

LOVE AND LOSS

IN LIFE AND IN TREATMENT

Linda B. Sherby



LOVE AND LOSS

In Life and in Treatment

Have you ever wondered what a therapist really thinks? Have you ever wondered if a therapist truly cares about her patients? Have you tried to imagine the unimaginable, the loss of the person most dear to you? Is it true that “’tis better to have loved and lost, than never to have loved at all?”

Love and loss are a ubiquitous part of life, bringing the greatest joys and the greatest heartaches. In one way or another all relationships end. People leave, move on, die. Loss is an ever-present part of life. In *Love and Loss*, Linda B. Sherby illustrates that in order to grow and thrive, we must learn to mourn, to move beyond the person we have lost while taking that person with us in our minds. Love, unlike loss, is not inevitable but, she argues, no satisfying life can be lived without deeply meaningful relationships.

The focus of *Love and Loss* is how patients’ and therapists’ independent experiences of love and loss, as well as the love and loss that they experience in the treatment room, intermingle and interact. There are always two people in the consulting room, both of whom are involved in their own respective lives, as well as the mutually responsive relationship that exists between them. Love and loss in the life of one of the parties affects the other, whether that affect takes place on a conscious or unconscious level.

Love and Loss is unique in two respects. The first is its focus on the analyst’s current life situation and how that necessarily affects both the analyst and the treatment. The second is Sherby’s willingness to share the personal memoir of her own loss which she has interwoven with extensive clinical material to clearly illustrate the effect the analyst’s current life circumstance has on the treatment.

Writing as both a psychoanalyst and a widow, Linda B. Sherby makes it possible for the reader to gain an inside view of the emotional experience of being an analyst, making this book of interest to a wide audience. Professionals, from psychoanalysts, psychotherapists, and bereavement specialists, through students in all the mental health fields, to the public in general will resonate and learn from this heartfelt and straightforward book.

Linda B. Sherby is a psychotherapist, psychoanalyst, and supervisor in private practice in Boca Raton, Florida.

PSYCHOANALYSIS IN A NEW KEY BOOK SERIES

Donnel Stern

Series Editor



When music is played in a new key, the melody does not change, but the notes that make up the composition do: change in the context of continuity, continuity that perseveres through change. *Psychoanalysis in a New Key* publishes books that share the aims psychoanalysts have always had, but that approach them differently. The books in the series are not expected to advance any particular theoretical agenda, although to this date most have been written by analysts from the Interpersonal and Relational orientations.

The most important contribution of a psychoanalytic book is the communication of something that nudges the reader's grasp of clinical theory and practice in an unexpected direction. *Psychoanalysis in a New Key* creates a deliberate focus on innovative and unsettling clinical thinking. Because that kind of thinking is encouraged by exploration of the sometimes surprising contributions to psychoanalysis of ideas and findings from other fields, *Psychoanalysis in a New Key* particularly encourages interdisciplinary studies. Books in the series have married psychoanalysis with dissociation, trauma theory, sociology, and criminology. The series is open to the consideration of studies examining the relationship between psychoanalysis and any other field—for instance, biology, literary and art criticism, philosophy, systems theory, anthropology, and political theory.

But innovation also takes place within the boundaries of psychoanalysis, and *Psychoanalysis in a New Key* therefore also presents work that reformulates thought and practice without leaving the precincts of the field. Books in the series focus, for example, on the significance of personal values in psychoanalytic practice, on the complex interrelationship between the analyst's clinical work and personal life, on the consequences for the clinical situation when patient and analyst are from different cultures, and on the need for psychoanalysts to accept the degree to which they knowingly satisfy their own wishes during treatment hours, often to the patient's detriment.

