The Effects of Preparing for Sudden Death

ROB GORDON

The threat of death is what makes many traumatic events traumatic. A traumatic situation that involves a threat of dying can confront the person with a moment to prepare themselves for death. This death encounter is often undertaken in a state of high arousal and what happens to the person is often not a series of thoughts or feelings, but instead a series of profound existential actions that restructure their lives and remain in force until recognised and reversed. ROB GORDON draws on a number of cases to outline some of the phenomena to be found in such situations and some principles of theory and technique in the treatment of these conditions.

Bill worked with homeless, alcoholic and violent men. He was often alone when terrible things happened. Once, he found himself in a violent confrontation with a man who lifted a heavy object to hit him. He knew he could not avoid it and was sure he would die. Something made him turn his back saying, ‘Well if you must …’ and walk slowly away. The blow never fell.

Another time, he came upon two drunken men with a bottle of whisky and a knife on the corridor floor in an isolated part of the building. They had blood on them; as he looked more closely he saw part of a body that told him they had just murdered someone. He took the initiative and said warmly, ‘Oh, you’ve cut yourselves; that’s no good, you should be careful. I’ll get a bandage for you.’ He sauntered on down the corridor waiting for them to attack him. He approached the lift and thought if they attacked him he would upset the fire extinguisher and make the floor slippery, giving him a chance. Then he saw that it was empty. The men were murmuring and moving behind him as he waited for the lift. He felt sure he was not going to get out alive. The lift arrived and he got away. He worked a few more days, then was unable to do more and developed chronic PTSD. I saw him some years later. His poem describes his state.

So I walk alone
Looking at my feet
Trying not to look around
At people in the street
I shuffle to the side

When they pass me near
Surely they are watching me
Can they see the fear
So, I walk alone.
Or so it looks to them
But walking all around me
Are the souls of tortured men
The ones who died, not knowing
Not caring how they died
The ones who were just murdered
For those my heart has cried
So, I walk alone
There’s no tears left for me
Just emptiness, no feelings
No pain just misery
There’s no music in the magpie’s call
No magic in his flight
For everything is dark and cold
I’m dead but still alive
So, I walk alone.

Death Encounter

The threat of death is what makes many traumatic events traumatic. There are often moments when those involved think they, or their loved ones, will die and they prepare themselves for it. The fact that this state lasts a few seconds, minutes or at most hours leads it to be overlooked by both victims and clinicians. The tendency to re-evaluate experiences in the light of what is known after the event means survival is taken as a fact and the event is viewed as ‘highly dangerous’ or ‘a narrow escape’ in retrospect. However, the outcome is unknown and was ‘fatal’ as the experience is lived through; it presented the victim with the task of preparing for imminent irreversible loss. The encounter with death is the antithesis of life and this makes it the most traumatic event that can be conceived.

The moment of the death encounter may be obscured to memory and may have to be inferred by the clinician from the circumstances and symptoms. The victim may be unable to move on from the overwhelming experience and consequences of the moment of death. People usually make some form of preparation for imminent death, however hurried, that involves some form of radical psychic re-organisation. They may farewell loved ones, abandon future plans, detach from their self, or detach parts of their lives such as career and interests, or give up on life itself and all it involves. In the moment of encounter, they often realise the futility of aspects of
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A fire crew were trapped in their truck in a bushfire. Pete got out of the truck into the inferno to cut a fence. He fell and was engulfed in glowing ash. He could not cut the fence and was sure he would die from the heat. As he struggled back to the truck he kept wiping a clear oozing liquid from his face. He could not understand what it was and concluded that it was his brains melting and coming out of his nose. As they drove, he thought the thumping in the back of the truck where the rest of the crew were was the detached heads of his comrades rolling about. Eventually they got out. The only member of the crew whose life was not derailed by this event over the next few years was the driver, who did not think of dying, being too busy avoiding burning trees and working out where they were. Pete continued his job for a year then gave it up and sat at home. He was deeply pessimistic, expecting to die from some unexplained illness any time. He helped out his friends, but did little around his own house. But one job he would never do was to fix up his old Ford because when he did he knew that there would be nothing else and that would mean the end. This superstitious attitude had ruled his life for some years.

