Last Breath: Art Therapy With a Lung Cancer Patient Facing Imminent Death

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Abstract

Art therapy can be an effective way to focus on end of life issues with cancer patients facing imminent death. This viewpoint discusses ethical challenges in the treatment of a 63-year-old man with terminal lung cancer who was participating in short-term individual art therapy. Difficult issues that often surface in the final days of life may include greater need for trust, dependency on others, feelings of inadequacy, loss of control, and fear of death. The situation may present pertinent ethical dilemmas for the art therapist, which directly impact the choice of therapeutic intervention that best serves the interests of a dying client.

Jack (pseudonym) hacked and sputtered, drawing in smoke as I held the match to the cigarette that was quivering between his thin blue lips. We sat on a bench by the entrance of the clinic, sheltered under an awning from the warm spring rain. All around us, new growth pushed skyward, straining toward the sun. Sparse patches of grass and flower buds dotted the brown, brittle remains of last year’s growth. I blew out the match and looked around anxiously, hoping none of my colleagues would see me helping my patient kill himself. Or so it felt to me.

Jack was a 63-year-old man who was referred to me for short-term art therapy treatment for end of life issues. He had been diagnosed with terminal, metastatic lung cancer that had traveled to his brain. According to his doctors, he had only weeks to live. Jack had heard about art therapy and expressed an interest in wanting to paint before he died. He was unmarried and had no friends or extended family other than a sister with whom he had not been in contact for years. The clinical program director asked me to focus on increasing the quality of what was left of Jack’s life and to address any concerns or unresolved issues prior to his death. Most importantly, I was simply to let him enjoy the process of making art.

The first time I met Jack, he was accompanied by a silent but pleasant nurse’s aide. Fluid rumbled in his chest when he breathed, making raspy noises as he pushed his walker with effort into the art therapy room. He looked tired, as if his next breath might truly be his last. Although I had been working at the community cancer support services program for nearly 2 years and had seen a number of terminally and critically ill cancer patients before, there was something especially disturbing about Jack’s condition. Imminent death seemed to hover around him like a low-lying rain cloud.

Jack fell into a chair and shooed the smiling aide away, ordering her to return in an hour. He justified her presence by explaining that he was no longer able to drive and that the “damn cancer” had made him incontinent and impotent. In the next labored breath, he asked if I would please take him outside for a cigarette before we started. Before I could even respond, he heaved himself up out of the chair and lurched forward in the walker toward the exit. I had no choice but to follow.

As Jack smoked, I wrestled with a feeling of being an accessory to a crime. “Isn’t this going to kill him?” I thought to myself, wondering, “Is this ethical?” As if to distract me from my own thoughts, Jack began to talk about his situation while he smoked. From his rambling monologue I learned a great deal about his condition, how he found out he had cancer, and his unfortunate prognosis.

During this first smoking break, I also realized that I had known Jack when I was a teenager. He had worked in the same suburban town where I had grown up. While in high school I had worked for a local photographer and would often take his finished portraits to a framer in town. As Jack continued to talk, I began to recognize him as this same picture framer. The withered, dying man next to me once had been a vibrant, youthful, opinionated man who enjoyed socializing with other merchants on Main Street, and who was afforded a certain amount of respect as a successful store owner in an affluent town. Now my ethical dilemma was whether or not to share this information with him.

Yalom (2005) and Rogers (2003), among others, described the benefits and drawbacks of therapist self-disclosure. On the one hand, disclosure of personal
information may expedite formation of the therapeutic alliance, if the disclosure is relevant to therapeutic goals and is revealed to be in the best interest of the client. On the other hand, sometimes a disclosure is made due to the therapist’s anxiety, desire for personal gratification, or need for acceptance. Then the results can incite distrust and confusion about roles and boundaries within the therapeutic context. In this situation I decided that the timing of my disclosure, if there were to be one at all, was most important. The work with Jack was short-term and the therapeutic relationship was not yet established. I decided to not say anything because it seemed that a disclosure would serve no benefit.

As we slowly made our way back to the art therapy room, I did not realize that Jack and I had already embarked on an important therapeutic journey together. I also did not realize that over the next 4 weeks Jack would create a watercolor that would come to represent, in my opinion, the powerful summation of his experience with imminent death. Prior to our first session, I had considered what art material would be most effective in working with Jack and, in the end, chose watercolors. Taking into consideration his physical limitations, I concluded that acrylic or oil paints would require a greater degree of fine motor skills than he possessed and that tempera paint might seem infantilizing to him. Watercolor often is a good choice because it is fluid and easily manipulated. Under other circumstances, I might have allowed the client to choose his own material by exploring and experimenting with different kinds of paints and brushes. However, with Jack, given his terminal status and his physical limitations, I felt that it would be more expeditious to select the art medium for him.

