CHAPTER 5

Death and Psychotherapy

THE LEAP from theory to practice is not easy. In this chapter I shall transport us from metaphysical concerns about death to the office of the practicing psychotherapist and attempt to extract from those concerns what is relevant to everyday therapy.

The reality of death is important to psychotherapy in two distinct ways: death awareness may act as a "boundary situation" and instigate a radical shift in life perspective; and death is a primary source of anxiety. I shall discuss the application of each way, in turn, to the technique of therapy.

Death as a Boundary Situation

A "boundary situation" is an event, an urgent experience, that propels one into a confrontation with one's existential "situation" in the world. A confrontation with one's personal death ("my death") is the nonpareil boundary situation and has the power to provide a massive shift in the way one lives in the world. "Though the physicality of death destroys an individual, the *idea* of death can save him." Death acts as a

catalyst that can move one from one state of being to a higher one: from a state of wondering about *how* things are to a state of wonderment *that* they are. An awareness of death shifts one away from trivial preoccupations and provides life with depth and poignancy and an entirely different perspective.

Earlier I considered illustrative examples from literature and clinical records of individuals who, after a confrontation with death, have undergone a radical personal transformation. Tolstoy's Pierre in *War and Peace* and Ivan Ilyich in "The Death of Ivan Ilyich" are obvious instances of "personality change" or "personal growth." Another striking illustration is everyone's favorite miraculously transformed hero: Ebenezer Scrooge. Many of us forget that Scrooge's transformation was not simply the natural result of yule warmth melting his icy countenance. What changed Scrooge was a confrontation with his own death. Dickens's Ghost of the Future (Ghost of the Christmas Yet to Come) used a powerful form of existential shock therapy: Scrooge was permitted to observe his own death, to overhear members of the community discuss his death and then dismiss it lightly, and to watch strangers quarreling over his material possessions, including even his bedsheets and nightshirt. Scrooge then witnessed his own funeral and, finally, in the last scene before his transformation, Scrooge knelt in the churchyard and examined the letters of his name inscribed on his tombstone.

DEATH CONFRONTATION AND PERSONAL CHANGE: MECHANISM OF ACTION

How does death awareness instigate personal change? What is the inner experience of the individual thus transformed? Chapter 2 presents some data that indicates the type and the degree of positive change that some terminal cancer patients have undergone. Interviews with these patients provide insights into some of the mechanisms of change.

Cancer Cures Psychoneurosis. One patient had disabling interpersonal phobias that almost miraculously dissolved after she developed cancer. When asked about this cure, she responded, "Cancer cures psychoneurosis." Although she tossed this statement off almost flippantly, there is an arresting truth in it: not the dismal truth that death eliminates life with all its attendant sorrows, but the optimistic truth that the anticipation of death provides a rich perspective for life concerns. When asked to describe her transformation, she stated that it was a simple process: having faced and, she felt, conquered her fear of death—a fear that had

dwarfed all her other fears—she experienced a strong sense of personal mastery.

Existence Cannot Be Postponed. Eva, forty-five years old and deeply depressed, had advanced ovarian cancer and was highly conflicted about whether she should take one last trip. In the midst of our therapeutic work she reported this dream:

> There was a large crowd of people. It looked something like a Cecil B. DeMille scene. I can recognize my mother in there. They were all chanting, "You can't go, you have cancer, you are ill." The chanting went on and on. Then I heard my dead father, a quiet reassuring voice, saying, "I know you have lung cancer like me, but don't stay home and eat chicken soup, waiting to die like me. Go to Africa—live."

Eva's father had died many years ago of a lingering cancer. She last saw him several months before his death and had sorrowed not only at her loss but at the way he died. No one in the family had dared tell him about his cancer, and the symbol of staying home and eating chicken soup was apt: his remaining life and his death were unenlightened and unheroic. The dream bore powerful counsel; Eva heeded it well and altered her life dramatically. She confronted her physician and demanded all available information about her cancer and insisted that she share in the decisions made about her treatment. She re-established old friendships; she shared her fears with others and helped them share their grief with her. She did take that last journey to Africa which, though it was cut short by illness, did leave her with the satisfaction of having drunk deeply from life until the last draught.

