What are the themes in the psychoanalytic literature on assisting people with a terminal diagnosis?

A thematic analysis

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material, which to a substantial extent, has been accepted for the qualification of any other degree or diploma of a university or institution of higher learning, except when acknowledgement is made in the acknowledgements.

Signed: Date:

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"Today is a good day to die for all of the things of my life are present"

Crazy Horse

Alongside a strong professional interest in the contributions therapy can offer to assist dying people, this topic also holds deep personal significance. How can we face the fact of our own mortality? To ask the question of myself becomes more difficult. "My death" seems more unimaginable than "our death". I have often reflected on whether I can authentically lay claim to the attitude expressed in the words of the Native American Indian, Crazy Horse, and returned a sense of doubt. Although my role is primarily one of researcher, in choosing the topic of death and dying, I also acknowledge an attempt to grapple with my own mortality. I am enriched in this effort by each of the people whose poignant struggles in confronting death are shared in the case studies to follow.

Abstract

Terminal illness and knowledge of imminent death can evoke intensely painful and overwhelming feelings of fear, despair and terror. Accounts in the psychoanalytic literature on work with dying clients are infrequent however much of the material that is available provides the foundation for this research. This dissertation is a qualitative study using thematic analysis to identify and analyse the themes in the psychoanalytic literature on assisting dying clients. The research findings demonstrate that practitioners writing about therapy with terminally ill people reveal the immense vulnerability of dying clients, and describe the development of a powerful and often deeply intimate connection within the therapeutic relationship which can mobilise and support the resilience of clients in close proximity to death.

Dissertation Outline

Chapter One introduces the research topic, gives a rationale for the study, and describes the literature search and inclusion/exclusion criteria. The data set is introduced, followed by a brief orientation to each of the publications.

Chapter Two reviews the literature on the psychoanalytic understanding of death and dying, discussing divergences that have occurred as psychoanalytic models have developed and also identifying the commonalities which unify contemporary theoretical concepts with their early beginnings.

Chapter Three presents the theoretical elements that form the structure of the research process. Symbolic interactionism provides the epistemological base in which the theoretical perspective of social constructionism is embedded. Reflexive methodology underpins thematic analysis, the research method chosen to conduct the research. Five key issues relating to the application of the method are discussed.

Chapter Four describes the application of thematic analysis in detail. The first five phases of thematic analysis are presented as they have been applied to the study in order to explore and organise the data set in rich detail and identify the themes in the data. Tables and thematic maps illustrate the identification and organisation of themes.

Chapter Five comprises the final phase of the research: the analysis and presentation of the findings through an analytic narrative that illustrates the story the data tell across the themes.

Chapter Six discusses the findings in relation to the wider literature, presents further methodological considerations, considers implications of the research, the strengths and limitations of the study, gives suggestions for further research and finishes with some concluding thoughts.

Chapter One

Introduction

Our culture, to a large degree, tries to avoid death as a reality; however, we will all eventually die. The fact that death is universal and inevitable does not make us any less reluctant to look death in the eye. Schwass (2005) points out that "[i]n this age…it often seems that death is seen less as a natural event than as a failure in medical treatment" (p.14). When denial and fear surround our approach to death and dying, we may deny ourselves the opportunity to live well and perhaps also to die well. Death sometimes happens suddenly; however, when people die a "slow death" through illness the longer process of dying can hold gifts as well as challenges and this is where psychotherapy may be helpful to clients in the final phase of life.

This qualitative study explores the publications of psychoanalytic psychotherapy with dying clients by using thematic analysis to identify the themes on assisting people who are facing death and dying. An initial search of the literature relevant to psychotherapy with clients who have been diagnosed with a terminal illness or who are receiving palliative care reveals a dearth of material on this subject from psychoanalytic practitioners. "Even now…very little has been written about psychoanalytically informed work with the dying" (Rhode, 2008, p.146). Anshin (1985) states that "working through the fear of death, the facing of death becomes a creative and ego-integrative experience as, without denial, we encounter the tragedy of personal death with appropriate grief" (p. 254). This statement embodies an ideal outcome of facing death from a psychoanalytic theoretical orientation, but research and publications which address facilitating such an outcome from this modality are not commonly found in the literature.

Rationale for the Study

The motivation for this research topic arose from my professional involvement at Hospice. Initial ideas of investigating how terminally ill people can be assisted through psychotherapy were conceived from a broad outlook, with the intent to explore the question from a number of different theoretical approaches. The literature search at this preliminary stage revealed a substantial amount of material concerning thanatology written from many different perspectives and a modified systematic literature review was proposed as the most suitable method to conduct the research. However, as the research progressed, I decided to narrow the focus of the study to literature solely generated from a psychoanalytic approach, for two significant reasons.

First, many of the articles from the psychoanalytic literature stated how little material there is available to practitioners written from this theoretical approach, thereby identifying a significant gap in the research (Daehnert, 2008; Eissler, 1955; Hildebrand, 1992; Mayer, 1994; Norton, 1963; Rodin & Zimmerman, 2008). While a systematic literature review could provide a summary of the literature on the topic of assisting the dying from a range of psychotherapeutic approaches, I decided it was more worthwhile to study this smaller body of literature in greater depth to attempt a useful contribution to an area of research with an identified gap.

Second, psychodynamic psychotherapy, the modality through which my practice is informed, has its foundations in psychoanalysis. Therefore my interest in investigating how people are assisted specifically through this approach contains heightened professional and personal significance. Although there are differences in technique between psychodynamic psychotherapy and psychoanalytic psychotherapy, such as frequency of sessions, use of the couch and views on relational dynamics, fundamental theoretical principles are common to

both disciplines (Friedman, 2006). Following the decision to concentrate the research specifically on the psychoanalytic literature about assisting the dying, the material selected was essentially psychoanalytic in its approach. The term "psychoanalytic" is used throughout the study.

The change in approach from a wide scope of exploration of a number of modalities, to investigation of a small clearly defined body of literature in depth, required a corresponding adjustment in the choice of method. Thematic analysis was chosen as the most appropriate method to apply to the research because it permits comprehensive engagement with the literature in a way which can "provide a rich and detailed, yet complex, account of the data" (Braun & Clarke, 2006, p. 78). Therefore the aim of this study is to identify the themes in the psychoanalytic literature which address assisting people with a terminal illness in the process of dying.

Literature Search

The literature search, inclusion and exclusion criteria, and a description of the final data set are included at this point to give a more comprehensive context to the literature review which follows in Chapter Two.

The literature search was carried out using the electronic databases Psychoanalytic Electronic Publishing (PEP), PsycINFO, and the Auckland University of Technology (AUT) library catalogue using the terms "psychotherapy" combined with "facing death", "end of life", "work with dying", "terminally ill" and "palliative". As previously stated, at the outset of the project the intention was to address the central question of the study by exploring several modalities within psychodynamic psychotherapy and the preliminary search revealed that an extensive amount of material has been published on the subject of psychotherapy with the dying. Many of the publications focus on short-term treatment in institutional settings

with people already in the final stage of dying and are spread across a broad range of different modalities, for example psychodynamic counselling, and relationally reflexive inquiry with the terminally ill. As the project progressed, and it was determined that the focus of the research would centre entirely on psychoanalytic psychotherapy (for the reasons outlined above), the search was ultimately limited to PEP as the most established and reliable source for publications in the psychoanalytic community. Thirteen articles were sourced through the searches in PEP and through the references in the articles found through PEP. Books were obtained through the AUT library catalogue and inter-loan service and a chapter from an edited book was included that had been sourced from a book review found in PEP. A summary search log is included (Appendix A).

Inclusion and Exclusion Criteria

Articles included were comprehensive case studies of ongoing psychoanalytic psychotherapy with clients in a non-institutionalised setting who were diagnosed with a terminal illness during the therapy or who sought such therapy following the diagnosis of a life-threatening illness.

Articles excluded were studies about children, families, groups, people in institutions and therapy with the dying that was not from a psychoanalytic perspective. Publications before 1960, publications not in English, and whole books were excluded because they were too extensive to code; however a chapter from an edited book was included. Two psychoanalytically oriented books of particular significance to the topic were excluded from the final dataset because some of the material was derived from experience in institutions and they were too extensive to code: On Death and Dying (Kubler-Ross, 1969) and Dying: A Psychoanalytical Study (Hagglund, 1978). As the Hagglund study reported cases of ongoing psychoanalysis, and both publications incorporated insights relevant to the topic, a brief

summary of their salient points is included in the review of the literature (Chapter Two). Similarly, material from a study on the therapeutic role of dreams during the dying process has been included in the review. The study was initially included and coded but finally excluded because although the authors concluded that dream analysis was of assistance to the dying, the case material was from a patient who was not receiving on going psychotherapy. This final exclusion reduced the final data set to 12 publications.

Final data set

Eleven of the 12 publications comprising the data set were written by practitioners of psychoanalytic psychotherapy writing about their work with dying clients. In the remaining publication the client was dealing with a life-threatening illness. Therapy was generally conducted weekly - in most of the cases two or three times a week - however, most of the authors mention that adaptations to this framework became necessary to accommodate the increasing frailty of the dying person.

While this selection of articles is not completely exhaustive, it does include much of the sparse material available on work within the psychoanalytic therapeutic dyad and based on my reading of the broader area, it is sufficiently thorough as a sample to exemplify the psychoanalytic literature with individual case studies from 1960 to the present day. A brief description of the articles follows as an introduction to the chronology and theoretical orientation of the articles and also to each unique dyadic relationship.

Norton (1963) Treatment of a dying patient. A detailed case summary of the last three and a half months in the life of a 32-year-old mother is given in this paper. She was depressed and suicidal in the terminal phase of breast cancer and the therapist concluded that her treatment provided immense protection against physical and psychological pain.

Roose (1969) The dying patient. This article discusses the treatment of a man in his sixties who was isolated, depressed, deeply despairing and in fear and denial of death. The therapist encouraged and facilitated the goal of regression to the point of a fantasy of reunion to achieve comparative peace and calm in the face of death.

Hildebrand (1992) A patient dying with aids. Following an introduction about the effects of AIDS and homosexual relationships in this context, the article describes the psychoanalysis of a 37-year-old man who began therapy after suffering paranoid psychosis after being told of a positive diagnosis of AIDS from a test that had been performed without his knowledge.

Mayer (1994) Some implications for psychoanalytic technique drawn from analysis of a dying patient. This paper describes the analysis of a 46-year-old woman diagnosed with a recurrence of cancer two years after therapy began. Day to day analytic work continued for a further two years until just before her death. In her presentation of the case, the therapist reflected in depth on the applicability of maintaining an analytic technique with her dying client.

Adams-Silvan (1994) "That darkness is about to pass": The treatment of a dying patient. This article describes the psychoanalytic treatment of a middle-aged woman with cancer. The therapeutic stance was oriented to object relations and continued twice weekly for three years with the initial goal of mobilizing a healthy narcissistic cathexis. After two years the client wanted to "let go" and eventually completed suicide, which the client considered a loving and estimable act.

Knoblauch (1997) The patient who was touched by and knew nothing about God. This chapter from a book draws on concepts from self psychology in the therapy of a middle aged woman with psychogenic dyspnoea who was dying of cancer. The case study is preceded by

a discussion of selfobject experience in developmental terms and religious experience in dying.

Minerbo (1998) The patient without a couch: An analysis of a patient with terminal cancer. A description of the last five months of an eight-year analysis is given in this paper. The client was a 48-year-old woman who contracted cancer at the beginning of the fifth year of the analysis. In the terminal phase therapy was conducted by phone three times a week. The therapist concluded that the client was able to integrate the meaning and consequences of her disease and accept death with dignity.

Schaverien (1999) The death of an analysand: Transference, countertransference and desire. An exploration of a dependent erotic transference and the associated countertransference issues was developed in the analysis of a 46-year-old suicidally depressed man diagnosed with cancer during the therapy. Despite pressures on the analytic frame, its maintenance allowed the individuation process to continue to the end.

Bustamante (2001) Understanding Hope: Persons in the process of dying. The psycho-social stages during the experience of dying are outlined in this article written by a psychiatrist with a focus on the experience of hope while dying. A clinical illustration is given which describes the psychoanalytic treatment of a 28-year-old woman with terminal cancer who had suffered the amputation of her leg and was depressed and in despair.

Carvalho (2008) The final challenge: Aging, dying, individuation. This paper is about the psychotherapy of an elderly woman approaching the end of life who was experiencing a decline into dying and death. The process of enabling the client to accept the bodily and emotional correlates of dying facilitated reconciliation with herself rather than being at odds with herself. The therapeutic approach focused more on the intrapsychic than the intersubjective relationship and included object relations and Jungian concepts.

Rodin and Zimmermann (2008) Psychoanalytic reflections on mortality: A reconsideration. A review of psychoanalytic concepts on mortality is presented in this article with a case illustration of a young man who sought psychoanalysis following the diagnosis of a life-threatening malignancy.

Daehnert (2008) Crossing over: A story of surrender. "Your job is to keep me emotionally alive until I die" were the words of this client following the diagnosis of inoperable cancer after seven years of her eight year analysis. Her approach to death was seen as an opportunity for further integration and transformation in which both therapist and client were immersed in death and loss.

Summary

This dissertation focuses on the psychoanalytic literature about therapy with dying clients in which there is an identified gap. It aims to contribute a comprehensive understanding of this area through an in-depth exploration and thematic analysis of case studies over the last five decades.

Chapter Two: Review of the Literature

This chapter traces a brief chronology of the psychoanalytic understanding of death and dying, beginning with Freud and following through to more recent theories. It will review the divergences that have occurred as psychoanalytic models have developed and also identify the commonalities which unify contemporary theoretical concepts with their early beginnings.

Inherent in the inquiry of this study, which centers on the themes in the psychoanalytic literature about assisting people who are facing death, is the basic assumption that therapy can assist people who are dying. While it seems self-evident that clients who seek psychotherapy are invested in the hope that therapy will be beneficial, it is important to acknowledge this assumption in the context of death and dying specifically. Mayer (1994) makes the point that "the idea that an ongoing psychoanalytic process is possible and productive as patients face death is treated skeptically by most authors" (p. 3). Such an assertion also seems implicit in Freud's statement that analysts have shown "an unmistakable tendency to put death on one side, to eliminate it from life…to hush it up" (Freud, 1915, p. 289).

As Norton (1963) emphasises, case material on dying patients is rare in the psychoanalytic literature and similarly, Hoffman (1979) notes that little attention has been paid to the process by which the individual anticipates, reacts to, and comes to terms with his own death, and comments that there is agreement about the fact psychoanalysis has not accumulated a body of clinical material in the area of death and dying. Similarly, Eissler (1955) remarks on the surprising failure of psychoanalysis to build on Freud's original formulations and devote more effort to the study of death itself, given that Freud made death a central concept in his theories (Garcia, 1996; Hoffman, 1979). The impact of

modern psychoanalytic thinking in work with the dying has also been minimal (Rodin & Zimmerman, 2008).

Historically, the work with death and dying has been very closely linked with Freud's theories and the understandings have been influenced by concepts concerning early infant development, narcissism, regression, merger and reunion with the intention to provide protection from the psychological pain of dying. One of the most frequently cited statements Freud made on the subject of death concerned the difficulty of envisioning our own death: "It is indeed impossible to imagine our own death… in the unconscious every one of us is convinced of his own immortality" (1915, p. 289). Hoffman (1979) points out that in later publications Freud reiterated the idea that awareness of death and death anxiety as such are impossible because death defies imagination. However, Freud also asks, "Would it not be better to give death the place in actuality and in our thoughts which properly belongs to it, and to yield a little more prominence to that unconscious attitude towards death which we have hitherto so carefully suppressed?" (1915, p. 299).

