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To cite this article: Michael Ashby (2016): Unconscious dying: the lightly tilled soil of palliative care and psychodynamics, Mortality, DOI: 10.1080/13576275.2016.1255602

To link to this article: http://dx.doi.org/10.1080/13576275.2016.1255602

Published online: 14 Nov 2016.
Unconscious dying: the lightly tilled soil of palliative care and psychodynamics

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ABSTRACT
It goes without saying that death, and foreknowledge its inevitability, has always been the ultimate human challenge, that drives, at conscious and unconscious levels, everything that is done, thought and believed. Given the dominant worldview of logical positivism, scientific mastery and personal control, coupled with modern epidemiological realities, decision-making and care for people who are approaching death is a major challenge for society and health systems. For over 50 years the lead has been taken by the hospice/palliative care ‘social movement’, and recently more broadly in health, especially in aged and intensive care, and by policy-makers. The overwhelming discourse and methodological approach tends to be linear, empirical and logical, in line with the zeitgeist, the ‘regimes of truth’ and ‘evidence base’ that are dominant in the system. This paper explores the possible unconscious personal and organisational forces at play when health services and society engage with the threat of death. It posits the view that a wider reticence to acknowledge the possibility of deep instinctual forces limits the capacity of the health system, its professional teams, individuals and wider society to work towards ‘healthier’ relationships with death, the dying, the dead and ourselves as ‘mortal threat’ at all times. Concepts such as identification, projection, transference and ‘organisation in the mind’ will be explored in the death, grief and palliative care context, as well as a notion of ‘ingestion’ or ‘transmission’ of pain and loss of others as a driver of organisational discord and burn out.

Introduction
The so-called hospice and palliative care ‘movement’ has done much to improve care of dying people. The ambitious holistic and multidisciplinary agenda it sets out includes and subsumes the psychological, emotional and spiritual domains of the dying process. These domains tend to be aligned with academic and clinical psychology, psychiatry and the behavioural sciences on the one hand, and pastoral or religious care and theology on the other.
As psychodynamic and psychoanalytical insights currently tend to be unfashionable in these disciplines and professions, it is unsurprising that they are not really present in the palliative care and death studies literatures, and virtually absent from clinical practice.

In yet, every encounter with a patient who requires palliative care deals with a person who is under threat, faced with pain and loss, played out in family and social settings where psychodynamic insights have much to say, especially about behaviours that may arise in the unspoken and unconscious dimensions of human experience. Every consultation is a fragment of psychotherapy, with all the conscious and unconscious forces at work that one might expect to be operating for people under threat, with the stresses of uncertainty, and the impending reality of death, in a society with no socially sanctioned space for loss, deterioration and biological extinction. It seems reasonable to apply psychodynamic theory to generate working hypotheses to explain phenomena that are presently enigmatic and/or unaddressed by more conventional interventions in medicine and psychology. It is not suggested that the psychoanalytical canon arrives with mechanistically proven scientific explanations of what happens, but rather that it offers a framework and language to describe what appears to be happening. A psychoanalytical approach is obviously hard if you do not possess the training, but psychodynamic understanding, based on reading and experience can enrich the understanding of the phenomena observed by clinicians and inform more enlightened responses by clinicians and teams. At a team and an organisational level, group forces and individual behavioural insights have the capacity to improve quality of care for patients and clients, and the health and harmony of teams and their employers.

This article aims to analyse and interpret some of the language and ideas that presently inform decision-making and care as death approaches through the lens of psychodynamics. It is only verifiable or refutable through the experience of the reader, in what Michael Ignatieff referred to as the ‘writer-reader covenant’: the author presents truth as it seems to him/her and then asks the reader ‘is it true for you?’ (Ignatieff unpublished, Adelaide Festival, Writers’ Week, 2000).

It will examine death ‘denial’ constructs in the light of Freud’s death wish theory, the nature of love as a ‘currency’ of caring, the ‘softening’ euphemism of ‘passing’ away, Winnicott’s theories of ‘holding’ and ‘the good-enough mother’, the good and ‘good-enough’ death theories, the tendency to hagiography of palliative care workers and a ‘tyranny of niceness’ surrounding death, the unconscious possibilities in the relationships between professional carers and dying people, the effect of the pain of clients on teams and organisations, and how grief permeates everything and everyone. What might classic psychodynamic terms such as transference, counter-transference, projection and identification mean in palliative care and grief therapy practice? What do we understand about our own narcissism, stages of development and castration or Oedipal anxieties? It will conclude by making certain suggestions about supervision, education and clinical practice, and also some organisational reflections.