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In Life and in Treatment

Linda B. Sherby

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IN MEMORY OF MY HUSBAND,
GEORGE EDWARD BRANDEBERRY,

AND
IN APPRECIATION OF ALL MY PATIENTS
WHO HAVE SO GENEROUSLY SHARED
THEIR LIVES WITH ME

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CONTENTS

<i>Foreword</i>	xi
Introduction	1
Journeys	5
1 Falling in Love in Treatment and in Life	10
2 The Love Stories Continue	26
3 The Erotic Countertransference: Exploring an Analyst's Sexual Feelings	40
4 Forced Termination: When Pain is Shared	57
5 Self-Disclosure: Seeking Connection and Protection	74
6 From Disconnection to Reconnection	88
7 Illness and Death: Self-Disclosure Revisited	107
8 The Power of Love and Loss in a Psychoanalytic Treatment: Looking Back	124
9 Endings: The Power of Love and Loss in a Psychoanalytic Treatment	142
10 Mourning: Letting Go and Holding On	162
Epilogue: Legacies	183
<i>Acknowledgements</i>	187
<i>Notes</i>	189
<i>References</i>	190
<i>Index</i>	195

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FOREWORD

Donnel B. Stern

I have often thought about writing a book that portrays life as a psychoanalyst. I mean really portrays it – an affectively alive book that lets readers know what it's like to live a life at the same time that you're doing treatment every day. How the life influences the work and the work influences the life. I have thought of writing a novel (who knows, maybe I still will) and I have thought of writing a memoir. Well, I don't have to worry about the memoir anymore, because Linda Sherby has written it, and she has done it in a way that I hope and believe will draw readers from inside psychoanalysis and outside it. It is easy to imagine this book crossing the ordinary barriers that separate professional books from books of general interest. In fact, if there is any justice in this world, it will cross those barriers. It is the one psychoanalytic book I have read that most deserves to become widely popular. More than that, it is the one psychoanalytic book I have read that really would be fascinating to people who are not themselves psychotherapists. Once you've read it, see if you don't agree: anyone who is a reader will find this book hard to put down. And yes, I do know how unexpected it is to say that about a book in a series written for psychoanalysts.

The problem anyone trying to write a memoir about being a psychoanalyst faces is the integration of the life and the work. In fact, I think that's probably the problem for anyone trying to write a book about what life as any particular kind of worker is like. Has it ever occurred to you how rare it is to read a book about the nature of work? We have many books about love. But there are so few about work. Work can seem to pale when set against the passion of life, so that as soon as you start to describe the life, the work takes a back seat.

Oh, there are certain seeming exceptions: actors and actresses, rock stars and other prominent musicians, famous painters, dancers, and so on. A few creative geniuses in business, government, and academics. But think about it. When you read those books, it's the rare exception for the focus to be on the work. It's the work that brings to attention the subject of the biography or autobiography; but it's the life, lovers, and friends of that person that is the stuff of the book.

And that's what so unusual here. Linda Sherby is hardly a celebrity. That's not why her life interests us. She is an everyday person. Well, sort of. An everyday person who can write like the wind. One of my favorite novels happens to be Laurens Van Der Post's *A Story like the Wind*, which concerns the lives of the Bushmen of Africa.

FOREWORD

Love and Loss, despite having nothing to do with the Bushmen, is a story like the wind. It grabs you in a way that you're not used to being grabbed by anything in the psychoanalytic literature. Unless some other duty calls, if you are a psychotherapist you are not likely to put this book down until it ends. And if you're not a psychotherapist – well, you're not likely to put it down, either. It is that gripping.

How did Linda Sherby do this? Why has she been able to write something so thoroughly compelling? I think I know why she could do it, and why I didn't. The reason I couldn't figure out how to do it myself was that I didn't have a particular theme relating the life and the work. Linda does. With enormous generosity of spirit, she has allowed us to know everything she can think to tell us about her life with her husband, George, whose illness and eventual death is the thread along which the pearls of her narrative are strung. As Linda works with her patients, we understand how it is for her; we feel what it is like for her to live her life, to love and lose George. It's indelible. Linda gives it to us straight and to the heart. All of us have been there, even if we have never lost a spouse. We have lived with heartache while we continued to want to help other people with everything we had. But never has anyone come back from a place like that with a narrative that braids the life and the work together as Linda has done here. That's what's unique about *Love and Loss*. That's why Linda could do it when I, and no doubt many others, could not manage it. She has been willing to supply the thread of life along which the pearls of work could make a necklace.

