Mortality and Impermanence: 
Death and Death Talk in the Consulting Room

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by
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It cannot be that I ought to die. That would be too terrible. . . . And, what was worst of all was that It drew his attention to itself not in order to make him take some action but only that he should look at It, look it straight in the face: look at it and without doing anything, . . . nothing could be done with It except to look at it—face to face-- and shudder.

From Leo Tolstoy’s Death of Ivan Ilych (1960, pp. 132-134)

Abstract

Death is all around us. An ever-increasing awareness of death is a phenomenon that is articulated frequently by our patients. We may not always hear their references to death, but they are most certainly in the room. Death talk pervades our analytic sessions as patients become more aware of their mortality. Sometimes this awareness is accentuated by the mere passing of time, or perhaps by thoughts of how much time they have left to live, or by thoughts of having to terminate their treatment. It will be argued that the more psychic space is created for talking about death, the more the death talk occurs. In turn, analysts are invited to think about death as it appears in psychoanalytic sessions, including the attendant defenses and resistances that keep death awareness and death talk at bay.

Introduction

We will all surely die. We must. There is no escape. Death is all around us. Though death is everywhere, most of us, like Tolstoy’s Ivan Ilych, have a difficult time acknowledging It, let alone looking at it in the face. Tolstoy’s exhortation is: look at it directly, do not flinch. This is quite a daunting challenge. It is as if we must pay attention to each breath we take, for it may be our last. Yes, it is everywhere, but it is so hard for most of us to ever truly acknowledge its ever-present nature. We keep it at a distance—at arm’s length. We treat it as an abstraction, a concept. It is a rare thing to find someone who can contend with a vivid, raw awareness of death, let alone embrace such an unwelcome inevitability.
There is a Buddhist story that aptly captures the inescapable, ever-present nature of death. It goes like this:

_There was a woman who lived at the time of the Buddha. From what we know, her name was Kisa Gotami. Kisa had only one child—a son who died. In her grief, she carried her dead child to all her neighbors, asking them for medicine to bring this child back to life. The people said: “She is mad. She has lost her senses. The boy is dead.” Eventually Kisa met a man who replied to her request: “I can’t give you medicine for your child, but I know a physician who can.” The woman said: Pray tell me sir; who is it?” And the man replied: “Go to Sakyamuni, the Buddha.”_

_Kisa repaired to the Buddha and cried: “Master, give me the medicine that will cure my boy.” The Buddha answered: “I will need a handful of mustard seed. Bring it to me.” And when the woman in her joy promised to procure it, the Buddha added: “The mustard seed must be taken from a house where no one has lost a child, husband, parent, or friend.” Poor Kisa now went from house to house and the people pitied her and said: “Here is mustard seed; take it!” But when she asked “Did a son or daughter, a father or mother, die in your family?” They answered her: “Alas, the living are few, but the dead are many. Do not remind us of our deepest grief.” She found that there was no house spared the ravages of death._

Perhaps it is because of my advancing age, or due to the events surrounding the recent death of my mother, that I am paying more attention to death lately-- thinking of both the possible death of loved ones and my own. Even as this is going on, I, not surprisingly, have begun to see death and death talk reveal itself more frequently in the analytic hour. All of a sudden patients seem to be bringing _It_ (death) into the room in rather vivid language, often with a florid dramatic flair. I have at times, wondered whether they know—perhaps with some kind of uncanny intuition—that I am working on a paper on death and impermanence for this IFPE panel. Of course, another explanation for the recent increase in the frequency of death talk is that I am just simply listening better these days. Perhaps I have taken the wax out of my ears? Good for them for speaking of death, and -- perhaps I should also say—in a rather self-critical, if not self-deprecating way, “good for me” for finally being able to listen, to hear this death talk. It is about time I hear their concerns. Finally.
Theoretical and Clinical Influences

It is fair to say that I have been working on this paper for quite a while—though mostly in my head. It has been on my mind and I have been struggling. Before getting on with some clinical material, I would like to mention just a few of influences that have shaped this paper. As you’ll see, some of them came through the doors of philosophy, theology, some from Buddhist writers, and some from clinicians.