Psychodynamics

Psychodynamic theory and psychoanalysis is one of the most influential intellectual and clinical movements of modern times, albeit a controversial and contested canon, particularly with regard to the original work of Sigmund Freud, and co-workers past and present. Despite all the attacks about scientific validity and clinical effectiveness, the insights stand as
monumental and influential. At the very least, they can be road-tested against experience as a way of talking about aspects the human condition where current humanities-based disciplines, science and clinical practice still frequently ‘hit the wall’.

The psychodynamic ‘facts of life’, in the Tavistock Institute tradition, may be summarised as follows:

- Prolonged dependency on others in infancy and its consequences for later psychological development
- Inevitability of death and our struggle with this knowledge
- Necessity of tolerating and management of our relationships with others
- Transcending personal narcissism
- Struggle between loving and hating impulses in our relations with others and ourselves
- Human mind and personality as products of a development process that never ends
- Anxiety as a necessary condition for being alive. (Cooper & Lousada, 2005; Money-Kyrle, 1978)

These observations and interpretations of human behaviour allow the construction of a more realistic narrative about the nature of caring in general and palliative care in particular. They have the capacity to challenge what might be termed a ‘Pollyanna’ depiction of caring as an one-dimensional experience that tells us the story we want to hear about ourselves as people and professionals: that care is loving, unselfish and perhaps, in the professional sphere, almost ‘selfless’.

Psychodynamic theory posits that groups and individuals tend to suppress, and indeed repress both consciously and unconsciously what they fear and wish to avoid. Pain, death and grief are things that are the subject of overriding fear and avoidance. In societies that are commonly, and increasingly, lacking in a transcendent narrative about the human condition and its finitude, it is not surprising that individual and collective averting of the gaze is the norm. Those who swim against the popular tide, and attempt to subvert the zeitgeist, do so at some cost that is common to all trend-setters, innovators and social reformers. (James & Field, 1992) A certain charisma and social action agenda is required, and this is manifest in the death studies, grief and loss and hospice/palliative care ‘movements’ from the second half of the twentieth century onwards.

Independent specialty status for palliative care within the professions (medicine, nursing, allied health) has been hard won. Starting off outside the health system as a radical change movement, it had to win acceptance by curbing its revolutionary zeal, minimising threats to existing craft groups, and adhering to the ‘regimes of truth’ around knowledge generation and research. This mainstreaming process required that the nascent specialty show its credibility by research, as much of its was seen as ‘soft’ by the rest of the health sciences academy (which often itself was not on as firm a terrain as it made out!). This was in many respects both necessary and successful, but also meant that some of the subjective aspects of death and dying remain hard to capture and measure, and hence remain under explored or unspoken. This process of legitimation and professional peer acceptance has undoubtedly led to a valuable integration and embedding of palliative care and its principles and practices in health systems.

At the same time it has made the field more linear in its thinking and less likely to speculate and play with subjective and complex facets of the experience, especially the unconscious.

The dominant underlying ideological and spiritual driver of these social movements has been one of Judeo-Christian service: putting others first in a tradition of charity and
self-abnegation. The evangelical protestant influences on the early British hospice movement in the mid twentieth century, and the older tradition of catholic monastic care as a basis for a modern model for care of the dying has been well documented in the historical and record (Clark, 2006). The struggles of that tradition with the true nature of human existence, in particular the subconscious sexual and narcissistic forces at play, are also well known.

What follows is an attempt to try and explore what the realities of dealing with dying may be in psychodynamic terms, and how these insights may assist a deeper, and, dare one say, more 'honest', understanding of the tensions and influences at play in an area that is almost always acknowledged to be 'difficult'.

**What might classic psychodynamic terms such as transference, counter-transference, projection and identification mean in palliative care and grief therapy practice? The unconscious possibilities in the relationships between professional carers and dying people**

The dominant basis for caring is one that might best be described as benign charitable concern, that the suffering person merits care based on love by family and friends, and professional compassion for health workers and volunteers. It is neither comfortable, nor 'professional' to acknowledge that, deep down, there may an element of ‘thank god it’s not me in the bed’. Worse still, can anyone cope with the idea that they may project their own fear of death, to say nothing of their other personal psychodynamic ‘bagage’, onto the person who is dying or grieving, often without knowing it? Identification and projection are common experiences: this client reminds me of my own mother, but do I then behave towards her in my personal filial role, to what extend can I detach from the personal and be ‘professional’ if you take all of yourself everywhere? What energy is consumed in an inauthentic professional relationship that of necessity actively represses projections and transferences that would be truly unprofessional? Whether it is the nurse who says she/he cannot look after a child because of his or her own parental role, the doctor who avoids breaking bad news because of an identifying bereavement, or the team being plunged into discord because of a demanding client, or moral indignation about a medical decision, all practitioners need to deal with the personal in settings and social contexts that allow little or no understanding of these forces. Cooper and Lousada have explored how various ‘forms of feeling’ are either facilitated or discouraged in welfare systems, particularly those of dependency and loss, and how contemporary social anxieties influence care and emotional depth in service settings. (Cooper & Lousada, 2005)