I have every confidence that George was as committed to this book as Linda herself has been. The book was, and is, an act of courage for both of them, and it came at no little sacrifice. It would have been easier not to write it. It is a memorial to George, and to Linda's devotion to George, and it is a gift to its readers.

INTRODUCTION

I write this book as a psychoanalyst and as a widow. I write it as someone who knows with every fiber of my being that love and loss are a ubiquitous part of life, bringing the greatest joys and the greatest heartaches. In one way or another all relationships end. People leave, move on, die. Loss is an ever-present part of life, from the first separation from our mother's body, through growing up and leaving home, through navigating the break-up of relationships, through the dying of those we love, to the final loss of our own death. In order to grow and thrive, we must learn to mourn, we must both move beyond the person we have lost while taking that person with us in our minds. If we fail to achieve this delicate balance, we live our lives either bogged down in endless pain or incapable of being connected with others in a deep, meaningful way. *Love and Loss* examines both my own and my patients' struggles with loss and mourning, illustrating that seemingly unbearable pain can be both born and transformed.

The book itself is one of the ways I have dealt with my personal mourning, the death of my husband. It is one of the ways I have been able to both hold on to him and to the relationship I so cherished, while engaging in the process of letting go. Goethe wrote, "We die twice: first, when we die, and then when those who knew us and loved us die" (cited in Kernberg, 2010). This quote captures one of my prime motivations for writing this book, the desire to keep a part of both my husband and our relationship alive by putting it on paper, recording it, seeing it in black and white. Since I can no longer have him as my living, breathing husband, I at least have this book that partially captures our life and our love.

Unlike loss, love is not inevitable, but no satisfying life can be lived without it. Intense and connected relationships are integral to our growth and fulfillment as human beings. Love and loss intertwine throughout our lives, forever present in one form or another. And just as love and loss exist in life, so too do they exist in treatment. Every therapeutic relationship begins with the assumption of an ending. From the first time a patient walks into a therapist's office, the expectation is that they will one day say good-bye. During the course of treatment, many feelings transpire between patient and analyst, including feelings of caring and love. Both patient and therapist are also likely to confront loss, not only from the termination of the treatment itself, but losses that arise in their respective lives, be it divorce, physical impairment, aging, or death.¹

INTRODUCTION

The primary focus of this book is how patients' and therapists' independent experiences of love and loss, as well as the love and loss they experience in the treatment room, intermingle and interact. There are always two people in the consulting room, both of whom are involved in their own respective lives, as well as in the intense, mutually responsive relationship between them. Thus, at any one moment, both patient and analyst are being affected, both consciously and unconsciously, by their immediate interaction, by their own history and dynamics, and by their own and the other's present life circumstances, all of which exist simultaneously and stimulate thoughts, feelings, conflicts, and fantasies in each party. Love and loss in the life of one of the parties affects the other, whether that effect takes place on a conscious or unconscious level.

Psychoanalysts have long understood that what the therapist brings to the consulting room must be examined and understood. Earlier analysts were most concerned about how the therapist's history and conflicts affected the treatment situation, while more contemporary analysts have drawn attention to the continual conscious and unconscious interaction between both members of the dyad. Both points of view are crucial and must be attended to in any treatment. I believe, however, that what the therapist brings to her sessions because of her current life situation – although certainly affected by her past history and the uniqueness of the patient/therapist dyad – has been insufficiently examined. A therapist will have different concerns, feelings, and stresses if she is getting married or divorced, if a child is about to be born or to leave for college, if a spouse is ailing or a parent dying. Regardless of how therapists might strive to keep their personal lives, concerns, or feelings out of the treatment room, they are inescapable. A therapist who has miscarried will react differently to a pregnant patient than a therapist who has three healthy children at home. A therapist whose mother has just died may well respond in a different manner to an excessively demanding patient than she did prior to her mother's death. There are always two people in the consulting room, each living lives in the present. Their mutual interactions become entwined leading at times to great confusion and at other times to profound connection or insight. It is these current life circumstances and their affect on the treatment that I will explore in this book.