From philosophy, I have been influenced tremendously by Becker’s (1973) Pulitzer Prize winning book – *The Denial of Death*. Becker’s book reveals the efforts of an entire culture to keep any awareness of death stifled or hidden. To Becker, all the conventions conspire to keep death awareness out of our minds. This was an equilibrium shattering book at the time I read it; its challenging message has haunted me for the past forty years.

The influences from literature are numerous. Tolstoy’s (1960) provocative little volume on *Ivan Illych* referenced above is right on point in so many ways. Not only is it a timely exhortation to not fritter away our lives in meaningless activity, he also reminds us—especially those of us who work with the soul—to take all death seriously. Implied in Tolstoy is the thought that unless we take our own deaths seriously—not dwell in abstractions about loss and death—but grasp its reality, its realness, we will never be able to help others face their own deaths. In this respect, I’ve come to think of all psychoanalysts as representatives of the dark side—the chthonic side—the underworld. Perhaps we are versions of Doctor Death—not necessarily in a Kevorkian sense—but as one person who can be there in the lives of individuals to help guide them toward this inevitability and to help process all the conflicting emotions and feelings along the way.

Other more contemporary writers have had death on their minds as they age and have weighed in on the subject. Chris Hitchens’s (2012) book boldly entitled *Mortality* immediately comes to mind. Although published posthumously, Hitchens wrote this little black book during his struggle with cancer and its varied medical treatments. Throughout *Mortality*, Hitchens is intermittently ironic, sad, frustrated, and angry. It has a “rage, rage, do not go gentle” quality to
it. He rants, he criticizes, even as he is determined to live every moment to the fullest until the very end (which he assumes is the end). In fact, Hitchens invented a felicitous phrase to describe how he intended to live the last days of his life. He called it his “year of living dyingly.”

Judith Viorst (2005) has expressed in a rather lighthearted way her mixed emotions over the aging process and inevitable death in her book of verse I’m Too Young to Be Seventy and Other Delusions. Viorst acknowledges her brave attempt to be “plucky and spunky” as she fights the good fight—as illustrated in phrases such as: I’m “working on savoring every goddamn second” (p.19) of my remaining years, and in the title of one of her poems “On Not Being a Good Sport About the Fact That I’m Going To Die One of These Days.” She concludes this poem with the line “Do I mind? Do I Mind? You bet your sweet ass I mind” (pp. 72-73). Even more humorous is Billy Crystal’s (2013) take on the aging process as summed up in his new book Still Foolin’ ‘Em. But, to the question: What does death mean to me? Crystal simply responds, “Death just means . . . no more” (p. 266).

Buddhism has certainly influenced my thinking about this project as witnessed earlier. The enjoinder to not flee from, but to attempt to grasp and come to terms with death and impermanence are central themes throughout the Buddhist literature. For example, Dzongsar Jamyang Khyentse (2012), a Tibetan lama reminds us how hard it is for most of us to accept “even the most patently obvious truth that death is imminent and inevitable, and not one living being . . . can escape it” (p.4). In addition, he points out our aversion to accepting the “the horror of the truth of impermanence, . . . the illusory nature of our world, and above all, the vast and profound truth of shunyata [emptiness]” (p. 18). In this light, the sand mandala under construction for this conference is a vivid reminder of what we attempt to deny—impermanence, emptiness, and death.

Another Buddhist influencing this project is the Zen Priest and teacher, Joan Halifax. Halifax has dedicated her life to working with the dying in a variety of capacities. She and her colleagues attempt to offer comfort to those who are dying from a Buddhist perspective that encourages openness, acceptance, and being present. In Halifax’s words which sound remarkably similar to Khyentse’s above: “We give our best to experience everything as totally as we can, not withdrawing from the vividness of any experience, no matter how scary it seems” (2009. p. xix).
Patient Vignettes and Death Talk

Here are some patient comments that illustrate the various ways patients have introduced their awareness of the reality of death into their analytic sessions. Let’s see if we can begin to view death from their perspectives, and understand how similarly-- and sometimes differently-- they look at it. We’ll see how they each struggle with the awareness of it, how they defend against an awareness of it, even as some are willing to embrace thinking/feeling about it, even as some work toward an acceptance of death while attempting to stare it in the face.