Wanting to give him at least some choices in the art process, I left the choice of subject matter up to Jack. “What do you want to paint?” I asked. “Well,” he replied thoughtfully, “when I was a picture framer, I enjoyed framing landscapes and always wanted to learn how to paint them.”

I offered Jack a large envelope filled with various landscape photos to use for his painting. He narrowed his choices to three favorites. We discussed what he liked about each and which were most suitable for the watercolor medium. Eventually he settled on a warm-toned but rather desolate picture of a desert landscape. There was no live growth in the picture; the viewer sees only distant mountains and an unusual, complex rock formation in the middle distance of the scene. I could not help but wonder if this landscape represented his feeling of isolation.

We began with my brief instruction on how to use the watercolors and how to create the illusion of space. Jack was rapt with attention, asking questions and processing the information easily as his cognitive skills appeared to be fairly intact for someone with late stage cancer. He struggled with the fine motor aspects of painting, however, in how he grasped the brushes, mixed paints, and painted with halting, jerking strokes. He expressed frustration with his lack of control and compared it to his other rapidly deteriorating bodily functions, bitterly blaming the cancer. Sometimes it was hard to watch him struggle but I felt it was important to intervene only when asked, and then with discretion, as I sensed his deep humiliation. When Jack asked for help, I either placed masking tape on the edge of the paper to help contain his jerky strokes or offered a larger brush that was easier to hold. In a more trusting moment I would guide his hand along to steady his movements. All of these interventions were made with awareness of his need to remain as autonomous as possible in the face of an illness that sometimes left him feeling utterly helpless and without control.

About halfway through a session and often after a particularly frustrating moment, Jack would announce that he wanted to have a cigarette. I followed him out of the building, feeling a mixture of guilt and pity. I was still uncertain whether I was improving the quality of life for a dying man or was being complicit in his denial. Nonetheless, these cigarette breaks seemed to hold some therapeutic benefit. I came to realize that in his deteriorated physical state Jack took such enormous effort to simply hold a paintbrush and concentrate on painting that he was unable to talk while he worked. I also found that the smoking breaks offered him a time to review his life and to speak tenderly of the joyful moments and wistfully of his unfulfilled dreams. Because smoking was a social activity for Jack, I understood that this was his way of revealing himself to me.

In the second session Jack decided to alter his desert scene by replacing the rock formation with a large church building. He struggled to paint the image as he reviewed in his mind the rules of two-point perspective and his knowledge of art and architectural history. His church image featured a large steeple that was rounded at the tip. He commented that the phallic-shaped steeple was “wrong,” that it “wasn’t working,” and that he “couldn’t get it right”—all of which seemed metaphorically to refer to his own physical incontinence and impotence. He tried to make a cross on the top of the steeple but his hands shook so badly that the cross was unrecognizable. Immediately before asking for my help, he commented that it was strange that he had decided to make a church because he was not a religious person. “Why, then, do you think you chose this image?” I asked carefully. “Well, probably because I’m dying!” he said loudly. “I’m also kind of worried about whether I’ll be buried or cremated—you know, all of those things that you need to think about when you’re dying.”

Jack’s willingness to discuss such difficult topics was both refreshing and startling to me. I also felt moved by his bravery and dignity. Later, during a smoking break, Jack was melancholy, wondering aloud whether his life had meaning. He questioned his success as a businessman and wondered if others in the town had respected him. I answered that I thought it must be true. But Jack seemed unconvinced. “How would you know?” he cried, not making eye contact with me. “You’re probably just saying that to be nice because I’m dying.” “No,” I answered. “I’m not saying this to be nice. I know this is true.”

“How?” he asked. “Because I knew you when I was growing up,” I answered. “I used to come to your store. I worked in town and I knew what people thought of you.” In response Jack slowly pulled the cigarette from his lips with his palsied hand and turned to look at me, as if seeing me for the first time.
In the third session Jack announced that he was dissatisfied with the church image and wanted to change it into a castle. We discussed architectural elements that would make the structure appear more castle-like and Jack went to work. He painted small, square windows on the top of the towers and long, rectangular windows on the turrets. He then focused on the entrance of the building, arching the door and creating a chevron pattern that gave the doorway a sense of archaic weight and substance. He painted a faint, gray, winding path that led to the door; the path looked difficult to follow. I thought perhaps the faint path to his castle represented Jack’s growing reticence to interact with the world around him, given that he was so close to death. I remarked, “That’s a pretty heavy door. And it looks a bit hard to follow that path. Do you want to make it this hard to get into the castle?” Jack considered this, eyeing his painting. “Good point,” he said. His jerking hand sloshed his brush around in the yellow paint and covered the path in a brilliant golden wash.

