TIME IS A UNIVERSAL PART OF EXPERIENCE. It dictates our orientation to past, present, and future in the totality of any moment. In daily life, we have the luxury of oscillating among the three perspectives: we live in the present, with hope for the future based upon the experience of the past. Our sense of time is internalized so that we take it for granted.

Awareness of the irreversible passage of time pervades any experience of potential or imminent loss. Thus a diagnosis of life-threatening illness acutely heightens the sense of time for the patient and family. Its subjective meaning is inextricably entwined with the reality of the clock and calendar. Time becomes the organizing pivot of the experience: "If one can eliminate time sense, one can also avoid the ultimate separation that time brings—death" (Mann, 1973, p. 6). It is this omnipresent awareness of time that makes the threat of loss more critical than any other life stress.

The diagnosis of a life-threatening illness leads many individuals to enter psychotherapy. Their focus is the emotional stress engendered by the illness, rather than more general intrapsychic and interpersonal concerns. As a six-year-old child explained: "I felt much better because I knew that I had somebody to talk to all the time. Every boy needs a psychologist! To see his feelings!"

Aspects of the psychotherapeutic framework include: time; space; the identity of the patient; the therapeutic content and process; and the therapeutic relationship. How that structure

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is defined will vary in the exigency of life-threatening illness. This flexibility does not give the therapist license to ignore, reject or take lightly basic ground rules. Rather, the utmost challenge lies in adapting a structure to the impinging reality without sacrificing the uniqueness of the therapeutic inter- action.

Time

The time commitment in psychotherapy has three facets: frequency, duration, and appointed time of sessions. In tradi- tional psychotherapy, this structure is critical to the contain- ment of the process. Thus there is both theoretical and prac- tical adherence to the "fifty-minute hour." With illness and approaching death as the reality at hand, the scheduling of sessions may vary considerably. Whereas the traditional struc- ture is optimal for the patient during certain phases, there are times when more fluidity is necessary. Effective availability is based upon this recognition, and implies the therapist's con- sistent and abiding presence.

FREQUENCY

How does the abstraction of availability translate into speci- fiable properties regarding time? Not only is there an ebb and flow in the frequency of sessions, but also the patient must be given specific "permission" to participate in the regulation. Within a traditional model, any modification of the frame- work by a patient may be interpreted as manipulation or resistance. The therapist must certainly be alert for such motivation, whether conscious or unconscious, in the patient

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with a life-threatening illness. Nonetheless, the basic contract can allow for patient-initiated regulation as a norm; its meaning may be inferred within the therapeutic context.

The patient's request for more frequent contact during a stressful period often parallels the reality of the illness process. Conversely, one encounters phases when patients request diminished frequency, if not cessation, of sessions. The reasons for such a request may be highly adaptive to the individual's functioning. The patient who is facing the enormity of loss may at times need to control his or her emotional thermostat, and shut off confrontation and intensity. In exercising this option, the patient must be secure in the knowledge that contact with the therapist may be reinitiated without fear of reprisal.

The understanding that the frequency of sessions may vary is a sine qua non of psychotherapy with patients with a life-threatening illness. A therapist who responds to the patient's "self-regulation" as a narcissistic blow to the sanctity of the process has not accepted this modification. Expressions of relief at lapses in the process may reflect the therapist's own difficulty in handling intensity on a sustained basis. The patient's retreat may be in reaction to such cues.

The frequency of sessions also depends upon whether the patient is being treated in the hospital or in an outpatient clinic. Time assumes a different meaning in the hospital. Hours and days often stretch out so that more frequent meetings, even on a daily basis, may not feel different to the patient from weekly sessions. During brief or uneventful admissions, there may be no need for such an increase. Whether or not the therapist works at the treatment institution will place

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bounds on his or her availability. However, telephone contact can bridge time between sessions or, if necessary, serve as a temporary substitute for face-to-face encounters.