The health care worker–patient/client relationship is often defined by the inherent power imbalance of any professional relationship, as knowledge is power, power over the domain of expertise (law, accountancy etc.) and palliative care often exhibits an 'ownership' of death and dying: ‘trust us we are the death experts, just as masons have the secrets of building’. This is most manifest in the euthanasia debate. Statements are made by palliative experts about the dire consequences that will ensue if those who do not know what palliative care can do (the public) are successful in their political quest for assistance to die. The palliative care death experts are the wardens of our common fears, the lion tamer or witch doctor who keeps the evil spirit of death away, with scientific knowledge. These possibilities are confronting to contemplate as they violate societal assumptions and norms about professionals
and their capacity to shield us from the cruel world, but maybe also from our own true natures and fates.

As unconscious transactions between client and carer are usually not understood, the two-way street is not noticed. A dying person fears may be projected on to team members and teams themselves. Indeed, it is said that patients make us feel what they cannot tell us\(^1\) (Carroll, 2014), so emotional energy or traffic might be viewed in a scientific metaphor, and the first law of thermodynamics, whereby energy is neither created nor destroyed in the course of a chemical reaction. Similarly pain and negative emotions have to ‘go’ somewhere, and in human psychodynamics, they ‘go’ into and through those who care. Some of the energy sticks and is processed consciously or unconsciously at an individual level, but mostly it will be passed on in debriefing (formal and informal) and supervision. Much of it though goes out into the team, the family and the world.

There are very limited ways to express, and indeed to theorise, about the cumulative effects of dealing with death and dying on individual workers and teams. The most common model is individual and collective team burnout. Despite extensive formal and informal work to prevent it, unhealthy behaviour and dynamics are common, often poorly recognised and most action seems to focus on the individual rather than the system. In other words the model is itself medical rather than social, psychological or anthropological. There is a tendency to ‘treat’ the burn out symptoms rather than work on the systemic circumstances that generate these problems of poor team health and functioning that can easily occur especially when the pressures on services are so intense.

The emotional energy required to engage with and care for dying or grieving people is widely agreed to be large. It is clear that one cannot simply snap out of burnout, and energy depleted over a long period of exposure to pain and suffering can take a long time to regain, and in some cases cannot be replenished and the worker leaves the field for good. It might be useful to understand these capacities as finite resources that are more like bone mineral content, vitamin D or iron stores in the body. Physiological stores are built up over the life span, and cannot be restored overnight when depleted, and will often take months or years to recover despite intensive therapy, so too perhaps with the psychological, emotional and spiritual resources. What if really bad burnout were ‘incurable’, like post traumatic stress disorder?

In a biography of the late human rights activist, Helen Bamber, it is observed that workers in a specialist centre for the care of victims of torture, the staff actually treat each other quite badly, and use bad language in a way that might seem inconsistent with human rights and welfare work (Belton, 2012).

- …she thought they tolerated the relentless awfulness of the material they dealt with ‘by making the organisation itself awful’…
- …we treat each other terribly; we dash around in chaos; and Helen in her own way is a complete dictator. But we support her and moan. It is a very primitive organisation trying to do very sophisticated things.
- the people she began to recruit here were, most of them, difficult and maverick … she knew she would need men and women who shared her own strangeness, and … her naive refusal of the world as it is.
- I think we must reflect patients’ experiences all the time.
The biography reflects that the reason for this is due to some kind of flow of pain and negative emotion into the facility. The judicious use of bad language is probably a vernacular way of conveying our real unconscious feelings of anger, negativity and powerlessness.

In an ABC interview with Andrew Denton in 2009, Helen Bamber gives a moving and instructive account of her encounter as a young volunteer in concentration camps after their liberation in 1945. She describes an emaciated, and obviously dying woman rocking from side to side, a woman who cannot be saved and is not safe or secure, and how she sits and rocks with her, and tells her she cannot undo what has happened to her and cannot prevent the inevitable death: but she will listen to her story, and ensure that it is not forgotten. This is an important lesson about boundaries: no matter how awful the woman’s situation and the gross injustice and cruelty that have befallen her, the carer or therapist is not responsible for the cause, but can however, at least, be present and offer support and emotional solidarity.