“Hmm. Too much. Now it looks like a yellow brick road. Don’t want that,” he said. I suggested a way for him to mute the color but still keep the path visible. He followed my suggestion and, being pleased with the results, he added a large boulder near the entrance of the path, as if to provide somewhere to hide when necessary.

It was clear to me that something shifted after I validated for Jack that his life had been meaningful and had had purpose. Recognizing that one’s life has had purpose is a key goal in working with dying patients (Kubler-Ross, 1997b). My validation allowed Jack to form a trusting therapeutic relationship with me and to be more willing to accept intervention and assistance. This trust also gave me access to his internal emotional state—all of which seemed symbolically expressed in his creation of this complex piece of art.

Kubler-Ross (1997a) wrote that clients may be helped to view death not as an end but as “a highly creative force” that can promote growth (p. 1). With this in mind, I considered the landscape surrounding Jack’s castle, which was painfully impoverished in its depiction of a dry, arid desert, lacking any greenery or growth. This pictorial statement did not surprise me given Jack’s feelings of hopelessness. Several times in the previous sessions I had asked Jack if he wanted to add any trees or plants to his landscape and he had adamantly refused, saying, “It’s a desert! Nothing grows there!”
Now in our fourth session, having established a more trusting therapeutic relationship, I asked him again: “Would you like to add plants or anything around your castle?” Looking at his work, Jack tilted his head and considered. “Well, I guess it looks kind of strange having a castle in a desert,” he said. “Maybe I can add some bushes. Just a few.” Soon the once arid landscape was speckled with low and scrubby but nonetheless green, living bushes. Jack seemed pleased with the results, as he simultaneously hacked and grinned with pleasure. He even went on to add a coat of green to part of the desert sand, simulating grass. “Ha!” he laughed. “Looks pretty good!”

After dotting his landscape with a few more bushes (Figure 1), Jack announced that he wanted to add some tree-covered mountains to the back of his landscape, but our time had ended. His aide had arrived at the door, smiling. “Guess we can do it next week,” he said and heaved himself up into his walker, knocking over a can of brushes. I scrambled to collect them. I noticed that he seemed weaker and more tired this week. “Okay,” I said. Then something made me ask, “Do you want to take your painting with you? Or should I keep it here?” “No. You keep it,” he answered, as he lurched his walker through the door.

I did not see Jack again. He did not arrive for his next scheduled session. I looked for his obituary in the local papers, but did not find it. Sometimes reading the obituaries was the only way my colleagues and I knew our clients had passed away, given that we were not next of kin and our only relationship was as their community support providers. If a family member did not call to tell us of a loved one’s death, we were often the last to know, if at all.

I finally contacted the liaison at the cancer unit of the local hospital that had referred Jack to our services. The liaison confirmed that he had been admitted to the oncology unit and had died 3 days later. “It was really kind of sad,” she told me. “We all felt so sorry for him. No one was with him in the end. We tried to call next of kin—he had a sister, I think. But we had no contact information for her. Only the nurse’s aide who worked with him recently was here. She came one afternoon.”

I thanked her and hung up the phone. Holding his painting in one hand and staring out the window at the bench where we had sat only a week earlier, I felt a deep sadness. I realized that no matter how often I had experienced death in my work with cancer patients, it never seemed to get easier. My sadness was that no one was there when he died. I thought of Jack’s gruff but brave candor as he talked about his impending death and his great dignity and composure in the face of it.

When working with terminally ill clients, a therapist must be willing to carefully consider unconventional treatment approaches and to explore the ethical gray areas of therapist transparency and boundaries (Kubler-Ross, 1997b). I navigated the ethical challenges in my relationship with Jack with this in mind. In the end I felt more resolve that my disclosure about my previous relationship with him had helped this dying man believe that his life had made a difference to others in some way. Had I disclosed this information at any other point in our work together, the result would have been very different. As for his smoking, an activity that was implicated in his death, I wrestled with my collusion but also felt that any discussion of its self-destructive aspects in our brief treatment would have been a waste of precious time.

Kubler-Ross (1997b) wrote, “The last reason perhaps for patients’ good response [to therapy] is the need to leave something behind, to give a little gift, to create an illusion of immortality perhaps” (p. 261). Looking at Jack’s artwork, I am grateful for the experience with him and for his painting—a gift of art and legacy from a very brave man.

References