

# Loving as a Defense Against Life: The Analysis of a Terminally Ill Patient

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One might say that Mrs. C and I fell in love. From the moment she walked into my office, it seemed as though she and I had been fated to meet, and that knowing each other was going to affect us profoundly. Our positive feelings for one another did not seem to be tempered by the mundane disappointments, fears, frustrations and miscommunications that pervade most relationships. Our relationship seemed free of earthly imperfections.

Even the idea that there would ever be a change from these blissful, halcyon days was far removed from our consciousness. We acted and felt with each other as though this perfect state of affairs would continue indefinitely. While all the rest of the world seemed to be floundering in a sea of discontent and disharmony, together we were safe, warm and calm.

Reason would have told me otherwise. Mrs. C had been referred to me as a terminally ill cancer patient. She had a cancer which medical science has no successful method of treating, and her prognosis gave her only one year to live. (Yet, she seemed to be the picture of health; it was not difficult for me to put out of my mind that our time together would, most likely, be extremely limited.)

Even beyond that, of course I knew that the state of being in love is a psychotic process. No relationship remains free for long of conflictual feelings. Hate and aggression, as well as love, are essential components of reality. In real-life relationships, the feeling of "being in love" is usually all too quickly replaced by a more realistic mutual understanding in which character flaws and limitations are able to be observed and tolerated. In analysis, it is, of

course, these very character deficiencies that make up the material of analytic work.

The particular difficulty in the analysis of a terminally ill patient is that dramatic changes occur around the issue of time. Time is no longer framed by an extension out, expanding forever into an indefinite future. Death is no longer seen as an event far away, and life is no longer a process moving along towards some eventual, vaguely conceived end. The near and distant future are collapsed into a foreshortened perspective.

The problem that this foreshortening creates for psychoanalysis is that there simply is not enough time to do the analytic work. Resistances may take more time to resolve than the patient has to live. And, it seems as though if one tries to rush the process, the unconscious will rebel and communicate emphatically that it has its own sense of time that remains independent of the wishes and needs of the ego.

Yet, in my analysis with Mrs. C, none of these ideas was consciously present. While she had been medically treated for cancer, the treatment offered no promise of saving her life. This conclusion had been communicated to her, and she herself believed in the hopelessness of the treatment. Although she had little conscious recognition of psychic conflicts (which I later concluded were having debilitating effects on her physical health), she did have a strong belief in the power of psychoanalysis to save her life.

So while analysis is a method devised for the exploration and resolution of character difficulties, it became established early in the treatment that Mrs. C was there to save her life. In point of fact, Mrs. C had had, historically, very little interest in understanding herself, and this newfound interest came as a last desperate attempt to change her character in the hope that the effort would cure her of cancer. She entered treatment with me in an attempt to not die, and her conscious thought was that through our work together she had a fighting chance of accomplishing this goal. This attribution to me of the power to save her life was an appealing idea. It fed all my grandiose hopes and fantasies, and I found myself easily falling under the sway of the idea that, together, we would accomplish the miracle of reversing her cancer.

The sessions with Mrs. C were immensely pleasurable. I found myself greatly looking forward to her visits, and, while we were in the room together, we both reveled in our positive feelings for each another. Death was nowhere in sight, and we spent our time together planning how we were going to vanquish the enemy.

Mrs. C exhibited the passivity typical of the cancer personality, and one had the feeling that she was in great need of being taken care of, rather than that she was an adult with responsibilities for others. In sessions, Mrs. C and I communicated to each other a fierce determination to help her to live. We decided that the best way of accomplishing this was for her to take an active stance in both her life and her treatment. She had come to recognize, on an intellectual level, that passivity would lead to death. Together we conferred on which activities would be life-affirmative. She decided that she should drop one art class and begin another with a preferred teacher. She decided she should continue her practice of visual meditation. She talked about changing her diet in accord with principles formulated by nutritionists who work with cancer patients.

She made a conscious commitment to stop sacrificing herself to her husband and children, and instead to use as the determining criterion for a conflictual decision whether or not the choice would lead to furthering her attempt to get well. She thought that a woman helper around the house would free her to devote more time to aspects of her life which would help heal her, and she determined to find and hire such a woman.