**Love: the currency of care as death approaches**

One of the key insights of psychodynamics is that where there are intense feelings these can often exist in oppositional tension, particularly with regard to the polarities of love and hate of the other. As Adam Phillips points out it is not that people have mixed feelings about each other, it is that they have strongly opposing feelings at different times, or the same time. The ‘bikie’ with ‘love’ tattooed on the knuckles of one hand, and ‘hate’ on the other, understands this better than the doctor. So whereas in the life of the logical mind and the ordered family or civilised society, love and hate are seen as, literally, ‘poles apart’, lived experience and psychodynamics show that the two can co-exist in close proximity, with the thinnest of walls between them. This juxtaposition of two emotions normally seen as polar opposites, distant from one another, are in fact close due to the nature of aggression and its triggers, and closer for some people and some relationships than others. One brain ‘controls’ both hands, but the ‘spectral’ distance ‘in the mind’, with a partition that can be paper-thin, is often maintained by learning and social mores, but in biological terms is part of a more primitive diathesis.

A monist view of love presents problems in health care practice and to some degree, also possibly, ethics. In palliative care discourse: family and friends in close relationship are loved ones and the patient is the ‘loved one’, or even dare one say it the love ‘object’? This ‘Pollyannaish’ vocabulary marginalises those who do not have good relationships, where abusive parenting or marriage is faced with death (and the death or loss of ‘chance’, the chance of last minute redemption, of ‘coming good’ before it is too late). There is a literature on ambivalent grieving (often referred to as intense ambivalent grief: the most difficult type). In practice, the societal ‘regime of truth’ is that caring has meaning and benefit, plus there are established patterns of social duty for carers and the ‘cared for’, that have been, historically, largely gender-determined. But if the currency of care is ‘love’ the problem is that when this is healthy, comfortable and appropriate because the relationships are good, all is well, but heaven help you if the reverse is the case. How many people care out of are socially constructed duty, when in fact they may (conscious or unconsciously) be willing or unwilling, angry or happy, loving or hating, and therefore righteous or guilty? Rudolf Steiner spoke of the importance of action coming from the person’s own will and not from social duty, that care should be authentic and not phony (Steiner, 2011).
It is also problematic that so much is based on the romantic sexual love of modern popular culture. One cannot make the assumption that romantic love itself is a common currency that can be both reliable and predictable with regard to, say, care during a terminal illness. There is, none certainly a PhD to be written about but what about first partners as carers for divorced partners (usually men), where presumably, some kind of pre-or post-romantic love, or duty, is the motivation.

Lacan gave this chilling, perhaps lightly cynical, wake up call about the nature of romantic love: it is, he says where you ‘give something you haven’t got to someone who does not exist’. He also famously said that Jesus Christ exhorted us to treat others as we treat ourselves, and that is where the problem starts, says Lacan, because we are so hard on ourselves, and a capacity for self-love is so poor. There is however no doubt that love can give birth to care, and that is a profound social and human good, and that it lies at the heart of most religions, and certainly the Judeo-Christian tradition. Philips points out that the super-ego kicks in and seems often not to let the ego have a chance, before the self talk and beating up of self starts. So love is good when it is good, and it may be what makes the world go round, but it cannot be assumed to be an inherent good, above question and analysis. Nor are the lines between love and duty and love and hate as clearly demarcated as they often appear, or as we collectively no doubt would like to see them.

We are also confronted with the injunction to speak no ill of the dead, although British quality newspaper obituaries make a fine art out of disobeying this (Starck, 2006). May be there is a sense of fair play due to the fact that the dead can no longer speak for themselves. There could also be a deeper sense of the dead coming back to haunt the living, that they are perhaps in some way watching and that despite all secular rational dominant world views, the disapproval of the dead is still at least a perceptual possibility. The other sense may well be that the dead have earned their protection by the ordeal of dying. Walter has radically questioned the nature of the relationship with the dead by adopting a continuing social bonds view that sees reintegration of the dead person into the world of the living (Walter, 1999).

It is also noticeable that religions also struggle with dying. Despite the fact that most of the major world faiths have rich traditions that give meaning to death, they may also to some degree be influenced by prevailing social conditions, and indeed be sociologically shaped. Evangelical Protestants may see death as a failure of a prayer community. Those following the protracted, but very modern dying, of the late pope John Paul II would be forgiven for wondering why, if the spiritual leader of a billion people was reaching the conclusion of his earthly journey, the Vatican rhetoric was all about trying to postpone the inevitable (even if his successor displayed commendable good judgement in retiring when he needed to)(Keeley, 2008). As Kellehear has pointed out, throughout human history dying has moved from the ‘other world’ to ‘this world’ trials, with the individual and the material taking over from the transcendent collective and eternal (Kellehear, 2007).