Andy, another member of the crew talked to me with his wife, saying that at the time he was sure no human being could survive such heat and they would die. I asked what went through his mind then. He said ‘I haven’t got the firewood in for winter.’ His wife snorted with scorn (their relationship had been deteriorating since the fire) saying he might have thought of her and left the room. I
Death encounter has a quality and intensity that sets it apart from the other elements of traumatic experience. The pervasiveness of the effects often seem unrelated to the brief moment in which death is usually faced before survival is evident. Identification and assessment of death encounter is an essential (though overlooked) aspect of the care of traumatised people. Its treatment involves working with the aspects of the psyche implicated and reversing the changes as a preliminary stage for the development of a new attachment to life. Death encounter can cause distorted intimate relationships, post trauma identity, values and priorities, relationship to body and sexuality, create discontinuity between pre- and post-trauma life, ‘out of body’ experiences, disrupt attachment to the future and leave the sense that death was interrupted and is now the only state that makes sense, causing a particular form of para-suicidal thinking.

Not everyone facing death accepts it; even in apparently hopeless situations many set their minds to survive. Their issues are different (like the fire truck driver). Helplessness and unpreparedness for the event are crucial to the response. Survival-oriented life affirmation is protective. A newspaper account of an Indian Ocean Tsunami victim who was rescued after being at sea on debris for several weeks, reported the survivor to say that he stayed alive to care for his mother. Mobilisation of attachments protects against trauma (Henderson & Bostock, 1977).

**Presentation and Phenomenology**

Death encounter is part of a complex, sometimes protracted situation. The moment of encounter is usually passed over because many other aspects are more vivid and compelling such as; lead up, warning, conflict and uncertainty as the situation develops, aspects of the threatening situation, efforts to survive, termination of the threat, post threat actions and subsequent problems. The encounter itself is a personal psychological experience and may not even be evident to other people present, let alone those close to the affected person afterwards. Nothing in the environment demands this be attended to; police statements concern the perpetrator, emergency recovery agencies are concerned about current needs. The death encounter seems to be overlaid with other experiences and the subject is treated as having survived. As time passes, although it may not be clearly remembered, it becomes the nodal point around which post trauma experiences coalesce, increasing a sense of dislocation.

A number of features in their presentation indicate people who have accepted death. No one is likely to have all, but there is overlap in their reactions. They can be grouped under several headings.

**Behavioural lethargy** - often the first complaint is they do not feel like doing anything. They feel indolent, unmotivated, uninterested in activities and interests previously vital to them. They distract themselves with meaninglessness activity (TV, playing computer games, rearranging the house), neglect responsibilities and avoid commitments.

**Disconnection from their former lives** - they describe having lost the sense of having a future; they lose interest in their job, have no purpose and goals that previously motivated them seem pointless. Their old lives hold no interest, they are unable to resume their activities, but have no interest in anything else.

**Cognitive preoccupations** - they are often cognitively active, ruminating about death but not in the past as a posttraumatic response, rather it is directed toward the future, feeling they should be dead, do not deserve to be alive, or they feel a sense of attachment to death (‘I belong dead’) that they find difficult to articulate. Sometimes they wish the worst had happened then they would not be caught in this limbo state. Death imagery is often present, they dream about it and see it wherever they can. Media or road kill in the environment takes them back to their predicament.
distant, uninteresting. This nothingness is distressing and they sometimes say they would prefer outright pain. They describe themselves as if they were a ghost wandering the world and not belonging to it.

**Suicidal ideation** - their suicidal thoughts have a different quality from depressive or posttraumatic suicidality, which is more related to a need to relieve pain or to get away from suffering. They tend to portray suicide as resolving an unbearable tension between feeling they should be, or are already dead, but trapped in life. They want to get it over with and end the suspense, or they constantly hark back to the event itself, saying it would be better if they had died to reduce the uncertainty or dislocation.

**Continuing in the threat** - sometimes they are constantly on standby waiting to die – they don’t make plans as though they feel dying has been temporarily interrupted. This promotes morbid thinking, selective attention to death in their environment and bias toward identifying death threats in loud noises or ambiguous situations.

**Emotional conflicts** - they demonstrate emotional complexes of guilt, regret, anger, disappointment at not dying, that are related to survivor guilt and grief.

**Disorientation and Dissociation**

They feel they watch others going about their lives from outside the action. They lose time without knowing where it has gone. (Bill used to sit at his kitchen table in the morning, then realise it was late afternoon and he had no memory of the day.) They get lost on the way home from appointments and become confused, bewildered and disoriented away from their familiar environment.

**Damaged attachments** - they complain of detachment or disconnection from all who were important to them before the event. They no longer feel close to their loved ones or colleagues, who become like strangers; they listen to their talk as though it does not concern them. They lose attachment to people, but are in such a lonely state that loved ones become the lifeline to their existence and they need extensive contact and support. They are often unable to articulate what they need and loved ones become frustrated, judgemental and impatient.