As long as the sessions involved the two of us planning how to save her life, I felt that we were in total union. We were working towards the same goal, and we had the additional pleasure of loving each other while we were doing it.

Yet, as the analysis progressed, it became increasingly apparent to me that our perfect and blissful union was marred. Mrs. C had all the good intentions in the world of acting in the life-affirmative ways we planned together, but she frequently seemed unable to implement the plans, and her behavior revealed an inability to act in a self-assertive fashion.

For example, there was an occasion when she and her husband were invited out. She was in bed with a cold, and the weather was rainy and cold. While she knew that staying home would be in the best interest of her health, she was unable to act according to that perception. Rather, what had emotional priority was pleasing her husband, who wanted to go, and wanted her company.

Similarly, for weeks she reported in sessions that she had not made the necessary phone calls to find a woman to help around the house, as we had agreed she would do. She procrastinated in calling the nutritionist to whom she had been referred. She resisted spending money on herself, even for her health. Self-denial be-

came an issue early in the analysis when Mrs. C, entering treatment, wanted two sessions a week but was unable to act against her husband's wishes not to spend the money.

To be sure, a pattern of self-denial need not be life-threatening. One can live a long life without domestic help, or going out even on the rainiest night. And, in fact, the ways in which Mrs. C sacrificed herself before contracting cancer were highly neurotic, but not dangerous to her survival. Long before the illness, she accepted without protest her husband's frequent absences and emotional withdrawal; she refrained from requesting vacations in spite of her longing to travel with him; she denied herself clothes, though she cared deeply about her physical appearance, and, indeed, took care to dress with a certain artistic flair.

After she developed cancer, self-neglect was something she could not afford. Her body simply did not have the reserves to permit her to cheat or cut corners in its care in any way.

This obvious pattern of self-destructive behavior initially had the effect of stimulating in me maternal, nurturing feelings. I found myself fantasizing about how I could help her outside of the sessions. I wanted to do her food shopping, feed her, find her a helper. It began, even, to seem that it was a cruel twist of fate that brought us together in this limiting professional capacity, where we were doomed to the frustration of never acting out these loving feelings for one another.

But, as Mrs. C persistently demonstrated her resistance to acting in the ways she said would help cure her, my feelings for her changed. She was killing herself before my eyes and I was helpless to prevent this self-annihilation. I became conscious of an uncomfortable feeling of impotence. It is likely that this feeling masked a deeper, and perhaps stronger, feeling of rage, which remained, at that point, unconscious.

### *Countertransference Resistances*

At one point in the analysis the countertransference became one of paranoia. The figure of Mrs. C's husband began to assume disproportionately large dimensions in my mind. He assumed, for

me, the aspect of a wrathful, punishing super-ego—telling me that I was doing something wrong.

In fact, I began to be obsessed with the idea of my wrongdoing, and my fear of him carried over into my life even when I was not with Mrs. C. I used every new treatment idea I heard about as the occasion to consider the incorrectness of my treatment of Mrs. C. A student in a class I was attending referred to the establishing of an omnipotent transference and concluded that it doesn't work. I asked myself if that was what was happening in my treatment of Mrs. C; had I created the situation out of my own needs? I wondered if the student's conclusion of the inevitable failure of an omnipotent transference signalled the failure of my treatment with Mrs. C. An instructor in another class said that the difficulty in conducting an analysis is that the patient merely wants to convince the analyst of the patient's point of view, and the analyst wants to convince the patient of the analyst's point of view. Again, I asked myself if that was what was happening in Mrs. C's treatment—was that what I was doing wrong?

At the time, I did not conceptualize my fears as an induced countertransference. There was no doubt in my mind that my feelings were my own, that I was perceiving the situation accurately, and that my fears had a good probability of coming true: This horror was that Mrs. C would die and that her bereaved, distraught, and wrathful husband would sue me.

I discussed my fantasy of being sued in a transference/countertransference class. The instructor joined my paranoia and suggested that I become an expert in the legal aspects of practicing psychoanalysis. He recommended that I be thoroughly prepared for the feared eventuality, and in this way protect myself. One member of the class thought that it would be wonderful for me to be sued so that I could bring important therapeutic issues into the courtroom and win. Both ideas did have a certain appeal.