It might also be said that the hospice movement pioneers, inculcated with Christian ideals as they so often are and have been, urge frankness about death partly because they have a redeeming narrative of eternal life, or at least a sense of bodily death not being the end. For those without such consolation, or those who do not find this comfort in their religion, the stark reality of extinction is a big challenge, and hence there is a need to soften the blow, or avert the gaze. It is obvious that the movement has been a creature of western, and originally British ‘Commonwealth’ pathways, although the British cultural tradition in not known for its openness, especially in the sphere of human emotion. In yet the UK has been a principal
host of both psychoanalysis and the hospice movement, and much of the early work about bonds and loss (see Freud, Bowlby and others cited here). If British society and health and social care systems have been the perhaps somewhat unexpected major vectors of a radical death awareness consciousness, it might still be worth asking in which culture death, dying, loss and grief are comfortably confronted. A more universal human tendency is perhaps to hide these painful realities as much as possible. ‘[o]ne cannot look directly at either the sun or death’ (cited in Slemrod, 2003, p. 371). T.S. Eliot concurred three centuries later that ‘human kind/Cannot bear very much reality.’ (Eliot, 1971) In this they are allies of Freud’s pleasure principle (see below).

The existential philosophical tradition has had big impact on modern thinking. Its hallmark is to deal with the one reality we can be sure of, namely individual mortal bodily existence. This is brought into sharp and painful focus by Isaiah Berlin (Ignatieff, 2000), in his response to the deportation of fellow Jews to death camps, usually without knowledge of their fates, as an affront to their human dignity in that this ignorance robbed them of the chance to face death:

> Why does this deception, which may in fact have diminished the anguish of the victims, arouse a really unutterable horror in us…Surely because we cannot bear the idea of human beings denied their last rights…of knowing the truth, of acting at least with the freedom of the condemned, of being able to face their destruction with fear or courage, according to their temperaments, but at least as human beings, armed with the power of choice.

This is a confronting challenge for present times, suggesting that dealing with death is an existential responsibility for each mature adult, to avoid the accusation of ‘mauvaise foi’, of abdicating one’s responsibility for oneself. The ‘choice’ here is not between one treatment and another, or opting in or out of life-prolonging interventions or life support at the margin of life, but whether to face up to and deal with one’s own dying.

There are three big threshold moments in a life about dying: firstly, the childhood moment when death becomes a reality, secondly, (unless death has already arrived swiftly without warning), the diagnosis of a fatal illness or its incurable relapse (we could still live on but for the illness in question), and, thirdly, the crossing of a final ‘Rubicon’ moment when our final days have arrived and death is imminent and inevitable, like a final common pathway, where no turning back is possible, even if our illness(es) could be cured, we would still die. Medicine, society and the law fail to recognise the last two, and our most honest personal encounter is probably with the first.

Whilst it is well accepted that it takes around 18 years to grow to adulthood, there is no such socially accepted space to recognise a slow process of dying in old age. Indeed most ‘health ageing’ emphasises positivistic approaches and attitudes that ignore or downplay the realities of death and dying. It is this insight that lies behind the seemingly oxymoronic health promotion concept of ‘healthy’ dying. It is necessary to recognise and create or recreate a safe social, ethical, legal, political and spiritual space for death and ‘death-ways’. Kellehear has pioneered the notion of public health promoting palliative care and death-friendly societies (Kellehear, 1999, 2005).

**Death ‘denial’ constructs in the light of Freud’s death wish theory**

It is of note that the use of euphemistic and apparently consoling language has gained steady dominance. The expression ‘passed away’ is a use of language that appears to impart
a sense of gentleness to cushion blow or soften the brutal stark reality of what has been termed by Buddhists as ‘unwelcome change’. It has been growing in usage in funeral notices and the media over the last half century (Hardy & Douglas, 2016). This trend towards the avoidance, or at least the averting of the collective gaze away from death seems understandable from a psychoanalytical point of view in that the pleasure principle indicates that avoidance of pain or loss will usually take the form of subconsciously indeed consciously active repression.

It is also noticeable that police and emergency service spokespeople will often refer to a dead person as having or being ‘deceased’, as if to say more would make the tragedy they are recounting some how more unbearable than it already is. It may be that this language practice has its origins in England after World War I, where Jalland observed that the horrendous losses of that war led to a disenchantment with organised and established religion, and spiritualism became popular as a means of processing the enormous grief of mothers, sisters and widows. The term ‘passing, or ‘passing over’, or ‘crossing the threshold’ hold some comfort in the sense that there is some promise of spiritual life after death, that is accessible to the living (Jalland, 2010).

The spin or self-spin is part of the need to not look too directly at mortality, and to tell stories to soothe the fear and anxiety generated by foreknowledge of certain death. It is clear that health workers (often surprisingly reluctantly) will struggle enough to talk about the death of a patient, and academics seem to be able to discuss it as an abstract concept or something that happened to others, although it has been said that there is no such thing as death the abstract only one’s own death.