My personal desire to memorialize my relationship with my husband and my professional interest in examining how an analyst's present life affects the treatment come together in *Love and Loss*. To achieve these two goals, both personal and professional, I present extensive, in-depth clinical material, as well as a good deal of autobiographical information. Such self-disclosure is unusual for a psychoanalyst and I have undertaken it with the knowledge that it may carry profound effects for me both with present and future patients, as well as with professional colleagues. Psychoanalysis began as a profession in which the analyst attempted to reveal nothing, thereby encouraging the patient to transfer onto the analyst his own imaginings and past history. Much has changed over the years and greater self-disclosure is seen not only as acceptable, but inevitable. Still, the autobiographical facts that I reveal are more extensive than what is widely practiced and I do realize there are implications

INTRODUCTION

in what I have chosen to do. Although I certainly have not revealed everything about myself, if my patients read this book they will have far greater information about me than is generally the norm. I could say that privacy in the age of the Internet has become impossible anyway and, to some extent, this is true. Patients do have more information about us than they have had in the past. But I cannot comfortably fall back on this rationalization.

What I will say is that when I saw patients during my husband's illness and eventual death, I found that they were able to take in and often grow from a significant amount of disclosure on my part. Additionally, and not surprisingly, I found that different patients took in different amounts of information, that they reacted differently and that their responses were very much in line with who they were as people. The therapist's adage, "Everything is grist for the mill," is indeed operative here. Anything can be examined and understood. Do I think I may have made my future life as an analyst more difficult for myself? Quite possibly. But obviously it is a consequence I have been willing to accept for both personal and professional reasons.

I have also written this book with the hope that it will be read, not only by psychoanalysts and psychotherapists, not even only by those studying to become analysts or therapists, but by the general public. I am a staunch believer in the value and efficacy of psychoanalysis and recognize that its message has been lost in both the myths of its past and the desire for instantaneous cures within our overall culture. Psychoanalysis as a profession needs to be both humanized and seen for what it actually is. Analysts are caring but fallible human beings whose in-depth treatment method has relevance in today's world. As a rule, analysts are neither totally detached from their patients nor engaged in unethical sexual behavior with them. They are neither superior, overly intellectualized practitioners nor cavalier charlatans only in it for the money. Generally, therapists are thoughtful, considerate human beings who give people the time and space to explore their own minds, to be listened to and to be heard, perhaps for the first time.

Because I hope this book will appeal to a wide audience, I have used little professional jargon. When such words seemed unavoidable I define them as simply as possible. In addition to presenting copious clinical material, I have also attempted to provide a window into my thinking process. I want you, the reader, to see my uncertainties, my unanswerable questions, and my willingness to put not only my patient, but myself under a microscope that examines and investigates, but does not judge. This is yet another form of self-disclosure, as I provide you an entry into my mind as a therapist.

This brings me to the patients presented in the book. Most of them are composites of patients I have worked with over the course of my forty plus year career. This means that although I have attempted to remain true to the patient or idea I am trying to present, I have incorporated aspects of many patients, such as family histories, physical appearance, or presenting problem, to create one viable, true-to-life patient. Sometimes the composites draw not only from patients, but from friends, acquaintances, or even my own imaginings. A few of the patients presented,

INTRODUCTION

with their consent, are almost entirely true depictions with just minor changes such as names, places, or slight deviations from actual fact. To those patients I would like to express my great appreciation for both their courage and their willingness to open themselves to the scrutiny of others. Although actual case histories would have been preferable in every instance, my patients' best interests and confidentiality must always come first. In some instances I felt it would be deleterious to ask patients for permission to write about them, in other cases I had no idea how to contact the patients nor did I think it would be helpful to reappear in their lives after many years.