The matter can be summed up simply: "Existence cannot be postponed." Many patients with cancer report that they live more fully in the present. They no longer postpone living until some time in the future. They realize that one can really live *only* in the present; in fact, one cannot outlive the present—it always keeps up with you. Even in the moment of looking back over one's life—even in the last moment—one is still there, experiencing, living. The present, not the future, is the eternal tense.

I remember a thirty-year-old patient who was obsessed by the vision of herself as an old woman spending Christmas alone. Haunted by this vision, she spent much of her adult life in frantic pursuit of a mate—so frantic a pursuit that she frightened away any prospective suitors. She rejected the present and devoted her life to rediscovering the security of early childhood. The neurotic obliterates the present by trying to find the past in the future. It is, of course, paradoxical; and I shall have

more to say of this later, that it is the person who will not "live" who is most terrified of dying. "Why not," Kazantzakis asked, "like a well-filled guest, leave the feast of life?"[1]

Another individual, a university professor, as a result of a serious bout with cancer, decided to enjoy the future in the immediate present. He discovered, with astonishment, that he could choose not to do those things he did not wish to do. When he recovered from his surgery and returned to work, his behavior changed strikingly: he divested himself of onerous administrative duties, immersed himself in the most exciting aspects of his research (eventually attaining national prominence), and—let this be a lesson to us all—never attended another faculty meeting.

Fran was chronically depressed and fearful and had for fifteen years been locked into a highly unsatisfying marriage which she could not bring herself to end. The final obstacle to separation was her husband's extensive home aquarium! She wished to remain in the house so that her children could keep their friends and remain in the same school; yet she could not undertake the two hours of time needed for the daily feeding of the fish. Nor could the huge aquarium be moved except at enormous expense. The problem seemed insoluble. (On such trifling issues is a life sacrificed.)

Fran then developed a malignant form of bone cancer which brought home to her the simple fact that this was her one and only life. She said that she suddenly realized that time's clock runs continuously, and that there are no "time-outs" when it stops. Though her illness was so severe that her need for her husband's physical and economic support were very great indeed, she was nonetheless able to make the courageous decision to separate, the decision she had postponed for a decade.

Death reminds us that existence cannot be postponed. And that there is still time for life. If one is fortunate enough to encounter his or her death and to experience life as the "possibility of possibility" (Kierkegaard)[2] and to know death as the "impossibility of further possibility" (Heidegger),[3] then one realizes that, as long as one lives, one has possibility—one can alter one's life until—but only *until*—the last moment. If, however, one dies tonight, then all of tomorrow's intentions and promises die stillborn. That is what Ebenezer Scrooge learned; in fact, the pattern of his transformation consisted of a systematic reversal of his misdeeds of the previous day: he tipped the caroler he had cursed, he donated money to the charity workers he had spurned, he embraced the nephew he had scorned, he gave coal, food, and money to Cratchit whom he had tyrannized.

Count Your Blessings. Another mechanism of change energized by a confrontation with death was well illustrated by a patient who had cancer that had invaded her esophagus. Swallowing became difficult; gradually she shifted to soft foods, then to puréed foods, then to liquids. One day in a cafeteria, after having been unable even to swallow some clear broth, she looked around at the other diners and wondered, "Do they realize how lucky they are to be able to swallow? Do they ever think of that?" She applied this simple principle to herself and became aware of what she *could* do and *could* experience: the elemental facts of life, the changing seasons, the beauty of her natural surroundings, seeing, listening, touching, and loving. Nietzsche expresses this principle in a beautiful passage:

> Out of such abysses, from such severe sickness one returns newborn, having shed one's skin, more ticklish and malicious, with a more delicate taste for joy, with a more tender tongue for all good things, with merrier senses, with a second dangerous innocence in joy, more childlike and yet a hundred times subtler than one has ever seen before.[4]

Count your blessings! How rarely do we benefit from that simple homily? Ordinarily what we *do* have and what we *can* do slips out of awareness, diverted by thoughts of what we lack or what we cannot do, or dwarfed by petty concerns and threats to our prestige or our pride systems. By keeping death in mind, one passes into a state of gratitude, of appreciation for the countless givens of existence. This is what the Stoics meant when they said, "Contemplate death if you would learn how to live."[5] The imperative is not, then, a call to a morbid death preoccupation but instead an urging to keep both figure and ground in focus so that being becomes conscious and life becomes richer. As Santayana put it: "The dark background which death supplies brings out the tender colors of life in all their purity."[6]

