Walking through the Valley of the Shadow of Death The Dying Patient in the Therapeutic Encounter: A Relational Body Psychotherapy Perspective

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Abstract

Meeting with the dying patient in the therapeutic encounter introduces us to considerable human suffering and our ineluctable extinction. Literature regarding dying in the field of body psychotherapy is scarce.

In this paper, I present my clinical work with a terminally ill patient, interweaving my experience as body psychotherapist as well as a family physician. From a relational body psychotherapy perspective and based on psychoanalytic, relational, and existential theories, I discuss the intricacy residing in meeting the terminally ill patient in the therapeutic encounter, emphasize the significance of an embodied relationship, and demonstrate how the psychotherapist's body could potentially function both as a diagnostic tool and as an agent of healing.

Keywords: terminal illness, dying, body psychotherapy, resonance, relationality

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"Even though I walk through the valley of the shadow of death, I will fear no evil, for you are with me" (Ps.23:4, ESV)

Introduction

Over years of practice firstly as a family physician and then as a body psychotherapist, I have been confronted time and again with death and dying. Facing death has evoked in me a myriad of feelings, attitudes, conscious and unconscious behaviors. I have found myself oscillating between fear and dissociation, vulnerability and denial, and savior fantasies and surrender.

While the topic of the dying patient has received significant space in psychiatric and existential literature (Kübler-Ross, 1973; Yalom, 2008), very little has been written on this subject from the perspective of a body psychotherapist (Endrizzi et al., 2016). In this paper I will discuss the intricacies residing in meeting the terminally ill patient in the therapeutic encounter. I shall emphasize the significance of an embodied relationship with the terminally ill patient, and demonstrate how the psychotherapist's body could function both as a diagnostic tool and as an agent of potentiating moments of human interconnectedness and liveliness in the shadow of impending death. I will illustrate those issues by sharing my experience as a body psychotherapist with a terminally ill patient of mine interweaving my own history as a family physician and my personal perspectives.

Every Breath You Take

The Fear of Death

He breathes heavily, every muscle makes a tremendous effort to keep breathing. "Everything will be OK," he keeps smiling as usual.

Shaul, a former high-tech vice president, 65 years old, has been coping with heart failure the past few years. His medical condition keeps deteriorating and helpless in the face of the known ominous statistics he keeps fighting back. He struggles for remnants of dignity and vestiges of functionality while pretending he is fine, refusing to expose his fears, weakness, and suffering.

We have been meeting for a few months; he presents a peaceful and pleasant affect, keeps telling me about moments of success and highlights along his career, and keeps moving away every time I try to capture moments of vulnerability. Unable to reach him and make contact with his suffering, while observing his body screaming with every breath he takes, I am filled with frustration. Nevertheless, from time to time, I am relieved with our small talks, turning both of us away from dealing with death.

I am listening to one of his stories, when all of a sudden my chest tightens, my breath becomes heavier, and I feel the struggle in every breath I take. Panic spreads in me; I can feel the impending death knocking at our door with every breath. I look at him with my own torn eyes; his smile is gradually dissolving when he is staring at me and asks, "What's wrong?"

"It's your breath," I whisper. "You are fighting for each one without knowing that the next one will come."

Inescapable silence in the room; the sound of his strenuous breathing fills the space, his muscles are tightened, he can hardly look at me when he hesitantly says, "I am afraid to die."

Shaul's struggle to breathe confronts me with the fragility of life— our inevitable demise evokes in me the fear of death.

There has been a broad discussion regarding the fear of death in the psychoanalytic, relational, and existential literature (Frommer, 2016; Freud, 1926; Kohut, 1977; Razinsky, 2013; Yalom, 2008). Despite controversy and profound changes in psychoanalytic literature and practice over the years, fear of death has been attributed to annihilation anxiety and our inability to imagine and apprehend our own demise (Freud, 1926; Frommer 2016; Kohut, 1977). From an existential vantage point, fear of death plays a major role in our internal experience; the tension between our awareness of the inevitability of death and our wish to continue to be, presents a core existential conflict that is both terrifying and essential for living meaningful life (Van Duerzen-Smoth, 1997; Yalom, 1980, 2008).

While writing this paper, I was surprised to discover how scarce the literature is regarding dying in the field of body psychotherapy. When I experience Shaul's strenuous breath and struggling in my body, I also let the dread of dying invade me. The body-to-body communication through body resonance (Pinkas, 2016; Rolef Ben-Shahar, 2014) between us makes the verbally unspoken fear of death emerge into our encounter. Bucci (2008) relates 'the unspoken dimension' to her multiple code theory, suggesting that an experience seeks to use language that connects intuitive and somatic levels in addition to traditional, rational ways of using verbal language. According to Bion (1967), when mentalization of a feeling is absent, communication finds a somatic channel to go through. Embodied with Shaul's fear of death and mine, a viable connection is possible making space for the terror to be confronted.

