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TO DIE IN TREATMENT: AN OPPORTUNITY FOR GROWTH, CONSOLIDATION AND HEALING

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ABSTRACT: This paper addresses death's place in human development and specific psychotherapeutic treatment, using a case illustration with a dying individual. Based on an ongoing diagnostic assessment and utilizing the principles of ego psychology and object relations along with thanatology and crisis models, formulations of essential treatment parameters emerged. The premises are that psychological growth and change can continue up through this final stage of life, and that a dying person is still an individual with needs similar to, but not identical with, those who go on living. Within this context, realistic and relevant interventions evolved to maximize this individual's capacity psychologically and physiologically to survive longer. As patient passed on to death, he was more intact, less alienated, and psychically and physically more comfortable. This has implications for victims of AIDS along with those who fall under the hammer of fate to catastrophic illnesses long known to humankind.

In clinical social work literature there is a paucity of case material about death and dying. Writings of other mental health professionals offer rich clinical illustrations emphasizing humanistic, existential, and pragmatic beliefs. Therapeutic focus can assist individuals with goals "that can be accomplished, conflicts that can be resolved, meanings that can be found, hopes that can be realized, and relationships that can be started or brought to fruition" (Rando, 1984, p. 307). It is through seeking to make the most of one's being in the "now" that one finds remaining potential and personal strength, thus becoming fuller, richer, and more complete.

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This article describes psychotherapeutic treatment with a dying individual. While the therapy spanned two and a half years, the primary focus will be on the last months of life. Ego psychology and object relations theory in concert with crisis and thanatology modalities guided the diagnostic assessment and affected the therapeutic goals. Within this context, relevant and realistic interventions evolved to develop missed internal structuring that maximized this individual's capacity psychologically and physiologically to survive longer.

Working with the dying can be unchartered waters for many clinicians. Listening to and bearing another's life-threatening and/or terminal illness can induce enormous countertransference feelings of tragedy, helplessness, hopelessness and fear. As psychotherapists, we may tend to avoid this work or refocus on extraneous issues. Yet, we can be confronted with these situations unexpectedly in our given fields of practice and may be bound to treat a patient facing an impending loss of self.

Well aimed psychotherapy with those who have a limited life span will highlight the following premises. First, the experience of dying can be one of growth, albeit the final one in human development. Next, it will dispel the hopeless and helpless fallacy that there is nothing we can say or do to comfort; it is possible to facilitate or make resolvable the crisis of dying, even when we cannot solve the "actual problem". Lastly, a dying person is still an individual with needs similar to, though not identical with, those who go on living. It is hoped this article will help clinicians find treatment with the dying more manageable and more enriching than ever thought possible.

CONCEPTUAL FRAMEWORK

The overall treatment goals in work with the terminally ill are to foster growth and development as long as there is life and to make dying more psychically manageable. The therapeutic approach transcends the technical skill and ought to be considered in the context of the total situation. This includes the therapeutic pace (dependent upon time left), the specialness of the patient's arena (the self with catastrophic illness in a particular situation), the uniqueness of the therapeutic relationship, the therapist's use of self; the needs and desires of the patient; and the diagnostic indications for treatment.

Ego Psychology and Object Relations Theory

The individual in this case illustration fits within the understructured borderline range with a diagnosis of Schizotypal Personality Disorder. The bulk of the therapeutic work involved developmental part-

nering, internalizing new mental representations, unifying self and object representations, and developing self and object constancy.

Eissler (1953) emphasized evaluating the ego's functioning which determines the toleration and capacity for treatment; hence the parameters of the interventions. Therefore, in adult therapy, guided by an ongoing diagnostic developmental assessment, the therapist serves as "developmental partner" (Edward, Ruskin, & Turrini, 1981) for the missed parental partnering which, in part, provides a corrective emotional experience. The work of examining and reframing the already perceived and replayed internalized self and object representations, mends splitting and furthers the ego's integrative function toward formation of whole self and object representations.