DURATION

The duration of individual sessions depends on the patient's physical status, as well as on the concerns at hand. The therapist's goal for a session may be as simple as providing reassurance of continued presence, or it may be to facilitate the patient's working through of an issue. Meaningful exchange can be accomplished by words, touch, silence. What is critical is that the therapist not lose sight of the agenda in the intensity of the moment.

On occasion, particularly during hospitalizations, the therapist must interpret the meaning of a patient's illness behavior. For example, the patient may claim to be too sick to see or talk at any length with the therapist. Is the patient really incapable of interaction, or is the illness being used as a means of avoidance? An error in interpretation in either direction can be damaging to the therapeutic alliance.

If the therapist implies that the patient is using the illness to avoid emotional issues, when the patient is in fact physically drained, a "blame-the-victim" cycle is set in motion. The patient experiences justifiable resentment at the accusation. At some later point, he or she may confront the therapist. However, it is often too threatening for a patient to express anger toward a caregiver and thus the basic trust of the therapeutic alliance may be ruptured beyond repair. Another avenue is that taken by the patient who passively accepts being labeled an "avoider." The vulnerability and powerlessness in

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the face of physical illness are now further exacerbated for this individual.

The therapist must maintain caution in another direction: that of permitting a patient to disengage under the guise of the illness when, *in fact*, the patient is clinically depressed. While the patient gives messages of wanting only to be left alone, on a more basic level, he or she may be overwhelmed by depression, yearn for contact, and yet be unable to take the initiative. The firm, persistent, and gentle efforts of the therapist are often a turning point in the patient's reengagement.

What cues are available for the therapist to make a differential interpretation of illness behavior? First, it is imperative that the therapist understand the patient's medical condition. There is no substitute for facts. Second, the therapist weighs the patient's self-report and his or her own observations. Third, and of utmost importance, the therapist must communicate with other members of the caregiving team. They can give a general index of the patient's physical and emotional status, which then serves as a baseline for the therapist's assessment.

APPOINTMENT TIME

The structured and secure expectation of meeting at a regular time can do much for the patient's sense of stability within the therapeutic relationship. During hospitalizations, an appointed time provides the patient with a critical pivot for the day. However, as much as is positive in the regularity, there are obvious drawbacks to the "office-hours" regimen. What happens during evenings, nights and weekends, times for which fears of illness and death hold no respect?

The Deepening Shade

I have mentioned many times what I call the "2 A.M. syndrome."
It is in the middle of the night when I feel the most depressed.
The dark is associated with death; there is the feeling that you are
going to die alone; and there are times when I really feel the need
to talk to somebody. Unless there's an available resident, intern
or nurse, there is nobody to talk with. . . . That's where there is
a real deficit.   (Jaffe, 1978, p. 177)

That night was a bad night. It must have been about two in the
morning when I woke up. The little room was pitch dark. . . .
There came upon me a terrible sense of aloneness, of vulnerability,
of nakedness, of helplessness.   (Alsop, 1973, p. 19)

Of the various means of dealing with the "2 A.M. syn-
drome," few have been tapped by mental health professionals.
As a general solution, the patient is encouraged to discuss the
night fears during regular therapy sessions. An adolescent
thus commented to his therapist: "I do all right all day. My
aggression comes out at night." As the anxiety is brought to
light, its intensity and frequency of occurrence may diminish.
However, it is common knowledge that the patient may never
mention the night fears during the day, even in response to
the therapist's direct inquiry. Somewhat paradoxically, it is
daylight which provides a cover for the dark.

What emerges is the necessity for a flexible "on-call" sched-
ule among therapists working with these patients. A patient's
fear of being alone and abandoned—at the root of night
anxieties—is often assuaged simply by knowing of the thera-
pist's availability. Furthermore, night staff can be trained in
focused listening skills and thus provide a measure of comfort
and relief.

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Psychotherapy

Space

Space—the physical setting—establishes concrete boundaries for the therapeutic process. As the therapy hour is a time apart, so the setting affords a private space apart from daily life. The office becomes an extension of the therapist, with some of the same projective attributes.