Disidentification. In everyday clinical work the psychotherapist encounters individuals who are severely anxious in the face of events that do not seem to warrant anxiety. Anxiety is a signal that one perceives some threat to one's continued existence. The problem is that the neurotic person's security is so tentative that he or she extends his or her defensive perimeter a long way into space. In other words, the neurotic not only protects his or her core but defends many other attributes (work, prestige, role, vanity, sexual prowess, or athletic ability) with the same intensity. Many individuals become inordinately stressed, therefore, at threats to their career or to any of a number of other attributes. They believe in effect, "I *am* my career," or "I *am* my sexual attractiveness." The therapist wishes to say, "No, you are not your career,

you are not your splendid body, you are not mother or father or wise man or eternal nurse. You are your *self*, your core essence. Draw a line around it: the other things, the things that fall outside, they are not you; they can vanish, and you will still exist."

Unfortunately such self-evident exhortations, like all self-evident exhortations, are rarely effective in catalyzing change. Psychotherapists look for methods to increase the power of the exhortation. One such method I have used, with groups of cancer patients as well as in the classroom, is a structured "disidentification" exercise.* The procedure is simple and takes approximately thirty to forty-five minutes. I choose a quiet peaceful setting and ask the participants to list, on separate cards, eight important answers to the question "Who am I?" I then ask them to review their eight answers and to arrange their cards in order of importance and centricity: the answers closest to their core at bottom, the more peripheral responses at the top. Then I ask them to study their top card and meditate on what it would be like to give up that attribute. After approximately two to three minutes I ask them (some quiet signal like a bell is less distracting) to go on to the next card and so on until they have divested themselves of all eight attributes. Following that, it is advisable to help the participants integrate by going through the procedure in reverse.

This simple exercise generates powerful emotions. I once led three hundred individuals in an adult education workshop through it; and, even years afterward, participants gratuitously informed me how momentously important the procedure had been to them. Disidentification is an important part of Roberto Assagioli's system of psychosynthesis. He tries to help an individual reach his "center of pure self-consciousness" by asking him to imagine shedding, in a systematic way, his body, emotions, desires, and finally intellect.[7]

The individual with a chronic illness who copes well with his or her situation often spontaneously goes through this process of disidentification. One patient whom I remember well had always closely identified herself with her physical energy and activities. Her cancer gradually weakened her to the point where she could no longer backpack, ski, or hike, and she mourned these losses for a long time. Her range of physical activities inexorably diminished, but eventually she was able to transcend her losses. After months of work in therapy she was able to accept the limitations, to say, "I cannot do it" without a sense of per-

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*Suggested to me by James Bugental.

sonal worthlessness and futility. Then she transmuted her energy into other forms of expression that were within her limits. She set feasible final projects for herself: completing personal and professional unfinished business, expressing unvoiced sentiments to other patients, friends, doctors, and children. Much later she was able to take another, major step—to disidentify even with her energy and impact and to realize that she existed apart from these, indeed apart from all other qualities.

Disidentification is an obvious and ancient mechanism of change—the transcendence of material and social accouterments has long been embodied in ascetic traditions—but is not easily available for clinical use. It is the awareness of death that promotes a shift in perspective and makes it possible for an individual to distinguish between core and accessory: to reinvest one and to divest the other.

DEATH AWARENESS IN EVERYDAY PSYCHOTHERAPY

If we psychotherapists accept that awareness of personal death can catalyze a process of personal change, then it is our task to facilitate a patient's awareness of death. But how? Many of the examples I have cited are of individuals in an extraordinary situation. What about the psychotherapist treating the everyday patient—who does not have terminal cancer, or who is not facing a firing squad, or who has not had a near fatal accident?

Several of my cancer patients posed the same question. When speaking of their growth and what they had learned from their confrontation with death, they lamented, "What a tragedy that we had to wait till now, till our bodies were riddled with cancer, to learn these truths!"

There are many structured exercises that the therapist may employ to simulate an encounter with death. Some of these are interesting, and I shall describe them shortly. But the most important point I wish to make in this regard is that the therapist does not need to *provide* the experience; instead, the therapist needs merely to help the patient *recognize* that which is everywhere about him or her. Ordinarily we deny, or selectively inattend to, reminders of our existential situation; the task of the therapist is to reverse this process, to pursue these reminders, for they are not, as I have attempted to demonstrate, enemies but powerful allies in the pursuit of integration and maturity.