A consequence of optimal developmental partnering, though not due exclusively to the parental part of the dyad, is that confident expectation (Benedek 1938) tends to develop out of the countless experiences when there is a "good enough" parenting capacity. The slow internal formation of sound and satisfying mental self and object images (Mahler, 1975) enhances the establishment of self and object constancy. Object constancy is the capacity to retain the representation of, and thereafter a connection with, important objects independent of the state of need or their actual presence. Self constancy is the cohesive awareness of the self as a separate and individual entity that is continuous yet flexible and variable in time and space. These unfolding achievements serve as resources for the person, whether developing child or developing adult in treatment, to draw upon when faced with the inevitable stresses of life's cycle.

Crisis and Thanatology Modalities

Lawrence LeShan (1973), Elisabeth Kubler-Ross (1975) and Therese Rando (1984) refer to this limited life span as the final chance to do those things that find or maintain meaning and value in one's life. We learn the care of the dying when we stay close enough and are willing to follow their lead. They tell us where they need to go, what remains that is important for them to attend to, what their key unresolved problems are, what will make their life more personally meaningful, and what fears on the road yet to travel haunt them. Central to remember is that we, as therapists, can only facilitate what an individual wishes; we must be alert to our own unrealistic or inappropriate expectations that do not fit those of the dying person's.

How do we take an inescapable, irreversible, and unendurable reality and make it bearable? What can we do when we cannot "solve" the problem of dying? We can share the attendant feelings, an offering of the richest empathy. The experience of "really talking" can alleviate loneliness, bring fears into awareness and offer some resolution. The ex-

perience of really being heard by a therapist who can tolerate these communications provides a source of comfort, understanding and appreciation. It diminishes depression and increases mastery. The antithesis, the absence of talk, can lead to prolonged flooding of anxiety, depression and psychologically suffering alone with increased physical pain (Norton, 1963; LeShan, 1973; Rosenthal, 1973).

Norton (1963) speaks of the uniqueness of the relationship and the use of self, "The essential therapeutic tools in dying treatment are the therapist's constant availability as an object, his reliability, his empathy, and his ability to respond appropriately to the patient's needs" (p. 559). This relationship, referred to by Eissler (1955) and Rando (1984) as the "gift", of concerned "being with", and giving of oneself, can be incorporated as a good internal object. This notion goes beyond the usual therapeutic milieu of time, fee and setting constraints and is counter to the overall training of the therapist's stance—those frustrating yet growth conducive therapeutic givens most appropriate for a nonterminal person. These can be relaxed when working with the dying. The gift of a genuine, spontaneous, yet thoughtfully acted upon, compassion from the therapist to the person can ease the struggle with psychic and possibly physical pain. Another vital consideration is the therapist's availability to the end of the journey if at all possible. One of the worst fears is abandonment; that can precipitate a depression.

LeShan (1969) and others speak of another potent distinction between standard psychotherapy and therapy with the dying—the use of transference. Transference reactions ordinarily used in treatment of the living are rarely worked through with a terminally ill person. Time is better spent on not analyzing the transference but on enabling inner growth by utilizing these manifestations as well as the real relationship to internalize a positively experienced person that soothes. Eissler (1955) extends this concept further, "It is conceivable that through . . . transference, an approach which can reawaken the primordal feelings of being protected by a mother, the suffering of the dying can be reduced to a minimum even in the case of extreme physical pain" (p. 119). Thus, thanatology literature advocates a *functional concept* of developmental partnering and transference. Here, as in conventional clinical practice, via attentiveness and fine attunement the balance is found between theory and practice, thus the art of the treatment transcends the technical skill.

CLINICAL ILLUSTRATION

Background

Al, age 59, was referred by a rabbinical friend to a suburban mental health agency for home health aide services because patient was in a "weakened con-

dition due to cancer." A home visit assessed the need for concrete service. I observed his chaotic, messy living conditions. Al was an eccentric looking individual with long white hair, very unclean appearance and guru type demeanor.