Defenses against Death Anxiety

We have been talking about his impending death for a few months. He has been sharing with me his anxieties generated by thoughts of how he might die, the pain and the suffering that might be involved. He expresses his concerns for the well-being of his wife and children he would leave behind. From time to time we discuss existential anxieties (Yalom, 1980) induced by the realization that death will bring finality to his life and he would cease to be. While his fears are present in our meetings, so is life. While his inextricably death reminds him to live fully, to enjoy the view out of the window, the smile of his grandchild and the beauty of a flower, it is also pushing him to fight death. He never gives up physiotherapy sessions, meditation, and good nutrition. He is a real fighter, filled with determination, passion and hope to stay alive despite his ongoing deterioration.

We are sitting together, his body is scraggy, his eyes are sunken, his voice is getting weaker and weaker, his hands are quivering, and his ability to breathe seems as a miracle to me when he is talking.

"I haven't done my physiotherapy exercises for two days," he says, criticizing himself. "You're tired," I say.

"Yes," he whispers calmly. "I am so tired".

"You look exhausted, Shaul". He looks at me with a defeatist gaze. After a few moments of silent shared sadness, tightness in my chest strikes me. I look at him, his eyes are wide open, and he is fighting to straighten up. "I'll do the exercises today, I'll get better, I can't be so weak", his voice is louder.

Anxiety deluges me, my heart is racing when I hear his words.

"What do you think will happen, Shaul?" He looks into my eyes, his body starts shivering, "I have to fight back, I cannot stop, not now," he mutters, "but I'm so tired, what am I going to do?"

I hold his hand; his warm touch floods me with my love for this precious man. Sorrow fills every cell in my body when I realize again that he is dying. How easily I forget. It seems that no matter how many times we have been talking about his imminent death I keep burying these feelings and unconsciously choose not to see. I am stunned by our shared denial of his death. His helpless eyes are penetrating mine waiting for deliverance. I breathe deeply, centering and grounding myself, and decide to embody his death in the room. "Shaul," I say," your body is weak and deteriorating. You are a real fighter, but there are things that won't happen. Your heart's function won't get better; you won't be able to take a walk outside anymore, and your breathing won't get easier."

Silence. His eyes are torn with anxiety, screaming his terror. I can hardly breathe; I struggle for being fully present with him.

"So, what for?" he utters. "What for?"

These intense moments with Shaul, confront me with our desperate grasping of sparks of life in the abyss of death so we can both elude this fate. When faced with death most individuals develop denial-based strategies such as suppression and repression (Yalom, 1980). We resort to defenses of omnipotence and dissociation of the vulnerability of our embodied human condition in order to maintain our emotional stability, to bolster ourselves, and cope with our ineluctable fate (Frommer, 2016; Shabad, 2016).

While fear of death and the consequent defense mechanisms constitute a collective human experience, each of us has his unique way of relating to death (Razinsky, 2013; Shabad, 2016). This diversity influences our clinical perspectives and interacts with our character structures and sensibilities (Frommer, 2016).

For decades, as a young daughter to a very ill father, and afterwards as a practicing family physician, I have unsuccessfully tried to defeat death by fighting it with medical interventions

and taming it by apprehending it intellectually. After years of engaging with my omnipotent defense and savior fantasies, I began to acknowledge the destructive effects of denial of death on me and my patients.

When Shaul keeps fighting for getting better, exhausting himself, I recognize the price he pays for his denial, with which I find myself cooperating to some extent. As a body psychotherapist, I try my best to be fully present and hold together with Shaul his impending death and serve as a self- object for him. However, unconsciously I am trapped in the tempting web of denial. Akhtar (2011) encourages therapists to speak about death and attempt to counter defensive and dissociative processes that protect both patient and analyst from experiencing the loss of omnipotence and the inevitable vulnerability from acknowledging that this story would not end happily. Encountering Shaul's denial despite our open conversations regarding his death elucidated for me how potent the temptation to dissociate and deny is, and how elusive and fallacious this process can be.

Submerged in the tempting swamp of denial, the tightness in my chest and deep sadness pulled me out to face the impending death. Retrospectively, the decision to confront Shaul with reality, derived from a wish to help him let go. Watching him fighting with all his resources invested in getting better, I felt that redirecting his efforts towards being present with his family would be for his own good. Shabad (2016) poses the following question to himself as a psychoanalyst when a patient walks into the office, "How can I best offer my personhood to this individual so that he can fulfill himself before he dies?" (p. 395).