Successive prominent theorists writing about death such as Eissler (1955) and Pollock (1971) were aligned in their ideas with Freud's contention that no one believes in his own death and death is not something a person can really sense and fear. Fear of death is considered to be symbolic of earlier separation anxieties, object loss and abandonment rather than connected with actual physical death. Although theorising about what death represents in the unconscious and linking fear of death with childhood fears enriches psychoanalytic understandings of death anxiety, it also "takes theoretical attention away from the concrete and literal fact of death" (Akhtar, 2009, p. 107). Akhtar's statement identifies the disinclination of theorists to deal directly with the process of confronting death and dying. Moreover, Akhtar (2010) asserts that "as analysts, we have paid inoptimal attention to the

psychological significance of the fact that all human beings die and that knowing this fact has enormous psychological ramifications" (p. 18).

Hoffman (1979) also recognises this theoretical gap and extends his critique further. He contends that there are significant inconsistencies in psychoanalytic theories about death, for example, the premise that it is impossible to imagine our own death conflicts with the idea that we actually are aware of our mortality and we avoid it because of the narcissistic injury inflicted by the awareness of death. Most significantly, he critiques the failure of major theorists to integrate the concept of conscious awareness of mortality into psychoanalytic theory. Until this time, theorists were more focused on dealing with the use of denial of death by patients, despite their knowledge of a fatal illness (Eissler, 1955; Brodsky, 1959). Freud remarks that "when there is a psychical diversion brought about by some other interest, even the most intense physical pains fail to arise" (1926, p. 171). From this theoretical approach, in order to provide protection against psychological and physical pain, treatment favoured facilitating regression in the service of maintaining an intensely cathected object relationship with the therapist (Norton, 1963). Hoffman presents a significant divergence from earlier theories, which promote protection against actual and threatened object loss and discount death awareness as a psychologically important variable, when he proposes that death awareness is "a unique factor emerging in the course of (human) development with unique implications for adaptation" (p. 249). He suggests a perspective in which coming to terms with the boundaries of the self in time is viewed as analogous to self differentiation.

Around the same time, in the 1960's, a comparable departure from the traditional stance in psychoanalytic thinking is represented by psychoanalytically trained psychiatrist and thanatologist Elisabeth Kubler-Ross in her renowned book On Death and Dying (1969). In common with traditional thinking, Kubler-Ross states that "in our unconscious, death is

never possible in regard to ourselves" (1969, p. 2). However, she firmly places theoretical attention on the concrete and literal fact of death in her work with people who are dying and in her identification and development of the five-stage model of dying: denial, anger, bargaining, depression and acceptance. Diverging further, she formulates a comprehensive understanding of how people may be assisted to come to the final stage of acceptance that is not based on regression and intense cathexis of the therapist as a comfort for the lack of future and the destruction of the potential self. Kubler-Ross states that "[i]n the long run, it is persistent nurturing from a therapist who has dealt with his or her own death complex sufficiently that helps the patient overcome the anxiety and fear of his impending death" (p. 41). However, the relatively linear progression proposed in the model has been critiqued in that it may underestimate the capacity of those facing death to hold fluctuating self-states (Rodin & Zimmerman, 2008). The wish to live may not represent denial or preclude awareness of the closeness of death, and both may exist together.

A review of the psychoanalytic literature on death and dying would be incomplete without a reference to existentialism, which emphasises the premise that the fear of death lies at the heart of much anxiety. According to Hoffman (1979), the beginnings of an existential perspective, where death awareness and death anxiety are viewed as major factors in human adaptation can be recognized in Freud's writings; however, they are not enlarged upon. Stedeford (1984) proposes that existential fear of death lies deep in everyone and often remains unconscious, but its presence has a profound impact as the knowledge of death becomes inescapable in terminal illness. Yalom (2008) suggests that the terror of death is the underlying cause of many symptoms; in the adult unconscious dwells the child's irrational terror so that death is experienced as a cruel, mutilating force. These ideas are consistent with Freud's ideas about death anxiety in so far as they reiterate the unconscious aspect of death awareness and relate it to childhood fears. Yet the difference in the existential

approach is that the capacity to become aware, confront and adapt to facing death as a reality is stressed as being possible and meaningful. As a result of his clinical experience Yalom concludes that the greatest service to be offered to clients who are facing death is sheer presence, within which there is a strong message: "No matter how much terror you have, I will never shun or abandon you" (p. 130).

Psychoanalysis from a Jungian perspective views death as a specific and purposeful objective of the individuation process which can become an active process "without automatically pathological implications" (Zoja, 1983, p. 57). Initially, Jung subscribed to Freud's psychoanalytic principles, but in breaking from Freud, subsequently developed analytical psychology which retains an emphasis on the significance of the unconscious and dream analysis. Material from a Jungian perspective is included because dream analysis – one of the core techniques in psychoanalysis – has been found by Jungian psychoanalysts Welman and Faber (1992) to apply to work with the dying. From this paradigm, death is viewed as a spiritual rebirth and the approach to death requires an unconscious and conscious intention to enter the process and embrace the final phase as a natural part of life. The therapeutic potential of dreams during the dying process was studied by Welman and Faber to better inform understanding and clinical treatment of the dying. From the results of the study the researchers suggest that analysing dreams in the psychotherapeutic care of dying patients "may foster creative development, assist patients to integrate meaningfully subjective experiences pertaining to dying and counteract the sense of isolation experienced by the terminally ill" (pp.79 - 80).

Following the traditional psychoanalytic paradigm, Hagglund (1978) conducted a study with five participants in which he observed interaction within the two-person relationship. He concluded that in the course of regression during the dying process a point

is reached where either defensive organisation or creativity becomes the predominant ego function. He determined that creativity in mourning derives from the mutual creative illusion (in the transference) of the mother-infant dyad in contrast with the defensive organisation against mourning which is directed at control of objects, anxiety and acquisition of power. When the therapist supports primary narcissism by mutual creative illusion, defensive mechanisms become unnecessary and the therapist can be made use of as an auxiliary ego which serves the purpose of allowing the client the illusion of preserving his personal features after death through the therapist (who does not die). This is thought to enable the client to complete a final decathexis of objects before death. Basic commonalities with earlier theories are represented in this study which predominantly directs treatment towards merger in a fantasy world, within an idealised transference relationship, but a divergence is evident in the emphasis on creativity in mourning the loss of self and objects.

In De Masi's more recent psychoanalytic contribution to thinking about death entitled Making Death Thinkable (2004) he echoes Freud (1915) in saying that "death is located beyond all thinkable experience" (p. 22). De Masi maintains that "psychoanalysis cannot offer any comfort for the lack of future and the destruction of the potential self, implicit in the prospect of death. At this point, we encounter the ultimate limit of every human endeavour, including psychoanalysis … the therapeutic process … finds here its limit" (pp. 121-122). De Masi concludes that at best we can hope for a balance between illusion and reality in facing death, and achieve reconciliation through projecting our inexhaustible potential into people and values which we have struggled for and loved.

Summary

Traditional psychoanalytic views emphasised the defensive needs of people facing death and have been inclined towards the view that death awareness was unimaginable or

intolerable. Developments in psychoanalytic thinking, influenced by the stage theory of psychological adaptation to impending death, relational and existential concepts, and ideas about self differentiation and individuation, have stimulated more direct exploration of the experience of dying within the therapeutic dyad, with the possibility that facing into death has the potential to promote psychic growth.

Chapter Three: Methodology

Acknowledging and making explicit the assumptions which inform the researcher's notions about the nature of reality is important in relation to qualitative research (Braun & Clarke, 2006). According to Alvesson and Skodberg (2000) the research question, the way of perceiving, evaluating and representing the empirical material (the publications) and the claim to say something about 'reality' must all be considered problematic because of the difficulty in "describing or interpreting 'objective reality' or people's intersubjective, socially constructed reality or their interior psychological worlds" (p. 240). In addition to this difficulty, in the act of engaging with the material, the subjectivity of the researcher becomes ingrained in the process itself (Flick, 2009).

Therefore, in order to describe the philosophical underpinnings of the researcher in relation to the research and acknowledge the assumptions inherent in this stance, this chapter will present three theoretical elements which inform one another and provide the structure of the research process (Crotty, 1998, p. 2). It will give an overview of the epistemology followed by the theoretical perspective in which the epistemology is embedded. It will outline the methodology, which is aligned with these perspectives, and then describe how the methodology is applied to thematic analysis, which is the method selected as best suited to address the research question. The final section addresses five key issues, which need to be considered and made explicit in relation to how the method is applied (Braun & Clarke, 2006).

Social Constructionism

The epistemology that guides the theoretical perspective in which this study is grounded is social constructionism (Flick, 2009). Research in the social sciences is confronted with the problem that the researcher can only encounter the world through "those

versions of the world which subjects construct through interaction" (Flick, 2009, p. 77). The assumption that there is a 'reality' existing outside subjective or socially constructed viewpoints and that such 'reality' can be validated and represented in texts as 'true' is an assumption that is rejected in social constructionism. Rather, constructionism holds that people actively create realities through the meanings they attribute to objects, events and interactions. "Both everyday subjective constructions on the part of those who are studied and scientific (i.e., more or less codified) constructions on the part of the researchers in collecting, treating and interpreting data and in the presentation of findings are involved" (Flick, 2009, p. 77).

In its contention that all meaning is constructed, constructionism is well removed from the objectivism of the positivist stance; however, attention to the 'object' (represented in this research by the publications of practitioners) is a central focus of the research. Crotty (1998) suggests that meaning is not merely inherent or already existing in the object. Objects are not 'found,' but "they are made by the interpretive strategies we set in motion" (p. 47). Crotty goes on to state that research conducted from the constructionist approach requires an openness to new and richer meanings beyond the traditional associations with the object, and he views this approach to the object as "an invitation to reinterpretation" (p. 51).

Symbolic Interactionism

Symbolic interactionism, embedded in interpretivism, is the theoretical perspective that provides the framework for observation and interpretation in this study. Research embracing the interpretive tradition necessitates viewing individuals as inherently social, interacting in society and influenced by their interpretations of their interactions with others. Symbolic interactionism proposes that "people create reality and their lived experience as

they reflect on, interact with and respond to others; thus, reality is fundamentally intersubjective" (Prus, 1996, p. xii).

The central concept of the symbolic interactionist perspective relates to the use of symbols and language (Charon, 1998). Through the use of symbols individuals interpret, define and actively create and re-create the world. "The interaction that gives rise to our reality is symbolic - it is through symbolic interaction with one another that we give the world meaning and develop the reality toward which we act" (Charon, 1998, p. 61). A second pivotal notion of symbolic interactionism is that the observer must be able to see the world from the perspective of the other and to consider the subjective meaning others impute to their actions (Crotty, 1998). Put together, these significant concepts indicate that through language and dialogue we can become aware of the perceptions, feelings and attitudes of others and interpret their meanings.

The work of psychotherapy occurs within an intersubjective matrix (Mitchell, 2000) as client and therapist make meaning of their lived experience through the use of language. Practitioners reflect on their work with patients through writing case studies, with the purpose of interpreting and understanding the interaction that has transpired between them. In turn, this research represents the process of interacting with the writings of practitioners working with patients who are facing death to actively identify themes from the literature which have relevance to how therapy with the dying can assist them and to offer fresh insights and understanding concerning this process.

Reflexive Methodology

Reflexive methodology provides the strategy that underpins the process of this research. The two main characteristics embodied in this approach are careful interpretation and reflection (Alvesson & Skoldberg, 2000). The emphasis on interpretation implies that all

understanding generated from research is the result of interpretation. There is no simple relationship between 'reality' and research results but, ideally, a high degree of awareness of the importance of language, pre-understanding and theoretical assumptions which all determine the interpretation. Alvesson and Skoldberg (2000, p. 248) describe the crucial ingredients of interpretation as "the researcher's judgement, intuition, ability to 'see and point something out', as well as the consideration of a more or less explicit dialogue" with the research subject, the researcher and the reader.

The second characteristic, reflection, signifies the act of turning attention inward on the part of the researcher as a person situated in a research community and a society with intellectual and cultural traditions. Reflexivity is also about "ways of seeing which act back on and reflect existing ways of seeing" (Clegg & Hardy, 1996, as cited in Alvesson & Skoldberg, 2000, p. 248). Reflexive methodology describes a process where there is open play of reflection across four different levels of interpretation: the empirical material, interpretation, critical interpretation and reflections on representation and authority. Figure 1 below (Alvesson & Skoldberg, 2000, p. 255) illustrates the four levels of interpretation and the interaction between them, which is open to flexibility in terms of the particular emphasis that may be applied between levels.

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Figure 1. Levels of interpretation. M. Alvesson, & K. Skoldberg, (2000). *Reflexive methodology: New vistas for qualitative research.* Olivers Yard, England: Sage Publications. Copyright 2000 by Alvesson and Skoldberg. Reprinted with permission.

Reflexive methodology is suited in its application to thematic analysis in two significant ways. Alvesson and Skoldberg (2000) propose that they "conceive of different variants of reflexive interpretation, adapted to where the emphasis lies" (p. 257). Reflexive methodology provides a strategy for constructing, analysing and interpreting the data in a way that allows for flexibility of emphasis. The focus in this study is most concentrated at the level of interpretation (level two in the diagram), as the themes are actively identified, reviewed and refined in a recursive rather than linear process, requiring interpretation and re-interpretation. Throughout this process, interpretation is required when coding the text, while looking for patterns of meaning represented as themes, and in the reporting of the content and meaning of the patterns. Although this level is the most prominent, considerable emphasis is also given to the empirical material (level one). While the data are not regarded as 'raw' but as a construction, the ideal that language should describe socially constructed reality exactly is not attempted in this study. However, the publications form the empirical material which has been read repeatedly and coded as closely as possible to the text. Levels three and four are less central to this study but each level has significance and therefore, in line with a constructionist framework, the sociocultural context of the individual case studies are addressed (level three) and issues of authority on the part of the researcher are considered (level four) and briefly discussed in Chapter Six.

Five Key Issues

According to Braun and Clarke (2006) "there needs to be an ongoing reflexive dialogue on the part of the researcher…throughout the analytic process" (p. 82). Braun and Clarke point out five key issues that should be considered through ongoing reflexive dialogue during the research process. They suggest these issues generally cluster together and should be made explicit in order to ensure theoretical consistency, and because the form and end result of thematic analysis varies. Reflexive methodology advocates a strategy where

reflexive dialogue is promoted with respect to how the method is applied. The following paragraphs will outline the specific form of thematic analysis in this study in terms of the five key issues and how they apply to the methodology.

A rich thematic description of the entire data set is given so that the predominant themes reflect the whole data set. Such a rich overall description is particularly relevant to this study because investigating work with dying clients represents an under-researched area within psychoanalytic psychotherapy. The paucity of written material and studies addressing the topic in this field is stated by several of the authors in the included publications (Daehnert, 2008; Mayer, 1994; Norton, 1963; Rodin & Zimmerman, 2008).

The approach to developing themes can vary across a continuum from data-driven to theory-driven (Boyatzis, 1998). Themes identified in this study are strongly linked to the data themselves, and the data have been coded without trying to fit them into a pre-existing coding frame, therefore this form of thematic analysis is data-driven. Such an inductive approach involves reading and re-reading the data for themes related to assisting clients who are dying, and the "models being discovered and built are subject to change during the process of inquiry" (Boyatzis, p. 31).

The question of the prevalence and prominence of a theme is one for researcher judgement but requires flexibility and consistency (Braun & Clarke, 2006). Themes are identified according to how they characterize something significant in the data relating to the question, not necessarily how many times a theme appears in a data item or across the data set. However, Braun and Clarke state that "ideally there will be a number of instances of themes across the data set" (p. 82) therefore prevalence has been counted at the level of the data items in the first stage of theme development.

Finally, themes are identified at a latent level in an attempt to recognise the underlying ideas and conceptualisations in the data so that meanings can be theorised as underpinning the data.