Discussing the case in class clarified for me the reason underlying my fear of being a wrong-doer. What I was guilty of, for which Mr. C would not forgive me, was the wish to take his wife away from him. I wanted to wrestle her free from the clutches of the people in her life who didn't love her as much as I, didn't understand her as well as I, and who were not as committed to therapeutic efficacy as I. I wanted to protect her, comfort her, banish those terrible people from her mind and her life. I imagined that I was better for her; I could nurse her back to health. The

temptation was to do what it is that no analyst can do—be myself a substitute for her real life.

My grandiosity about my abilities to save Mrs. C's life depended on the existence of a defense, a countertransference resistance, in my own functioning with the patient. In order to believe in my power to save her, I needed to deny that she could not be saved. In fact, while I was with Mrs. C, I was able to defend against the idea that she was, ultimately, incurable—that her cancer would best both of us. I felt confident that she would survive her cancer, that there was no trace of death in her.

Yet, my defense was not impenetrable. I experienced an inexplicable splitting in my feelings between the times when I was with Mrs. C and when I was away from her, but thinking or talking about her.

When I spoke about Mrs. C in supervision, I would find myself confessing that I knew she was going to die. But I never experienced these proclamations as coming from my own ego. Rather, it felt as though the words were pushed on to me and out of me. And I would recoil in horror after hearing what I had said.

I had discussed Mrs. C with two supervisors, and each reflected a different side of my awareness. One supervisor joined me symbiotically (as I joined Mrs. C when I was with her) and agreed that she really might live, that she was doing quite well, etc. This supervisor I loved. The other strengthened my observing ego and informed me that the patient would die. This supervisor I hated.

It was only towards the end of Mrs. C's treatment that I allowed myself to know consciously and unequivocally that she was dying. She came in for a session, and I thought she looked incomparably beautiful. I was reminded of a friend who had, at quite a young age, died of cancer. My friend had not been a particularly beautiful woman, but as she approached death, I saw a radiance and a depth that transformed her.

Yet, in spite of this memory, I was able to bury awareness of her imminent death from my consciousness. We continued the treatment for several more months, both of us having contentedly fallen back into our fantasies of mutual immortality.

The only other time that I felt sure of Mrs. C's imminent death was during our last session, which occurred shortly before her death. Her condition had deteriorated to the point where she was unable to leave her bedroom, and we had arranged for a home-visit session. Neither she, nor the family members with whom I

had been talking by telephone, had prepared me for the state in which I found her.

### *Resolving the Countertransference Resistance to Aggression*

Subsequent to Mrs. C's death both her daughter and her sister, Tina, began analyses with me. It is through my work with each of them that I came to understand the need for my own cure in regard to my relationship with Mrs. C. In order for my work to be successful with these two new patients, I would need to allow myself the experience of having negative thoughts and feelings about Mrs. C that I did not permit while she was alive.

My very powerful reactions to the early sessions with Tina and Leslie confirmed the strength of the countertransference resistance that I was embroiled in during my treatment of Mrs. C.

Tina called for her first session shortly after Mrs. C's death. When I opened the door to let her in, I was jolted by the immense amount of hatred I felt for her. I had met her before, and had had frequent phone conversations with her during the time that her sister was quite ill. I had had extremely positive feelings for Tina while Mrs. C was alive, and felt that she was my one ally in the family who supported the work that Mrs. C and I were doing.

Here, confronted with Tina alone, I found myself hating her. I felt that I had gotten stuck with the ugly-duckling second-best. I looked at her body and her face, and while Tina is not an unattractive woman, I remembered her sister as incomparably more beautiful and appealing.

And, my feelings towards Leslie were equally strongly negative. I felt a tremendous resistance to working with her. I remembered Mrs. C's complaining that she couldn't even stand the sound of her daughter's voice because it was incessantly whiney and complaining. I, too, experienced Leslie's presence as offensive. Insofar as I (irrationally) attributed Mrs. C's death to her daughter's ill treatment of her, I felt that I was consorting with the enemy, and, thus, being disloyal to Mrs. C.