Their comments are grouped into 4 categories: 1) Those mentioning their first awareness of death, 2) those who are grappling with an awareness of death during late mid-life or in late life, 3) those who talk about death in the context of termination, and 4) those who are facing impending death.

Death Talk in the Consulting Room: A Typology

Group I: First Stirrings of Death Awareness

The remarks in this group have been made by patients who have been in psychoanalysis with me for at least five years, but/and who are talking about death for the first time since entering treatment. These individuals tend to be younger, on average, than those mentioned later.

1st patient: I hate those damn old people. They look like post-menopausal skeletons. I’m obsessed with old people. They remind me of decrepitude and death. I saw one woman there whom I met ten years ago. Can you believe that? Time passes so quickly. I can’t deal with it. I hate the aging process and I know that death is around the corner.

Same patient late in same session: I am freaking out about life’s brevity. Time goes by so fast. Life is so short, so brief. I must do something meaningful, before I die.

2nd patient: Time is running out for my life. It is not like it used to be. Time is limited. I will die. Death, my own death, I am looking at it.
3rd patient: Death, mortality—it’s all on my mind these days. Every day it goes through my head. The anger, the sense of insult, that my life would be taken away from me prematurely. I hate thinking about it.

Associations/Comment/Questions: What are topical threads here? Alarm, anxiety, urgency, anger, insult. Is this how Chris Hitchens responded when he first heard of his diagnosis? What defenses are used to soften the blow and to help get one back to normal? The expressed wish to make life meaningful during their limited years is noteworthy, even as some attempt to push this gnawing awareness of death out of their minds.

Group II: Mid to Late–Life Death Awareness
These comments are from people who are in late middle life or in late life and are looking at death as an inevitable, if not impending, occurrence. Death is on their horizon.

1st patient: Aging is my nemesis now. I’m in my final years. I hate the aging process. Death is around the corner. My mother dies. Who is next? Me, of course. I gotta get a grip. I actually think of going to church these days. How unlike me. I’ve got to get a grip.

2nd patient: I think about death all the time now, now that I’m in my 70’s. Much more than I used to. I never used to. Something is being ripped away from me before I’m ready. Goddamnit! I’m angry; I’m not ready. But, if I talk about it, people might say I’m whining.

3rd patient: We are all going to die. I don’t like it. When I’m with friends—at a gathering or whatever, I look around the room and get it—that none of us will be here in 20 years. My death, my husband’s. It all scares me. His decline, my decline, his death, my death. People don’t want to talk about it. There is a death pall in the room.
[same patient, next session] I want something to believe in. I’m so incredibly scared. Yea, they will say “relax, it’s all impermanence.” I say bullshit, what do they know?
4\textsuperscript{th} patient (an agnostic): Please reassure me that I will never die. Or, if I do, promise me that there is a heaven or reincarnation—or—something. Death is all over the place: my own, my husbands, my mothers. (She has repeated this plea many times.)

5\textsuperscript{th} patient (a devout atheist): I don’t want to face the darkness, oblivion. How nice it would be to have something to believe in—something to comfort me.

\textbf{Associations/Comments/Questions:} There is a sense of urgency. Such death talk is more common now. These patients are seeing death everywhere—their own and others. Death is no longer an abstraction for them. They are upset with the passage of time. We see their defenses against death awareness kick in, although their defenses do not seem to be as strong nor as effective as they were for those in the earlier group. Death is more than just a “dawning awareness” with this group. Death is truly an eventuality. It is more of a \textit{given}—even though most speak of not being ready for it. We see one patient pleading for reassurances, a couple of others wishing they had some religious beliefs to comfort them. The notion of \textit{plea bargaining} comes to mind.

\textbf{Group III: Termination and Death Awareness}

In this section we’ll look at patients who have introduced talk about death in the context of thinking about termination as they struggle with the thought of possibly bringing an end to their therapy or analysis. The connections and associations between death and the end of analysis are poignant and certainly worth mentioning.