Summary

The development of themes in this study has involved interpretive work, in line with a constructionist paradigm which recognises that the individual accounts studied exist within a sociocultural context. Consequently, this research does not describe 'the way things are' but rather, the 'meaning that is made from them', thus placing this study firmly into the domain of subjective research.

Chapter Four: Thematic Analysis

Thematic analysis is outlined in depth in this chapter. Braun and Clarke (2006) have described a rigorous and explicit six step method for using thematic analysis as a way of "identifying, analysing and reporting patterns (themes) within the data" (p. 79). This chapter describes the first five phases of thematic analysis as they were applied to the study in order to explore and organise the data set in rich detail and identify the themes in the data. The first phase was familiarisation with the data, followed by the generation of initial codes, then searching for themes, and reviewing and refining the themes. The method was applied rigorously throughout a process that was recursive rather than linear. The sixth phase, producing the report, is presented in Chapter Five.

Phase one: Familiarisation with the data set

The data collection, inclusion and exclusion criteria and the final data set were described in Chapter One. The next step in phase one, familiarisation with the data set, involves reading and re-reading in an active way, searching for meanings and patterns (Braun & Clarke, 2006). The entire data set was read twice before coding and five patterns were immediately recognised. Each of the articles included five broad categories relating to the writing:

- accepted theory topical to the case
- detailed case material and dynamics in the dyad
- theory derived from the therapists' experience with the client and countertransference
- quotes from the client
- poetry and prose

It seemed important to differentiate these categories, and they were kept distinct throughout the entire process by coding them using different coloured paper. The use of the directly spoken words of the client brought the client more clearly into the dyad and gave the client a 'voice'. The inclusion of prose signifies that in dealing with dying, something more is needed beyond the theoretical to express the ineffable nature of dying. Ultimately, these initial patterns did not influence the final themes as codes were generated equally across the entire data set.

Other impressions of patterns arising from the initial reading related to the level of intimacy and connection between each therapist and client as it was conveyed in the case material itself, the analytic technique, the descriptive language used, and the content and expression of countertransference, both to the client and to the reader. A very strong bond, sometimes coupled with deep intimacy, was conveyed in several of the articles, which led to questions about whether these patterns were linked to the length of the therapy relationship, the theoretical stance of the therapist, the gender and age pairings and the historical position of the therapy. During this phase, notes were also made about how the therapist considered that the client was being assisted.

Phase Two: Generating initial codes

Codes distinguish a feature of the data that appears significant and "interesting to the analyst" (Braun & Clarke, 2006, p. 88). They refer to the "the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon" (Boyatzis, 1998, p. 63). As Braun and Clarke note, the process of coding is part of the analysis because the data is being organised into meaningful groups.

Generating codes progressed in a two-step process. First, every sentence of the data was reread and summarised, resulting in a short phrase or 'unit of meaning' being extracted

from the data and encoded as a meaning unit. Boyatzis (1998) describes this step as recognizing a "codable moment" (1998, p. 3). In line with the suggestion made by Braun and Clarke (2006), the extracts of data were coded "inclusively" (p. 89), by keeping a little of the surrounding data when relevant because a common criticism of thematic analysis is that the context is lost. For example, from the original text which read "and she was becoming relentless in her pursuit of an intense, total connection with me" (Daehnert, 2008, p. 2003), the following was recorded on meaning unit 1576: relentless pursuit of intense, total connection with therapist. The only exception to all of the data being coded sentence by sentence was the introduction in the article by Hildebrand (1992), in which he discussed the sociocultural effects of AIDS and homosexuality.

At this level the data was coded as closely as possible to the text, however, in line with the methodology (see Figure 1, p. 30) it is acknowledged that some interpretation was already occurring in this stage of the process. The information in the meaning units was written by hand on small sheets of different coloured paper corresponding to the five categories mentioned above. For ease of identification and to save recording the name of each article on every meaning unit, different coloured pens were used for each article and a reference to the page number in the article was included on the meaning units, each of which was numbered. Encoding the entire data set resulted in the generation of 1,744 meaning units.

The second step in generating the codes required each meaning unit to be reviewed to encapsulate its meaning in a word or a short phrase; for example "facing into death". Figure 2 illustrates an example in the full context of each step: the original data, the meaning unit extracted and the codes generated.

"The point is that the analyst's capacity to make good psychoanalytic interpretation is mightily increased by a profoundly compassionate, empathic involvement with his or her patient." (Mayer, 1994, p 15).

- Step One: Meaning unit 194 was encoded on yellow paper (therapist's theory derived from clinical work).
- Step Two: Meaning unit was reviewed and codes were entered above underlined sections.

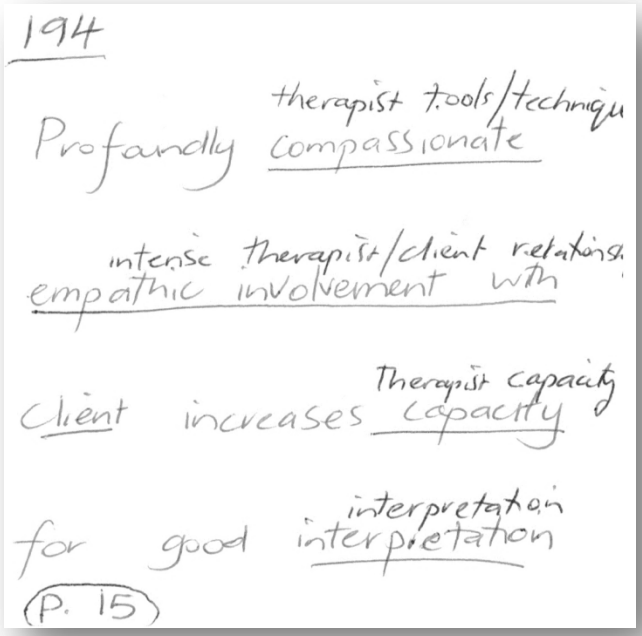

Figure 2. Example of a meaning unit and the codes generated from a portion of the data.

The individual extracts of data (meaning units) could be coded into as many different categories as they applied into, so an extract could be uncoded, coded once, or coded as many times as relevant (Braun & Clarke, 2006). In this step of the coding process the number of newly created codes resulting from a given meaning unit varied from one to seven, ultimately resulting in the generation of 3,544 codes. During the generating of codes, the meaning units were reviewed with reference to the relevant passage in its context in the data, to ensure that

the interpretation of each new code retained the authenticity of its meaning as closely as possible.

Phase Three: Searching for themes

In phase three, analysis is re-focused at the broader level of the themes more than on the specific codes (Braun & Clarke 2006).

Development of 1st order themes. As the meaning units for each article were reviewed and the codes were identified, patterns that were repeated across the data set began to be recognised. A category for each newly generated code was entered on to a separate summary sheet for each article. If a code did not fit under an existing category, a new category was created. Using Figure 2 (p. 37) as an example, the four codes generated from this meaning unit were entered on the summary sheet for the article by Mayer (1994). The codes were recorded in different coloured pens corresponding to the coloured paper used for the five patterns identified during the initial reading so that every code could be linked to its classification as described above: theory, case material, theory and countertransference derived from the therapy, prose and poetry, and client quotes. At this stage it was still unclear whether this information would be useful. After the entire 1,744 meaning units had been reviewed and coded, the categories and number of times each category appeared were recorded on a separate sheet for each article. The codes and tallies for every article were then entered in alphabetical order onto a large sheet of card which served as the master template. By the completion of this step, a template had been created that consisted of 91 categories into which all 3,544 codes had been allocated. These 91 categories functioned as the 1st order themes which are listed in Table 1.

Table 1 1st Order Themes

No.	1st Order Themes	Codes		No.	1st Order Themes	Codes
1	Painful feelings and self-states	**227**		47	Therapist questions	**24**
2	Defences	**212**		48	Loss	**24**
3	Therapist technique and capacity	**210**		49	Selfobject/function/continuity	**23**
4	Connection with self and others/no connection	**162**		50	Suicide	**23**
5	Assistance/comfort/relief	**136**		51	Individuation	**22**
6	Powerful and intimate therapist/client relationship	**112**		52	Timelimits	**22**
7	Fear and terror	**91**		53	Truth/untruth	**22**
8	Positive feelings and self-states	**86**		54	Transformation	**22**
9	Death awareness/facing death as reality	**85**		55	Traumatic history	**22**
10	Interpretations	**85**		56	Trust	**22**
11	Countertransference	**84**		57	Death anxiety	**21**
12	Intense feelings	**78**		58	Gift	**20**
13	Needs/longings	**72**		59	Developmental stages/deintegration	**20**
14	Alterations and extensions to therapy/no alterations	**68**		60	Attunement to inner life	**19**
15	Aliveness/wish to live/creativity/ vitality	**64**		61	Wish for death/death as purposeful	**17**
16	Transference	**63**		62	Merger/reunion	**17**
17	Pain-physical/psychic	**63**		63	Awareness and articulation of feelings	**17**
18	Understanding	**55**		64	Crisis	**16**
19	Ego	**52**		65	Self-examination	**15**
20	Meaning making/meaning of life	**51**		66	Conflicting feelings	**14**
21	Psychic processes	**46**		67	Intolerable reality	**13**
22	Spirituality/faith/God/religion/ sanctification/	**45**		68	Endings	**13**
23	Surrender/letting go	**44**		69	Death of client	**11**
24	Hope/no hope	**43**		70	Nature/stages of death	**11**
25	Fantasy/reality	**41**		71	Therapist as learner	**11**
26	Therapeutic process	**38**		72	Emotional maturity	**11**
27	Physical decline/stress	**37**		73	Treatment goals	**11**
28	Expression of feelings	**36**		74	Attachment system	**10**
29	Mourning	**35**		75	Management of feelings	**10**
30	Increased capacity	**35**		76	Fatigue/self -depletion	**10**
31	Uncertainty/certainty	**35**		77	Oedipal issues	**10**
32	Control/no control	**35**		78	Rare case reports/therapist reluctance to deal with dying	**9**
33	Unconscious/conscious processes	**35**		79	Shifting self-states	**8**
34	Acceptance	**35**		80	Courage facing death	**8**
35	Dependence/independence	**34**		81	Immortality	**7**
36	Critique of theory	**32**		82	Client plea	**7**
37	Relational repair/forgiveness Relational conflict/non-resolution	**31**		83	Superego persecution	**7**
38	Client attributes	**31**		84	Timelessness of therapy	**7**
39	Depression	**30**		85	Self-destruction/self-assault	**6**
40	Life goals while dying	**29**		86	Giving up the fight	**6**
41	Integration	**29**		87	Identity	**6**
42	Proximity of death	**27**		88	Readiness for death	**5**
43	Self-esteem/ positive/negative	**25**		89	Silent sessions	**4**
44	Protectiveness with family	**25**		90	Narcissistic wounding	**4**
45	Loneliness/isolation in dying	**24**		91	Special status of the dying	**3**
46	Dreams/nightmares	**24**				

The 1st order themes are listed in order, beginning with the theme represented by the greatest number of codes; however, as this is qualitative analysis, the prevalence of a theme in terms of the number of times it is identified across the entire data set does not necessarily determine any particular theme as more crucial (Braun & Clarke, 2006). The significance of a theme depends on whether it captures something important in relation to the research question, rather than on quantifiable measures. For example, "Special status of the dying" was the least frequent 1st order theme, coded only three times, yet the theme represented an impression which permeated the whole data set at a latent level. However, Braun and Clarke suggest that ideally, there will be a number of instances of a theme across a data set therefore prevalence was counted at the level of the data items during this initial stage of theme development.

The 1st order theme *Painful feelings and self-states* was coded the most often (227), as might be reasonably anticipated when grappling deeply with death. Closely following were *Defences* (212), and *Therapist technique and capacity* (210), and the next two themes *Connection with self and other* (162) and *Assistance/comfort/relief* (136) also seemed significant in their applicability to the research question as well as being coded frequently.

Development of 2nd order themes

Analysis of the codes began in this phase, after all the data had been coded and collated and the 91 codes which formed the 1st order themes had been identified across the data set. The next step required the consideration of how the 91 1st order themes could be sorted and collated so that they could combine coherently to form fewer, more overarching themes. This part of the process required thinking about the relationships between the themes and levels of themes and how they might fit together (Braun & Clarke, 2006). Visual representations proved helpful, particularly the use of tables to organise the 1st order themes

into consistent and coherent theme-piles. Some themes seemed to fit together easily such as *Fear/terror, Expression of feelings, Loneliness/isolation in dying,* and *Death anxiety,* whereas it was more difficult to find a collective home for other themes such as *Client attributes* and *Truth/untruth*. Different ways of clustering the 1st order themes also led to different possibilities for theme-piles, so the process was not simply linear but required many alternative combinations to be explored, going back to the original 91 themes frequently in order to settle on the combinations which seemed to represent the most authentic and accurate fit.

At this stage of the process, in line with the methodology, an open play of reflection was occurring between the levels of interpretation (Figure 1, p. 30). Reflecting on the meaning units, codes and 1st order themes entailed multiplicity of interpretation and favouring of certain interpretations (level one - two) and the recognition of "winners and losers" as a result of a particular interpretation (level two - three), while also continuing to refer to the data throughout the process.

The use of tables to sort and cluster the 91 1st order themes into combinations of theme-piles eventually resulted in the identification of 12 2nd order themes. The essence of most of the 2nd order themes could be captured using an already existing label, although some were renamed to more accurately characterise their meaning as a whole. The 2nd order themes are listed below.

- *Client's inner world*
- *Painful feelings and self-states*
- *Relationship*
- *Therapist*
- *Aliveness/creativity/positive feelings*

- *Dying*
- *Death awareness and facing death*
- *Therapeutic process*
- *Transformation*
- *Assistance*
- *Client's attributes*
- *Loss*

Table 2 demonstrates how the 1st order themes were clustered together to form the 2nd order themes.

Table 2

1st and 2nd order themes in an overview

1st Order Themes			2nd Order Themes
Defences	Ego	Psychic processes	Client's inner world
Surrender	Spirituality	Unconscious/conscious processes	
Depression	Dreams	Truth/untruth	
Fantasy/reality	Hope/no hope	Self object function	
Self-examination	Identity	Superego persecution	
Shifting self-states	Self destruction	Attunement to inner life	
Painful feelings and self-states		Awareness/articulation of feelings	Painful feelings and self-states
Fear/terror		Conflicting feelings	
Intense feelings		Management of feelings	
Expression of feelings		Control/no control	
Loneliness		Certainty/uncertainty	
Death anxiety			
Transference		Connection with self and others/loss	Relationship
Understanding		Powerful/intimate client/therapist connection	
Dependence/independence		Relational repair/forgiveness	
Trust		Traumatic history	
Merger/reunion		Protectiveness with family	
Attachment system		Oedipal issues	
Interpretations		Therapist tools/technique/capacity	Therapist
Countertransference		Therapist uncertainty	
Critique of theory		Therapist questions	
Therapist as learner		Rare case reports/therapist reluctance	
Aliveness/creativity		Meaning making/meaning of life	Aliveness/creativity/ positive feelings
Immortality		Life goals while dying	
Needs/longings		Positive feelings and self-states	
Pain-physical/ psychic		Physical decline	Dying
Fatigue/depletion		Proximity of death	
Suicide		Death	
Giving up the fight		Nature/stages of death	
Special status of the dying			
Timelimits		Death awareness/facing reality of death	Death awareness
Wish for death		Intolerable reality	
Crisis		Readiness for death	
Alterations to therapy		Therapeutic process	Therapeutic process
Treatment goals		Developmental stages	
Timelessness of therapy		Silent sessions	
Acceptance		Increased capacity	Transformation
Integration		Individuation	
Transformation		Psychic growth	
Assistance/comfort/relief		Client's needs/longings	Assistance
Client attributes		Emotional maturity	Client's attributes
Self-esteem		Courage facing death	
Mourning		Loss	Loss
Endings			

The next step required exploring the relationships that might exist between the 2nd order themes. Experimenting with thematic maps to offer visual representations of possible relationships led to the thematic map shown in Figure 3. The major themes are represented in ovals and those that seemed more like related sub-themes are joined and represented in rectangles.