A woman had a regularly scheduled therapy session prior to each hospital admission. She often verbalized how the therapist's office was a "refuge" before the onslaught. Upon hearing that the therapist would be away at the time of her next admission, the patient asked whether she might sit in the office alone. She felt that just being in the setting would help to prepare her.

With the physically ill patient, a consistent setting cannot always be depended upon for structure. Whereas the therapist's office serves as the base, other locations include the clinic, hospital, or the patient's home. Especially when the patient is seen in the hospital, the setting no longer stands protected and apart. Rather, the therapeutic process is enmeshed in the physical and emotional confrontation of the illness.

A hospital affords little privacy. Thus therapy sessions may be constricted, interrupted, or abbreviated by the presence of other patients, visitors, or staff. Another aspect is the lack of bodily privacy for the hospitalized patient. Nudity, exposure, and scrutiny become part of the expected routine. Patients appreciate the fact that, unlike most caregivers, the therapist is not directly involved in physical care.

The hospitalized patient may at times experience the thera-

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pist's presence as engulfing because the framework is altered: the therapist comes to the patient. Individuals in therapy, particularly children and adolescents, often use "time out" or leave sessions early to cope with intensity. With curtailment of physical autonomy, the patient's anxiety may escalate dramatically. It is a rare patient who asks directly that the therapist leave or that a session be ended. In compensation for this sense of "captivity," the therapist must be acutely sensitive to the patient's cues concerning spatial boundaries.

In the weeks following his amputation, a ten-year-old child cursed and screamed whenever his caregivers entered the room. His reaction was, in part, a desperate plea for space and distance at a time that he felt trapped, without option of escape. The therapist thus held initial sessions for only a few minutes, increasing their duration gradually with constant reassurance of her return. Such respect for the boy's vulnerability permitted him a sense of control and trust. Within a few days, he could accept the therapist and other caregivers more openly, without a sense of overwhelming threat.

Identity of the Patient

In traditional psychotherapy, the identity of the patient is strictly defined: individual; couple; parent-child or family. Many therapists feel that once the definition is established, it should not be changed. The boundaries of confidentiality are similarly explicit. When a therapist works with the patient with a life-threatening illness, the contract regarding "who is seen" is more open from the start. Although psychotherapy may be initiated with the physically ill patient, or with a family member, this one individual becomes the therapist's

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point of entry into the family system. By no means does all individual therapy become family-based. However, in the face of life-threatening illness, bridging maneuvers to involve the entire family can be critical.

Individual staff members may also seek out the therapist for help in dealing with their own experience.

A physician requested a private appointment with the therapist, in order to clarify the source of his depression and exhaustion: "How much of my feeling is due to the imminent death of my favorite patient, and how much stems from uncertainties in my personal life?"

A nurse whose mother had recently been diagnosed with an advanced malignancy was having enormous difficulty in facing cancer "on two fronts," work and home. As the outcome of several sessions with the psychologist, she decided to take a leave from the oncology unit.

Geist (1977) points out that the therapist's response to these requests can enhance the working relationship. The staff gain in psychological sophistication and show increased empathy for patients. A deeper bond between the therapist and other team members in turn fosters intimacy in patient care.

Because of this broader definition of the identity of the patient, confidentiality becomes a more complex issue. In a family confronting life-threatening illness, the boundaries of confidentiality may be more permeable than is traditionally dictated. The therapist bears heightened responsibility for handling privileged communication within an emotionally intense system. Skill is required to convey the facts and implications of the therapeutic material, without exposing its essence.

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The Deepening Shade

Issues of confidentiality can usually be worked out within the family, if the therapist remains sensitive to their potential loss. Individual are encouraged to share feelings with others in the family, either on their own or as facilitated by the therapist. Maintaining confidentiality can be paricularly complex in dealing with children and adolescents. The child must be secure in the "safety" of the therapeutic relationship, while at the same time understanding the need for contact between the therapist and parents. It is critical that the therapist not become a divisive wedge between parents and child or be viewed with a sense of threat as the bearer of secrets which cannot be shared. Most children express relief at knowing of this communication, provided that their own relationship with the therapist remains intact.