It is surely true in a time when developed countries have never tried to live so far above reality of their true selves that technological progress and biological ingenuity become the allies of a natural group repression of the finite nature of life. Personal extinction is not so much denied as written out as the script, as in Catherine Mayer’s book ‘Amortality’ (Mayer, 2011). If the psychodynamic understanding is that groups tend to collude to suppress and avoid pain, it is not then surprising that societal gaze is collectively averted from the realities of death, dying, pain, loss and grief. It is, then, difficult to incorporate the notion of a death wish, of negative libido, of self-harm.

One of the first ‘noble truths’ of dealing with our mortality and our losses, is that just as nobody can prevent our eventual inevitable deaths by dying for us (note the careful use of language and acknowledgement of obvious theological exceptions, and sacrificial service, such as in war), so too nobody can do the grief work of another, nor protect oneself or others including children from the pain of loss.

So a parent who says they would like to take the place of their dying child is expressing a genuine personal, and probably spiritual impulse with Darwinian possibilities, but you cannot do another person’s suffering for them: the Christ image is not actioned in the world by simply willing it. Maximilian Kolbe’s sacrificial replacement of another prisoner condemned to die in Auschwitz does not translate into everyday life, in particular nobody can do another’s grief work any more than the spiritual or emotional ‘work’ of the other. Freud talks of the task of grieving: ‘treuer arbeit’ has to be done at the appropriate time (Freud, 1957), and whilst the timing of appropriate is to some degree individual, long delay, and repression or avoidance in order to mitigate pain of loss or sublimate it, will often lead to its appearance or indeed eruption later in life, often with adverse consequences. Just as water
‘finds its own level’ in a flood, grief will usually return and demand our conscious or uncon- 
scious attention, especially in future relationships: in the territory of future bonds.

Ernest Becker in his book ‘the Denial of death’, published shortly before his own death in 
1974, puts the view that the death wish is the under-reported headline of Freud’s work. 
(Becker, 1973) It is profoundly counter-cultural to suggest in the modern world, that the 
dominant sub-conscious force in our lives is the fear of death, but this is seemingly contra-
dicted by the death wish, self destructive forces (Freud, 1957). However, it is a plausible 
explanation of much contemporary angst. If we did not harm our selves, or score ‘own goals’ 
imagine how much smaller your local hospital would need to be (drug and alcohol, self 
harm, eating disorders etc.). The global society that has emerged in the early 2000s has made 
many things better than ever before. It has also spread cultural, social and economic circum-
stances that cause enormous stress. As the battle of the body is won (and in parts lost) the 
battle for the mind is raging. The anti-psychiatrists (RD Laing, Thomas Szasz and others) may 
yet make a triumphant posthumous return as it is seen that society makes you sick (Laing, 
1960). One part of that sickness is that so much is invested in the here and now, and of 
defeating nature and our true selves, the psychological price gets higher too, including 
dealing with loss and death.5

‘Good-enough’: Winnicott’s theories of ‘holding’ and ‘the good-enough 
mother’, ‘the good or the good-enough’ death

Palliative care judges its success by the comfort and support it seeks to generate for dying 
people and their families. Like any area of medicine and healthcare, failure is hard to bear. 
Dying is an unpredictable, chaotic and challenging in both biological and social terms. It 
cannot really be ‘tamed’ as the historian Phillipe Ariès suggested (Ariès, 1981). So what is the 
ideal of the ‘good’ death indeed can any death be ‘good’? One sense of this is that the death 
is with integrity, in that it is consistent with the life that the person has lived. So if that person 
has lived a troubled life with, say, drug and alcohol abuse and social marginalisation, it should 
not be a surprise if they are unable to die a quiet and tidy ‘hospice’ death.

There is a small but substantial literature on the concept of the ‘good’ death. Steinhauser 
et al. did a landmark study nearly 20 years ago in Chicago that identified some its key 
elements, and how the priorities of patients might differ from those of their carers (Steinhauser, 
Christakis et al., 2000; Steinhauser, Clipp et al., 2000). McNamara made a sociological critique 
of the ‘good death’ in palliative care in an Australian ethnographic study of palliative care 
nurses. She found that there were internal and institutional pressures to achieve a peaceful 
and comfortable death, with disappointment if this was not achieved, that may have its own 
individual and team dynamic consequences (see below). Just as there are few ‘perfect’ births, 
so too the final transition can be bumpy. It is has been suggested that a more realistic and 
pragmatic alternative may be the ‘good-enough’ death (McNamara, 2001, 2004; McNamara, 
Waddell, & Colvin, 1994).