Was that a legitimate decision? Who am I to pull him out of his denial? Would facing his ephemeral existence help him fulfill himself better?

"What for?" he keeps murmuring to himself. Terror stabs my chest. What have I done? Surges of fear and pain are pulling me apart. His eyes torn with dread feel like a sword penetrating my heart. Holding his hands, I am breathing deeply and trying to ground myself. The terror we both feel fades away, making space for despair. My breath becomes slower; my body is heavy and calm. I can feel dying inside my body. No effort, no fighting, deep silence, I surrender. His body is relaxed, his eyes closed, he is resting.

"You've been through so much," I whisper." You have been fighting like a lion; I feel that you are resting now. There's a part in you that lets go."

"Yes… I am left with nothing," he says sadly.

"You have lost so much," I tell him." So many things will not be possible any more. But what are the things that you have? Is there anything that worth living?"

He is silent, his head up, and his brown eyes looking at me helplessly. Hands together we are enjoying the view of the sea through the window; we are looking at his family album and cherishing our own precious relationship. Despair is gradually dissolving into open heartedness and interconnectedness interweaved with sadness and gratitude.

To be or not to be

Embodied presence with the dying patient

Working with terminally ill patients exposes us to considerable human suffering and our ineluctable extinction. Frommer (2016) emphasizes the magnitude of sustaining intersubjective engagement with a therapist who is capable of exploring and experiencing together with his patient the realm of death. He argues that "mortality seeks relationality" (p.373). I would like to extend Frommer's argument and say that the dying patient craves for bodily relationality.

Orbach (2003) paraphrased Winnicott's famous saying—there is no such thing as a baby—by saying there is no such thing as a body, only a body in relationship with another body. I believe that the dying body asks for our bodies to be in relationship with them.

Resonance is a central skill in body psychotherapy, which accentuates the capability of body-to-body communication, and the formation of the shared body (Pinkas, 2016; Rolef Ben-Shahar, 2014). Pinkas (2016) introduces the concept of bodily reverie in which the body serves as a sensory receiver and amplifier allowing us to resonate with the other and the other to resonate with us. The body constitutes subjectivity, transformation, and process, which incorporate myriad of aspects of live communication (Carroll, 2011). The body is not only a place of physical symptoms and pain, but also of creativity, containment, relationship, and healing potential (Endrizzi et al., 2016).

Shaul and I communicate and share his death mostly bodily. I think that feeling Shaul's death inside my body, allowing myself to be there, and the possibility of mutual holding of mortality made space for experiencing the inextricable demise in a less terrifying way. Without undervaluing the importance of contemplating and speaking of death, I think that an analytic stance might deepen the body-mind split. Dying is a bodily process that craves to be met in its wholeness.

My hands are touching his fragile chest. Touch is the only thing that calms him in the last weeks. He struggles to breathe, his voice gets weaker every day, and he can hardly talk. We communicate mostly through touch and the soft look in his sunken eyes. He closes his eyes, his tightened forehead is more relaxed, and serenity wraps him. His breathing gets slower and slower. I can feel his surrender to his death in my body. My heart is open, filled with love and compassion. Sadness spreads in my body intertwined with a sense of alleviation. Is he going to die in my hands?
After a long stay in the dying experience he suddenly opens his eyes squeezing my hands. "I don't want to die," he whispers." I am afraid." We are looking at each other, my eyes start shedding tears, sitting next to him while he is on his way to the other side of the shore. Precious moments of sharing death and agony, granting life, and treasuring humanity and love.

For many long years I have been present with dying patients. Time and again I have been dissociating, denying, and trying to hold back the inevitable demise. As a young girl at first and later as a grown up, I could not face my father's illness and impending death. As a family physician I have found the ubiquitous presence of death challenging. I have found myself relating to death in a variety of ways, from fighting it, through dissociating and denying to being present empathically and compassionately. Even though I learned to talk to my patients about death openly as a doctor, it was not until practicing as a body psychotherapist that I realized how I split from myself in front of death. Being present in my body allows me to recognize that addressing death verbally might be the semblance of bearing death mutually.

To be or not to be? Am I willing to let death take place in my body? To what extent can I ground the dying experience in my body?

First and foremost, I believe it is about my intention and choice. By acknowledging the importance of the body's presence in the therapeutic encounter generally, and with the dying patient especially, I repeatedly insist, in spite of the drive to split, to be fully present and let the other be felt in my body.

