen reality dislodges transference, colors our ability to fantasize, and intrudes into projections which otherwise cooan and shape our feelings of separation and loss. The patient-therapist relationship is jarred. Attempts to "protect" the patient from knowledge are suspect, even when the patient appears to collude with the thera-



apist's need. This is a time when the realities take precedence. Therein Kayla's story is a model for others who may be confronted with a similar situation. For Kayla's honesty in self-disclosure communicated recognition of the very real aspects of the therapeutic relationship, as well as respect for her patients on a person to person level. In all other contexts her way is unique to her, an outgrowth of her personality and philosophy as developed over a lifetime of experiences. Perhaps it is these highly personal qualities which shape our professional behaviors when we are under stress, more than theories we espouse or the psychodynamic formulations to which we adhere.

The opportunity to compare and contrast differences in professional behavior when confronted with a life-threatening illness came to me—one of the four consultants, some two years later. I report it as yet another way of dealing with professional responsibilities when under stress. Once again it is not a model but a highly personal response stemming from my own psychological configuration.

By way of introduction I want to report two dreams. In the first I was coming up a steep incline, in unfamiliar terrain. At the crest, directly in front of me, on a bleak landscape there was a strange tree. Its many limbs twisted and barren, fanned out from the knarled trunk—clearly a very old and rugged tree. Directly before it, almost seemingly attached, was an enormous, brambly tumble weed. Suddenly the tumble weed lifted, drifting away. The tree was freed. In the second dream I was as I had been when I was forty, some 30 years ago. I was scheduled for an abortion that I did not want and the need for which (in the dream) I could not understand. I cried out in protest.

The first dream followed my learning that I had a form of uterine or ovarian cancer. The second, a couple of weeks later, immediately preceded my scheduled hysterectomy. The reader may speculate on the nuances of interpretation. Most certainly these dreams reveal my unconscious response to my illness. There was not only my sense of shock, but a deeply held belief that although I am old, I am robust, so that the cancer would lift and I would be freed. In the second dream my self perception is that I am still young, in my prime, my vital capacity threatened by the removal of my potential for creativity.

What in Dec. 1988 was thought to be a low grade very slow growing carcinoma, was determined in March 1989, to be more pervasive (this following numerous tests, a couple of surgeries, and some surgical complications). Chemotherapy was instituted in late March 1989. The anticipated completion of this course of treatment will be mid-August 1989. The doctors are non-committal as to prognosis, but clearly (my projection) they share some of my own expectation that the outcome will be a decent remission.

During these months I have often thought of Kayla and have reflected on the likenesses and the differences in our responses as profes-

sionals confronted with a life threatening illness. First the likenesses. We were both practicing clinicians. For some time hers had been a limited practice. In contrast, although I had been wanting to reduce my patient load, I seemed to have difficulty in achieving this goal—in cutting back without cutting out. A unifying consequence of our shared professionalism was that we each had firmly held convictions as to our responsibility to our patients and to the treatment they had entrusted to us.

There was a half generation between us and differences as to when in life we had come onto the professional scene. Kayla's professional training, undertaken in mid-life, had been the means to a gratifying second career in which she took justifiable pride. However I don't believe it had ever carried a full time commitment. I, in contrast, starting as a young woman right out of graduate school, was immersed in my profession. It was who I was! It provided a rich experience with many opportunities. I felt myself fortunate to have so early on selected a career which offered both such breadth and such depth in its practice.

Given these differences and similarities it may be surprising that we each dealt totally differently in discharging our professional obligation to our patients. In both instances patients were fully informed as to their therapist's health, diagnosis, prognosis, etc. Kayla elected to continue practice for as long as the doctors gave her hope of the effectiveness of treatment. Only then did she move toward termination. And indeed even in that phase she urged her patients to work on their own issues, to think of themselves and not be overwhelmed by sadness of her. Certainly we consultants were moved by her will to continue until almost the last drop of life. In retrospect there is a quality of the doomed heroine. She emerges a tragic figure.

My reaction to illness was colored by the verdict coming on the heels of a difficult surgery. I felt overwhelmed. I had no idea of when I would be strong enough to deal with patient needs. I fretted as to what to do. How to take care of their needs and of mine as well? I had no doubt that I came first. In my current state I could maintain responsibility only for myself. I had to heal. Having always worked closely with clinicians who are both friends and colleagues, I was fortunate in having a ready trusted source for sharing my load. And a load it was! I didn't have the energy to contemplate how I might feel some months hence. I felt burdened. To ask patients to wait or to accept an interim referral felt unfair to them and to me. I would have to trust that their next therapist would help them grieve their loss and move on in their lives and their treatment. Fortunately a colleague who shares my suite of offices took over telephoning my bad news, offering appointments where indicated to discuss the unforeseen turn of events, making appropriate referrals. I realized I was closing out my practice. I wept for my loss and then experienced an enormous relief—there was no one I needed to caretaker. I was free.