The ‘good enough’ construct was originally based on the work of the English child psy-
chotherapist Donald Winnicott (1896–1971). Winnicott talked of an idealised form of ‘good’ 
mothering that was inherently unrealistic and that the mother just needs to be ‘good enough’, 
and therefore needs to release herself of the impossible burden of perfection. A key ally of 
this concept is that those around the mother need to share this understanding, and ‘hold’ 
the ‘good enough mother’ so she can in turn hold the infant in his/her rage (Winnicott, 1986).
By analogy, the ‘good enough’ death needs to be ‘held’, and someone in turn needs to hold the carer(s).

The main reason to invoke this analogy was to explain to carers, both family and professional, that there are limitations to the capacity to relieve another person’s suffering, that care seldom perfectly meets all the needs and wishes of those being cared for. Carers need not feel that they have failed if they cannot help the patient, and family, to achieve an idealised ‘good’ death. Palliative medicine has urged other specialties to recognise their own limitations, and so it is healthy for it to do likewise with its own inevitable limitations. For this reason, the French term ‘accompagnement’ (literally accompanying) of the dying person as a linguistic expression of palliative care seems to be apt, a ‘walking-with’ rather than heroic takeover that results in dashed expectations on everybody’s part (Abiven, 1990).

Palliative care workers become repositories of many stories, not that there is right and wrong way to do things, but themes of what works and what does not emerge. Some of these stories may in some way seen as (Jungian?) archetypes: the brave confrontation with death’s realities, the deathbed redemption, reunion with alienated family or friends, overcoming of perceived denial in families. These have some connection with the mediaeval notion of the good death as an exemplary spiritual exercise, with comfort being taken by others in the courage of the dying person, linked to spiritual duty and fortitude.

The effect of the pain of clients on teams and organisations, and how grief permeates everything and everyone

The pain and grief of others obviously affects us all. There have been two key contemporary ideological shifts in thinking about grief: the oscillation model of Stroebe and Schut (1999) and Stroebe, Schut, and Van den Bout (2013), and the sociological reintegration of the dead into the ongoing worlds of the living (Walter, 1999), vs. medical/psychological ‘recovery’ model. These insights can be seen as being like wave and particle theories of energy transmission in physics, alternative explanations of the same phenomena which are not mutually exclusive but rather deepen understanding and open up conversations that may have been prematurely cut off by regimes of truth or prevailing ideological correctness. The importance of these theories for this discussion is that palliative care services, and indeed most health and human services to some extent, and all organisations from time to time, have to deal with grief. Indeed any hospital, as well as giving hope and help to thousands, is also a repository of community pain and loss. As such the ‘container’ is like Pandora’s Box, it is indeed a location of sadness and loss, as well as being the locus of community death anxiety, as almost any modern western election campaign will show you (Walsh, Campbell, Ashby, & Procter, 2016).

Pain is circulated amongst staff and transferred across and around an organisation, with conscious and unconscious behaviour directed at mitigation of pain and resultant anger. People tend to ‘oscillate’ between apparently ‘normal’ functioning and grieving, which, not being legitimised in a health setting, will usually take other forms. It also means that patients and families will behave illogically and appear at times not to hear the reality of bad news and poor prognosis. The organisation therefore as system experiences apparent ambivalence and confusion reflected from the experiences at a personal level. When the message comes from sociology that we cannot ‘cure’ loss, the organisation’s dominant medical paradigm is undermined. The take away message here is that if you put up a sign saying ‘bring us all your
troubles’ then the community does just that, and managing that container with all its hopes and expectations is ultimately not achievable, at some level it is not meant to succeed: the ‘good enough’ is the best that can be striven for.

The implications for services are clear. It should be a surprise to none that teams will tend to hide from conflict and issues they do not like. They will tend to fight surrogate battles that allow them to work their own narcissistic impulses. Transgressors will be persecuted and those who buck the dominant group norms will be alienated. Managers and leaders may be grudgingly obeyed, but resistance and disillusionment will abound.

What do we understand about our own narcissism, stages of development and castration or Oedipal anxieties? Tendency to hagiography of palliative care workers and a ‘tyranny of niceness’ surrounding death

It is still not uncommon to hear well meant comments from the public about nurses as ‘angels’, especially by patient and families in palliative care services, and these comments clearly reflect deeply felt and freely given gratitude and acknowledgement. Implicit in this terminology is a sense of kindness and genuine caring, but also a broader sense of admiration for those who can work with death and dying, those who can function everyday close to such frightening and ‘sad’ events. Most palliative care workers will tell you that they are told at social gatherings where their specialty is uncovered, that surprise is expressed about how hard it must be to work in such a ‘sad’ environment, and how the questioner ‘could not do it’.

