
Some Illustrative Patients

In this chapter, we will present the evaluation and management of three illustrative patients, beginning with the case of the "sick Tarzan," whose history and interview were presented in Chapter 16. All the cases presented in this chapter, including the "sick Tarzan," are actual case histories. Of course, some identifying data have been changed for reasons of confidentiality.

MANAGEMENT OF THE "SICK TARZAN"*

We are now prepared to formulate a comprehensive three-dimensional management plan for our patient, armed with information and insights from all our previous chapters. In rereading the case history, it should become clear that there is a discrepancy in the model of illness between the patient and the doctor. For example, "My doctor thinks I had a heart attack. All I need is to get back my strength, which I lost from being in here too long." In fact, the patient believes "Once you start laying in bed without moving and letting your blood move, you might as well bury yourself." Once we understand the patient's own unique theory concerning illness and ways of recovery, we can understand why it is so important for the patient to become active and why he may feel compelled to try to lift his bed.

His commitment to activity, however, is not necessarily unamenable to reason. He in fact believes that being too active and not "resting a

*Please reread Chapter 16.

minute" after sexual intercourse with his wife might have caused his disease ("I didn't give my heart a chance to rest").

The doctor, then, might consider attempting either to change the patient's model of illness to correspond with his own or to modify it just enough to allow optimal medical treatment to proceed. To make this decision, the physician has to assess why and how strongly the patient's model is held. In Tarzan's case, the importance of activity was emphasized over and over again, as though it were a prophylactic against death. It becomes clear during the interview that the patient had used activity as his most characteristic life-style and that he felt very proud of his strength and "bigness": "I've got a *big* chest so I can take in a lot of air"; "I don't drink small amounts of anything"; "In my youth, I was so strong that . . . I had to wrestle with four or five fellows at one time"; "I was what they called a natural strong man"; and so on. To a man with this kind of self-image, feeling weak and ill must be a terribly uncomfortable state. And this was exactly what he felt: "But today I feel sorta weak. . . . I think it's because they don't let me move my blood in the hospital." The patient's need for activity now is not simply a logical outcome of his general belief concerning health maintenance, but it also has a defensive quality—he needs to overcome his feeling of weakness from being inactive.

The physicians, with the help of the psychiatrist, decided to attempt to modify the patient's model rather than to change it completely. Strongly held beliefs that serve defensive functions are not easily given up, and the emergency nature of the medical condition militated against an attempt that might possibly have resulted in a rupture of the doctor-patient relationship. To attempt to change his activity orientation would have been to attempt to change his long-term (background-context) personality and coping style.

The patient's apparent denial of heart disease itself ("My doctor thinks I had a heart attack") was not complete: "I didn't give my heart a chance to rest." If he does not deny the presence of disease, he does deny the emotional upset that one might expect to be associated with it: "*Nothing bothers me. . . . I don't let nothing bother me.*" Behind this denial, we get a glimpse of great suffering in the past—he apparently had thought that he had cancer in his 30s but was told that "it was all from nerves." Since then, he adopted an attitude of "nothing bothers me." Although this attitude may not be conducive to the patient's preparing for danger situations in a deliberate fashion, the ability to deny anxiety and fear may be helpful, if used in moderation, once he is on the coronary care unit (see Chapter 19). So long as the patient's behavior is not maladaptive due to the denial, denial can be a protective mechanism. The

question in this case might be how to change the behavior (e.g., lifting up the bed) without frightening the patient excessively, as would happen if one confronted him with the consequences of extending the heart lesion. If his denial were not functioning, we might again have a patient who is, as he described he had been when he thought he had cancer, worried, with pains in his head and diarrhea lasting for years.

The patient gives a good indication that an important person to recruit as a collaborator in the management may be his wife: "She wants me to stay home with her on Saturdays, I stay home with her." We notice that the patient is rather boastful, especially concerning his strength and, perhaps, masculine prowess. He did not respond well to nurses' reproaches concerning his activity. Perhaps an authoritarian approach threatens his sense of masculinity and need to be in control. His need for control, which goes along well with his activity orientation, is pretty clear throughout the interview itself, including, "And, someday, you fellas are going to come to the same conclusion—that moving the blood is the most important thing of all."