As the treatments of Tina and Leslie progressed, however, I found that these initial feelings changed. Many of Tina's trans-

ference communications seemed to be pleas to me to allow her to become as important to me as her sister was. The transference meaning of this wish was to be the sole or primary recipient of the mother's love, and arose out of the conviction that her endeavor was doomed to fail. The death of her sister was experienced on one level with great relief. Tina felt, for the first time, the possibility of having a relationship with someone without her sister coming between. And, indeed, as Tina's treatment continues, and I come to know the world as she experiences it, I observe my feelings for Mrs. C diminishing, and Tina's presence in my mind assuming larger proportions.

The changes in my feelings towards Leslie have not been quite as dramatic. I continue to find her irritating. Yet, I have come to understand that the offensive aspects of Leslie's personality are not unrelated to her mother. As I increasingly understand Leslie's feelings of anger towards her mother, my mind opens to the consideration of Mrs. C's destructive impact on her daughter. The hatred that Leslie felt towards her mother now seems justifiable.

There is a sense in which I regret the occurrence of these processes. My relationships with Tina and Leslie will never have the kind of unconditional and enveloping love that Mrs. C and I had. I feel as though this is a process of growing up, and that I have lost the wonder of a first childhood infatuation, where there was only hope and promise for the future. I don't like letting go of ecstasy for reality.

Through supervision, I was able to accept that I could not save Mrs. C's life, and that her death while in treatment with me was inevitable. I could not influence her; her character resistances were too firmly entrenched. It was too late for her to make the changes (psychically and physically) needed for health to outpace disease.

When I reached this conclusion, I lost interest in influencing Mrs. C to stay alive. I stopped being interested in whether or not she continued her visual meditation. I accepted that she might never get a woman in the house to help her. I no longer cared whether she followed a nutritional program, and I gave up on the idea of convincing her to see a nutrition specialist. I decided that since her time was limited, I should simply continue with the task of analyzing her, even though it would be without the bliss of the symbiotic love we previously shared.

While I did not discontinue my role as an analyst, my acceptance of our inevitable separation through her imminent death had a profound effect on my feelings. I continued to find Mrs. C my

favorite patient, and to get excited and look forward to our sessions. But there was an emotional distancing that had not been there before. I felt, for the first time since meeting her, prepared to let her die.

Our relationship began to take on aspects of an unrequited love affair. I believe that when I realized that I cared more about her living than she did, that I thought she would die. It seemed as though I was chasing after her life and that I was much more concerned about the chase than she herself was. Her death, and her urgings towards it, had become her weapon of rejection of me. It was the recognition of this situation that led me, I believe, to withdraw emotionally.

A curious phenomenon occurred shortly after my resignation to the hopelessness of our enterprise. Mrs. C announced that she had made an appointment with a nutritionist. This decision paralleled others, all seeming to indicate that at last she understood that only a determined battle for life held out the promise of success.

Mrs. C kept that appointment and came away with renewed determination to do everything needed to stay alive. The doctor informed her that if she followed his instructions, she would have a one in a thousand chance of survival; otherwise, no chance at all. This prognosis relieved and motivated her. She believed that the nutritionist was the only doctor who was straightforward about the implications of her disease, and who presented the information in such a way that she could hear it. He was the first to offer her any hope, slim though it was.

This time, Mrs. C kept her commitment. She followed every suggestion either I or her nutritionist made, to the letter. She was careful about the care of her body. She stopped sacrificing herself and began to say no to her husband and her children.

Six weeks after her initial consultation with the nutritionist, Mrs. C had a follow-up appointment. He found her remarkably, almost miraculously improved. Her liver, which had been enlarged to more than double its size, had now returned to its normal size. Each diagnostic indicator suggested marked improvement.

We were ecstatic. Mrs. C seemed to be showing signs of disease reversal, on both physical and psychological levels. It really did seem as though she might be able to pull it off—and win.

I now believe that it was my acceptance of Mrs. C's imminent death that gave her, finally, the feeling of being understood and permitted her to begin her fight for her life. My loving feelings for

her had bypassed her own sense of unworthiness. Mrs. C's unconscious feeling about herself was that she should die because she deserved to die. My error had been in loving her too much. If I could accept her death, then I understood, as she did, that her life was not worth fighting for. This understanding, and the ensuing aggression that may have been evoked, was precisely the stimulation she needed to commit herself seriously to a struggle for life.