1\textsuperscript{st} patient: (Thoughts re: a first discussion around the possibility of termination.) The word “termination” sounds so much like Death. No wonder I have had a hard time thinking about it. It sounds like a declaration of death. But I want to live, I want to thrive. Don’t talk to me about termination or death. I want thriving, not death.

2\textsuperscript{nd} patient: I can’t think about ending my analysis. I would rather die. Ending would be like dying. I resist letting you know I am improving for fear that you might think to get rid of me.
3rd patient: I resist thinking about it. I can’t I won’t do it. I don’t want to do it. I want to stay here forever—as long as we are both alive.

4th patient: Of course we have to begin to think about who might die first? Me or you? (Wonderfully similar to a case discussed by Irwin Hoffman (1998) about Hoffman and his patient Manny.)

Associations/Comments/Questions: With these patients there is an intermixing of and a confusion between death and termination. The thought of termination feels like death to them. How does one part with or leave a process that in many respects brought them to life? This seems unbearable. To leave this place—the first place they ever felt understood or seen—seems horrifically unfair. I would rather die than terminate, says one. “Who will die first, . . . me or you?” asks another. Then, for some, we see the defenses, the resistances kick in once again.

Group IV: Death Awareness and the Terminally Ill
I have worked with a few terminally ill patients over the years, though only one recently. I find it difficult. It is especially difficult to find the right words to use with them. Their struggles and pains are so often heartbreaking—significantly more poignant, more immediate that those in the first three groups. Although it might be said that we are all terminally ill, there is an intense sense of immediacy to their struggles that can’t be overstated.

1st patient: - I live every day with death present. As you know, my heart could just stop beating at any time now. I’m not ready for death, but it is out of my hands. How do I do this.? What about my kids? It could happen any minute, any second, It’s unbearable.

2nd patient: (a middle-aged woman in the last stages of a debilitating cancer) This is so hard. I can’t die. I want to be here for my son. So glad I was able to talk with my father and have some closure with him. Maybe I am ready. I’ll never be ready. . . . I think I am ready to die. I’m not afraid to die.
**3rd patient:** Why bother with psychoanalysis, I’m going to die anyhow. Why bother? Psychotherapy isn’t worth it. Death will come. The end.

**Associations/Comments/Questions:** How to work with these patients? Death is coming soon for them. There is so much grief, sadness, sometimes anger and rage. The old defenses don’t seem to work any longer. Only one of the three seemed ready to die.

**Some Thoughts for the Analyst**

With all this death talk in the room, where do we go from here? What do we do with it once we finally begin to hear it? It’s not easy to know how to handle death talk with any patient, let alone with those who are about to die. I think my resistances and my clumsiness are at their worst with this group. It’s obvious to me; it’s probably apparent to them. Even at the very moment I write this, I am inclined to move away from my desk and **do** something: get up and clean my office, fix that broken light, rake the lawn. I can’t bear it, but I know I must. And, I know I must also permit their pain and anguish in. I have to feel it; let it affect me. I have to let their death anxiety in--their fears, that terror--let it become my own. I must live with it. I must resonate with it -- certainly in the consulting room—and, yes, sometimes I take it home with me. I must stay as close to their anxiety, angst, and terror as I can. I must stay closely in touch with the vicissitudes of my countertransference thoughts and feelings. Moreover, I must stay open to being aware of what is coming in my direction via projective identification if there is to be any hope that I will be of help to them during this time of need.

Another way that I like to characterize our job is to say that we need to keep *leaning into* all of it. We need to move even closer to the death talk, try to deepen it. Don't' flinch. Together we stare it in the face. Here is an example of *leaning in* taken from Irvin Yalom (2008), who writes about his work with dying patients in his book *Staring at the Sun*:

These thoughts about death. . . Let’s keep analyzing them, let’s dissect them. I know that the thought of death feels overwhelming—but stare right into it, tell me, what in particular is the most frightening thing about your dying. (p. 208).
Yalom goes on from here, illustrating where this kind of approach might lead a patient. Probably the most important thing he emphasizes is that you are going to likely treat death talk and death anguish as you would any other weighty material presented by a patient. You attempt to see it, grasp it, and experience it from their perspective. Deepen the work. Try to get patients to go exactly where they need to go with their death talk. With my patient #3 in group #1 above, for example, I said something like “You are furious about the thought of dying—the anger, the rage you feel that your life might be taken away from you prematurely. How frightened and angry you must be. Tell me more.” Patient: “I can’t. It is just infuriating.” Analyst: “How unfair that your life would be taken away from you before you had a chance to fully live it.”