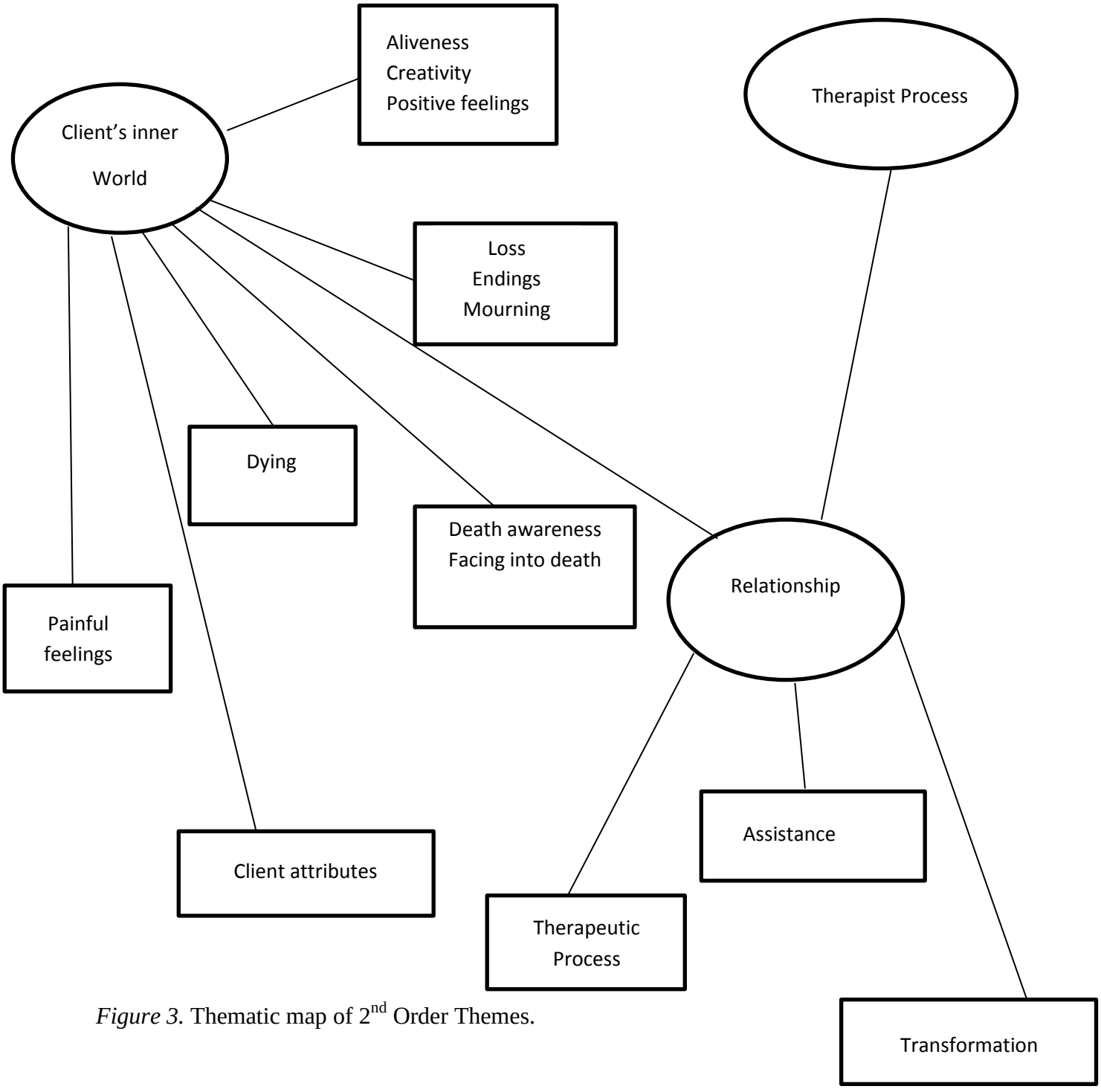

Figure 3. Thematic map of 2nd Order Themes.

Phase Four: Reviewing Themes

The 2nd order themes now made up a set of candidate themes which needed to be reviewed and refined to ascertain their reliability as themes and to determine whether there was enough data to support them. Braun and Clarke (2006) describe two levels of reviewing and refining. Level one requires reading all the coded extracts for each theme to decide whether they appear to form a coherent pattern.

All of the coded extracts for the 1st order themes were reviewed while the codes were being recorded on the summary sheets for each article and transferred to the master sheet. If a code did not fit under an already existing theme, a new theme was created. The codes for the candidate 2nd order themes now needed to be re-read to consider whether they formed a coherent pattern. Each candidate 2nd order theme was reviewed at the level of the codes for coherence and some re-sorting of codes was necessary. One area that required significant re-sorting concerned the 1st order themes that related to both client and therapist. During the initial coding process I wondered whether some of the codes concerning the therapist belonged within an already-existing theme, or whether they needed a separate theme solely about the therapist. Therapists wrote about their own defences, their conflicting and intense feelings, their sense of loss and other specific countertransference responses that were initially coded under already-existing categories. For example, most of the 186 codes forming the theme *Painful feelings and self-states* were about the feelings of the client, but 28 of them referred to the feelings of the therapist. After reviewing the 2nd order themes, it became apparent that all the codes referring to the therapist needed to be separated and reallocated to either of the following 2nd order themes - *Therapist* or *Therapist process.* This re-sorting involved the reallocation of 144 codes under 28 different 1st order themes.

Reviewing the themes at the level of the codes was a lengthy and intricate process. Some further examples of the re-sorting that was necessary are described below to give a sense of the process. Psychic maturity/growth was one of the components that made up the 1st order theme *Psychic processes* which had been sorted under the 2nd order theme *Client's inner world* but now perhaps belonged more appropriately to *Transformation.* After reviewing the codes relating to psychic maturity, it was found that although the codes referred to an intrapsychic process, they were identified within the context of psychic change owing to the therapeutic relationship. Therefore these codes were split off from their original place within the 1st order theme *Psychic processes* which had been allocated to the 2nd order theme *Client's inner world* during phase three (searching for themes) and reallocated to the theme *Transformation.* Similarly, the codes comprising the 1st order theme *Needs/longings* fitted better with the 2nd order theme *Aliveness/creativity/positive feelings* rather than *Assistance/comfort. Client plea* found a more comfortable home under *Relationship* because reviewing the codes revealed that they were related to something heartfelt that the client wanted from the therapist. The process continued until data was found to cohere together meaningfully within the 12 2nd order themes named above.

Development of 3rd order themes. The process of developing the 3rd order themes seemed to mark a pivotal moment in the research. I approached this point with a sense of anticipation as it seemed to be the culmination of a lengthy and intricate process that would lead to identifying the outcomes at the crux of the work. The challenge of achieving consistency in the overarching themes through further sorting and clustering, and continued thinking about the relationships between the themes and levels of themes and how they could cohere together meaningfully, with continued reference to the coded extracts, resulted in eight 3rd order themes:

- *Client's Inner World*
- *Painful Feelings*
- *Therapist and Therapeutic process*
- *Relationship*
- *Dying*
- *Aliveness/Positive Feelings*
- *Transformation*
- *Assistance*

The second level of reviewing the themes requires considering the validity of the individual themes in relation to the entire data set to decide "whether the candidate thematic map accurately reflects the meanings evident in the data set as a whole" (Braun & Clarke, p. 91). At this point the entire data set was re-read to ensure that the themes were supported by the data and accurately reflected the meanings in the data set as a whole.

Phase Five: Defining and Naming Themes

Defining and naming the themes for presentation is the task of the fifth phase, along with further refining of the themes.

Defining the 3rd order themes. The eight 3rd order themes are defined below in order, beginning with the themes that were coded most frequently.

Client's Inner World. The features of the client's inner world such as their defensive patterns, ego functioning, capacity for self-examination, level of attunement to inner life, dreams, unconscious processes, and fantasies were the codes included in this theme.

Painful Feelings. Painful feelings and self-states, such as despair, emptiness, disempowerment and numbness, appeared as the most-often coded feature in this theme

which also included descriptions of fear and terror, other intense feelings and the management and expression of feelings.

Therapist and Therapeutic Process. The technique and tools of the therapist such as empathy, skilled listening, interpretations, use of countertransference and the analytic approach made up this theme along with aspects of the therapeutic process such as alterations to the therapy and consideration of treatment goals.

Relationship. The client's sense of connection with others and the powerful, intimate relationship between the client and therapist were the central aspects of this theme, which also tied in with issues of dependence, trust, understanding, attachment and merger. Some of the codes were also about loss of relationship and highlighted the struggle of the client towards reconnection through forgiveness and relational repair.

Dying. The theme *dying* encompassed many of the elements involved in the experience of dying, as well as the attempt of the client to face into the reality of the end of life. These elements included physical and psychic pain, fatigue and physical decline, the awareness of time limits, thoughts of suicide or giving up the fight, the wish for death, and mourning of losses.

Aliveness/Positive Feelings. The psychological vitality of the client and the wish to live, the drive to find continued meaning and make goals for living, to express yearning and the desire for needs to be met in the final phase of life comprise this theme. Positive feelings such as hope, wholeness, self-compassion, calm and peace were felt by clients, as well as a sense of aliveness.

Transformation. This theme embodied the client's psychic growth and the achievement of an increased capacity for functioning, integration and self-cohesion, and

individuation and transformation, together with acceptance relating to the client's perception of his/her situation.

Assistance. The theme of assistance included the attainment of comfort, relief, or help, sometimes in small increments, but also through interventions that had a significant impact on the emotional experience of the client.

Further Review and the Development of Three Central Themes. An exploration of the possible relationships between the eight 3rd order themes, and consideration of how the relationships could be understood and represented, led to the identification of three final overarching themes:

- *Vulnerability*
- *Powerful Connection*
- *Resilience.*

These three overarching themes captured the essence of the eight 3rd order themes, which were grouped together in the following configurations. *Client's Inner World, Painful feelings,* and *Dying* cluster together and are represented by the theme *Vulnerability*. *Therapist/Therapeutic process* and *Relationship* fit together in the embodiment of *Powerful Connection*. *Aliveness/Positive Feelings, Assistance,* and *Transformation* are integrated by the theme of *Resilience*. The eight 3rd order themes were now represented as sub-themes of the three overarching themes. Further interpretation is apparent in the consideration of why these themes were dominant (apart from quantitative factors), and in the deliberation of counter-images as possible alternatives (Chapter 3, Figure 1, p. 30). Figure 4 illustrates the newly configured themes and sub-themes using a thematic map (Braun & Clarke, 2006).

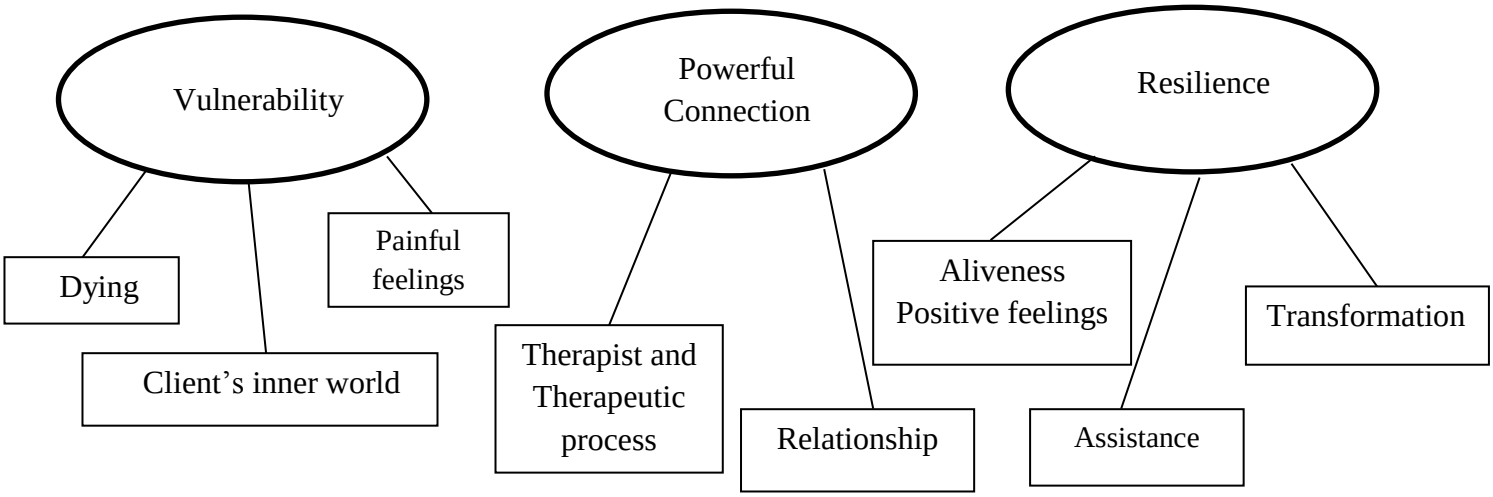

Figure 4. Overarching Themes and Sub-Themes

Defining the Three Central Themes. The three overarching themes are defined in the following section. An in-depth exploration and analysis of these major themes will be presented in Chapter Five.

Vulnerability. Vulnerability is a complex concept. In common usage it has been defined as "capable or susceptible to being hurt or wounded" (Dictionary.com, 2013). Psychological conceptualisations of vulnerability proposed by Ingram and Price (2010) emphasise that regardless of external variables, the locus of vulnerability resides within the person. Brown (2012) interprets the concept of vulnerability in a specific way in her definition: "Vulnerability is the core, the heart, the centre, of meaningful human experiences" (p. 12). Each of the definitions contributes to the understanding of the concept, as it is applied to the study, from differing perspectives. As an overarching theme in the study,

vulnerability incorporates these definitions of the concept in the way that it encompasses the three sub-themes of the *client's inner world* and the intense and *painful feeling*s experienced by the clients as they were *dying*. Susceptibility to trauma is inherent in the physical decline and psychological distress of dying, the locus of vulnerability resides in the internal world of the person, and deep understanding is made possible through acknowledging and opening up to vulnerability in the process of dying.

Powerful Connection. In all the cases in the data set, the therapist, by means of the therapeutic process, was effective in engaging the client in a relationship that permitted a powerful and sometimes intimate connection to develop. The way the therapist and client developed and sustained the connection was unique to each dyad, but the overarching theme of powerful connection is characterised by all of the codes relating to the establishment and therapeutic use of this relationship.

Resilience. Contemporary thinking about resilience proposes that it is a "distinct process, independent of illness dimensions" (Reich, Zautra & Hall, 2010, p. xii) involving two dominant aspects: the capacity to rebound from stress, and the continuation of recovery, even including growth and enhancement of function, as a response to stressful experience. In relation to the data set, the wish to live, to continue to find meaning in living, to ask for and receive help, and the capacity to perceive dying as an opportunity for growth and transformation, signify the concept of resilience as it relates to the sub-themes of assistance, aliveness/positive feelings and transformation.

Summary

This chapter described the first five phases of thematic analysis as presented by Braun and Clarke (2006) and outlined in depth the application of the method to the exploration and organisation of the data set in detail. Familiarisation with the data set, generation of initial

codes and searching for themes entailed the encoding of 1,744 meaning units resulting in 3,544 codes and 91 1st order themes. The development of 12 2nd order themes and eight 3rd order themes, leading to the three final overarching themes of *Vulnerability*, *Powerful Connection* and *Resilience* has also been outlined. The overarching themes and the eight related sub-themes were defined.