To bring the complex relationship between patient and therapist to life, I have also used considerable dialogue. This dialogue is not based on verbatim transcripts and in only rare instances does the dialogue represent direct quotes from my notes written either during or after specific therapy sessions. Mostly the dialogue flows from my own mind as I attempt to capture the intensity of a particular interaction, the significance of a certain dream, or the repeated struggle between the desire for and terror of change and growth. I have made every effort to stay true to both my own voice and those of my patients. You, the reader, will decide how well I have succeeded.

JOURNEYS¹

I am following the gurney that carries my husband, George Edward Brandeberry, to the hospice facility where he will die.

With me is Melodee, George's daughter. Lacing her arm through mine she says, "The last journey."

She is referring to the tribute I read at my husband's eighty-third birthday party just one week before. In that tribute I spoke of the wondrous journey of our relationship, the amazing trips we took all over the world, and the tortuous journey of the last sixteen months as we dealt with the fear, pain, and uncertainty of his increasing health problems. The party was bittersweet. We knew that George would enter the hospital the Monday following his party. He was jaundiced. We thought he needed gallbladder surgery. We didn't know if he could survive general anesthesia. But I held out hope. After all, I never believed he would see this birthday. The previous year, on his eighty-second birthday, his PSA, the number that indicates the insidious rise of prostate cancer, had jumped precipitously despite chemotherapy. Yet here he was, one year later, still fighting for his life. I hoped that my husband's strength and tenacity would carry him through yet another crisis.

Now, as we follow the gurney, I say nothing. The decision to put George into hospice was difficult, but not agonizing. Even this final time, George took care of me. Once in the hospital we discovered that George's jaundice was due not to his gallbladder, but to growths in his bile ducts that were blocking their drainage. It was not good news. His oncologist did not think it was a metastasis of his prostate cancer, but possibly an entirely different cancer. The bile ducts had to be drained, and a biopsy of the growths was necessary to determine the type of cancer. Neither procedure could be done immediately because my husband had to be off his blood thinners for several days to prevent excessive bleeding. So we waited. And George grew weaker. Finally they made an attempt to drain the bile. George became nauseated, his heart, which was already severely compromised, became too unstable. They stopped.

They were to try again the next day. Before that second attempt, our internist came into the room and asked George if he stopped breathing during the procedure whether he wanted to be resuscitated.

Much to my surprise, this man who had fought and fought and fought to live said, "No. It's enough already."

"I'm not arguing with you," I began.

"Yes you are," he interrupted.

"No, I'm not, I just want to ask you one question. Are you doing this for you or for me?"

"For me," he replied. I believed him. He had had enough. He was ready to stop fighting.

George made it through the second procedure, but his body was breaking down. The charge nurse and George's cardiologist asked if I had considered hospice.

I made the decision, choosing a hospice facility I visited years before when a patient of mine was dying of ovarian cancer.

I called Melodee who had been with me and George for over a week. I also called George's grandson, Luke, and Luke's girlfriend, Emily. We had hired Emily to be George's companion and my helpmate for the past year. She stayed with George so that I could see patients, attend to my ninety-seven-year-old mother, and generally deal with life outside of George and his illness. She was perfect for George: kind, loving, and concerned, without being anxious, intrusive, or hovering.

While I waited for them to arrive, I called patients. Despite all the medical crises of the past sixteen months, more than half of my patients did not know of my husband's illness. Those patients I told that a family member was dying, that I needed to take some time off from work, and that I would contact them when I was ready to return. For those patients who did already know, I said that my husband was dying and that I would contact them when I was ready to return. I immediately heard my patients' anxiety, their fear that I would never come back to work. I reassured them. I knew I would resume working. I just wasn't sure exactly when.

