Psychotherapy and the Patient with a Limited Life Span *Lawrence LeShan and Eda LeShan*

A patient said to her psychotherapist, "I know that I'm intelligent, I have courage, and my opinions are as good as anyone else's. Just knowing this has made a big difference in my whole life. I can see the good things I've given my children, not just the bad things. I think I even love them and my husband a lot more now." Another patient said, "You know, Doc, for the first time in my life, 1 like myself. I'm not half so bad a guy as I always felt I was." A shy girl had written poems all her life; they represented her ego ideal, her hopes and her dreams, but she could not believe in herself enough to let others see them. *With* much anxiety she showed some of them to her therapist. At his response-they were of very high caliber-she began to accept her own value as a person, and to talk hopefully about publishing her poetry. A brilliant woman *with* special skills in theoretical research had been blocked completely for nine years in her ability to do work in her field and was filled with self-doubt and self-dislike. One day she said with triumph and joy, "I started work on an article last night I have it mapped out and the first two pages written. I think it's going to be pretty good." A 39-year-old woman who had never had a love relationship told her therapist one Monday morning of her wonderful week end at the beach with a man she had met six months previously. As they had watched the sun go down, she had felt inside like the colors of the sunset The affair begun that night was one of deep meaning to both of them, and she was able to give and receive the kind of love she had never known existed.

Each of these patients was dying from cancer. None of them lived more than one year after the reported incident, and three died within four months.

In the course of a research project into the relationships between personality and neoplastic disease, these patients and others were given the opportunity of intensive psychotherapy after their cancers had been diagnosed. Conducting over 3,500 hours of therapy with these patients brought their needs and what psychotherapy can hope to accomplish in such conditions into sharp focus.

There can be great value to the patient in the fact of someone's believing in him enough to really work to help him toward greater self-understanding and inner growth at a time when he cannot 'repay' by a long period of adequate functioning--cannot "do as I tell you to and grow up to be a big, strong, successful man." His being is cared for unconditionally, and so he cares for it himself. The presence of the therapist affirms the importance of the here and now. Life no longer primarily seems to have the quality of something that is fading away, but take4 on near meaning and validity. In the search for himself, in the adventure of overcoming his psychic handicaps and crippling, the patient may find a meaning its life that he never had found before. If the psychotherapy focuses on his strengths and positive qualities and what has blocked. their full expression, rather

than on pathology-as Is so often unfortunately the case in psychotherapy-the patient may come more and more to value and to accept himself, and to accept his universe and his fate. Frequently the patient who is dying has lost his cathexes, by the natural attrition of life, by inner neurotic dictates, by an attempt on his part and on the part of those closest to him to "spare" each other from discussion of their mutual knowledge, or sometimes by a partial withdrawal in a magical attempt to ease the pain of the final parting. He is, therefore, very much alone and isolated in a universe which, because of his isolation, seems hosted and uncaring-as Pascal said, "The eternal silence of these infinite spaces frightens me." [1] The therapist, by his presence and by his real interest, can give the patient meaning through warm human contact, can, by providing the opportunity for a strong cathexis, give him an anchor rope to the world and to others, so that with Bruno and Goethe, he can feel that "out of this world we cannot fall." [2] Or, like Camus's "stranger," when he had asserted, in the only way he knew, his oneness with humanity and was close to death, the patient can lay his ear "upon the benignly indifferent universe" and feel how like himself, "how warm, friendly and brotherly" it is.• With contact and connectedness returned, and with the focus on life rather than on death, the patient's fear of death seems to diminish considerably.

In inexorable reality situations, the fear of death-and with it guilt and self contempt--seems usually- to be related to a sense of never having lived fully in one's own way, of never having sung the unique song of one's own personality. Thus it is by the quest for one's own essence-by finding and engaging in one's own type of relationships and activities that the fear *of* death may, perhaps, lie most successfully eased. This view-was empirically developed in this research, but it is not new; it was advanced by Montaigne,' and perhaps it is only a restatement of Epicurus "Where life is, death is not."

Psychotherapy, for the patient who is aware that "time's winged chariot" is hurrying him on, cannot deal only with the technical aspects of personality as they are found in the textbooks. The larger questions are too pressing, too imminent. Values must be explored. As one patient put it, "Once the big questions are asked, you can't forget them. You car. only ignore them as long as no one raises them." Death, the figure in the background, asks the questions, and the therapist must join in the search for answers which are meaningful to the patient. In our experience, this can be done most effectively by a search for the values most natural and syntonic to the patient-in terms of who he is, what kind of person he is, and what type of relationship would make the most sense and be the most rewarding and satisfying to him. Certainly if the patient has serious theological convictions, including some concept of afterlife, it is not the function of the therapist to attempt to disturb them; yet such convictions seldom-for who is not a child of his age?-obviate the patient's need to explore himself and his relationships with others. Thus today it is often the psychotherapist who attempts to help the person who has lost his way-and perhaps the psychotherapist also who must try to help the person who lives in the shadow of death-to find his answers to the three questions which, according to leant, it is the endeavor *of* philosophy to answer: What can I know? What ought I to do? What may I hope?