Chapter Five: The Research Findings

This chapter comprises the final phase of the research: the analysis and presentation of the findings. It involves the task of producing "an analytic narrative that compellingly illustrates the story" the data tell across the themes (Braun & Clarke, 2006, p. 93).

The most significant result of this investigation is the identification of three overarching themes in the psychoanalytic literature on assisting people with a terminal illness who are dying: *Vulnerability*, *Powerful Connection*, and *Resilience*. Practitioners writing about therapy with terminally ill people reveal the immense vulnerability of dying clients, and describe the development of a powerful and often intimate connection within the therapeutic relationship which can mobilise and support the resilience of clients in close proximity to death.

The three overarching themes and the eight sub-themes incorporated within them comprise the basis of the research findings. The analytic narrative presented in this chapter illustrates the story of the data, and captures what is convincing and of interest about each theme in relation to assisting dying clients. The model below (p. 54) provides an introduction to the main body of the findings and an illustration of how each theme and its sub-themes cohere internally and are also interconnected.

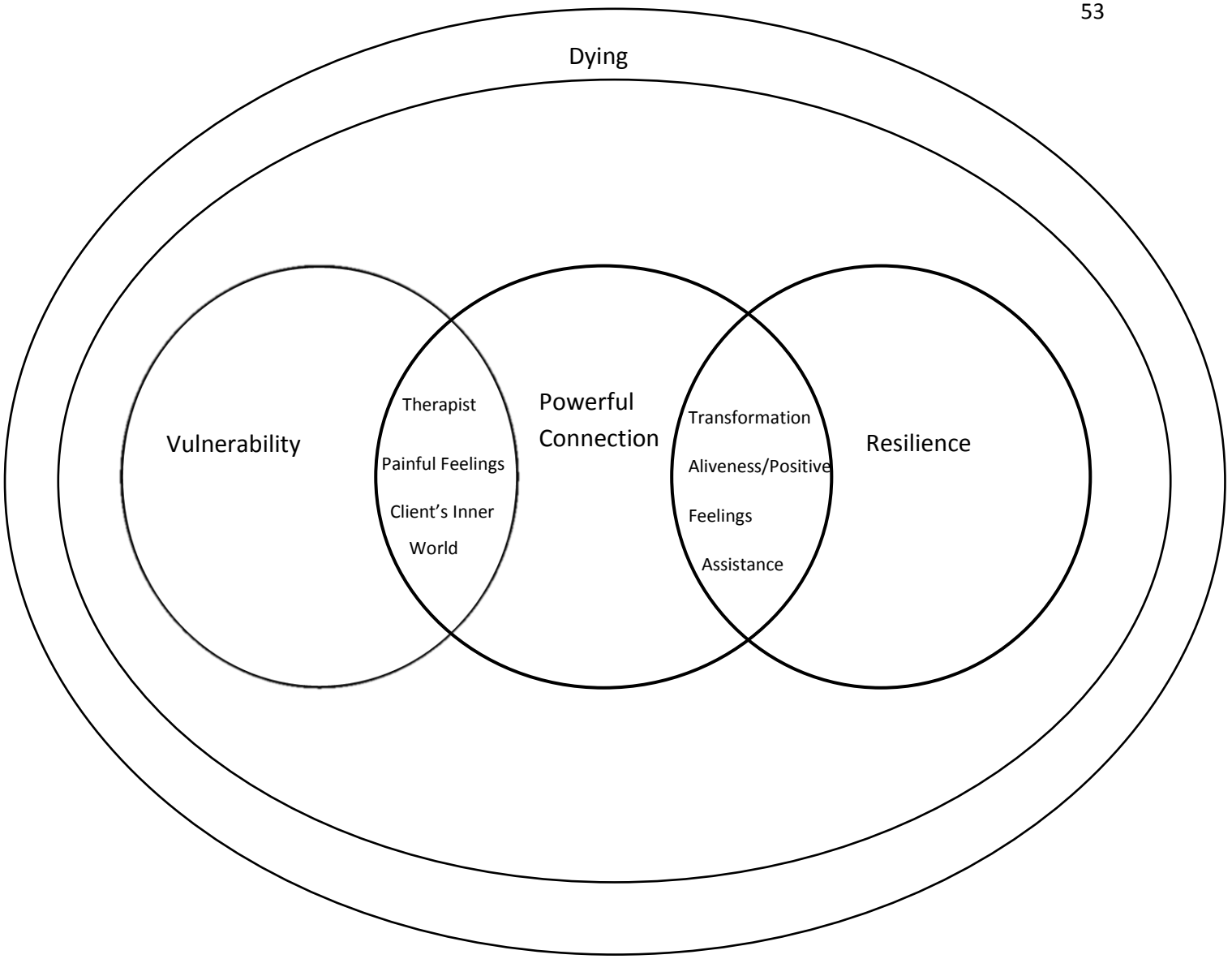

Figure 5. Model of themes in the psychoanalytic literature on assisting dying clients

The model illustrates that the therapeutic process, represented by the outermost ring, holds, encompasses and defines all that occurs within the therapy. The client's all-pervasive experience of dying and dealing with the process of dying is embodied by the inner ring. Powerful connection between client and therapist lies at the heart of the therapy and its potential to assist with the client's vulnerability and motivate their resilience is symbolised by the areas of interconnection with the other circles. Through powerful connection the therapist, who is also vulnerable, becomes immersed along with the client, in the client's inner world, and both struggle with intense and painful feelings. Resilience is conveyed in

the sense of aliveness, assistance, and transformation experienced by the client, also made possible by the intersection with powerful connection.

The themes are interconnected to a degree which poses a challenge in terms of the structure of the narrative. Writing about vulnerability in terms of assistance does not easily make a fluent and cohesive account unless it also refers to powerful connection. Likewise, it is difficult to write about the elements that assisted clients by activating resilience, and separate them from powerful connection. However, the essence of each theme coheres firmly around a single central concept and clearly captures something distinct about a key feature of the data; therefore I have given structure to the narrative by addressing each theme and its component sub-themes individually, while also recognising that there will be numerous points of interconnection throughout the narrative.

Vulnerability

Vulnerability is an overarching theme identified as the central concept embodied in the three sub-themes: *dying*, *painful feelings* and *client's inner world*. The ways in which vulnerability permeates these three sub-themes will be discussed and illustrated with extracts from the data. The theme of vulnerability has been identified as prevalent throughout the therapeutic process as therapists work with and attempt to help dying clients. Additionally, vulnerability as a theme relates specifically to the research question in that it shows the immense need of the client for assistance and also begins to identify the ways in which assistance could be meaningful. Moreover, the opportunity for the most powerful assistance sometimes arises out of the client's state of vulnerability and their capacity to express and be present to painful feelings.

Dying. The vulnerability of the clients in relation to the diagnosis of a terminal illness is immediately apparent in the accounts. After receiving the diagnosis, seven of the

clients sought therapy as a response to a deep sense of being overwhelmed and an inability to cope, which was expressed by symptoms such as depression, suicidal thoughts, psychosis, and despair. As one client expressed, she had "no outcome, no future" (as cited in Carvalho, 2008, p. 5). Bustamante (2001) describes the client's response as "a sense of extreme vulnerability" and "expressions of rage and anger at having been singled out" (p. 50). The remaining five clients were already engaged in therapy when they became aware of the closer proximity of death. The reaction of her client was described by Mayer (1994) as "profound numbness, rage, depression, and fear, compounded by a sense of victimization" (p. 5).

The shock of the diagnosis was often shared and felt by the therapist, which was especially magnified when the pair had a therapeutic history. Upon hearing of her client's diagnosis, one therapist stated "from that day until his death two years later he was rarely out of my mind" (Schaverien, 1999, p. 15). Minerbo (1998), who had been treating her client for five years, wrote about her response: "I reacted intensely to this news. I could have cut off treatment, and our relationship, then and there" (p. 84). Such statements strongly imply that a level of vulnerability also exists for the therapist. Therapists wrote about their own death anxiety (Bustamante, 2001; Minerbo, Roose, 1969; 1998; Schaverien, 1999) and also about vulnerability within an interpersonal context. For example, Schaverien (1999) spoke of her client's increasing capacity to relate and how this "deepened the feelings between us. Analysing whilst death approaches brings the reality of the frailty … of both people to the fore" (p. 20). Furthermore, in one case the client even reported being assisted through her awareness of the therapist's vulnerability, as expressed in the words of Daehnert's client: "It feels good that I can tend to that vulnerability in you without feeling like I'm taking care of you" (as cited in Daehnert, 2008, p. 208).

Vulnerability was inherent in the physical pain and psychological suffering that emerged through the unavoidable process of physical decline. Increasing dependence and

regression featured strongly in most therapies, compounding a sense of vulnerability. A year after his diagnosis, Schaverien (1999) described her client as "in considerable distress, vulnerable and regressed; he was able to acknowledge how dependent he felt" (p. 18). For this client to be aware of his dependency and acknowledge the feeling to his therapist represented a significant achievement in his emotional development. Bustamante (2001) notes the tendency towards increased vulnerability when marked physical deterioration begins. He states that "feelings of vulnerability, loss of control and desperation increase and are more intense than at the outset of the illness" (Bustamante, 2001, p. 51). This was also borne out for Schaverien's client as his tumour developed to a point where he couldn't speak. Schaverien writes "it was a shocking realization followed by tremendous grief. We both experienced the sadness" (p. 20). Ultimately, it was his therapist's sharing of emotion while he was deeply vulnerable that provided the conditions for this client's emotional growth.

Physical deterioration, urgency about timelimits and the closer proximity of death contributed to clients' opening up to vulnerability in attempts to face the reality of death. Carvalho (2008) writes of his client tacitly acknowledging the fact that "she now had to face catastrophic deintegrative processes…decline into death" (p. 5). Hildebrand (1992) remarked on the motivation of his client to explore himself and his inner world because "now facing death he felt he had to come to terms and grips with things" (1992, p. 462). Norton (1963) noted that her client was facing the "knowledge of her impending early death with an impressive insistence on reality" (p. 544).

Rodin and Zimmermann (2008) suggest that facing mortality offers the possibility of emotional development and they describe the directness and honesty of the client in facing his illness even though he regarded it as a cruel blow. However, the element that increased the vulnerability of some clients in facing death was the disconnection they experienced over the inability of their families to face into death with them. Rodin and Zimmermann refer to

how the client "recalled a painful moment in which his father … avoided discussing his illness with him" (p. 191). Norton (1963) explained that the only demands her client made on her family were "that they allow her to share her experience with them" but "both her husband and her parents had so decathected their relationship with the patient that it proved impossible for them to help" (p.545). Schaverien (1999) also noted this dynamic and stated that her client's family "could not face the possibility that he would die and so did not want to discuss it" (p. 15). Minerbo (1998) described the effect on the client when her husband tried to downplay the seriousness of her illness: "not only did this attitude make her feel misunderstood, it also made her feel she could not voice her fears and anxieties to those around her" (p. 84). In contrast with the reluctance of family members to face the reality of approaching death, therapists offered assistance through their commitment and capacity to face into imminent death alongside clients, without diminishing or denying reality. This was true whether the theoretical approach was oriented to the client's regression and merger with the therapist or towards individuation and promotion of the potential for growth.

The importance of remaining undefended in order to be able to assist the client in facing death was recognised and noted by therapists. Minerbo (1998) accepted the inevitability of her own vulnerability, which is embodied in her statement that "if I were to help her in the dying process, I myself had to be able to bear the pain of knowing she was dying" (p. 91). Norton (1963) noted her feelings of grief, guilt, anxiety and anger and stated "I am sure it is apparent that defences against anyone of these countertransference responses … would have markedly interfered with my usefulness to the patient as the object she needed" (pp. 559 - 560).

In the interests of avoiding replicating in therapy the experience of the client with their family and to remain fully present to the client in facing death, therapists did at least three things. First, they acknowledged vulnerability to their own death anxiety, compellingly

expressed by Minerbo (1998): “her approaching death was also making me conscious of my own vulnerability and mortality as never before” (p. 84). Second, they recognised when denial was present: “It had not occurred to me that she could indeed die while I was away. I realized that this was a denial on my part” (Minerbo, 1998, p. 87). Third, they affirmed their intention of staying with the client until death. Roose (1969) writes: “I made him feel, by dint of an authoritative and direct approach, that he could not drive me away and I would not leave him” (p. 390). Norton (1963) reported that her client was “truly convinced I meant it when I said I would be with her until her death” (p. 559).

Painful feelings. The painful feelings and self-states that dying clients experienced featured prominently throughout the dataset. Vulnerability lies at the core of painful feelings and difficult emotions. Strong feelings such as helplessness, self-hatred, terrible emptiness, profound sadness, panic, disintegration and disempowerment describe some of the ways that clients were vulnerable to overwhelming emotions which in some cases, contributed to the wish for death or “giving up the fight” and thoughts of suicide. Death anxiety is apparent in the emotions of fear and terror described by clients. Clients talked about their deep despair and fear of death, and for some weeks one client asked repeatedly what it was like to die (Roose, 1969). Death anxiety was also sometimes conveyed rather as fear of pain, lack of control, and fear of the manner of dying more than fear of death itself. Clients also spoke about the aloneness and isolation in dying and their regret that the therapist could not come with them. The present vulnerability of some clients resonated with affect related to previous trauma which had been repressed and never resolved. Bustamante (2001) discerned that “Behind her tears I could perceive emotions that were once denied and were now being felt” (p. 52).

Assisting clients in relation to the intense and painful feelings prevalent in working with the dying was approached by therapists in several significant ways. Therapists

established trust, accepted and provided a container for feelings, facilitated and supported the expression of emotions, remained with the presence of intense emotion and encouraged working through in mourning.

In therapies that were sought following a diagnosis, therapists noted that trust had to be established quickly and they were aware of the importance of addressing initial feelings of anxiety before the client could engage in sharing emotion deeply (Hildebrand, 1992; Norton, 1963; Roose, 1969). To address this issue, Hildebrand (1992) ventured to the client that he "might be afraid of trusting me with his feelings" (p. 461). Following this comment, and an interpretation, the client began to cry for the first time. In the initial sessions with Norton (1963) the client expressed her anxiety over the therapist becoming defeated about her dying. Norton was able to assure the client that she could help her with her feelings about dying by showing her readiness to listen openly and remain with the client, rather than withdrawing out of discomfort.

Hildebrand (1992) noted the importance of a containing function in relation to the feelings of loss and frustration that imminent death arouses. "We can contain their anger and allow it to be a trigger for the developmental, cognitive world of thinking and ultimately acceptance of one's fate" (p. 459). In summing up how the treatment had helped his client, Hildebrand stated: "the attempt to help the client understand the tremendous aggressive rage in himself … had helped minimize the anxiety and paranoid fears which perhaps otherwise might have taken him over" (p. 466). Minerbo (1998) also wrote about the importance of a containing capacity to facilitate the expression of feelings and emotions: "The fact that I was able to contain and interpret the horror of her dying made it easier for her to speak of her coming death and voice her fear of death" (p. 91). Other therapists also noted the importance of assisting clients to voice and express their feelings and the benefits to the client as a result. "Increasingly, she expressed her feelings rather than holding them back … she began to have

a sense of resolution and acceptance" (Knoblauch, 1997, p. 510). Carvalho (2008) writes "She was able to complain much more vigorously, rather than 'whinge' self-deprecatingly, and she was able to be much more directly angry about her situation" (p. 11). Schaverien (1999) explained how increasing awareness and expression of his feelings of rage and envy helped the client: "Gradually as he expressed these feelings, they began to be less fearsome and overwhelming … they dominated less and were gradually assimilated" (p. 17).