**Existential or spiritual dislocation** - the experience challenges their philosophy of life, spirituality or religious beliefs. They may previously have had values and beliefs that oriented them in their lives, now they are unable to assimilate the death encounter and it throws the structure into question which precipitates them into an identity crisis. A woman wounded in a massacre said, ‘I have always been the best person I could – I went to church every Sunday – how could God let this happen to me?’

**Inability to identify the cause** - the person coming for help usually does not present the death encounter as the problem. The moment of acceptance of death is usually unrepresented in their memory. They will often say there is a ‘blank’ in their memory. This is an important signal, but naturally leads them to conclude there is nothing to remember. Where they remember something going on in their mind at the moment of encounter, it seems like a thought, and they cannot imagine it being responsible for their pervasive problems.

**Sense of deterioration** - there is a growing sense of desperation that progressively separates them from others. The patience of family, friends and employers wears thin. Increasing pressure is placed on the person to function and they may even receive cautions at work. They become increasingly self-critical and derogatory and think they deserve the criticism. They cannot understand why it is happening and fall back on moralistic judgements of themselves, or retire into solitude or emotional hostility to those pressuring them. They often present in crisis, sometimes brought by others, or desperate to understand what is happening.

Where these reactions are present, the death encounter itself needs to be recognised as a psychic injury. The structures affected by it need to be assessed. Since a traumatic event precipitated the death encounter, many symptoms also occur in posttraumatic stress and other severe states (especially when childhood sexual abuse first comes to light). Death encounter may be accompanied by posttraumatic stress that may continue or, as is the case for most traumatised people, abate. Death encounter problems are indicated by death-related content and disconnectedness related to the present and future, whereas in general, posttraumatic symptoms tend to refer back to the event. Death encounter seems to pervade the foundations of life and values. However, a combination of both problems is likely and they should not be segregated. There are various other responses to death such as the ‘death imprint’ (Lifton, 1976) and the superstitious death preoccupation (Torr, 1987), but these are concerned more with exposure to death as distinct from active acceptance of one’s own death.

**Death as a Stressor**

Imminent death of self or loved one is probably the ultimate stressor. Freud (1915) asserted that there is no representation of one’s own death in the unconscious. It exists as a conscious idea, but we daily ignore the inevitable fact we will die. The idea of continuing life is a pivotal assumption for the structure of experience. If death is the negation of life, each person must consign it to a dissociated place in their mind if they are to have long term plans and enduring attachments.

The threat of imminent death disrupts the assumption of continued life, tearing open the boundary between conscious experience (lacking emotional intensity) and unconscious foundations of personality (embodying powerful psychic forces). The sensory reality of the threat imposes the idea of our own death simultaneously on both systems and provokes radical reorganisation of all based on the assumption of life.

Death is not an abstract idea; it presents itself as a specific, tangible predicament. The form of the death situation creates the phenomena of the problem. Various aspects can be considered in assessing the death encounter. The agent of death varies; it may be an event (Bali bomb), person (assailant), situation (car accident), natural force (tsunami) or God (illness). In the moment of acceptance of death, future life ceases to exist and it is decisive whether the person thinks death means nothing or something somewhere else. Death means separation from the past, life, world, other people, everything of
interest. It is different whether the event involved a near miss (a bullet missed or gun misfired) or the worst actually happened and the person survived (fire engulfed the car but they lived).

Imminent death may not be traumatic to a person who undertakes a profession or activity involving potential life threat (police, military, diving, parachuting), but assumptions cannot be made; the individual meaning must be determined.

Several people may be shot or burnt and have very different physical injuries depending on which bodily structures are damaged; death trauma represents psychic injury and is just as specific to the individual; the death encounter is unique for each person. The psychic structures damaged in the trauma need to be assessed. Those most likely to be affected hold the person into their life, but they need to be articulated, since they are taken for granted as assumptions or unconscious structures.

We are attached to our lives by biological imperatives, instincts and drives for survival, including bodily appetites and psychological drives such as curiosity, interests and enthusiasm.

The self as a structure binds us to life: who or what am I and how is it recognised by others? Expectations and emotional investments in the future, plans, hopes, desires and goals hold us into life. Life structures form the fabric of our everyday existence; routines, habits and familiar things, places and people are taken for granted, freeing us to deal with fluctuating day to day challenges. Loved ones and relationships, social systems and roles, culture and spiritual or existential meanings are other stable structural features binding us to our lives.