As long as a child's psychotherapy sessions were kept separate, he did not protest the therapist's meetings or telephone contact with his parents. He knew that these discussions focused on his coping with the illness. Interestingly, when his mother was upset one day, the child suggested that she talk to the *other* psychologist in the clinic.

Adolescence is a time when privacy and confidentiality are paramount concerns. This is especially true for the adolescent who feels physically and emotionally exposed by life-threatening illness. For this reason, a team of co-therapists to work with the patient and the parents can be particularly effective. Although there is ongoing communication between the two therapists, the adolescent appreciates the less direct link between his or her own therapist and the parents. The therapist can thus provide a sense of emotional sanctuary for the adolescent.

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Psychotherapy

The therapist plays a pivotal role in the integration of the patient's total care. With the ethic of confidentiality as a guide, and with the patient's consent, the therapist may share selective aspects of the therapeutic material with the caregiving team. The therapist communicates only essential content which bears directly on the care of the patient. Included are: a statement of the patient's emotional status, with the precipitating event if relevant; implications for the individual's ability to cope; and recommendations for care by other team members. Information which does not contribute to these categories is generally best left unsaid. The intimate nuance and subtlety of the material belong exclusively within the therapeutic relationship.

A woman with leukemia was exceedingly depressed during a routine hospitalization. The staff did not understand the marked change from her typical outgoing manner. In talking with the therapist, the woman revealed that just prior to admission, she had heard of another patient's relapse. She was frightened by the implications for her own situation. Once the woman's reactive depression was explained, the anxiety of the staff diminished, and they were able to provide her with the extra emotional care she needed.

Rumors abounded as to whether the mother of an adolescent patient had died naturally, or had committed suicide. The girl confided to the therapist that the death had been a suicide, and talked at length about its impact on her. The therapist's communication to the staff included: the fact that the patient's mother had committed suicide after a long psychiatric history; the feelings of abandonment and guilt described by the girl; how the experience might affect her coping with the illness; and her need for re-

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assurance despite a counter-dependent facade. When the therapist provided factual data, the "sensationalism" vanished, and the staff developed particular sensitivity toward this patient.

Therapeutic Content and Process

A hallmark of traditional psychotherapy is the unstructured flow of content and process. Past, present, and future interweave in the unfolding of themes. Letting a process emerge at its own pace and time is a luxury precluded by the very nature of life-threatening illness. Its immediacy demands a focus on the present, framed by the themes of separation and loss.

The patient's and family's previous experiences with loss will bear significantly on the present. Thus, an individual's "loss history" is a critical tool in highlighting areas of strength and vulnerability. The history encompasses loss in its broadest sense; for example, through illness and death, termination of relationships (such as divorce), geographical separation, and loss of employment. The history should include the person's earliest memory of loss from childhood, subsequent experiences up to the present, and a description of how the individual functioned in each context. What were the most stressful aspects of the experience? What type of support was positive, deleterious, or lacking altogether? It is of utmost importance to know the patient's and family's past "acquaintance" with the illness they are now facing. Have they known anyone with the disease, and if so, what was its trajectory and outcome? The meaning of the same diagnosis can vary dramatically depending upon these factors. Through this care-

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fully focused assessment, the groundwork is laid for thera-
peutic intervention.

One "loss history" revealed that many family members, including
children, had perished in the Holocaust. The diagnosis of ad-
vanced disease in an only child and grandchild precipitated a
massive depression throughout the family system. The grand-
mother lamented: "We lost so many already, and now. . . .What
more can we bear?"

A man diagnosed with an early-stage malignancy was given an
excellent prognosis by his physician. Despite this reassurance, how-
ever, the patient maintained that he was sure to die within the
year. It turned out that the one person he had known with the
same disease had died, and thus he viewed his own diagnosis as
an unequivocal death sentence.