With Mrs. C's remarkable improvement, my feelings again changed. I interpreted (to myself) her carrying out of my instructions and those of her nutritionist as cooperation, and felt greatly encouraged. I began, again, to feel pleasurable involvement and had a strong sense that we were working together. I again thought that she could live.

Thus it came as a shock to hear in a phone call that her abdomen had suddenly 'blown up like a balloon.' I insisted that she call her nutritionist immediately. At her request, I called to ask what he thought the difficulty was. He found out that a week earlier Mrs. C used the last of a medication that he considered essential to her welfare.

Mrs. C did not recover from this reversal. The bloating never subsided and she died less than two weeks later.

Mrs. C had not been telling me everything. She had not been sufficiently verbalizing conflicts that were impeding her from acting in life-affirmative ways. This conflict had not been resolved analytically, and instead had been acted out.

What had transpired between us that had prevented Mrs. C from talking to me?

As Mrs. C's feeling of closeness to me increased, so too did her desire to please me. As her desire to please me increased, her ability to freely express and reveal her real thoughts and feelings diminished. Thus, her potential ability to talk openly, without fear of the effect on me, was decreased.

In effect, then, I am describing the emergence of a powerful, and potentially resolvable transference neurosis. I had become the object on whom Mrs. C transferred her core conflict. While it is true that she was resolving a transference-like situation with her husband and family, and had finally been able to assert her own wishes in regard to them, our relationship had now come to represent and suffer from her urge to sacrifice herself to the wishes of a larger, more powerful, more worthy object.

Shortly before her death, Mrs. C made a telling request of her sister that sheds light on this characterological resistance. She felt

too weak to call me herself and asked her sister to do so. She also asked her sister not to tell me that she wasn't eating, because, as she put it, "She would be disappointed in me."

It seems, then, that Mrs. C had become more interested in pleasing me than in telling me everything. And, in fact, as the urge to please me gained ascendancy in her priorities, her resistance to talking freely so that her conflicts could be successfully analyzed became stronger.

The importance of the analytic edict of "saying everything" comes from the conflictual nature of our psyches. That is, for every impulse, wish, thought, or feeling, there is an underlying contradictory impulse. The patient who says everything, thus, will verbalize both sides of the conflict: the wish to live, the wish to die; the feeling of love, the feeling of hate.

Through treatment, Mrs. C verbalized a great many wishes. She expressed a desire to live with me, to come on vacation with me, to have an apartment in New York City, to go on vacations with her husband. But, she never verbalized a longing or impulse for death—either her own or that of any of her family or friends.

The danger of impulses remaining unconscious is that they will be unwittingly acted upon.

Mrs. C's neglect, of herself as manifested in her failure to continue taking essential medication, can be interpreted as a wish to die.

I have puzzled a great deal over the nature of my countertransference and what might have accounted for the strength of my resistance to acknowledging that Mrs. C was dying.

It is usually believed that countertransference resistance is undesirable, and insofar as the analyst is not free to experience all her thoughts and feelings, the progress of treatment may be impeded. I have come to believe, however, that Mrs. C needed me to be in a state of countertransference resistance. And, further, that without my having been in this state of resistance, the treatment would have been discontinued.

It was clear that certain feelings were taboo for Mrs. C. Any communication to her of hopelessness had the effect of paralyzing her and driving her into a tomb of passivity, fear and isolation. And, similarly, when I was with her, I, too, became oblivious to the possibility of her death.

Feelings and thoughts may pass, unwittingly, between people. Escalona (1973) has observed the wholly nonverbal sending and receiving of information between mother and infant; Spitz and

Meadow (1976) point out the existence of the phenomenon between patient and analyst. We analysts have been less fortunate than the biologists, who have identified the microorganism as the agent of transmission for the infectious diseases. The subtle ways in which emotions are communicated, and "caught" by others remain more obscure.

When Mrs. C talked to me about her visits to her oncologist, I had the feeling that she conceptualized death as something she might "catch." She described the waiting room as filled with patients who looked as if they were merely waiting to die. She was sure that she, too, would die if she continued to expose herself to that environment.