Consider this illustrative vignette. A forty-six-year-old mother takes the youngest of her four children to the airport where he departs for college. She has spent the last twenty-six years rearing her children

and longing for this day. No more impositions, no more incessantly living for others, no more cooking dinners and picking up clothes, only to be reminded of her futile efforts by dirty dishes and a room in new disarray. Finally she is free.

Yet, as she says goodbye, she unexpectedly begins sobbing loudly, and on the way home from the airport a deep shudder passes through her body. "It is only natural," she thinks. It is only the sadness of saying goodbye to someone she loves very much. But it is more than that. The shudder persists and shortly turns into raw anxiety. What could it be? She consults a therapist. He soothes her. It is but a common problem: the "empty nest" syndrome. For so many years she has based her self-esteem on her performance as mother and housekeeper. Suddenly she finds no way to validate herself. Of course she is anxious: the routine, the structure of her life have been altered, and her life role and primary source of self-esteem have been removed. Gradually, with the help of Valium, supportive psychotherapy, an assertiveness training women's group, several adult education courses, a lover or two, and a part-time volunteer job, the shudder shrinks to a tremble and then vanishes altogether. She returns to her "premorbid" level of comfort and adaptation.

This patient, treated by a psychiatric resident, some years ago, was part of a psychotherapy outcome research project. Her treatment results could only be described as excellent: on each of the measures used—symptom check lists, target problem evaluation, self-esteem—she had made considerable improvement. Even now, in retrospect, it seems clear that the psychotherapist fulfilled his function. Yet I also look upon this course of treatment as a "misencounter," as an instance of missed therapeutic opportunities.

I compare it with another patient I saw recently in almost precisely the same life situation. In the treatment of this patient I attempted to nurse the shudder rather than to anesthetize it. The patient experienced what Kierkegaard called "creative anxiety," and her anxiety led us into important areas. It *was* true that she had problems of self-esteem, she *did* suffer from "empty nest" syndrome, and she also was deeply troubled by her great ambivalence toward her child: she loved him but also resented and envied him for the chances in life she had never had (and, of course, she felt guilty because of these "ignoble" sentiments).

We followed her shudder, and it led us into important realms and raised fundamental questions. It was true enough that she could find ways to fill her time, but what was the *meaning* of the fear of the empty

nest? She had always desired freedom but now, having achieved it, was terrified of it. Why?

A dream helped to illuminate the meaning of the shudder. Her son who had just left home for college had been an acrobat and a juggler in high school. Her dream consisted simply of herself holding in her hand a 35-millimeter photographic slide of her son juggling. The slide was peculiar, however, in that it was a slide in movement: it showed her son juggling and tumbling in a multitude of movements all at the same time. Her associations to the dream revolved around time. The slide captured and framed time and movement. It kept everything alive but made everything stand still. It froze life. "Time moves on," she said, "and there's no way I can stop it. I didn't want John to grow up. I really treasured those years when he was with us. Yet whether I like it or not, time moves on. It moves on for John and it moves on for me as well. It is a terrible thing to understand, to really understand."

This dream brought her own finiteness into clear focus, and rather than rush to fill time with distractions, she learned to wonder at and to appreciate time and life in richer ways than she previously had. She moved into the realm that Heidegger describes as authentic being: she wondered not at the *way* that things are but *that* things are. In my judgment, therapy helped the second patient more than the first. It would not be possible to demonstrate this conclusion on standard outcome measures; in fact, the second patient probably continued to experience more anxiety than the first did. But anxiety is a part of existence, and no individual who continues to grow and to create will ever be free of it. Nevertheless, such a value judgment evokes many questions about the therapist's role. Is the therapist not assuming too much? Does the patient engage his or her services as a guide to existential awareness? Or do not most patients say in effect, "I feel bad, help me feel better"; and if this is the case, why not use the speediest, most efficient means at one's disposal—for example, pharmacological tranquilization or behavioral modification? Such questions, which pertain to all forms of treatment based on self-awareness, cannot be ignored, and they will emerge again and again in this text.