From a relational stance, Frommer (2016) asks, "What do other minds need from other minds in contemplating the loss of self through death?" (p. 374). He believes that the intersubjective interplay makes looking directly into abyss the answer. From a relational body psychotherapy point of view, I would like to further ask, "What do bodies need from other bodies?"

I will argue that the dying body needs to be met by another body. I believe that meeting Shaul's body created the potential for a novel relational experience. Touch and bodily reverie (as described in the previous section) were the main ways in which Shaul's body and mine met.

Meeting of Bodies

(1)Touch

Much has been written about the healing potential of touch in the therapeutic encounter (Asheri, 2009; Orbach, 2004; Rolef Ben- Shahar, 2014; Totton, 2006). Endrizzi et al. (2016) describe their work as movement psychotherapists in hospice. They emphasize the value of touch in terminally ill patients. They believe that dread and anxiety can be understood as the lack of psychic skin (Anzieu, 1989). They highlight the importance of holding and touch in cultivating the secondary skin with intention of strengthening the psycho-somatic unit. They claim that touch recalls the environmental function of holding (Winnicott, 1965) alleviating the unthinkable anxiety of terminally ill patients. Warnecke (2011) sees touch in psychotherapy as particularly potent and formative "when fragmented aspects of a client's psyche and soma are bridged by the therapist's embodiment" (p.242).

Touch was one of the main channels of communication with Shaul in his last weeks. I used comforting touch (Rolef Ben-Shahar, 2014) providing a safe space in moments of pain and terror. Touch as comfort is described as highly valuable with fearful and regressive patients (Rolef Ben-Shahar, 2014; Totton, 2006). Dying patients are forced into regressive states and fearful moments. I believe their bodies crave touch and holding.

(2) Resonance and the shared body

When my hands touch Shaul's chest, his dying process resonating within me, we are both imbued within each other. Sharing the experience, grounded in our bodies, we are not alone. Our bodies belong to a wider body, regulating each other, and acting as healing agents cultivating transformation (Rolef Ben-Shahar, 2013).

Pinkas (2016) expounds the traditional analyst as a witness and interpreter who is not immersed inside his patients. Therefore, the natural process that one body can make with itself and another body is averted. She further delineates how some of our experiences (especially dissociative ones) are bodily, and underscores the magnitude of grounding our experience in our body. She claims that when an emotional aspect is missing we should work directly with the body in order to provide an easier access to the relevant material. She also suggests that the therapist's body might function as a diagnostic tool, as a self-object, and as an active healing agent. Working directly with the body enabled Shaul and I to touch unspoken emotional aspects of his fears and the experience of dying in a way, I believe, could not happen by merely talking. This shared experience procreated a healing space of transformation. My body was not only experiencing death but also served as a healing agent.

Nevertheless, while sharing this experience mutually, I am aware of the painful asymmetry between us. When I allow myself to bring my body into the therapeutic space, I represent the vital and living body whereas my patient represents the dying body. In addition to the asymmetry already present between therapists and patients (Aron, 1996), I feel that as a body psychotherapist I create a wider and painful gap of asymmetry between us. While being fully present in my body with Shaul, compassionate and open-hearted, I am also aware how grateful I am for being on the other side of the shore. How can I hold this tension between mutuality and asymmetry? Between life and death?

End of story

Shaul died a week later, peacefully surrounded by his family. While ending therapy with patients usually symbolizes death, with dying patients death is real. No happy endings are expected. I have to open my heart knowing death is coming. Shabad (2016) referring to dying, and asks in the title of his paper, "Will you miss me when I am gone?" (p. 391).

I am left with a painful void inside me, grieving silently. While missing Shaul and hurting from his loss, I feel rewarded by our special relationship, and I am aware of the gifts he has left me. He taught me great lessons regarding the precious moments of each passing moment in life and the power of open hearts. Writing this paper is an attempt to make my experience with Shaul a placeholder for his living spirit in his absence as well as sharing my insights with you. I believe that as body psychotherapists we are privileged with myriad ways in which we can forge pathways for engaging with dying patients while they are walking through the valley of the shadow of death.

BIOGRAPHY

Shamit Kadosh, MD is a family physician and a practicing body-mind psychotherapist in Israel. She has been teaching family practice residents and medical students for the past ten years in the Faculty of health Sciences at Ben Gurion University and in the Faculty of Medicine at Bar Ilan University. She headed a training program for residents in family medicine in the Department of Family Medicine in North Israel. Additionally, she is a lecturer in the body-mind psychotherapy program in Shiluv Institute, Haifa University. She is experienced in integrating scientific and clinical writing.
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