On reflection, it was clear that Mrs. C could not have tolerated hearing from me a realistic account of her prognosis. The term countertransference resistance, however, refers to the analyst's resistance to having some feelings. Free of it, the analyst will allow herself to be conscious of all affects aroused by the patient—and will consciously make decisions about the communication of her feeling states to the patient.

I believe that Mrs. C needed me not only to say that she could get well, but to feel that she could get well. I believe that she needed to catch from me the feeling of hope. The ability to make myself emotionally ignorant while I was in Mrs. C's presence probably had the effect of preserving the relationship.

Relationships were ended with those people who clearly stated that Mrs. C's condition was hopeless. Two oncologists she consulted before entering treatment with me fell into this category. In the beginning of treatment with me, she repressed the memory of their informing her of a terminal prognosis. She had, though, refused to be treated by them, or at their hospital. The memory surfaced later when she felt optimistic about her chances of recovery and sufficiently defended against hopelessness.

Among those who did not clearly state their assessment of her hopeless condition, but allowed her to sense it, was her treating oncologist. He never told her that she was dying, only that she would die without chemotherapy, and that he could not guarantee a normal life span with it. As long as she was able to keep out of consciousness his real understanding that she was dying, and that chemotherapy would not save her life, she was able to continue being his patient. Yet, the conflict and ambivalence she felt about being in treatment with him suggested that she did sense his genuine understanding of her condition. And, at the point when she was actually able to see clearly that he thought she was going to

die even with the chemotherapy, she terminated that relationship as well and refused further chemotherapy treatments.

Another example illustrates the point. Mrs. C had been friendly with a woman in her neighborhood. In analyzing a conversation with the neighbor Mrs. C came to understand that this woman expected Mrs. C to die. Upon this realization, the relationship was terminated.

As I unraveled the relationships with her family, it became clear to what extent they had been able to deny her prognosis. Mr. C and the daughter, Leslie, were both unaware that Mrs. C would die until the actual time of her death. Leslie said later, "She told me that she was going to live and I believed her." The sons engaged in the least amount of denial. They thought all along that her optimism was folly. One son was angry with me for not confronting his mother with the truth of her condition. The emotional distance Mrs. C complained of in her relationships with both sons can be accounted for by their understanding that she would not live. It may be that, contrary to her belief that her sons preferred a distant relationship, she herself distanced herself from them to protect herself from sensing what they knew and what they may have been subtly communicating to her about her condition.

### *Subjective Countertransference Resistance*

In coming to a full understanding of the countertransference and countertransference resistance aspects of the case, it is useful to have some insight into my personal history, and how my experiences affected my thoughts and feelings about cancer.

As a young child I was close to, and protective of, my mother. During adolescence, I became interested in my peers, and while my separation from my mother was successful from my point of view, it never ceased to be painful for my mother. Then, in 1976, my mother was diagnosed with terminal cancer. This event had the effect of bringing me, once again, close to my mother. I committed myself to doing whatever I could to save her life. I embarked on what was to become an extensive and prolonged search for information about cancer and cancer treatments. In sharing my findings with her, she and I arrived at a treatment plan for her which we both felt held out the most promise of success.

The relationship that my mother and I formed, based on my

interest in her and her cancer, was extremely gratifying to me, as it must have been to her. She was finally receiving all the attention from me that she had longed for all those years when I was busy living my separate life; I was able to reenact my past fantasies of rescuing her, but this time without the frustrations of an impotent child. I became, for her, the omnipotent and omniscient protector, in whose hands she lay safe and sound.

During the years that I was involved in helping my mother fight her cancer, I developed both an intense interest in cancer, and a somewhat unusual perspective. My interest in cancer had prompted me to talk about it with friends and colleagues. I loved talking about cancer, about people with cancer, about treatments of cancer, theories of cancer, feelings about cancer—all the thoughts and feelings that a mind is capable of generating—they were my favorite topics of conversation. I began to notice, though, that while I was having a wonderful time talking about cancer, my listeners would frequently get depressed or upset. They would say things such as “I don’t like talking about such things.” “This is such a morbid conversation—couldn’t we talk about something more pleasant?” At times, the apparent pleasure I was having in the conversation would provoke anger and accusations of my being heartless and uncaring.