In the treatment of every patient, situations arise that, if sensitively emphasized by the therapist, would increase the patient's awareness of the existential dimensions of his or her problems. The most obvious situations are the stark reminders of finiteness and the irreversibility of time. The death of someone close will, if the therapist persists, always lead to an increased death awareness. There are many components to grief—the sheer loss, the ambivalence and guilt, the disruption of a life

plan—and all need to be thoroughly dealt with in treatment. But, as I stressed earlier, the death of another also brings one closer to facing one's own death; and this part of the grief work is commonly omitted. Some psychotherapists may feel that the bereaved is already too overwhelmed to accept the added task of dealing with his or her own finiteness. I think, however, that assumption is often an error: some individuals can grow enormously as a result of personal tragedy.

The Death of Another and Existential Awareness. For many, the death of a close fellow creature offers the most intimate recognition one can have of one's own death. Paul Landsburg, discussing the death of a loved one, says:

> We have constituted an "us" with the dying person. And it is in this "us," it is through the specific power of this new and utterly personal being that we are led toward the living awareness of our own having to die. . . . My community with that person seems to be broken off; but this community in some degree was I myself, I feel death in the heart of my own existence.[8]

John Donne made the same point in his famous sermon: "And therefore never send to know for whom the bell tolls. It tolls for thee."[9]

The loss of a parent brings us in touch with our vulnerability; if our parents could not save themselves, who will save us? With parents gone nothing stands between ourselves and the grave. On the contrary, we become the barrier between our children and death. The experience of a colleague after the death of his father is illustrative. He had long been expecting his father's death and bore the news with equanimity. However, as he boarded an airplane to fly home for the funeral, he panicked. Though he was a highly experienced traveler, he suddenly lost faith in the plane's capacity to take off and land safely—as though his shield against precariousness had vanished.

The loss of a spouse often evokes the issue of basic isolation; the loss of the significant other (sometimes the dominant other) increases one's awareness that, try as hard as we may to go through the world two by two, there is nonetheless a basic aloneness that we must bear. No one can die one's own death with one or for one.

A therapist who attends closely to a bereaved patient's associations and dreams, will discover considerable evidence of the latter's concern with his or her own death. For example, a patient reported this nightmare on the night after learning that his wife had inoperable cancer:

> I was living in my old house in ______. [A house that had been in the family for three generations.] A Frankenstein monster was chasing me

> through the house. I was terrified. The house was deteriorating, decaying. The tiles were crumbling and the roof leaking. Water leaked all over my mother. [His mother had died six months ago.] I fought with him. I had a choice of weapons. One had a curved blade with a handle, like a scythe. I slashed him and tossed him off the roof. He lay stretched out on the pavement below. But he got up and once again started chasing me through the house.

The patient's first association to the dream was: "I know I've got a hundred thousand miles on me." The symbolism of the dream seemed clear. His wife's impending death reminded him that his life, like his house, was deteriorating; he was inexorably pursued by death, personified, as in his childhood, by a monster who could not be halted.

Another patient, Tim, whose wife had terminal cancer, had this dream the night after she, near death, had had to be hospitalized because of severe respiratory problems:

> I had just returned from some type of trip and found that I was pushed into some back room area. Someone had done me in. It was all filled with old stuffed furniture, plywood, dusty and everything was covered with chicken wire. There was no exit. It reminded me of Sartre's play. I felt stifled. I couldn't breathe, something was bearing in on me. I picked up some plywood box or crate that was crudely built. It hit against the wall or floor and had a crushed corner. That crushed corner really stuck out in my mind. It sort of blazed. I decided to take it up with the boss at the very top. I'll go right up to the top and complain. I'll go to the vice president. I then went up an extremely elegant stairway that had mahogany rails and marble floors. I was angry. I had been shuffled aside. They put it to me. Then I became confused about who I should complain to.

Tim's associations to the dream indicated clearly that his wife's impending death hurled him into a confrontation with his own. The outstanding image in the dream, the "blazing" crushed corner of the plywood box, reminded him of the crushed body of his automobile after a serious accident in which he had almost been killed. The plywood box also reminded him of the plain coffin he would have to order for his wife (according to Jewish burial ritual). In the dream it is he who finds himself in his wife's situation. He, too, cannot breathe. He, too, is pushed aside, trapped, crushed by something bearing down upon him. The major affect of the dream was anger and bafflement. He felt angry at the things happening to him, yet to whom could he issue a complaint? He awoke deeply confused about who, upstairs, would be the proper person to consult.