A common basic assumption of psychotherapy is that the psychotherapist works with a patient to increase the value of his long-term productivity and his longterm relationships with others, and, perhaps, to better his adjustment to his environment. Clearly these are not valid goals for the patient with a fatal illness. But are there other goals which therapists are committed to, or believe to be part of their responsibility? Heidegger has suggested that the age of man should not be reckoned only in terms of how long he has lived, but also of how long he has to* live.' Within this frame of reference, it is of major importance what the person is and does during his remaining life span-that Is, what it encompasses, rather than how long it is in chronological time. Perhaps life can be seen more validly as an extension in values than as an extension in time. Here may be an approach to a philosophy of therapy that does not differentiate patients according to the length of life left to them-an evaluation which can never be more than a guess, since the universe gives no one guarantees. If a person has one hour to live and discovers himself and his life in that hour, is not this a valid and important growth? There are no deadlines on living, none on what one way do or feel so long as one is alive.

Thus our point of view in therapy is that it is important-and indeed it is all that is possible-for the therapist to help the patient at whatever point he touches the patient's life. Psychotherapy has generally taken the approach of trying to help the patient shape his life in the future, and taken the pragmatic view that results measurable in time are the only basis on which to judge success. Our view here is rather in tests of the patient’s life, and respects for it, whatever its time limit.

The patient with a limited life Span has needs which psychotherapy can potentially fill. Unfortunately, however, very little therapy has been done, or is being done, with these patients. This paradox raises certain basic questions. For example, one might well ask if the more than 3,500 therapy hours, out of which the material presented here was derived, should have been given to these patients. Was the work worth doing, since 22 out of 24 of them died during the course of treatment? In view of the limited number of psychotherapists available, should this time have been given instead to children or to well young adults? We are not speaking here of the *research* value of the therapy-the findings are published elsewhere • and must be evaluated within their own frame of reference-but of the value of the therapy in itself. Was it worth while? Do patients have a right to this type of care as long as they live, just as they do to physical aid? Perhaps a comparison of the approaches of clinical medicine and psychotherapy may be helpful.

In some ways, clinical medicine and psychotherapy operate according to the same rules and goals, suiting the therapeutic approach to the needs and potentialities of the patient, and having as their major goals the easing of pain and the restoration of function. However, a sharp dichotomy arises at one point. When the patient's life expectancy is clearly limited, clinical medicine does not abandon him. Although the physician may be aware that he cannot save the patient's life or restore his lost functions, he continues to attempt to soften the blow, to sustain and invigorate him, and to protect him from pain. Every medical resource is brought to bear on the situation. These efforts continue as long as the patient lives-and sometimes extend even to massaging the heart after the patient is technically dead!

Psychotherapy operates quite differently in this area. So long as the patient's life expectancy is not clearly limited, it may be possible for him to get psychological help. Once the termination date is dimly seen, help becomes almost unobtainable. Even if he can afford private treatment and manages to secure it, the therapist's reluctance to become involved is likely to be manifested in a quality of remoteness and detachment which is quite different from his usual therapeutic approach. This is true not only of the patient with a known fatal disease, but also frequently of those in the later decades of life. Viewing this phenomenon on a superficial level, one might come to the altogether oversimplified conclusion that the therapist's preoccupation with the patient's continued ability to function and to relate to others is greater than his preoccupation with the patient himself.

A more careful consideration of this basic difference between clinical medicine and psychotherapy may make it possible to see some of the reasons why psychotherapists, by and large, avoid working with the dying patient, and it may, perhaps, suggest some implications about the basic values and goals of psychotherapy. There are many reasons why psychotherapists tend to feel that their task is to help the patient toward a long and healthy life. They feel that their function is not only to comfort and support-and in what denigrating terms do many psychotherapists contrast their cases in "supportive" therapy with those in "real" therapy!-but also to change him for the future. It may be worth while to look briefly at the reasons for this.

Each new science, as it develops, tends to exaggerate its potentialities, to see its future abilities in a somewhat magical light composed partly of hope and desire, to envision it serving as elixir vitae answering mankind's greatest questions and needs. Psychotherapy is no exception-one recalls Freud's vision of answering the question of the Sphinx. Psychotherapists, in working very hard to help their patients for the future as well as in the present, have often forgotten the unspoken assumption of omnipotence *which is* part of this orientation. Psychotherapists cannot mold the universe or control the future; they can help the patient now, in the moment in which they are in contact with him. They may per*haps* need an attitude of more humility toward their own ability-one recalls someone's definition of psychotherapy as "the art of applying a science that does not yet exist"-for at present the death of patients seems to threaten the psychotherapists' basic assumption of their own omnipotence. Psychotherapy, of course, has never had any right to expect guarantees from the future. If the psychotherapist can justify his work only by the results which he assumes will appear long after he has lost contact with the patient, he had better think through his basic assumptions.