Although difficult to find, a suitable aide was located. I then learned that Al had not been to a doctor in 12 years. Having clear symptoms of a life-threatening illness, Al assumed he was dying of cancer, but did not wish to go to a physician. In his fashion, he stated that his death by cancer was fated and not feared. With much appreciation for his verbalized feelings, personal history and vulnerability, I commented that his unknown illness could be contagious to his aide. A moral value was evoked; and he sought medical attention. His ambivalence about dying was reached, his resistance was overcome, he accepted medical treatment shortly before he would have succumbed to his advanced terminal condition. Al likened my efforts to "rescue him from dying" to his "rescue" as an adolescent of his father from a suicide attempt.

With the largest possible doses of radiation, he was given six months to live, whereupon he was transferred to a hospice. Our work, extending over two and one half years, was to help him live until he died, and to maximize growth and development to the best of his potential until his passing. Al demonstrated an unimagined, unexpected capacity for intrapsychic change up to his last words.

Al had a tragic life: an isolated marginal existence, a brilliant but underutilized intellect, a vulnerability for mental illness, and episodes of regression, depression and suicidal gestures. There were disturbances in the ego functions of perception, thought, judgment, and integration. His object relations demonstrated a life-long hypersensitivity to object loss. He used defenses of denial, splitting, projection, turning against the self, disengagement, intellectualization and sublimation. His superego was harsh and critical. Al's innate temperament, precocious intellect, and early abandonment traumas predisposed him to uneven development and to his later difficulties with adjustment and coping.

Al's parents were divorced when he was 3 and his mother abdicated maternal care. He lived in different foster care type arrangements until father remarried. At age 6, Al returned to live with his step-mother and father. Mother was described as amusing, flimsy, unpredictable, inappropriate, and unrelated. "I was as a toy to her that she got tired of"; yet she was perceived as an "umbilical mother". Father, an academician, was experienced as remote, depressive, somewhat weak, and yet upheld high standards of respect and courtesy for others. Representations of his step-mother were of a loving woman who would do anything for her son. Specific examples showed some overgratification and overstimulation, which may have interfered with his negotiation of separation-individuation.

During adolescence Al had severe tantrums, frequent depressions, and attempted suicide as did his father. All family members were in individual therapy at various times. No other children were born, although Al wished for this. After attending a specialized honors high school, Al joined the military where he completed college. Impulsively he married a woman he barely knew. When she divorced him 3 years later, Al became acutely depressed and suicidal. He voluntarily submitted to a lengthy psychiatric hospitalization where he received electric shock treatments. A few years later, aware he was "slipping", he spent 9 years in treatment until his female psychiatrist died suddenly in 1964. Al's brief career was as a computer consultant. In 1972 he turned to playwriting and a 10 year "phase of self analysis", supporting himself with public assistance and federal employment programs.

Family ties were estranged most of Al's adult life until his father's death in 1975 and again until his illness. Though his step-mother lived a distance away, upon hearing of his illness, she visited every few months until his death. There

had been rare contacts with his natural mother until 1982 when she suddenly sent him an inheritance, which was used to purchase a computer. She visited Al three times during his illness; the last time around his 60th birthday. Prior to the onset of our treatment relationship, Al developed friendships with the rabbi and family, his playwriting group and other artisans.

Treatment Related to Dying

For more than a year and a half at the hospice the course of the disease plateaued, enabling Al to enjoy a life-style of visiting outside friends, working on the landscape and spending many solitary hours at his computer. When the illness began to progress Al expressed a different and real awareness of his mortality without further remission, "I'll live until I die." He had come to know the doctor could not even provide the former palliative treatments.

During the last 2 months, Al experienced a consolidation of significant development enabling him to die "without tormenting" himself. The themes listed below will be illuminated to demonstrate how these growth processes evolved in the course of our work together. Included will be my thoughts about certain dilemmas.

1. Al made some individual and internal reconciliations with each of his 3 parent representations.
2. Al reflected on what his dying meant to him and the associated anxieties it provoked.
3. Al established enough object constancy and good enough object representations to enable him to experience his dying and death with an internalized soothing object.
4. Al was able to place a value on his life, enhancing self esteem and providing a sense of continuity and sameness on multiple levels.
5. Al became significantly more object related and differentiated.