Those who work with the individual with a life-threatening
illness view psychological defenses as coping mechanisms for
the present, rather than as barriers to the past. An individual's
defensive structure has developed over a lifetime of negoti-
ating reality. Faced with the ultimate reality—the threat of
death—his or her defenses may be mobilized to the hilt.
Defensive patterns which appear to be constructive for the
patient are identified as "psychological tools." Those with
deleterious impact become grist for the therapeutic process of
change. The therapist thus serves as an advocate of the
patient's defensive structure, in the service of optimal coping.

There is a future thrust for both patient and family, albeit
in markedly different ways. The family must focus on plans
which go beyond the patient's illness and death. Fear and
guilt often accompany the acknowledgment that despite the

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loss of one family member, life does continue. The patient, on the other hand, can consider the future only within the context of the present illness. In the words of a child with leukemia: "The doctors think my bone marrow is fine for now, and *for now* is *for now*." For the patient, the future is inextricably bound in contingency; for the family, the future means continuity.

And as my diet and my tumor have restricted my movements in space, so the probability that I shall die soon has restricted me to the immediate present in time. It has erected around me an invisible barrier that I bump into a dozen times a day. . . . I'm reasonably sure I'll be alive a month from now, and I sincerely hope I'll be alive three months from now; but beyond that I don't know. . . . In short, I have no future any more. And that I think is the greatest change of all. (Bell, 1961, p. 46)

The therapist must constantly maintain an acute awareness of both the cognitive and affective facets of time (Sourkes, 1977). On a cognitive level, the therapist monitors the reality of temporal issues; for example, how long the patient is expected to live, when the family is available, how much time should be devoted to therapeutic intervention at different points in the illness. For the patient and family, however, cognitive time may be out of phase with its affective counterpart. Thus, a family may panic over separation when in fact, the patient's condition is stable and death is not imminent. Or in contrast, a denial of impending loss may occur when time is short. These seeming inconsistencies arise from the fact that the patient and family live within a dualistic realm of time. The clock and calendar, by their imposition of finite

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limits, bespeak the reality of adult-time. Especially in confronting life-threatening illness, "the calendar is the ultimate materialization of separation anxiety" (Bergler and Roheim, 1946, p. 190). In contrast is child-time: the magical, omnipotent belief in endless time forever. While the context for psychotherapy is finite time, a shift into child-time does not necessarily imply denial or blocking.

A man acknowledged that there were no further treatment options for his advanced disease. Within the same session, he talked about travel plans for the following summer. When the therapist confronted him with the juxtaposition, the man replied: "Of course I am aware of the reality of my illness—and—I nonetheless hope for something better."

The patient may also be testing the therapist: "Which time framework will you buy? Or, can you tolerate the fluctuation which is the essence of my experience?" Adherence to child-time, to the exclusion of impinging reality, may signify fear and dysfunction. However, most families flow between the two sets of time, in a normal and adaptive process of maintaining hope. The therapist need only follow.

The Therapeutic Relationship

"What does that mean—'tame'?" [asked the little prince].

"It is an act too often neglected," said the fox. "It means to establish ties. . . ."

"What must I do, to tame you?" asked the little prince.

"You must be very patient," replied the fox. "First you will sit down at a little distance from me. . . . I shall look at you out of

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the corner of my eye and you will say nothing. But you will sit a little closer to me every day. . . . You become responsible, forever, for what you have tamed." (Saint-Exupéry, 1971, p. 80 f.)

Such is the essence of the relationship between the individual with a life-threatening illness and the therapist. The therapist's role for the patient is highly specific: he or she is an anchoring presence in a life situation which otherwise feels unstable and vulnerable. The feelings which the patient projects on the therapist (transference) and those of the therapist for the patient (countertransference) come to mirror the themes of attachment and loss which the patient is confronting in every relationship.