Now, what comes to mind here is a crucial technical question for us to consider: As we attempt to deepen this kind of death exploration by working through resistances, should we, in moments like this, attempt to tie it all together by relating the patient’s present sense of unfairness with the unfairness he felt about his early childhood losses? His father died when he was five, and then his mother before he was seven years old. Sometimes we might make such an interpretation and, at others, not. But, then let’s ask: “What are we up to when we do”? Are we retreating to the theoretical, the conceptual, the abstract? Are we hiding in or retreating to pro forma analytic technique? Are we steering the associations away from the urgent and solemn--away from the stuff with gravitas? Are we becoming too experience far? We probably should ask ourselves such questions--often. Can we just stay with the expanding, deepening process in an effort to not collude, to not create a misalliance with the patient—to not join in with the avoidance of something even more painful than his early loss? Can we simply stay with this intense, heavy material and not avoid talk of his impending death and oblivion?

It may be scary, gruesome, even hellish for the analyst to go deeper into these often horrifyingly painful places. As you do so, it might feel like you’ve immersed yourself in the emotional equivalent of a Hieronymous Bosch painting of Hell or the Underworld, but stay with it. Yes we must learn to lean into it. We must practice it. Here’s an example of my self talk while sitting with a patient.

Hmm, this patient is talking about his fear of death at this very moment. Can I hear it? Do I want to hear it? Am I able to hear it? Am I resisting it? Can I help this patient—the one
right in front of me--stare death in the face? Yes, I think I can. And, as I do, I need to
invite them to say more and . . . more. Be curious; expand the narrative around the death
talk, I remind myself. I must try to deepen the patient’s associations again and again, just
as I might do with any other material. I must help the patient face it, . . . I must help bring
him face to face with his fears and with death itself.

At this point, I have another essential question or two for us to ponder. In addition to--
perhaps concomitant with--our own defenses, might it be possible that we, as analysts,
sometimes have an agenda here? Might we? Do you? We probably need to ask ourselves such
questions as: What are my own thoughts about death? What happens at death? Is there an after
life? How afraid of impermanence and death am I? Do I experience terror at the thought of
oblivion? How are our particular defenses and preconceptions informing how we handle
death material? What are our resistances, my resistances? [I think I will stop here and get up and
rake the front lawn.] Oh yes, equanimity through an awareness of impermanence. Yes, that’s it.
But what if we think that a grasp of impermanence is such a good thing that we assiduously and
enthusiastically invite patients to accept this notion as their own. What about simply hinting in
this direction? Is this what Joan Halifax does in her work with the dying? Or, does she just stay
present with them -- “not withdrawing from the vividness of any experience, no matter how
scary it seems.” This is her claim. On the other hand, do we ever unwittingly force our thoughts
and beliefs upon our patients? Or, are we truly able to stay close to their feelings, close to their
narratives, their story lines, regardless of how messy it all gets? Can we keep staring into the sun
with them?

Yes, there are various eschatological perspectives, not just ours, not just those of this
particular patient. Perhaps you are working with a patient who firmly believes in an afterlife and
you don’t. Or, you are working with a patient like the one noted in Group 2 above, who wants
reassurances that there is an after life. How do you handle this? Especially when it flies in the
face of your beliefs? You may be more like Billy Crystal or Chris Hitchens who believe that
upon death, it is simply “No More.” What do you then do? Can we continue to just sit? Explore.
Expand upon feelings. Sit with and deepen the exploration of their fears and longings. Can we
simply work in a way that is oriented to accepting *what is?* Keep leaning into it all. Expand and deepen the death talk, don’t flinch. In short, keep doing analysis. Keep having faith in “O,” as Bion might say. Can you remain confident that if you keep expanding and deepening the work, patients will go where they need to go? So, in short, do we, can we (both analyst and patient) keep staring death in the face? Can we keep staring into the sun together?
References


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