In therapy this dream opened up important vistas. It enabled the patient, who had been previously in a panic state, to sort out his feelings and to work on each cluster in a more meaningful way. He had been overwhelmed with death anxiety, with which he had attempted to cope by physically avoiding his wife and by compulsive sexuality. For example, he masturbated several times a day in bed next to his wife (I described this patient briefly in chapter 4). As we worked overtly on his anxiety about his own death, he was finally able to remain near his wife, comforting her by holding her and, in so doing, avoiding a considerable measure of guilt that would have ensued after her death.

After the death of his wife therapy focused both on the loss of his wife and on his own existential situation which his wife's death helped him to see more clearly. For example, he had always been achievement-oriented but, after his wife's death, began to ask: "For whom am I working?" "Who will see it?" Slowly Tim began to glimpse what his wife's constant nurturing and his obsession with sex had obscured for him: his isolation and his own finiteness. He was highly promiscuous after his wife's death, but gradually he grew disenchanted with the sexual chase and began to grapple with the question of what he wanted to do in life for himself. An enormously fertile period in therapy began, and in the course of the succeeding months Tim made substantial personal change.

The loss of a son or daughter is often the bitterest loss of all to us and we simultaneously mourn our child and ourselves. Life seems to hit us, at such a time, on all fronts at once. Parents first rail at the injustice in the universe but soon begin to understand that what seemed injustice is, in reality, cosmic indifference. They also are reminded of the limit of their power: there is no time in life when they have greater motivation to act and yet are helpless; they cannot protect a defenseless child. As night follows day, the bitter lesson follows that we, in our turn, will not be protected.

The psychiatric grief literature does not emphasize this dynamic but instead often focuses on the guilt (thought to be associated with unconscious hostility) that parents experience at the death of a child. Richard Gardner[10] studied parental bereavement empirically by systematically interviewing and testing a large sample of parents whose children suffered from some type of fatal illness. Though he confirmed that many parents suffered considerable guilt, his data indicated that the guilt, rather than emanating from "unconscious hostility," was four times more commonly an attempt by the parent to assuage his or her own existential anxiety, to attempt to "control the uncontrollable." After all, if

one is guilty about not having done something one should have done, then it follows that *there is something that could have been done*—a far more comforting state of affairs than the hard existential facts of life.

The loss of a child has another portentous implication for the parents. It signals the failure of their major immortality project: they will not be remembered, their seed will not take root in the future.

Milestones. Anything that challenges the patient's permanent view of the world can serve as a fulcrum with which the therapist can wedge open the patient's defenses and permit him a view of life's existential innards. Heidegger emphasizes that only when machinery suddenly breaks down do we become aware of its functioning.[11] Only when defenses against death anxiety are removed do we become fully aware of what they shielded us from. Therefore the therapist who looks may find existential anxiety lurking when any major event, especially an irreversible one, occurs in a patient's life. Marital separation and divorce are prime examples of such events. These experiences are so painful that therapists often make the error of focusing attention entirely on pain alleviation and miss the rich opportunity that reveals itself for deeper therapeutic work.

For some patients, the commitment to a relationship, rather than the termination of one, acts as a boundary situation. Commitment carries with it the connotation of finality, and many individuals cannot settle into a permanent relationship because that would mean "this is it," no more possibilities, no more glorious dreams of continued ascendancy. In chapter 7 I shall discuss how irreversible decisions evoke existential anxiety precisely because they exclude other possibilities and confront the individual with the "impossibility of further possibility."

The passage into adulthood is often particularly difficult. Individuals in their late teens and early twenties are often acutely anxious about death. In fact, a clinical syndrome in adolescents called the "terror of life" has been described: it consists of marked hypochondriasis and preoccupation with the aging of the body, with the rapid passage of time, and with the inevitability of death.[12]

Therapists who treat medical residents (to take one example) sometimes note considerable existential anxiety in the thirtyish individual who is finally completing training and must, for the first time, shed a student identity and face the world as a grown-up. I have long observed that psychiatric residents, upon nearing completion of training, go through a period of major inner turmoil—a turmoil that has roots reaching far below such immediate concerns as finances, selection of an office and establishment of referral networks for private practice.