This need to help the patient in the future may be strengthened by the psychoanalytic view of the therapist as a father figure-an image which may be held not only by the patient, but by the therapist as well. As parents, therapists want their 'children' to grow up and to have long, happy, mature lives. The major flaw in this orientation becomes immediately apparent If one looks at actual parent-child relationships; if a parent receives all, or a major part, of his satisfactions not from

what his child is now, but from what he will become when he grows up, the relationship clearly leaves much to be desired.

Certainly it is vitally important for successful therapy that the therapist wants the very best for his patient, that he has dreams and visions for him. Only if this is true, in fact, can the patient learn to accept and value himself, to really want the best for himself. However, just as these wishes must be reality-tempered by the potentialities of the patient and his environment, they must also be tempered by the therapist's knowledge of his own realistic limitations.

Another reason for the reluctance to treat patients with a limited life span has been suggested to us by a psychiatrist colleague. The medical man has, in his experience in medical school and in his internship, been constantly made to realize his own helplessness in the face of death. To be highly trained medically, to have at one's command all modern medical resources, and still to be unable to save a dying person can be a very heavy blow. Some of those who are most hurt by this go into psychiatry, where, theoretically, at least, death does not enter the picture. The prospect of then working with patients who will die can mobilize all of the doctor's earlier feelings of defeat and inadequacy, and arouse his resentment and resistance. In this context, remarks made by several psychiatrists about an earlier paper on the special problems and techniques involved in psychotherapeutic work with cancer patients 1• may be relevant. They did not criticize the technical concepts presented in the paper, but said that they felt the idea of intensive psychotherapy with dying patients to be "obscene" and "disgusting.'•

The fear of the therapist of his own hurt also seems to be a major factor in the reluctance to work with the dying patient. The feeling that a therapist develops for his patient consists of more than countertransference; there is also love and affection. When the patient dies during the process of therapy, it is a severe blow. Not only are the therapist's feelings of omnipotence damaged and his narcissism wounded, but also he has lost a person about whom he feels very deeply. It is entirely natural to wish to shield oneself from such an event, which becomes even more painful upon repetition. We believe, in fact, that a practice composed entirely or largely of patients with a limited life span is too painful to be dealt with successfully; treating a small number of such patients seems to be a much more realistic approach.

The psychotherapist, too, cannot protect himself by the defense maneuver that necessity sometimes dictates to the purely medical specialist whose patients often die-the surgeon, for example, or the oncologist. This defense-the brusque. armored manner, the uninvolved relationship, the viewing of the patient's disease as of primary interest and the concentration on its technical details to the exclusion of as much else of the person as possible-may save the physician a great deal of heartache, but it is a defense which is impossible to assume for one who is in a psychotherapeutic role. The psychotherapist's answer to the heartache must come rather from a life philosophy which regards the time left for each person as an unknown variable, and holds that the expansion of the personality, the search for the self and its meaning are valid in

themselves-valid as a process, valid when they are being done, and not just in terms of future results.

These are perhaps some of the reasons why psychotherapists have done so little with patients with a limited life span-why they have left this painful period of life to the minister, the rabbi, and the priest. To the question, What can one hope to accomplish with the dying patient?, our answer is that the validity of the process of the search for the self is in no way dependent on objective time measurements, that the expansion of the psyche-in another age, one might have called it the growth of the soul-is not relevant to the fluttering of leaves on a calendar.

Some years after his psychotherapy, a patient wrote:
One of the primacy contributions of the therapy was the certainty it has provided that I am truly alive ...I can recall the long years of my life and the full river of emotion that poured through me for thirty years. Surely I was alone, feeling and suffering intensely, long before the analysis began. The whole record of my life until then shared intense fear and anxiety. But there is a difference now, and I believe, it consists in this: I have became integrated with my life, my body, mind and psyche are intimately bound to the real world around me; no longer do I project myself almost completely into the outer world to forget myself, to avoid the inner fears, panic and uncertainty .... I have the firm conviction now of being really made of one piece.

A sister of a patient who had died said to the therapist:
She knew she was loved and lovable before she died. It was the first time in her life she had been able to accept this.

A patient's daughter wrote to the therapist:
. . . and I know that every day she grew in courage and understanding and was learning to fight the fears that surrounded her. With a woman like Mother-I suppose with any human being--an illness such as hers could have been the final fear to entirely hem veer in and shut her off from human contact. But I do think that through her work with you. she somehow managed to WW through her Illness to greater understanding; not only of herself but of other people too, So please don't feel that your work was to rain. I don't believe that anything like that ever goes into a vacuum. Somehow it perpetuates itself. My father and I are changed because. of the change In Mother. sad I think it Influenced bar friends who visited her. Because of you, Mother's last months were filled with hope and thoughts of the future, to her very last hours. And the past few months were made far easier for those of us who loved her.... because of you, we'll always have a wonderful memory of Mother's last days and of the courage that fined them.

Of these three patients, two died during the course of therapy, and one is still alive, years after completion. Who is to say which of the three therapies was most worth while?

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