Rodin and Zimmermann (2008) likewise highlight the importance of the capacity to process authentically the feelings of grief, sadness and regret in a relational context. Minerbo (1998) reports that the client expressed that "she knew from experience that she could count on me to bear with her the worst fears and anxieties" (p. 84). Further examples of the way therapists assisted clients to process painful feelings are demonstrated in the moments when client and therapist were able to remain with the presence of pain and sorrow together. Schaverien (1999) recalls a poignant session where she had been in touch with her client. "He had permitted himself to stay with the meeting in the moment … [he] stayed with his grief … thus something positive emerged from this intuitive and genuine response to the immense sadness of the situation" (p. 20). In tolerating the vulnerability of staying with his grief while with the therapist, this client was released from a cycle of anger and depression.

Clients were vulnerable to intense feelings of helplessness and despair declining into a more pervasive state of depression. The stated goal of some therapists to maintain the process of mourning affirmed an explicit attempt to avoid deepening depression. Carvalho (2008) was alert to the tendency of his client to convert "the work of mourning into depression by splitting her mind and body into an antagonistic relationship" (p. 6). Each session of their work together "represented a struggle … to maintain the work of her mourning against the temptation of her melancholia" (p. 8). Carvalho asserts that "Maintaining her process of mourning permitted my patient a much improved quality of life,

a greater sense of connection with herself and an accompanying diminution of loneliness, together with greater creativity" (p. 6).

Likewise Norton (1963) identified the client's depression as a symptom requiring assistance through facilitating the process of mourning. The creative act of composing poetry and reading her poetry to the therapist allowed the client to begin to share with the therapist her grief over dying. Through the process of grieving the client expressed her anger over the unfairness of her early death and her intense feelings about the impending loss of those she loved. Norton summarised: "All of this seemed very much like working through in mourning [and] was accompanied by appropriate crying" (p. 549). The work of mourning for Schaverien's (1999) client was reflected by his growing capacity to experience the depth of his grief, which enabled him to relate more deeply with his family: "Once the grief was released he was able to risk the emotional impact of talking to his family" (p. 21). The client was then able to discuss with his father his wishes for burial and talk about his imminent death with his children.

Experiencing the deep loss of physical health and future life sometimes led to feelings of intense envy and jealousy of the therapist, expressed by several clients (Adams-Silvan, 1994; Norton, 1963; Schaverien, 1999). When Norton's (1963) client experienced jealousy of her therapist she became very angry; however, Norton communicated her acceptance of these feelings and interpreted to the client an Oedipal transference, which assisted the client to "externalize her punitive superego and gave her an ego ideal she could live up to" (p. 552). Adams-Silvan (1994) noted "When she expressed anger at and envy of me, I was able to accept and sympathize with the feelings and acknowledge their realistic basis" (p. 345).

Client's inner world. The inner world of the client refers to elements such as defences, unconscious and conscious processes, self-reflection and attunement to inner life,

self-esteem, identity, dreams, and spirituality. Attention to these elements of the client's inner world, particularly defences, led to protection from, and increased capacity to tolerate, vulnerability and "intolerable reality".

Defences played a large part in the dynamic of this sub-theme and were mentioned in every case. Although defences begin as healthy creative adaptations to life, they are used to unconsciously avoid or manage some powerful threatening feeling such as anxiety or overwhelming grief, and to maintain self-esteem (McWilliams, 1994). References to defences often centred on denial and regression - defences that naturally intensify when confronting vulnerability to illness and mortality. Idealisation and identification were included as functioning usefully in some clients and the use of other defences such as displacement, projection, repression, splitting, compartmentalisation, and internalisation was discussed. Therapists wrote about their caution when dealing with defences in work with the dying, expressed in the words of Adams-Silvan (1994): "I felt that to analyse her defences at this time was contraindicated" (p. 343), and "what I had to do was not interfere with her adaptive processes" (p. 345). However therapists used their understanding of clients' defences to assist the client by choosing to either encourage or analyse defences, depending on how they construed and were informed by the character style of the client and current theory. Bustamante (2001) states: "By listening to and respecting the patient's defences, we can … establish various therapeutic approaches" (p. 50).

Roose (1969) wrote comprehensively on his client's use of denial, perhaps in part because (in contrast with the other clients in the study) this client mostly did not retain conscious acceptance of his diagnosis, regardless of the fact that he was a doctor and had seen his own X-rays. Roose describes the client's denial as fluctuating but records that "[r]apid repair of his denial followed upon my initial acknowledgement and confirmation of the fact of imminent death" (p. 392). In the context of death and dying, Roose construed his

client's denial not as pathological, but as an adaptive response "in the service of the need to survive" (p. 391) to defend against "intolerable reality" (p. 392) and in order to facilitate regression to a state of reunion. Roose advises that for the client who uses denial effectively "we would not rush in to tear down this defence" (p. 392), but rather Roose "offered the patient a more promising way out of his dilemma through the facilitation of more primitive defence mechanisms in pursuit of the good mother through regression to the fantasy of reunion" (p. 394). Roose maintained that by not confronting denial and by encouraging the development of regression, the client was assisted by progressing to a state where there was "comparative peace and calm in the face of death" (p. 394).

By contrast, other therapists observed that denial was not used strongly by the client. Mayer (1994) remarked on her client's "impressive determination to challenge her wishes to deny her illness … and her impending death" (p. 16). Similarly, Norton (1963) notes that her client occasionally used denial, but "denial was almost always in the form of giving herself an extra year, not of being cured" (pp. 549 - 550). Schaverien (1999) queried whether the client's use of her (a strong erotic transference) was "a way of denying death, an eroticization" (p. 20). However, she concluded that he was not denying death but rather experiencing, through the transference, "a new-found freedom within himself" (p. 20).

Regression also featured as a common defence, unsurprisingly, as the stress of serious illness itself will cause a regressive reaction (McWilliams, 1994). Schaverien (1999) elucidates this point: "the manifest psychological regression of the physically ill person reflects a real change in the psychic structure that has rearranged the alignments in the mind" (p. 338). Norton (1963) describes how the client began to perceive her regression, which increased her vulnerability through shame and fear of rejection from the therapist. Norton explained that it was an expected part of the illness, after which the client "became less ashamed" (p. 550). Adams-Silvan (1994) was aware of the underlying presence of shame:

"the most obvious reason for shame: illness is badness" (p. 338). Furthermore, the therapist was concerned that if the narcissistic shield of the client was broached (through inexorable physical decline and dependence) she would die "with great shame and unhappiness" and "the emotional agony would have been indescribable" (p. 345). By upholding her defences and supporting her choice for suicide, Adams-Silvan helped the client "maintain her pride and confidence" (p. 345).

Therapists in addition to Roose (1969) wrote about regression and merger and explained how its use assisted clients as an effective defence against psychic pain (Adams-Silvan, 1994; Norton, 1963; Schaverien 1999). In contrast to the view where regression in dying is understood as useful to facilitate a protective state of merger (Adams-Silvan, 1994; Norton, 1963; Roose, 1969), Hildebrand (1992) viewed regression in the client differently: "he wanted to be allowed to regress to a true dependence … for the facilitating experience of having an analyst mother who can hold and create the illusion of … omnipotence" to facilitate building "his own identity anew" (p. 459). Hildebrand suggests that regression can be helpful to the client by addressing "the developmental task which his mother had failed to help him achieve" (p. 459). In relation to this ideal Hildebrand concluded that in the transference the therapist had been "perhaps a better and more thoughtful and facilitating mother than his real mother had been" (p. 466). Hildebrand reflected ultimately that in some ways the work he did was no more than supportive, but concluded that "by co-operating in his wish to struggle with his inner world it seemed to me that I was able to help him organize a better death for himself" (p. 466).

Idealisation of the therapist was significant in some therapies. Knoblauch (1997) regarded his client's pre-existing idealisation "as an important factor that contributed to the rapid unfolding of transference material" (p. 53) which facilitated the resolution of destructive past patterns of relating. Schaverien (1999) observed that when "idealisation had

broken down" repressed material emerged that allowed her to "interpret the pre-oedipal aspect of his feelings" which he was now able to recognise as being "merely one aspect of his inner world" (p. 17) reflecting significant improvement from when he had previously been "confused and frightened by the intensity of his feelings" and "violent fantasies" (p. 16).

Identification with the therapist was described by Norton (1963) and Roose (1969) as significant in strengthening self-esteem and re-establishing the client's ego ideal. Roose notes that "[t]he patient found some satisfaction in the conscious awareness of his regained self-esteem, even though it was largely obtained through borrowed strength, i.e. through identification with the therapist" (p. 391).

References to the inner world of the client established how vulnerability lessened as the client became more aware and more attuned to their internal world. Carvalho (2008) reports that when his client came to recognise how she nourished herself on a compulsive acerbic denigration of herself and others, that "with this understanding her internal world became much less punitive and judgemental" (p. 8).

Some clients were helped by a sense of re-connection with their spirituality in the therapy (Knoblauch, 1997; Schaverien, 1999). Schaverien describes how the client found "a renewed spiritual belief" (p. 24) and that "his body was at rest in a house – the spiritual parallel of this was that his soul too was housed" (p. 3).

Powerful Connection

Powerful connection, the second major theme, was evident in the sub-themes *therapist/therapeutic process* and *relationship.* Clients were held in the therapeutic process through the development of a strong alliance, which allowed the therapist to assist them in a number of significant ways.

Therapist/Therapeutic process. Therapists in every case wrote about how therapeutic technique, alterations to the frame and technique, interpretations, and countertransference were effective in assisting the client. They also questioned and critiqued themselves in their attempts to be as effective as possible, acknowledged when they were learning, and reflected on the efficacy of psychoanalytic theory in the light of their own clinical experience.

Minerbo (1998) comments on the marked difference in analysis before the onset of disease compared with after diagnosis "when no former relationship of trust has been established" (p. 90). Therapists whose clients were already engaged in therapy prior to the client's diagnosis were able to maintain an analytic stance in spite of alterations to the frequency of therapy and sessions held at home, or hospital or by phone (Carvalho, 2008; Daehnert, 2008; Mayer, 1994; Minerbo, 1998; Schaverien, 1999). After hearing of her client's diagnosis, Minerbo (1998) states: "I realized that it was perhaps then that she most needed analysis" (p. 84). Schaverien (1999) found that, despite the adaptations which had to be made to accommodate the physical deterioration of the client, and her self-questioning about holding to the analytic frame when confronting humanity in the face of death, what was effective for the client was possible as a result of maintaining analysis and the analytic frame. Schaverien states: "I consider this was analysis because the patient himself worked to maintain the boundaries and to ensure that the individuation process continued, at depth, up to the point of his death" (p. 4). Furthermore, analysis assisted in an essential way concerning the client's repetitive relational pattern of getting close then rejecting people. Schaverien writes: "I was really the only person who was constant and who could mediate his anxiety and this was because, despite impulses to do otherwise, I held to the analytic frame" (p. 16). However, holding to the frame did not preclude adaptation in the therapeutic process, as Schaverien observed after a session conducted in hospital: "The analytic process changed

and adapted to the reality of his life; the inner and the outer world were coming closer together" (p. 23).

Mayer (1994) was also very explicit about whether analysis as opposed to supportive work was what the client needed to help her during the two years she was dying. Mayer believed that while the client:

> certainly felt touched, supported and cared about as she experienced my compassion, neither she nor I considered that aspect of our relationship to be the only, *or in fact the primary means* by which I was helping her. Undoubtedly, it *did* help her, but it also was what enabled me to give her another kind of help, … which in the end defined our work as psychoanalytic. (p. 16)

Mayer maintains that the analyst's capacity to make good interpretations is increased by "a profoundly compassionate, empathic involvement" (p. 15) with the client, because with that capacity comes the confidence to "make interpretations that are both ruthless and inspirational" (p. 15). Mayer felt that her empathy and compassion for the client focused her, and she therefore relied on her countertransference to continue analysis with a certain ruthlessness. While not without questioning her responses as "human", Mayer felt she knew what she was doing to an unusual degree, with enhanced clarity. Mayer asserted that her client used analysis to help her live more fully and achieve a closure on her life "that involved facing herself and her conflicts as honestly and completely as she could" (p. 11).

Therapists' use and understanding of the value of interpretations in work with dying clients was generally formulated in line with whether the overall therapeutic stance was oriented analytically or more towards supportive work and whether therapy began before or after the onset of illness. Carvalho (2008), who had a therapeutic history with his client, made frequent interpretations and described his interpretive stance as directed "almost exclusively in terms of the relationship between the patient's mind and her body" (p. 5). The client was assisted to a point where "serenity became possible" (p. 6) through the restoration of her mind and her body to a more unified self. Numerous illustrations were given of

interpretations aimed towards resolution of the client's conflict between her "disparaged" body and her "ingenious" mind (p. 13). For example: "*I said that while she hated her body for hurting her and impeding her, her body was also herself suffering"* (p. 14). Carvalho observed: "she had moved from a hateful rejection of her body … to some acceptance of it" (p. 12). He concluded that at such moments it had been possible to restore his client to "terms" and this had assisted her to a state where "she felt less isolated and lonely and more at peace" (p. 15).

Minerbo (1998) interpreted the omnipotent aspect of the client in relation to motherhood which helped the client surrender the care of her children more confidently to their father. Minerbo also interpreted the client's reluctance to show "need" to her daughter, resulting in the client risking and achieving reconnection and relational repair with her daughter. Minerbo described how she found the edge of what was therapeutically possible in the use of interpretation after she became sure that the client's request for the therapist to see her grief-stricken daughter after her death was disguising an unconscious fantasy that the client herself could stay with the therapist after death. Minerbo wrote about her process:

> I thought because of the respect I had for her, and the trust she had deposited in me, I should risk this interpretation … she responded with '(d)o you have to be an analyst to the end?' … but I felt that no matter how hard the interpretation was to bear, she was agreeing with it. (p. 89)

Daehnert (2008) continued the last months of analysis with her client of seven years by phone, making use of interpretation even in the last session, (made possible by the client's husband translating). As the client sang a lullaby and made a rocking gesture with her arms Daehnert, now tearful, interpreted: "We're rocking you to your final sleep" (p. 209). Daehnert acknowledged her countertransference: "I felt uneasy … aware that I was hiding behind an interpretation" (p. 209). When the client continued the gestures, indicating towards the therapist, Daehnert finally "collapsed internally" as she surrendered to the image of

herself as the infant being soothed until the mother's dying moment, then she made a final interpretation: "You're rocking and singing a lullaby to the baby who is losing her mother" (p. 210). Client and therapist continued rocking for a few moments, then the client smiled and said goodbye. She died a few hours later. The fulfilment the client gained through the therapist's use of countertransference and interpretations had also previously been acknowledged when she stated in response to the therapist's tearful silence: "This is the greatest gift I've ever been given … I wait for you to use what is happening inside of you to create something I know you are going to give back to me" (p. 209).

Contrary to the five analyses discussed above (with an already established therapeutic history), the other seven cases, without such history were treated more conservatively in relation to analysis and interpretations. However, the few interpretations that were ventured helped clients at pivotal moments. Bustamante (2001) made a crucial interpretation to the client about concealed displaced rage, which allowed her to begin the process of individuation by "beginning to try to see the world with her own eyes" (p. 530). Norton (1963) made a single transference interpretation, which assisted the client thus: "She seemed relieved by this, smiled and said she had changed her mind about firing me" (p. 552). Hildebrand (1992) felt that he had made real contact with the client for the first time, as well as initiating the insight of the client, when he interpreted the client's rage by suggesting that: "perhaps the murderous feelings were because he had nowhere else except for the delusion to put his rage" (p. 461). The client was shaken by the interpretation, cried, agreed, and replied that he was "surrounded by people who seemed caring and thoughtful so that there was no way of expressing the affect of rage which he recognized as belonging to himself" (p. 461).

By contrast, Roose (1969) referred to the importance of not interpreting in order to achieve the goal of merger with the archaic mother (in the form of the therapist). Roose stated: "Nothing is interpreted. That would impede rather than further this process" (p. 394).