Melodee, Luke, and Emily arrived at George's hospital room. We cried and hugged and told George and each other how much we loved one another. George's voice was very weak. It was hard for him to make himself heard unless we stood close by. I stepped towards the foot of the bed so that Luke and Emily could say their tearful good-byes. George opened his arms and clearly, distinctly, loudly proclaimed, "I love you, Linda." I rushed into his arms sobbing.

And here Melodee and I are, following the gurney through the side door of the hospice. I don't like the man who is wheeling my husband. It's odd how clearly I remember him: a big, fat man with a missing front tooth, a caricature of the "dumb oaf" frequently portrayed in the slapstick comedies that I have always disliked. I see him as someone incapable of compassion, and I want my husband to be lovingly carried on his final journey. Or perhaps he is just someone to allow me to feel disgruntled, someone to take me away from my pain.

They are expecting us. My husband is taken immediately to his room, S105. It is as I remembered it, airy, light, welcoming. Each room is private. And quiet. There are no nurses bustling around with medication, no PA system summoning doctors, no call buttons, and no IVs. Melodee and I go immediately to talk with the head nurse on duty. She is a short, squat woman who tells us about the facility – we can come and go whenever we wish, on weekends and nights the front door is locked

but we can come in the side door by just pressing the buzzer, there is a refrigerator for any food we want to bring but we should put our name on it so that it isn't eaten by someone else. She has read my husband's chart. She tells us that he will be kept comfortable. He will be fed and given whatever pain medication or sleeping pills he needs.

I ask one question, a quintessential me question. "I know you can't say for sure, but how long do you think it will be?" When dealing with that which is totally unknowable, I always want to know, I want to gain some semblance of control over that which is entirely uncontrollable. Our doctors learned not to answer these questions. This nurse says, "Two weeks." I feel ambivalent about her response: both relieved and concerned. He'll still be with us, with me. I don't have to let him go just yet. But since we know the outcome, isn't it best to get it over with? I don't want him to suffer. I don't want my suffering prolonged. I've been in a state of almost-mourning for so long. I'm ready, I think, to begin the actual process. But another hug, another kiss, certainly that's reason enough to keep him around as long as possible.

Melodee and I go into my husband's room. He is, for him, somewhat agitated. "There you are. Where have you been?"

"We had to speak with the nurse," I reply defensively. But I realize immediately that I have been insensitive. How could I leave George alone and abandoned in a new place, his last place?

"I'm sorry," I say. I caress his face and kiss him, his skin no longer jaundiced, his cheek smooth except for a hint of stubble, his lips warm and welcoming as always. He is not at all skeletal, not ravaged by cancer. Quite the contrary. With all his medications for pain and his tremendously limited capacity to walk he has gained an enormous amount of weight. Although not a vain man, George hated the weight gain. He had been thin his whole life and now said that he felt like "a beached whale." He has lost his silky, wavy silver hair to the chemotherapy treatments. His goatee and mustache are mere fragments of their former states. His bright blue eyes are still blue, but have lost some of their luster.

But in so many ways, he is still the person he has always been.

"Who's going to pay for all this?" George asks.

"Don't worry," I reply, "It's covered by Medicare." Reassured that he's not excessively burdening me, he moves to his second concern.

"What about Emily?"

I know what he is asking. Once he is dead, what will she do for a job? What will she do for money?

"Don't worry, George," I tell him, "I won't abandon Emily."

George is again reassured. He tells Melodee and me to go home. It's late. We're tired. We haven't eaten. I tell him I'll bring Hadley, our six-month old piebald miniature dachshund in the morning. We say our good-nights.

From the time I first became involved with George almost thirty years before, I worried about his dying. It wasn't an unrealistic worry since he was twenty-one years my senior. And loss and separation were especially difficult for me. I could cry

at airports watching total strangers hug good-bye. George, referring to my constant worry would say, "I'll only die once, but you'll die a hundred times." It wasn't, however, my death that I worried about, but his. And I probably thought about his dying thousands and thousands of times, not hundreds. Sometimes the thoughts were spurred by actual medical emergencies. Sometimes they just flew unbidden into my head and I would rehearse one imagined death or another. Now, however, it is for real. All that went before was a dress rehearsal. This is the real thing.