Internal Reconciliations With Parent Representations

During the course of treatment and in the closing weeks, Al pursued, until his last words, an internal reconciliation with each parent. He came to some final objective and thus integrative understanding of who, apart from him, was the human being, his mother. He aptly described her as a "happy, eccentric recluse" with a biologic tie "who couldn't go for the long haul of mothering", who lacked consistent enough empathy, and who, now in her old age, was so mentally handicapped that "she would not even understand that her son was dying." She had rallied to visit him 3 times during his illness and Al noted her progressive deterioration. He decided, therefore, no more contact was needed. He expressed loving her because she was his mother. Al acknowledged her expressions of caring within her limited capabilities, her tokens of affection and her wishes to give these tokens. Increasingly mindful of her broader incapacities, beyond him, of her severely limited object relatedness, he concluded, "as her son, I lost out." In comparing their similar loner life styles, he brought out a distinction, "I wanted to stay involved with people in spite of liking my privacy."

Regarding Al's step-mother, this relationship tended to confound him. Due to his first maternal experience and subsequent placements, he went limping into the next maternal relationship. While Al had glimmers of what may have gone awry between them, he could not hold it. Al perceived her as his "real mama who would always protect her baby boy." However, he defensively charac-

terized their relationship as "their agreement to disagree" and wished that she had had a child of her own "for all their sakes". The tragedy is that Al could not achieve a good enough fit of closeness and distance with either mother, the failure was multi-determined by the individuality and interrelationships of these 3 people.

Al was able to internally revise and redefine his relationships and to resolve conflicts of loyalty between both mothers based on his own needs and wishes, not purely based on theirs. This was demonstrated in renewing these relationships; in maintaining them separately, independently, and without conflict; and in not playing either mother against the other or in the transference with me. This was also his attempt to mend the split between bad mother and good step-mother. Al used me as a needed substitute mother, one with whom he could have a comfortable fit, as a mediator and repository for his aggressive feelings in order not to harm the original mothers, and as a loving person who provided gratification.

Although contact between step-mother and son resumed when Al's illness was diagnosed, it remained infrequent and strained. Al requested she visit when he felt the end was nearing. At this time we had a meeting as well. She, too, was still attempting to work out an optimal and comfortable space between them, not too close and conflict ridden, yet not too distant as to be uncaring.

In relationship to Al's father, a great deal took place in the last month. Al had not been in contact with him for years and had not been reinvolved before his death. This had not been a discussable subject until weeks before Al's own death and it requires the following elaboration of extraordinary gains.

Two weeks before Al's passing, in the early morning hours preceding our session, Al had reread his father's will, the first time since his death 11 years earlier. In the original reading Al perceived he was excluded from the will, that "his father had left him out in the cold." Al presumed this due to enormous shame he harbored for "being a less than desirable son." To his utter amazement he had been included 100% should his step-mother predecease him.

Unbeknownst to me, when we began our session, Al had done all this work. However, he began by sharing a poem written by his father about his own future demise, one that had been given to Al by his step-mother at the time of passing. It also contained the birth and death dates. This was followed by a poem that Al had written about his father one week after his death. There were a few uncanny elements here. The date that Al chose unwittingly to share this, was the exact anniversary of his father's death. At the same time Al had no conscious recall of the present date, nor did he remember when his father died. He reacted anguished and stunned when I raised this. Moreover, his poem reflected unresolved feelings about his father. "He deserved to die because he was mortal and human," were lines written several times. Al then spoke of his experience in rereading his father's will. Perhaps in unearthing this, Al felt more shame for all the years he believed his "father had disclaimed him for who he was," to find out this was not fully true.

As I perceived Al this day he appeared to be near death; extremely weakened from another hemorrhage at 5 A.M. and psychologically ready to die on the anniversary of his father's death. The psychodynamics of an on-this-day determined death appeared to be overwhelming—destined to live out a death pact for the multiple meanings it had for him. It seemed potentially dangerous to prompt more tumultuous, vulnerable feelings. Instead I listened to his insights, choosing not to explore nor attempting to interrupt this dynamic. I felt saddened, expecting this to be our last session.