Psychosocial forces or processes bind these structural elements together in the unique combinations that make our lives what they are. Energy is invested in ideas or psychological representations of these elements. Bonds of identification, shared values, belonging, participation enacted through communication connected the person to a social world. Personal and collective plans and purposes, images of the future, desires and wishes to be fulfilled weld them into a simultaneously physical and social world.

Any of these structures or processes may be damaged by the circumstances of the death encounter, or an individual may be used to combat its damage. The singer Tori Amos (1991) has a song ‘Me and a Gun’ in which she hangs onto the fact she has never been to Barbados to ensure she survives a man raping her while threatening her with a gun. Just as a car accident will not necessarily cause serious injury, death encounter is not necessarily traumatic, it depends how it happens and who it happens to.

**The Moment of Death Encounter**

To be face to face with the apparent certainty of death is a serious stress. What is specifically traumatic is to go further and let go of life and accept death.

Mary had a shotgun pointed at her in a workplace hold-up. She could not meet the assailant’s demand. For an interminable moment nothing happened. Then another employee engaged the assailant and she departed. She was seen in the following few days and the encounter examined. She was sure he would shoot her because she could not give him what he demanded. Asked what went through her mind, she described a blank spot. I explained how important this moment was and discussed how she might need to reconnect with her future. She had several more sessions and all appeared to be well. Six months later she returned, devastated because her husband had accused her of having an affair. She had experienced growing numbness and detachment, feeling unable to relate to her family or colleagues. She felt only a vestige of connectedness to her husband of thirty years. He felt she was remote, unemotional, disinterested in any intimacy. This had never happened before and he did not consider the hold-up when trying to understand it. Her symptoms indicated she accepted death and was stuck in the detached state.

After considerable re-examination of the experience she remembered a thought did go through her mind in the blank spot. When she was sure she was going to die, she mentally said goodbye to her husband. I explained this was where the structures of her life were set aside and the farewell was made with the core of her being, remaining in force; from his side he felt she had departed from him. It took her some time to understand, then her face lit up, ‘Oh, I get it! I said ‘Goodbye’ but I haven’t said ‘Hello’!’ ‘Yes,’ I said, ‘go home and say hello.’ With further work she made a good recovery.

In high threat, biological and psychic energies are mobilised. The event is experienced with a clarity and intensity that prevents it fading. Images, ideas and emotions are etched in the mind as deep structures of sub-cortical regions of the brain are activated (Bremner, 2004) and the experience is processed holistically, keeping all modalities vivid. These regions are related to instinctive behaviour and the full emotional intensity and survival programming remains attached to the trauma sensory and cognitive information. Traumatic arousal interferes with cortical processing and the memory is not integrated in the normal way.

The high intensity in these subcortical regions coexists with limited capacity to verbalise the experience, since discursive language resides in the cortex, leaving a combination of high intensity memory traces, but difficulty remembering or communicating them.

Acceptance of traumatic death is an instinctive decision in the highly aroused subcortical regions, not adequately reflected in language. The person does not realise what has happened; Mary said her goodbye, but did not realise it was still in force. The extreme arousal of the death encounter opens up the personality, going to the core of being (reflected in instinctive brain structures) and decisions in this state are not thoughts in the normal sense, but actions taken from the foundations of their being that continue to hold sway over physical, emotional and social life until rescinded.

In the traumatic death encounter, death is accepted, but is not rejected afterwards in favour of survival, since the experience of survival is a relief and associated with reduced arousal, hence different cortical brain processes. The idea of the life conferred by survival exists in another part of the psyche – more conscious and accessible to language and everyday life. It is not reconciled with the death acceptance that underlies it as an intense, instinctually charged emotional reality not readily accessible to awareness or communication, as are the assumptions and life structures discussed above.
Death acceptance means values and priorities are oriented to death, emotional attachments are modified, physical and biological processes are organised by the imminent arrival of death. To go through the motions of old purposes of life while feeling no connection with them leads to a desperate situation. The therapeutic problem is how to identify what was enacted at the core of the personality in the face of death, and how to generate enough constructive arousal regain access to that place and integrate it back into the continuum of life.

The Blankness - Existential Discontinuity

Technically, the important factor is the blank spot in the memory. It signifies that point at which arousal exceeded what can be integrated and the system dissociates and is damaged. It may or may not be evident in the person’s memory. They may remember a moment when they went blank, but they are more likely to pass over this moment and go to the next thing that happened or break the narrative altogether, going off on a tangent about emotional repercussions of the experience. Often the actual moment of encounter has to be identified from the sequence of the action rather than direct report. When asked, people often have difficulty fixing the moment. This is a sure indicator of a discontinuity in functioning at that moment. It is not necessarily associated with disrupted functioning in the incident; they may report freezing, going into automatic, or acting on a clear intuition.