By morning George has lapsed into unconsciousness. Not yet realizing that he has begun his process towards death, I put our frisky puppy into his bed. He seems to startle awake. But it is only momentary. He is breathing, but no longer with us. He was given only a sleeping pill the night before. No other medication was necessary. My husband has made his decision. Just as he fought against all odds month after month to live, he has now decided to let go, to allow himself to die, to go quickly without a tortuous, drawn out ending.

All day I sit watching my husband with Hadley in my lap. It is unusual for her to be so calm and sedate. But today she lies contentedly in my lap while I stroke her and stroke her. Her fur is soft and silky. George and I both loved texture – tactile stroking, softness, fabrics or fur or skin that felt warm, inviting. Hadley has all that. She is a mixture of short and long-haired, mostly white, with brown markings down her back. She has long cocker spaniel like ears and a feathery white tail she wags almost all the time, looking as though she is waving a frayed flag in the wind.

Over the past sixteen months, my husband had begun to express a desire for a dog, although he would always add, "But it's not fair. I couldn't take care of it." Early in our marriage we had Brenna, a loving, smart combination black Labrador and German Shepherd whom George loved dearly. After we had to put her down, George said, "No more dogs." On several occasions I tried to change his mind, but he was adamant. We had cats, but no dogs. As George became sicker, more housebound, more vulnerable, he would watch countless animal shows on television, and his desire for a dog increased. I considered surprising him with one for his eighty-second birthday, but then decided I simply couldn't take care of one more being. But after a period when George's health had improved, I decided to take the risk. We got Hadley. I called her my happy dog. As it happened, George's health crashed two weeks later. Hadley was my last present to George and his most fortuitous, final present to me. So now I sit and stroke Hadley and stare at my husband.

Throughout the day various staff enter the room. They check to make sure that George isn't uncomfortable. They turn him, empty the bag with the draining bile, empty the bag with his urine that is becoming increasingly dark. The nurse we first talked to told us the urine gets darker as the patient nears death. The staff is kind, respectful, unintrusive.

As the day turns to early evening, the staff asks if Melodee and I plan to spend the night. It isn't until Melodee says that she wants to, that I realize they are telling us they think George will die that night. Does it make sense to say that I am shocked? Too soon, I think, too soon. But I had to know. I did know. I knew as soon as I saw

JOURNEYS

George that morning. And yet. And yet. Am I still not ready to let go? Can I not accept the reality of his being gone from me forever? Can I not accept the reality of losing this man who had embraced life with such strength and courage and who always, always cherished me? Reality breaks through my denial. Of course we'll spend the night.

We try to make ourselves comfortable on the two reclining chairs. Sleep seems impossible. At some point a doctor comes into the room. I remember that he is tall and thin and young. I remember that I tell him I don't know how he does this work. I know his response is kind, but I don't remember what he says.

At some point when the aides are tending to George, Melodee sees that his toes have begun to curl. "It won't be long now," she says.

I look at her incredulously. She nods at me.

"It's true," she says. "The toes curl when you're going to die." She had been through a similar death watch with her mother-in-law.

I must have dozed. It's 2:30 a.m.

"I think he stopped breathing," Melodee says.

I'm instantly at his side. He looks the same. The same in death as in life. Melodee and I stand at either side of his bed, looking at him, touching him. I try to take off his wedding ring. It won't come off. I panic.

"Don't worry," Melodee says. Like her father, figuring things out in the physical world comes naturally to her. She goes into the bathroom and gets the bar of soap. She lubricates George's finger. She slides off the ring. She hands it to me. We stand there looking at him, this man we both so dearly loved. We're not crying then. We're not talking. Just looking.

I leave to tell the staff that George has died. The nurse and an aide come into the room. They listen to his heart. They confirm what we already know. We pack up: Hadley, blankets, books. We take one last look.

We leave.