A couple of hours later I received a phone call that Al had hemorrhaged

again and needed a revisit. This time Al initiated more about this anniversary date of his father's death. He said, "I do not need to die on the same day to honor my father." I wondered what this meant. He then understood it meant to him atoning for his own sins. Al reframed his reading of the will as fortuitous, "to learn my father did not stop loving me; it was I who felt I ought to be left out in the cold for who I had been."

Now Al could begin to recall from a new perspective what his father had done for him out of love and caring, "how could I forget my father always loved me?" He remembered a story told by his grandparents of his father's refusal to relinquish him for adoption after the marital separation. He recalled his father's support, after his own marital failure and breakdown, by staying with him while he admitted himself to a psychiatric hospital. Neither time had he been left in the cold.

This day was a turning point. Al had shown another powerful wish to die on the anniversary of his father's death. He was able, however, to break the cycle of self-punishment and identification to the extent that he did not have to share this date with this father. Al chose to "memorialize" his father, in turn enabling him to memorialize himself, the son his father had not given up. Al had made a giant stride in healing some of the internal estrangement that was not as great as he had believed all these years. Time was of the essence; we could not delve into the fuller ramifications of some of his previous beliefs and feelings about his father and himself that would have been included in a treatment of greater duration. However, perhaps because he now perceived his father had not given him up and had not given up on him, this revised, more positive picture led to an internal reconciliation and allowed Al to draw something of value from his lost father.

The On-Going Development of Object Relatedness, Self-Constancy and Self Esteem

Demonstrations of the multiple ways Al became more object related appeared in several conversations. Al expressed looking forward to my visits and recognized my approaching footsteps. He also shared what I had done for him; expressing thanks for enabling him to go to a doctor and for being part of making it possible to have more than 2 years of additional living. This time facilitated accomplishment of personally significant tasks. In turn, this helped him to feel better about himself, his life, his perceptions of others and to cope with his impending death by discovering his "life had not been lived in vain." He also owned up to his ambivalence about living and dying and his availability for therapeutic help, noting he was "fertile ground."

Al also wanted to know of my feelings within this relationship. Helping him feel it was okay to ask his questions, he felt relieved and cried when he could ask what he wanted to know of me. More specifically Al wanted to know "why I came to see him" and "how he had enriched my life." Two very meaningful and moving questions. He wanted to know what about him I valued, and what I felt he had given to me in order to feel and know I valued that as well. I was being asked to be a real person. The questions had multiple purposes of affirming self worth, solidifying self constancy, and diminishing his death anxiety as we acknowledged, indeed, he would not be lost, forgotten or become nothing.

Responding to these questions was perhaps as hard as the asking. I answered the first question with "I came to see you because you were open and re-

sponsive in your wish for help. You had many losses in your life and because you let me know the impact of our work together, I felt a commitment in return as you moved from home to hospital to hospice." I also told Al about the qualities in him that I respected, his integrity, honesty, openness, hard work and courage. To how he had enriched my life, I replied that I felt gratified that I had helped him. On another level, through our work together I had discovered helping people in such situations was quite fulfilling.

Perhaps these questions could have been perceived as grandiose or manipulative. Another way of handling this would have been before answering these questions to have turned them around and asked Al how he would have expected me to answer. While we would have gained more insight into his transferential thoughts, it might have been understood as emotional detachment. What seemed most vital at that moment was his quest for the genuineness of a real person, a gift of self-disclosure, especially needed when one is facing death.

Management of Death Anxieties; Loss of Self and Object; Development of Self and Object Constancy

Al's preparation for his death came about in several ways. He talked about his fear and anxieties about dying, touching briefly upon his fear of annihilation; a first and most primitive fear in a child and now a last and most real fear in a dying adult. This became manageable as Al fantasized his death as a transformation of the self, continuing without the body and reintegrating into something else. As he grappled with the impact of loss of self, he spoke of memorials. Through memorializing his father's values and philosophy and how this was passed onto him, he was able to elucidate his own values. With intent and forethought he made specific arrangements for his body after death and planned the disbursement of special possessions.