In their efforts to assist the client, some therapists acknowledged that they were learning. Adams-Silvan (1994) reflected: "Only my patient could guide me. Like all who strike out in relatively uncharted territory, I knew that she *would* instruct me if I would only listen" (p. 339). Daehnert's (2008) client correctly intuited that death was new for the therapist. The client asserted: "Stay with me, and I will be able to teach you how to help someone die" (p. 201).

Relationship. A powerful connection between client and therapist was evident in most therapeutic dyads, and this relationship and was fundamental in assisting clients in several major ways: provision of an unwavering, committed presence; lessening of symptoms and the sense of isolation and aloneness in dying; a strong sense of being known and understood; the promotion of insight, growth and protection through the transference; and relational repair and increased connection in clients' close relationships with others.

The assistance provided by therapists' committed presence and reliability within the relationship was highlighted most compellingly in Daehnert's (2008) account. The therapist's presence was experienced as a reason for living, expressed in the client's words: "I just have to feel you with me. That's what I live for right now" (p. 202). Daehnert also writes: "We expanded the boundaries of our relationship to create a rhythm of being together that carried her into death" (p. 199). Minerbo's (1998) client said she would need the therapist now more than ever and asked the therapist to "stay by her until the end" (p. 86).

Schaverien (1999) recognised the powerful connection she described in the relationship as being partly attributable to the client's "need to compensate for unlived aspects" of his life (p. 5). The strength of the relationship was conveyed in the words of both therapist and client. The client announced: "This is the most intimate relationship of my life" (as cited in Schaverien, 1999, p. 11). Schaverien describes her "positive countertransference"

as “love” (p. 14). The strength of the relationship and the therapist’s committed presence helped the client return to therapy when it “became almost unbearable for [the client] to stay in therapy” (p. 13).

In the cases with a therapeutic history, powerful connection was already established. In most of the other cases, a strong therapeutic alliance generally developed quickly. Norton (1963) states that the client “very quickly became intensely involved with me” (p. 548). Norton describes the lessening of symptoms, which occurred once the relationship was established and the client could share her problems: “Discussion of these problems gradually led to a diminution of her depression, complete absence of any talk of suicide, impressive absence of anxiety and an increased sense of well-being and hope” (p. 548). Similarly, Knoblauch (1997) noted relief in the client’s symptoms stating that “[t]ransformations of [the client’s] self-experience were mediated such that she felt relief from her symptoms” (p. 46).

In other cases without a prior history where both client and therapist were male, the strong relationship was less evident but still apparent. Roose (1969) states “I began our relationship by telling him the truth about his dying. He could now trust me with his life … my answer meant to him that he will be with me forever” (p. 393). Roose also made reference to lessening of symptoms in the context of the certainty of the relationship. Although the client’s depression and agitation did not disappear: “They were alleviated” (p. 390).

Growth through the transference was noted by Schaverien (1999) when she commented that her client was “coming to life in a new way within the transference … it was this new-found freedom, within himself, which enabled him to relate” (p. 20). Daehnert (2008) believed that the client’s transference to her required her to surrender to

the "the role of the daughter and the child who was losing her mother" (p. 214). Though initially uncomfortable with the position of "receiving" something from her client, Daehnert realised that the client "became stronger and more alive with each of my acts of surrender" (p. 213). In the client's transference to the therapist as the client's "infant", the benefit for the client was that "rather than being depleted or used up by someone's use of her, she was becoming enlivened and transformed" (p. 214). Knoblauch (1997) described how the client was "able to access her conflict with authority in the transference" (p. 54). Instead of experiencing the "failure in responsiveness of father", through the transference the therapist's "understanding and responsiveness" permitted the client to re-experience "the presence and protection of God" and allowed her to work with the therapist "in the transformation of a central life problem" (p. 54). Mayer (1994) revealed the client's growth through the transference by explaining how the client's transference prior to diagnosis had been "an 'unobjectionable' positive transference" (p. 8), but now with limited time, the client began to understand the gratifications of the victim role through the transference. The client realised: "As long as she complained (about him, about me, about life), she could silently but subtly maintain the idea that she just hadn't gotten what she wanted *yet*, rather than confront the fact she never would" (p. 9).

In his consideration of the transference, Roose (1969) was: "impressed with its enormous power" (p.393). However, it was used not for the growth of the client but, rather to assist in protecting the client from psychological pain. Roose states: "to die alone, posed an impossible dilemma … the manipulation of the transference offered the patient a more promising way out of his dilemma … through regression to the fantasy of reunion" (p. 394).

Powerful connection sometimes assisted clients by enabling a sense of being deeply understood and accepted. Knoblauch (1997) noted that: "What appeared to be facilitative

was the acceptance and understanding of the unique meaning of her experience by her therapist" (p. 47). Daehnert (2008) quoted the client's words to her: "I need to feel connected to myself and somebody who knows me and loves me" (p. 202). Schaverien (1999) described the client's response to her understanding: "This is what I have been looking for all my life but I did not know what it was" (as cited in Schaverien, 1999, p. 9). Schaverien believed that the effect of her acceptance and genuine affection for the client "helped; it communicated itself to him and enabled him to internalize an image of himself as lovable" (p. 20).

Through the therapy relationship, clients experienced increased connection with others and repair in relationships outside therapy. Knoblauch (1997) notes:

> As treatment continued, [the client] further elaborated her encounters with others … not in dangerous terms in which the other would be unresponsive … but as safe and sanctified … Ironically, she could experience connection to others more in her dying than at any other time in her life. (p. 52)

Minerbo (1998) described the difference for the client in her relationship with her father and brother: "She was finally able to accept needing and being dependent on them without humiliation" (p.89). Minerbo was "very moved by the obvious reparation she was making to her loved ones" as the client was able to forgive her husband for a past infidelity, saying that "she now understood the real meaning of love" (p. 89). Rodin and Zimmermann (2008) note that a "gradual process of transformation eventually emerged in which [the client] came to believe that he could retain a sense of personal autonomy within a relational connection. He began to feel closer to his parents and to be able to mourn their limitations" (p. 192).

The therapy relationship sometimes helped clients' autonomy in claiming the right to die or stop treatment and be able to communicate such readiness within close relationships. After speaking of how she was doing the treatment for her family, and of the intimacy she experienced with the therapist, Daehnert's (2008) client said "I'm tired and I feel ready to

quit. It's my first step in claiming my right to die. My family will just have to adjust … it feels really good to have you say I've done enough" (as cited in Daehnert, pp. 206 - 207). Bustamante (2001) noted that the client had matured through the therapy and he was "astonished by her calm in this phase of the process of dying. She asked to speak with the people most important to her, who still denied that she was dying. She was firm in bidding them goodbye" (p. 54).

Resilience

Resilience, the third overarching theme, is identified as the central concept embodied in the three sub-themes: *assistance, aliveness and transformation*. Therapists assisted in the activation and support of resilience in their dying clients. A sense of psychological vitality, the capacity to make meaning out of living, and the motivation to stay emotionally alive while experiencing irreversible, painful physical decline was possible at times for most clients.

Assistance. Given that all the preceding sub-themes have been discussed in terms of how the client was assisted, a separate sub-theme entitled assistance may seem somewhat puzzling. The 1st order theme assistance was identified at the level of the codes where therapists wrote specifically about moments in therapy and used words such as "comfort", "relief" and "help" to describe what occurred in these moments. Therapists also mentioned what was of assistance to them in helping the client. Therefore what is conveyed by the sub-theme *assistance* consists of the elements therapists noted that manifestly contributed to an improvement through comfort or relief as therapy progressed, as distinct from the overarching themes on assistance identified through the thematic analysis of the data set.

In the last few weeks of her life, Norton (1963) describes how the client spoke of "an all-pervasive sense of peace and contentment … she felt as if I was always there comforting

her" (1963, p. 554). Daehnert's (2008) client spoke of the comfort she had in the therapist's voice and relief in the closeness of the relationship: "I liked what you said about how close we are … I felt so good, so relieved" (as cited in Daehnert, 2008, p. 206). The client perceived the therapist's emotional involvement as a gift which helped profoundly: "Your being affected is allowing me to die. Knowing you're affected is the greatest gift I've ever been given. Analysis is a preparation for death" (as cited in Daehnert, 2008, p. 203).

Adams-Silvan (1994) conveyed how she was able to help the client gain the stamina to tolerate distressing medical procedures by stimulating the client's use of fantasy to explore "her sense of not being able to live now even though she was alive … later she reported that the chemotherapy treatment had indeed been not as bad as usual" (p. 337). Carvalho (2008) explained how working through with the client's issues resulted in a shift to being able to find herself "with the companionship of pleasant memories from her childhood", and the painful ones "had lost their compulsive and bitter qualities" (p. 14).

During sessions in the home, Norton (1963) helped the client in practical ways such as making the bed comfortable and staying while the client fell asleep, which provided the function of "an external ego in much the same sense that the mother's ego functions as an external ego for the developing child" (p. 551). Norton read Psalms to the client and concluded that "my physical presence and my tone of voice were almost more important than the verbal content of what I said" (p. 553). Further to his stated goal "to help relieve pain and suffering" (Roose, 1969, p. 390), Roose also provided practical help by assuring the client that in the absence of someone to "bury him decently … I would see to it that he would have a proper decent religious burial" (p. 388).

Therapists noted ways in which their own resilience was supported. Daehnert (2008) named a poem that was "important to me as I attempted to remain grounded and emotionally

present to my patient while she was dying. It was also a poem I read to her often when she was too ill to speak" (p. 200). Schaverien (1999) believed that "the positive countertransference - the love I felt for him - came to serve an additional purpose once his terminal illness was diagnosed. It enabled me to accompany him in a way that might otherwise have proved difficult" (p. 14).

Aliveness. The resilience of the client was enhanced by the capacity to experience psychological vitality while dying. Clients were helped by the nurturing of "aliveness" because it allowed them to live fully in the present, continue to make meaning out of living, maintain the will to live, give a sense of some control and hope, support creativity and contribute to positive feelings.

Therapists noted the importance of appealing to the client's capacity for aliveness, and the wish to live, as aptly expressed by Roose (1969): "I stated that I knew nothing about death. All I could do was help him live" (p. 386). Minerbo (1998) wrote "I was on the side of life, and it was this aspect of her personality that I would address whenever possible" (p. 84). In Hildebrand's (1992) discussion with colleagues "it had been agreed that I would try and direct my interpretations to what we called the life instinct and its manifestations in him" (p. 463).

Mayer (1994) describes how the client was wholly engaged in the therapy so that "she felt powerfully motivated to use analysis to help her live more fully in the present, not in some specified time in the future" (p. 11). Daehnert (2008) felt the client's strong resolve to be fully alive when she died. The client asserted: "It is your job to help me stay emotionally alive until the day I die" (as cited in Daehnert, 2008, p. 201). The client became aware that she was giving to the therapist without feeling taken from, and she became "enlivened by the mutuality in giving" (p. 203). She could see life as a process without focusing on the

outcome: “Now I create moments and live intensely in moments. I’m living through my death” (p. 204). Moreover, “[s]he had discovered pleasure in mutuality, and it was this that allowed her to say, “I found the meaning of life before I died.” Life had become worth living” (pp. 214 - 215).

Adams-Silvan (1994) described how the exploration of the deeper meaning of the client’s experiences “seemed to revive - in the literal sense of the word - her will to live” (p. 335). In contrast with his depressed and suicidal state entering therapy, Schaverien (1999) describes the client’s hopefulness a year after his diagnosis, which she attributed to his growing sense of himself: “he was pleased to be alive and optimistic about the future” (p. 19). A week before he died, Schaverien felt that the client was not afraid to die and knew he had little time left. The client described himself as feeling “more alive now than he had ever been” (p. 24).

Transformation. The possibility of the client’s continued psychic growth and individuation while dying was held and discussed by therapists, with the exception of Norton (1963) and Roose (1969), and constituted a significant focus in the goals of treatment. Clients experienced transformation and psychic growth through self-integration, increased capacity, strength and expansion of self, acceptance, and individuation.

Daehnert (2008) describes how the client was making use of the therapist for self-integration and that the strengthening of her sense of self was “contingent on our connection. [The client] had begun to see her death as an opportunity for transformation, and she was becoming relentless in her pursuit of an intense, total connection with me” (p. 203). Daehnert states, “she became more emphatic about making use of me for her own growth purposes” (p. 211), and “her awareness that I was receiving something by being with her and that I was being impacted by her was what was transformational for her” (p. 213).

Clients were helped by gaining an increased capacity in some areas. Adams-Silvan (1994) wrote of the client's increased tolerance of her experience of medical practitioners as detached and unsympathetic, which in turn increased her capacity to tolerate medical procedures. Schaverien (1999) emphasised the client's increased capacity for relatedness.

Acceptance of death was felt by some clients. Daehnert (2008) noted that the client's "acceptance of the reality of her impending death" (p. 212) was possible through her longing to surrender and become fully recognised. When his young client was close to death, Bustamante (2001) was "astonished by her calm in this phase of the process of dying" (p. 54). Sensing the therapist's anxiety, the client "softly and with a gentle look said she was not afraid of dying" (p. 54). Writing about the night before the client died, Knoblauch (1997) reports that the client "had made her preparations and accepted the transition with a sense of readiness" (p. 53).

The client's process of individuation was highlighted in several cases. Commenting on the drive to truly live as death comes closer, Schaverien (1999) proposes that in work with the dying "the individuation process becomes urgent and seems to speed up" (p. 4). Schaverien referred to the client's individuation when his attitude "seemed to symbolize the beginning of a sense of himself as a separate and viable person with something he could give" (p. 19). She maintains that "the individuation process continued, at depth, up to the point of his death" (p. 4). Bustamante (2001) describes the key events in the client's individuation where she moved from dependence and submission to her family's demands, "toward a more definite sense of self-affirmation" (p. 54). Knoblauch (1997) highlights the importance of having a tie with the therapist that facilitates a selfobject experience which provides a sense of cohesion and continuity. Knoblauch refers to the transformation of the client's struggle with self-worth to a point in the therapy where "her descriptions of self-

experience began to shift from this sense of inadequacy toward an increasingly more positive self-concept and sense of hope" (p. 52).

Summary

The three major themes of vulnerability, powerful connection, and resilience have been introduced and illustrated with a model incorporating the sub-themes and showing the interrelationships between themes. A narrative has been presented, which describes and expands on the evidence for vulnerability, powerful connection, and resilience as the overarching themes in the psychoanalytic literature on assisting clients with a terminal diagnosis.

Chapter Six: Discussion

The aim of this research was to identify the themes in the psychoanalytic literature on assisting people with a terminal diagnosis. Thematic analysis was used to identify, analyse and report the themes within the data (Braun & Clarke, 2006). Vulnerability, powerful connection, and resilience were identified as the overarching themes which were described and analysed using a detailed narrative. This chapter examines the findings in relation to the wider literature on psychoanalytic psychotherapy with terminally ill clients, and addresses the implications of the research, methodological considerations, and suggestions for further research. Strengths and limitations of the study are considered.

Research Findings in Relation to the Wider Literature

It has been noted previously (Chapter One) that accounts of psychoanalytic work with dying clients are rare. Kogan (2010) notes that "we still have the tendency to shun this morbid topic"; however, "there has been a recent groundswell of scientific interest by psychoanalysts in the psychology of death and dying" (p. 83). More publications have appeared recently on the impact of death, such as those by Straker (2013) and Akhtar (2010), and the increasing literature on psychoanalysis with dying people allows an opportunity for examining the research findings in relation to the wider literature.