Jaques, in his wonderful essay "Death and the Mid-Life Crisis," stresses that the individual in midlife is especially bedeviled by the thought of death.[13] This is the time of life when a person may become preoccupied with the thought, often unconscious, that he or she "has stopped growing up and has begun to grow old." Having spent the first half of life in the "achievement of independent adulthood," one may reach the prime of life (Jung called age forty the "noon of life")[14] only to become acutely aware that death lies beyond. As one thirty-six-year-old patient, who had become increasingly aware of death in his analysis, put it: "Up till now, life has seemed an endless upward slope with nothing but the distant horizon in view. Now suddenly I seemed to have reached the crest of the hill, and there stretching ahead is the downward slope with the end of the road in sight—far enough away, it's true—but there is death observably present at the end." Jaques remarked upon the difficulty of working through the layers of death denial and gave an example of how he helped one patient become aware of death by analyzing his inability to mourn the death of friends.

A threat to one's career or the fact of retirement (especially in individuals who had believed that life was an ever-ascending spiral) can be a particularly potent catalyst for increasing one's awareness of death. A recent study of individuals making a midlife radical career shift suggests that most of them had made the decision to "drop out" or to simplify their lives in the context of a confrontation with their existential situation.[15]

Simple milestones, such as birthdays and anniversaries, can be useful levers for the therapist. The pain elicited by these signs of the passage of time runs deep (and for that reason is generally dealt with by reaction formation, in the form of a joyous celebration). Sometimes mundane reminders of aging offer an opportunity for increased existential awareness. Even a penetrating look in the mirror can open the issue. One patient told me that she said to herself, "I'm just a little gnome. I'm the same little Isabelle inside, but outside I'm an old lady. I'm sixteen going on sixty. I know it's perfectly all right for others to age, but somehow I never thought it would happen to me." The appearance of old people's characteristics, such as the loss of stamina or senile plaques on the skin, stiff joints, wrinkles, balding, or even the recognition that one enjoys "old people's" pleasures—watching, walking, serene quiet times—may act as a spur to death awareness. The same may be said about looking at old photographs of oneself and noting how one resembles one's parents when they were considered old, or seeing friends after long intervals and noting how they have aged. The therapist who listens carefully will be able to use any of these everyday oc-

currences. Or the therapist may tactfully contrive such situations. Freud, as I described in chapter 1, had no qualms about requesting Fraulein Elisabeth to meditate at the site of her sister's grave.

A careful monitoring of dreams and fantasies will invariably provide material to increase death awareness. Every anxiety dream is a dream of death; frightening fantasies involving such themes as unknown aggressors breaking into one's home always, when explored, lead to the fear of death. Discussions of unsettling television shows, movies, or books may similarly lead to essential material.

Severe illness is such an obvious catalyst that no therapist should let this opportunity pass by unmined. Noyes studied two hundred patients who had had near-death experiences through sudden illness or accident and found that a substantial number (25 percent) had a new and powerful sense of death's omnipresence and nearness. One of his subjects commented, "I used to think death would never happen or, if it did, I would be eighty years old. But now I realize it can happen any time, any place, no matter how you live your life. A person has a very limited perception of death until he is confronted with it." Another described his death awareness in these terms: "I have seen death in life's pattern and affirmed it consciously. I am not afraid to live because I feel that death has a part in the process of my being." Though a few of Noyes's subjects reported an increased terror of death and a greater sense of vulnerability, the great majority reported that their increased death awareness had been a positive experience resulting in a greater sense of life's preciousness and a constructive reassessment of their life's priorities.[16]

Artificial Aids to Increase Death Awareness. Though the naturally occurring reminders of death's presence are numerous, they are not, therapists often find, sufficiently potent to combat a patient's ever-vigilant denial. Consequently many therapists have sought vivid techniques to bring patients to face the fact of death. In the past, intentional and unintentional reminders of death were far more common than they are today. It was precisely for the purpose of reminding one of life's transiency that a human skull was a common furnishing in a medieval monk's cell. John Donne, the seventeenth-century British poet and clergyman, wore a funeral shroud when he preached "Look to eternity" to his congregation; and earlier, Montaigne, in his splendid essay "That to Philosophize Is to Learn How to Die," had much to say on the subject of intentional reminders of our finiteness:

> . . . we plant our cemeteries next to churches, and in the most frequented parts of town, in order (says Lycurgus) to accustom the common people, women and children, not to grow panicky at the sight of a dead man,