On a more profound level Al felt memorialized by those who had appreciated his "gifts" as well as through our relationship as described above. Memorialization in this context can be analogous to his *selfness* (essence) transcending his physical self by being internalized and preserved within others and thus becoming a legacy for those he had touched. Eissler (1955) comments "This . . . belief that the soul cannot perish comes in good stead in dealing with the patient on the terminal pathway" (p. 142).

Al's next level of anxiety was loss of the object, of being alone which occurred during each hemorrhage signaling the possible imminence of his death. He could talk of these powerfully "scared to death" feelings as he smiled at the pun. This precipitated and permitted further significant gains.

A month before the end, Al related an incident and his feelings that occurred earlier in the week. He had hemorrhaged and was having severe problems with bodily functions. He thought to himself he wasn't going to make it; at which point he almost called me, but decided he could hold his own hand and didn't need me, although knowing he could call was enough for him. While he could assure himself that "knowing" he could call was enough, he was also saying he would only count on himself to hold his own hand. I reminded Al he could call me and of his wish that he "not cry alone when in depair." I, too, had become overwhelmed by Al's fear of loneliness and separation and, therefore, in an effort to lessen this I increased my availability without fully thinking this through.

Three weeks before his death, coinciding with the deterioration of his health and almost daily hemorrhages, I began to visit daily. Each hemorrhage felt as if

it could be his last, and Al began to ask the nurses to call me as well. The realization of the error became apparent. I felt like a mother on a demand feeding schedule that had gotten out of hand. Yet, I had made an offering to a needy, dying man who understandably needed soothing and anchorage during incidents of great fright. Nevertheless, I found it impinging on other responsibilities and began to feel resentful. I could not fully live up to this unrealistic plan.

The alteration of some of this plan could only be done if it could be reframed into something positive. Unsure of what to say as I drove to visit after an emergency "please come, I need you" call, I knew a renegotiation was in order. As gently and sensitively as possible I approached the issue with my sincere wish to be available; I too wanted to be with him at these frightening times, even to be with him when he died. We acknowledged the joint wish.

We then agreed that even though we wished this, it was quite possible it could not happen that way. I wondered if there was another way we could meet this wish, asking him to reflect what this relationship meant to him. He replied, "I feel loved, I feel our rapport and like a baby at the breast." Within this "boundary softening moment" (J. Viorst, 1986), expressing this mental image, Al demonstrated a "regression in the service of the ego" (E. Kris, 1975) and, therefore, his capacity to perceive and accept mothering.

Utilizing this regression in the transference, I verified that he had this from me, even when I was not present. Al began to cry, telling me "how twisted" he felt. I noted for the first time in all the time I had visited while he was in bed, he put himself in a near fetal position. I wondered, "Is there is a way you can have me more of the time, even when I am not with you," so that, in essence, he could have these nurturing supplies whenever he needed. He did not know what I meant. I then suggested that perhaps he could try to invoke my image and what it conjures whenever he needs it, that he could have it any time, it was his. I urged him to "practice internalizing the comfort" he feels when I am with him.

As the idea settled, Al went through a process. He talked about "returning to his stoicism." I replied, "You cannot any more," implying he had reached out of his shell. As he spoke he reminded himself that my caring for him had been proven over the life of our relationship and I had never abandoned him. I verbalized the commonality of feelings—that we all wish when we need our parents they will come. Sometimes they just can't come. Al could hear this. He had already assimilated that I had not and would not desert him, that I wished to be with him. These gratifying images could help him through his time of need.