Vulnerability was found to be a fundamental feature of work with dying clients in the cases studied. The vulnerability of clients is also acknowledged in the wider literature by therapists working with terminally ill people. Rodin and Gillies (2000) report that the diagnosis of cancer frequently evokes anxiety, grief, and fears of physical suffering, fears of dying, and of dependency and vulnerability. Additionally, when a person is confronted with "a prognosis of fatality, a new order of magnitude is added to her vulnerability. The usual phenomena of vulnerability that accompany any illness are exaggerated" (Chochinov &

Breitbart, 2000, p. 340). Tasman (1982) outlines how fears of the unknown, of loneliness, loss of body function, loss of self-control, and loss of identity impact on the functioning of a cohesive self and asserts that "although vulnerability of the cohesive self varies individually, these stresses are present in all dying patients" (p. 515). In his suggestions on therapy using a psychoanalytic approach with cancer patients facing death, Straker (2013) recognises the vulnerability of patients, stating that they "may grieve about the loss of their health, their future, their important relationships, the places they will miss or never see again, life goals that remain unfinished" (p. 74). Straker writes of the intense emotions clients experience and the therapeutic importance to clients of the emotional relief in expressing intense grief, especially when significant others may be unavailable as they themselves are grieving, or as noted in this research, those close to the dying person may also be emotionally unavailable because they are denying to some degree the reality that their loved one is approaching death.

While some therapeutic dyads appeared more deeply connected than others, powerful connection was identified in all the cases studied and was also evident in the wider literature (Buechler, 2000; Mishne, 1998; Rubel 2004; Ulanov, 1994, as cited in Schaverien, 1999; Wheelwright, 1981). In his case material about treatment with the dying Herzog (2007) highlights the importance of a powerful empathic connection in the dyad. He asserts that the ability of the therapist to share the affective experience of terminally ill clients is essential and "it can be the principal element in converting a tragic and lonely process of dying into one that is considerably more comforting and humane" (p. 255). Rubel (2004) writes about the therapeutic relationship: "To be effective, it requires an immense mutual investment. As human beings, the empathic connections we make in the course of our work must be real if they are to be effective" (p. 2). Conceivably there may be cases where powerful connection does not feature as a key element, however no cases were found. A possible explanation might be found in the fact that therapy with people who are dying evokes powerful

countertransference responses (Adams-Silvan, 1994; Daehnert, 2008; Redding, 2005; Schaverien, 1999) therefore therapists may be partially motivated to write as a kind of catharsis as well as a symbolic representation of exceptionally meaningful experience.

Resilience is characterised in contemporary research by the "capacity for generative experiences and positive emotions" in response to aversive events (Bonanno, 2004, p. 21). The concept of resilience per se is not commonly discussed in the context of dying, however as a theme which encompasses the capacity for positive emotion, transformation, and a sense of aliveness in therapy with the terminally ill, the theme of resilience was found to be supported in the wider literature. Reference to resilience can be found in Hoffman's (1979) research about psychoanalytic conceptions of adaptation in the anticipation of loss of the self. Hoffman describes the response to loss and confrontation with mortality of some individuals as "an enhanced sense of resiliency and capacity to endure suffering" (p. 260). In her case presentation with a dying client, Redding (2005) describes resilience as "living with a sense of purpose: clarifying values and priorities, and learning to live in the present, sometimes moment by moment" (p. 70).

Research and clinical observations indicate that people vary considerably in how they cope with the knowledge of impending death that a diagnosis of terminal illness carries (Maxfield, Pyszczynski, & Solomon, 2013). While vulnerability may be a fundamental feature in all work with dying clients, the extent of susceptibility to painful states may vary. As Akhtar (2009) eloquently expresses "The despair of dying without having joyously lived is far more than expecting death after having lived well" (p. 108). The vulnerability of dying clients who are painfully aware of unlived aspects of their lives or who are facing death at a young age is especially intense and may lead to despair and terror in facing death. In the cases studied, therapists described the poignancy of some unfulfilled part or parts of the client's life and the additional sense of tragedy this imposed in facing death. Furthermore,

powerful connection was described as an element that was increased due to this dynamic. For example, Schaverien (1999) noted that some clients facing death need to compensate for the unlived aspects of their lives and draw the analyst into "an intense and almost irresistible process" (p. 5). Of the 12 cases studied, seven clients sought therapy because they were suicidal, depressed, or not coping with life following the onset of a terminal illness. It is possible that the torment of feelings relating to unfulfillment, that life has been unlived or wasted, and the severity of some clients' symptoms, may have contributed to the prominence of the themes of vulnerability and powerful connection as findings in this study.

In a recent edited publication on psychoanalytic conceptions of death and mortality, Garfield (2010) considers the question of analysis and assistance facing death. She observes that in the daily work of psychotherapy we most often deal with questions of life "so I find the question – can analysis or psychotherapy really help one deal with their impending death or mortality – compelling and part of my angst and struggle about my work" (p. 125). Garfield suggests that in work with the terminally ill the important questions pertain to how to help clients deal with mortality issues *and* simultaneously live a rich full life in the time that is left. There is a dialectic revealed in Garfield's objective that is reflected in much of the discussion about dealing with death and dying. The tension inherent in several continua has stimulated polarised debate in the literature; for example, denial versus acceptance, regression and merger versus individuation, the practice of conventional analysis versus adapted/ supportive analysis. Akhtar (2010) points out that dialectics are ubiquitous in the human psyche and that because each pole serves different functions, there are benefits in both, and in writing about death he illustrates "denial making it easier to go on living, acceptance making the experience of life richer and more textured" (p. 17). In a similar vein Hoffman (1979) writes, "The dread or anxiety associated with the anticipation of the loss of the self and the exhilaration associated with the sense of ownership of one's life are

inseparable aspects of the same experience" (p. 256). The themes of vulnerability and resilience also reflect dialectical tension. It is the development of powerful connection that contributes to the capacity for resilience through a sense of aliveness and purpose in life, while simultaneously acknowledging and bearing with the experience of the ongoing struggle inherent in painful states of vulnerability.

Implications of the Research

The results of the research contribute to the knowledge of therapy with clients who are terminally ill. In the publications studied, as well as in the wider literature, therapists made frequent mention of the lack of comprehensive guidance for analysis with dying clients and the reluctance of therapists to work within this area (Adams-Silvan, 1994; Daehnert, 2008; Norton, 1963). The threads of conversation and debate between practitioners can be followed through the years, as subsequent writers reflect on their clinical experience in the light of previous case studies, and attempt to contribute usefully to therapeutic knowledge about work with dying clients. As recently as five years ago, Rodin and Zimmermann (2008) claimed that "[d]espite the poignancy and power of the therapeutic process in the context of a life threatening, advanced, or terminal disease, the influence of modern psychoanalytic thinking on this area of practice has been minimal" (p. 181). The findings of the current research add to the knowledge of therapy with terminally ill people by identifying and highlighting the themes in the psychoanalytic literature on assisting dying clients, and enlarging the evidence for the effectiveness of the work in this under-researched area.

The findings can also be informative to therapists working with dying clients. Powerful connection between therapist and client can be understood as a central and compelling aspect of the therapeutic process in this context. Powerful connection enhances the therapeutic process in assisting clients to sustain meaning and psychological vitality while

living with irreversible physical decline and awareness of imminent death, and the accompanying experience of loss, grief and aloneness. The findings augment existing research which emphasises the potency of the therapeutic process with terminally ill clients and the possibility of growth and development at the end of life. Rodin and Zimmermann (2008) accentuate this point: "Serious illness may unite patients and therapists in an intimate bond, which may only be found in those who share an experience of tragedy" (p. 193).

Finally, the juxtaposition and prominence of the themes of vulnerability and resilience as findings of this research, illustrated in the model (Figure 5, p. 54), are in accord with current theoretical concepts which point to self-experience as multiple, fluid and shifting (Mitchell, 1997). Straker (2013) observes that "multiple and variable integrations of one's experience" may be underestimated in those facing death and moreover, that "it is probable that the capacity to simultaneously hold the idea of living and dying is the most important psychological task for those who are facing death" (p. 66).

Methodological Considerations

In the presentation of the methodology (Chapter Three) it was noted that interpretation at levels three and four (Figure 1, p.30) would be briefly considered in the discussion. The point was made that the data were not regarded as 'raw' but as a construction, and while the data was coded as closely as possible to the text, conscious interpretations of the empirical material were acknowledged. Accordingly, the demand for reflection in relation to the interpreted nature of the material was increased. The research has emphasised the active constructing of 'reality' through the perception and interpretation of language and interaction with the publications.

Interpretation at the third level involves critical interpretation which may challenge the context, perceptions and values of the publications (Alvesson & Skoldberg, 2000). The

historical and changeable nature of social phenomena means that what might be construed as true in one context may not be regarded as true in another. Furthermore, published research also affects social conditions. The publications of Kubler-Ross (1969, 1981) provide an example of theories producing change in attitudes to dying in a broader social context. Her writing brought death and dying to prominence and raised awareness of the possibilities for more humane dying. The influence of other prominent psychoanalytic theorists writing about dying clients (Eissler, 1955; Hoffman, 1979) is also evident in the narrower context of psychoanalysis with terminally ill clients. The influence of theoretical ideas and clinical work on the development of practice with dying clients is apparent in the discussion of concepts by practitioners as they address issues of theory and clinical practice in the publications. Psychoanalysts such as Norton (1963) and Roose (1969) were influenced by the work of Eissler (1955) which represented a departure from orthodox psychoanalytic therapy. Denial was not interpreted and regression was viewed as an opportunity to re-create in the transference the mother-infant sense of merger with the therapist, to provide protection from the psychological pain of dying and to foster an experience whereby the client can maintain the fantasy of an enduring relationship with the therapist. While the flexibility of these analysts in adapting their analysis to the needs of the dying client resulted in a reduction in the client's anxiety and fear, such a stance assumes that death awareness creates intolerable anxiety and analysts may underestimate the capacity of clients to face imminent mortality without the need for 'protection' or fantasised mother-infant merger.

Conversely, some analysts such as Minerbo (1998) and Mayer (1994) argue for the continuation of a firm interpretive analytic stance and make a convincing case for the productiveness and usefulness of analysis, despite their acknowledgment of the clients' challenges to their interpretations. Straker (2013) critiques this stance, asserting that in the refusal to collude with any attempts at denial of death, the needs of the dying client are made

subservient to an inflexible adherence to technique which Straker states "has, to me, the feel of cruelty" (p. 64). While the benefits to these clients through their analysis were evident, Straker's critique regarding the harshness of not permitting some denial has validity, particularly as terminally ill clients deny and face death intermittently as a way of coping. Yalom (2008) expresses the idea with simple clarity. "It's not easy to live every moment wholly aware of death. It's like trying to stare the sun in the face: you can only stand so much of it" (p. 5).

Other contemporary publications present the view that through the poignancy and power of the therapeutic process, analysis can provide an opportunity for the development of individuation, affirmation and exploration of spiritual dimensions, and the promotion of the potential for growth in the last phase of life (Knoblauch, 1997; Rodin & Zimmerman 2008; Schaverien, 1999). However, the moving analysis described by Daehnert (2008) seems to go beyond one position in the dialectics of denial versus truth, traditional analysis versus modification, and growth versus regression/merger, to the synthesis of both poles in each of the continua. Daehnert and her client met her approaching death with a progressively passionate engagement that was increased by mutual vulnerability and grief in the full knowledge of imminent death. Resistant to the notion of relaxing the psychoanalytic frame to become more "supportive", Daehnert describes how the analysis intensified and became more deeply creative by expanding the boundaries of their relationship. Daehnert allowed the client access to her dreams and acknowledged the client's perceptions of her countertransference, and the client's transference extended to include the client herself as "teacher" and "mother" to the therapist. Growth, transformation, and a peaceful death were made possible through mutual surrender and the client's experience of the joint impact and meaning of her life and death.

Finally, interpretation at the fourth level requires reflection on the authority of the researcher. As a researcher positioned in the psychotherapy community with a professional and personal understanding of the world, making interpretations of an already interpreted 'reality', the results of the study are acknowledged as perspective-dependent interpretations. I have not approached the material from an 'elevated' vantage point, but rather, I have respected in full the implicit claim to authenticity in the analyses studied, and recognised the publications as being representative of expert opinion.

Limitations of the Study

Subjectivity has been acknowledged and will inevitably have had an impact on the inclusion/exclusion criteria, and the interpretation of the data and the findings. Different outcomes are possible as a result of other researchers having analysed the same material, consequently the research is not necessarily replicable. The study has focused purely on psychoanalytic literature, and therefore understandings of how dying clients are assisted by other psychotherapeutic orientations have not been considered. Cultural aspects were not commonly addressed by the psychoanalytic authors and the study did not include material from diverse cultural perspectives, including Aotearoa/New Zealand.

Strengths of the study

Thematic analysis is a method that has allowed in-depth engagement with the material. The method is congruent with the methodology and was applied rigorously, and transparently. The case studies included diversity in the ages of clients, their social backgrounds, gender pairings in the dyad, and in the range of theoretical approaches within psychoanalysis. The findings provide a model for conceptualising assistance in work with terminally ill clients that is supported by the wider contemporary psychoanalytic literature.

Suggestions for Further Research

Further research in this area would be of value, particularly from the point of view of the client's experience. While clients were sometimes given a voice when therapists used the directly spoken words of their clients through the narrative, interviews to understand what meanings clients themselves give to how they were assisted during a terminal illness would contribute significantly to this important and challenging area. The meanings and implications of the spiritual dimensions of clients' experience is also an under researched aspect. Clearly, careful thought would be necessary in relation to the ethical considerations of such research; however, research with terminally ill clients receiving group therapy has been conducted (Breitbart et al., 2010). Studies conducted with individuals about how they felt helped in therapy may provide a strong empirical foundation in support of psychoanalytic approaches to treating terminally ill clients.

Conclusion

Thematic analysis is a method that has allowed me to have a very close engagement with the work of therapists and their clients, who were forced to confront the reality of death long before they might have hoped to. I was powerfully drawn to the work, intensely involved in it and appreciative of the opportunity to learn and develop. As Schaverien (1999) made note, writing with authenticity about working with dying people involves a degree of self exposure and the therapists accepted a level of vulnerability in presenting the case studies, especially the therapists who wrote about intense feelings, including the love they experienced for the client, and how this impacted on the work.

During my clinical training I was deeply privileged in having the opportunity to work with a terminally ill client until his death, 18 months after we first met. Sharing in the responsibility of my client's psychological care at a time in his life when depression and

despair threatened to overwhelm him evoked in me considerable anxiety and doubt about my ability to help. This moving encounter with death and loss continues to resound, through my inquiry in this study, and in the impetus toward deeper levels of understanding and insight in the work with people facing death.

I was excited to discover recently an edited publication released since the start of this study entitled "Facing Cancer and the Fear of Death" (Straker, 2013), in which one of the stated goals is to help psychoanalysts, doctors, and dying patients to face death with less anxiety and apprehension. It is my hope that the effort to increase wisdom and understanding, and find transformative meaning in the deaths and endings that we all experience, will continue to grow.

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Appendix A: Literature Search Log

PEP	**Search result**	**Included in interim dataset**	**Included in final dataset**	**Final excluding criteria**
Psychotherapy AND facing death	127	17	6	Focused on therapist experience or on character analysis or on theories about older adulthood
PsycINFO				
(psychotherap* adj8 "terminal* ill*") or (psychotherap* adj8 palliative) or (psychotherap* adj8 "end of life") or (psychodynamic* adj8 "terminal* ill*") or (psychodynamic* adj8 palliative) or (psychodynamic* adj8 "end of life")).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]	225	5	0	Mixed method approaches or brief interventions in institutional settings
PEP				
Psychotherap* AND "end of life"	79	3	0	Case studies not included and overlap with previous search
PEP				
Psychotherapy AND work with dying	58	9	2	Overlap with previous search Focus on therapists' process
Library Catalogue	3	3	1	Books too extensive to code
Sourced from references	8	5	4	Clients not in long term therapy