It is the discontinuity in the narration or memory that points to the death encounter. Even when they remember what went through their mind, it may amount to a secondary cognitive reflection of a far more profound existential action and unless this dimension is recognised, the effects of the action will remain in force. Some examples indicate the variety of representation of this moment.

A young man was part of a procession over a temporary bridge when it collapsed, tipping many people on top of each other into the water. He extricated himself quickly. After his injuries healed, he could not resume his life. He lost interest in sport and recreation, was indifferent to his partner, his life. He lost interest in sport and recreation, was indifferent to his partner, detached from family and friends and unable to work. He spent time watching TV and playing computer games and was angry when his family confronted him. He was not a verbal person and although he remembered the bridge breaking, nothing went through his mind. But his behaviour indicated he had abandoned life. Eventually I asked the first thing he remembered going through his mind after the crack. He remembered this clearly. The fall seemed long, but can only have been a second or two (suggesting he went into traumatic arousal), but it was blank in his memory. When he landed on other people he thought ‘At least I’m not dead.’ This only makes sense if he had expected to die in the previous moments. Using this as a starting point he was able to reconnect to his life. Acceptance of death may not achieve verbal expression, but be implied by what follows.

A young man responsible for others in a room next to where a massacre was taking place locked the door, told his charges he would tackle the gunman when he came in and be killed, but they must flee. The gunman was overpowered before he was put to the test. He developed posttraumatic stress disorder and felt that whenever things were going badly death would be preferable to life because it represented the solution to all problems and there were no uncertainties. A turning point in his therapy was when it was made clear to him that he had chosen death and unless he reversed the choice, he would always return to it when facing problems. In this case he was very conscious of what he had decided and ruminated about its failure to be fulfilled.
what they might have done. Presenting symptoms and disconnection from life are stronger indicators than their initial recall, especially metaphors or other expressions of deadness, non-aliveness or numbness.

The death threat is a wound that needs to be examined. The threat is identified by examining the account of the event and it is helpful for the clinician to be sensitive to the likely relationship to death, by using pictorial thinking and imagining the subject’s experience. Attention needs to be paid to memory discontinuities, disturbances, gaps or blank spots. They may not present as memory problems, but blank spots in the narrative that the clinician is curious about. If nothing can be added, these points will return during treatment, usually in relation to symptoms and each time they provide an opportunity to go through it again and remember more. As peripheral problems are resolved and the relationship develops, more resources can be devoted to remembering and deeper cognitive actions come to light and can be reversed. I suspect this cannot be hurried, especially in cases presenting after a delay. The facts and sequence of the experience need to be reconstructed first, then the thoughts. Emotions are best explored after, since they are consequences of the meaning given to it. When the death encounter is identified and the acceptance represented, the clinician needs to find out what the subject did to accept death.

The death idea has to be mobilised through symbols or the developing discourse of the treatment. Raising it prematurely complicates the process and intellectualises the problem. If it arises naturally and the clinician waits until the right moment, an emotional intensity can be generated that makes contact with the highly aroused problematic cognition and a new cognitive act is possible (as happened with Mary’s exclamation that she needed to say ‘hello’). It is most effective when the clinician leads the subject to realise what they have done in that moment and the relationship between these actions and the problems they have been working on. Material and symptomatic behaviour following this point needs to be examined for its relation to that moment; dreams, thoughts daydreams and behaviour may reveal more as the process unfolds.

The key to technique is to identify and verbally represent the moment of encounter, then work at the blank spot until the death threat is understood: how it was experienced and what the subject did about it—because they always say something. But it may take many sessions of persistence to fill the blankness. Complications often result from delayed presentation and have to be treated first.

Education about death encounter and traumatic arousal that needs to be provided is not just information; it provides language and a framework for meaning that was lacking amid the violated assumptions at the time and since. Recovery from high arousal is facilitated by building new assumptions, based on normalisation of responses to extreme situations. In addition to interpretation, organisation and education, the clinician can consider with the subject what gestures, symbols and rituals may reverse the act and undo the changes. Usually they can take the lead and initiate a process of rehabilitation. Where this does not happen, it is an indication that the death encounter has become combined with pre-existing conflicts that then need to be treated. With appropriate sensitivity and careful timing these actions can be reversed and this then clears the way to resolve the other issues left by what they have been through.

References


Author Notes

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