It is healthy to experience some discomfort about being seen as special for working in apparent close proximity to death, and this might apply more broadly to workers such as funeral company employees, gravediggers, mortuary staff and indeed all the emergency services. The choice of career to work close to death and dying may be seen by some as sacred or heroic. It might also be that a more sobering and less noble calling is in operation, namely that it is our own way to deal with death anxiety. The unconscious at work raises the possibility that working with death is a way of warding it off, like immersion therapy for arachnophobia, in cognitive behavioural therapy (CBT) you end up being able to plunge your hand into a jar of spiders, so too a professional life with the dying helps toward off one’s own death. The chilling realisation is then that it is not compassion but own fear of death that is the real ‘unconscious’ motive.

Sanchia Aranda wrote of the ‘tyranny of niceness’in palliative care (Aranda, 1997). It might be speculated that the continual demands of social group behaviour to be compassionate in the face of the awfulness of dying means that the workers feel the need to keep up a superficial veneer of acquiescent conflict-free behaviour. In this environment the personal is always subjugated to an assumed greater good. Self-care is a consideration, but within strictly sanctioned but unspoken personal boundaries.

It has been said that people don’t mind a lie provided it is a lie that is widely liked. But what if the lie is so big that we cannot face it? Rather than being a palliative care worker for the love of suffering humanity, it is also necessary to confront the fact that we are also strengthened by not being ‘the one in the bed’, a small step then from a sort of schadenfreude that somehow distances us from our own fate.

In Freud’s conception of the pleasure principle (Lustprinzips), the human psyche tends to seek the path that maximises pleasure and diminishes pain. Just as a simplistic view of
inorganic chemistry it that every atom wants to be like iron, whose atomic structure is the most comfortable one in terms of valency forces. In this conception it is easy to see that death would be both individually and collectively avoided.

Certain suggestions about supervision, education, and clinical practice, and also some organisational reflections

The implications for clinical supervision are clear. Psychodynamically informed supervision is necessary at an individual level. A holistic model is recommended for all ‘front line’ workers. (Carroll, 2014; Hawkins & Shohet, 2000). Organisational work that recognises dynamic processes at a system level is also potentially highly beneficial.

Most importantly, these psychodynamic insights are in essence, speculations about mechanisms at play in complex areas of human behaviour and pain. It is essential that any such propositions are road tested against the experience of the individuals and groups concerned. A chance to acknowledge, understand and process strong personal forces will usually be welcome and has the potential for better health for individual workers and their organisations. A more honest relationship with the parts of ourselves that we may not like is important because we take all of ourselves everywhere, knowingly or not. It would also be unfortunate if the stunning contribution of the global hospice and palliative care movement were to fail to look at itself in the full light of day. Death is after all, the elephant in all our rooms.

In conclusion, it can be seen that psychodynamic insights can open up an, at times confronting, but more informed view of the rich act of caring for dying people. It is suggested that this exercise, far from damaging the fine tradition of caring, can enrich it by the kind of rigorous self understanding that psychoanalysis seeks for its clients. However, it can only do this by questioning its own dominant worldview, regimes of truth and sociology. Most of all it opens up the fact that human beings are non-linear, complex, oscillatory and least logical when under threat. The threat of death is universal, and often unconscious. The health care and medical worlds struggle to accommodate this uncomfortable fact, because as Kant said: ‘out of the crooked timber of humanity, no straight thing was ever built’.

Notes

1. Michael Carroll, teacher of clinical supervision practice in a course delivered in Melbourne 2014, see Counselling Supervision, 1996.
2. https://abccommercial.com/contentsales/programme/elders. Elders With Andrew Denton: Helen Bamber – Series 2, Ep 2 Of 6. Helen Bamber has devoted six decades to helping heal people – people broken by genocide, slavery, ethnic violence and torture. This therapist and human rights campaigner runs the Helen Bamber Foundation for Survivors of Torture in London. At age 20, Helen travelled to Belsen to see what she could do to help the survivors of the Nazi death camp. The smell of death was everywhere, but she soon learnt the best way to help the dying and desolate was simply to listen to their stories and their pain. Over and over again she found herself saying, ‘I cannot bring back your dead, but I’m going to be your witness, and I’m going to make it my life’s work to go on telling your story’. Production details: Zapruder’s other films and ABC TV. Executive Producers: Andrew Denton, Anita Jacoby; Producers: Polly Connolly, Jon Casimir.
4. See for example, the complex British and indeed global reaction to the death of Princess Diana in 1997. The capacity of the British people to grieve openly about the death of someone most of them had never met, surprised everybody, including many British commentators and intellectuals, and led to a famous stand off between the royal family, the government and the press.


Disclosure statement

No potential conflict of interest was reported by the author.

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