Al's body language message of regression was clear and his wish to be fed as needed was stated. Yes, Al was angry and disappointed as he emotionally thrashed about trying to avoid this talk. However, this did not provoke a regression that could have been experienced permanently as a repetition of earlier abandonment traumas. He was able to draw from within that I genuinely cared, repairing some of the split good and bad mother. Now I was one mother, neither totally good or bad, but at least "good enough". He accepted a more adaptive coping mechanism that could have a lasting internalized value, even to take with him to his death.

We were then able to collaborate upon a better arrangement of frequency and regularity of appointments. Instead of losing the actual object or experiencing the anxiety associated with the fear of loss of the object, Al's growth helped him to maintain a connection without the person in the flesh. Through imagining the already taken in experiences of my soothing he was able to self soothe when alone. He felt he had the love no matter where I was. Perhaps it was because he had better internalized his worthiness, remembering how his father had not given him up and I had not given up on him, that we were able to renegotiate our sessions and work through new ways to keep me inside of him.

Ten days after the internal reframing of his relationship with his father, and a few days after we had worked on internalization of the soothing, comforting and loving image of me, Al gradually lapsed into a semi-comatose state. Upon my arrival, his day/night disorientation and his heavy drowsy state were apparent. Our last conversation continued to reflect his growths. He told me, "I know you love me, I can feel it inside. There is still more work to be done with Dad and step-mother, but I don't know what it is." I asked, "How can I help you"? He repeated, "I don't know what it is." I shifted and quietly said, "Al, we will always have some unfinished business, you have done so much already, let it go." He responded, "Then I won't torment myself," as he drifted back into his final coma more peacefully, less alone, feeling better about himself and his important family relationships. Al's coma deepened. He died four days later without further physical or emotional pain.

CONCLUDING REMARKS

Within the conceptual frameworks of ego psychology, crisis and thanatology modalities this article addressed the actual terminal phase of life of a patient in psychotherapy. It descriptively highlighted evolving internal growth and healing processes. Some of this patient's major developmental accomplishments were individual internal reconciliations with his parents; facing and managing death anxieties and what dying meant to him; solidifying enough object constancy to enable him to die with an internalized soothing object; establishing self constancy and affirming self esteem; and becoming more object related and differentiated.

Experiencing with this extremely vulnerable man the growth of ability to cope with his own dying and death inspired me to write this article. It made me a believer that well aimed clinical work is applicable even with those facing life threatening and terminal illnesses. Such help is relevant for those persons who wish for change and growth, for refining and rearranging inner perceptions and outer realities to achieve some final integration and peace within one's self and with one's world. Inherent in this process are imperfections, incompletenesses and partial resolutions for the patient and therapist. To bear with those, within the unique context of each therapeutic relationship enhances the therapist's professional growth as it enhances the patient's growth.

Loss of living time was the price Al paid for not attending to the early signs of his illness. In large measure this was attributed to his serious underlying developmental impairments and predispositions. By activating his dormant will to live we fostered new, though final, possibilities for emotional growth and healing through developmental partnering that slowed the destruction of Al's body and extended his life. For Al to experience what Eissler calls "a last step forward" permitted him to stabilize his remaining life and to make his dying and death more manageable.

In one of Al's final gestures, he gave me a gift of two very old can-

dlesticks that I should use on special occasions with my husband. The message in oedipal terms showed his acceptance of a triangle, that he had a part of me, and even the romantic and sensual part was not denied, although it had not been overt in our relationship. The symbolic message of candlesticks also meant the light he was giving me was for continuance, thereby making his death less of an end, extending his own life through mine.

Upon Al's death, his wishes for his bodily remains were respected. Contacts were made with family and friends, assisting them in personalized ways. I was aware of my experience of mourning; emotionally deepened and moved, physically weary, and not my usual responsive self to the beautiful seasonal changes. Six weeks later, I attended a memorial service in the home of a friend where everyone spoke of their relationship, memories and their thoughts and feelings about Al's complexities.

For the therapist who chooses to work with a dying person it means becoming connected and invested. The therapist then experiences with another his separation from life, decathects upon the actual death of the person, grieves and feels sadness. What does not cease to exist is the immortality of the internalized mental representations of that person with whom we have shared an often intimate and significant relationship.

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