In any psychotherapy, the transference is the crucial vehicle for exploration, since it is a prototype of the patient's development and functioning. With the urgency of life-threatening illness, an intense transference brings powerful emotions into high relief. However, the luxury of operating exclusively within the transference metaphor simply does not exist. Rather, the therapist must constantly translate back to the patient's "outside" life. That is, a close correspondence between the transference material and its implications for the patient's key relationships with family, friends, or other caregivers, must be maintained. One strives to foster a transference whose depth and intensity can fuel the tasks of living so crucial for someone with a limited life span.

In the following excerpt, a six-year-old child initiates a dialogue with his therapist, culminating in a profound revelation of his own sense of vulnerability.

Child: Did you ever have bad dreams?

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Therapist: Yes, sometimes I have had bad dreams. Usually when I have bad dreams, it means that I'm worried about something.

Child: What are your bad dreams, usually?

Therapist: I think that they are a bit like yours. You know, monsters and things like that.

Child: And snakes. . . .

Therapist: What else do you have bad dreams about?

Child: A snake biting. . . .

Therapist: When you have those bad dreams, what do you think you are worried about?

Child: You dying. Everyone dying in the world and leaving me alone.

It is the very intensity and security of the therapeutic relationship which permits such candor. In turn, the agenda is set for exploring the patient's sense of overwhelming loss in all significant relationships.

In traditional psychotherapy, the patient's contact with the therapist is strictly limited to the session itself. Thus, the therapist has little "real" identity for the patient beyond this boundary. In an interdisciplinary setting where the therapist functions as a team member, such anonymity is rarely preserved. This "demystification" adds a level of complexity to the therapeutic relationship, whereby the projective nature of the transference intertwines with the reality of the alliance.

A patient overheard several nurses discussing the approaching marriage of the therapist who worked on the unit. His reaction was to panic in fear of "losing" her to her new commitment. Furthermore, at the time he was dealing with difficulties in his own marriage which had been exacerbated by his illness. The

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therapist's control over a propitious time to disclose her situation to the patient (if at all) had been inadvertently preempted.

An aspect of the countertransference which is aroused particularly in those who work with the fatally ill is the "rescue fantasy" experienced by the therapist (Sourkes, 1977). In wanting to protect the vulnerable individual, the therapist encounters the danger of overinvolvement, a loss of boundary and role. By moving in to achieve a great deal of closeness with the patient, the therapist may in fact supplant the family by becoming a surrogate. The pitfalls of the "family surrogate" approach are evident for the patient and family as well.

The patient may feel threatened by an inordinate closeness to the therapist, while at the same time welcoming and needing the relationship. He or she feels trapped: "having to choose" between family and family surrogate, with a simultaneous fear of alienating either. The therapist must prevent the patient from ever experiencing such a forced choice position. One safeguard is to be found in the interpretation of the transference material. If the patient understands that the intense feelings which develop toward the therapist also have meaning for his or her other relationships, the sense of threat is minimized.

The family could feel estranged and supplanted just at the time they are desperately trying to "keep" the patient. Their pain is only exacerbated if they feel that the therapist is "better" than they in achieving closeness. The therapist and other caregivers must be aware of their own feelings of competition: such rivalry often serves as a danger signal of inappropriate involvement, coupled with a family's difficulty in relating to the patient.

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The discussion at a case conference focused on a man's inadequate support of his wife during her prolonged hospitalization. The staff noted the husband's infrequent visits, and his discomfort in his wife's presence. Both the therapist and the nurses described their closeness to the patient. It was at this point that the therapist realized the staff's error: all were vying for a "special relationship" with the woman to compensate for the apparent problems within her marriage. Furthermore, the husband's behavior was clearly an indication of his own difficulty in coping with his wife's illness. The therapist was able to highlight these issues in the conference, and subsequent work focused on the couple's relationship.

The therapist often becomes a facilitator: one who makes easier, smoother, and more meaningful preexisting family relationships. The therapist can then move in and out of the family, tied exclusively neither to the patient nor to the other family members. By avoiding the "surrogate" role, the therapist flows with the system, strengthening and enhancing the structure of the family.