I have come to understand that my emotional relationship to the notion of cancer was very different from that of many of the people to whom I talked. I have isolated several factors that comprise the difference. Firstly, I do not accept the notion of the intractability or unpredictability of cancer. I see cancer as a disease that arises out of a particular set of pre-conditions, that these pre-conditions can be identified and changed, and that when the cause of the disease is removed, the disease flees and the body can recover. I must specify here that the body cannot always recover, and does not always recover, even with the removal of causation; but that if the physiological damage to the body has not been so severe as to be irreversible, if the body retains the ability to recover, then it frequently does recover. And it is in the body’s ability, its desire to return to the homeostasis of health and life, that one could place such optimism.

Secondly, my interest in cancer, and the referral of the patient Mrs. C, came at a time in my life, and in my own analysis, when my sense of omnipotence was at a peak. I was rising in my profession; I felt excited by the challenge of accomplishing something against the odds. I felt a sense of confidence that I was the best

analyst in the world for this patient—that I knew more about how to cure her than any analyst alive.

It was with the personal experience with my mother, and the assumptions that I had developed as a result of that experience, then, that I began the treatment of Mrs. C. My mother had already outlived her prognosis by six years. She and I had vanquished the enemy of mankind, the contemporary plague of the earth; her cancer seemed forever removed, and death seemed very far away. I was a wellspring of optimism about treating cancer successfully, and had proclaimed my beliefs to the world by editing a book, an anthology of articles that were up-beat and positive in their ideas about the reversibility of cancer.

Thus, it was easy for me to join Mrs. C in her main defense—her need to deny the prognosis which gave her less than a year to live. Our medical predictions gave me no cause for alarm. I had been well prepared for the role of savior, and took easily to the task.

It is now, at the time of this writing, some years since the deaths of both Mrs. C and my mother. In regarding my experience of going through the dying process with my mother, I see certain parallels to the experience of treating Mrs. C.

As I denied Mrs. C's imminent death, during that same time of her treatment, so too did I deny the process that was insidiously killing my mother. Signs that might have suggested that my mother's cancer was returning were ignored.

I did not want to know that my curative powers with Mrs. C would not work because I did not want to know that my curative powers with my mother had ceased to work. To accept the inevitability of the death of either of them would have meant to accept my own impotence. To accept my own impotence would have meant that my confidence about my own immunity from cancer may have been delusional. To know the possibility of my own susceptibility to cancer would have made me all too human, all too prone to the vulnerabilities of mortality.

### *Resolving the Countertransference Resistance; or Curing the Analyst*

It is an obvious fact that an analysis does not proceed as therapy when the patient is no longer alive. Yet, it is not necessarily

true that the work of the analyst ends there. Through the process of reworking old material, analysts can deepen their understanding of the dynamic issues raised by the analysis. One psychoanalytic definition of cure is the acquisition of the ability to experience comfortably all one's thoughts and feelings, and to be able to put these into words. Neither Mrs. C nor I had come to that point. She was not able to put into words her aggressive impulses, her wish to die. I was not able to objectively entertain thoughts and feelings of all aspects of our relationship.

## *Epilogue*

In looking back on the analysis I realize that it was my blind love that prevented me from seeing and analyzing the suicidal impulses she acted on. It was her desperate need to be loved, a need filling a maturational gap that had been with her since childhood, that prevented her from telling me that it would be more loving of me to see that she didn't deserve to live, and that my loving her as I did was a terrible misunderstanding of her.

In our work with terminally ill patients, it may be hopelessly grandiose to think we can save their lives. Yet, perhaps we can set more modest goals.

Mrs. C spent her last years struggling for psychic awareness. She permitted herself access to thoughts and feelings which her entire character structure had worked against her having for her entire life.

As well, she was able to leave a legacy. Her daughter, sister, and one son are now in treatment with me. Perhaps the fact that their appeal for help has come earlier in their lives is cause for optimism. Our eternal hope as psychoanalysts is that we will reach our patients before the point of irreparable and irreversible damage.