The patient came into conflict over authority with the nursing staff about who could give orders to whom. This resulted in his increased anxiety and the need for more activity to reassure himself that he did have control after all. In part, the authoritarian attitude of the nursing staff may be related to the rigidly authoritarian nursing hierarchy generally found in hospitals and the "double bind" in which nurses often find themselves (Chapter 19). To the nurses, it is unthinkable that a patient should wish to violate orders deliberately!

Actually, there were indications that the patient was having difficulties adjusting to the coronary care unit as early as the second day of admission. For example, he was found sitting up in a chair and was agitated at night and "arrogant." He asked for large doses of Valium. Because of a communication gap, however, the nurses' observations were not known to the doctors, who might have attempted to understand the patient's source of increasing anxiety.

To summarize, then, we have a patient who has an activity-oriented, controlling personality and who feels threatened about being immobile in bed in the coronary care unit. He has difficulties with nurses over authority but has a supportive wife, for whom he would do "anything." He has documented serious heart disease and is in pain and danger of his life. He has a strong belief that he has to "move his blood" to survive.

On the basis of the discussion above and the PEG of the "sick Tarzan" (Figure 34), the three-dimensional management plans outlined below were worked out.

59 yrs, ♂, married, president of a small company, 2 daughters, ages 26 and 24

CONTEXTS			
DIMENSIONS	CURRENT (Current States)	RECENT (Recent Events and Changes)	BACKGROUND (Culture, Traits, Constitution)
BIOLOGICAL	Chest pain Nausea Relevant physical data Dx MI Diazepam, proccainamide Meperidine	Borderline hypertension (7-8 years, no meds)	Hx of heart disease and cancer in family
PERSONAL	Nausea Pain Thinks pain due to indigestion Believes exercise essential for survival	Increased smoking (3-4 yr) Increased drinking (3-4 yr)	No previous hospitalization Has a "strong man" image Uses denial as a defense Hx of "nerves"—thought he had cancer, decided to deny— "nothing bothers me" Active, "take charge" type of per- sonality boastful, dramatic Believes in exercise
ENVIRONMENTAL	ICU Bedrest Nurses Wife Very attached to wife; will "do anything for her" Being in hospital means busi- ness associates will be in charge	Father d. of MI 6 yr ago Mother d. of pulmonary edema (3 yr ago) 2 daughters married within last 4 yr, live in another state Sex immediately before MI hospitalization	Middle class Italian, Catholic background High school education Many relatives died of cancer Father was very authoritarian executive of a small company for 25 yr

Figure 34. PEG of the "Sick Tarzan."

Biological Dimension

1. Adequate pain relief with narcotic analgesics (meperidine, 50 mg intramuscularly every 3 hr): Pain relief is necessary for myocardial rest and gives the patient a sense of control.

2. Decrease diazepam, since large doses of tranquilizers may make the patient feel weak and drowsy.

3. Other necessary treatment of the MI and PVCs.

Personal Dimension

1. Treatment of pain with narcotic analgesics as above.

2. Nausea ceased to be problematic spontaneously.

3. Allow "moving blood" without compromising treatment: A schedule of token toe exercise was devised so that the patient could "move the blood" without having to strain the heart trying to lift up the bed. Taking into account the active, controlling, and taking-pride-in-being-a-strong-man personality, this plan was presented as follows:

DOCTOR: I think we can suggest a good exercise for this purpose. However, I wonder if I can ask you to do something that's very difficult for a strong and big man like you—in fact, this may be the most difficult thing that anyone can ask of you—but, since you have a lot of strength, you might be able to do this.

PATIENT: Well, maybe I can try. I can do anything, you know. What is it, Doc?

DOCTOR: For a very strong and active man like you, staying in bed for a few days is one of the most difficult things for anyone to ask you to do. But your heart needs the rest so that it can heal. While you are in bed, you can still move your blood by doing an exercise—you can move your toes up and down, which will pump the blood all the way through the toes. But I am not sure that you have the patience and strength to do this difficult thing. . . .

PATIENT: Well, Doc, I think I can try. I am an impatient man, but when I know that I am moving my blood, I can become the most patient man on earth.

In the long run, the patient was able to give up smoking and reduce drinking when these were presented to him as challenges to his will-power and strength to promote his health.

Environmental-Interpersonal Dimension

Perhaps the most important intervention occurred in this dimension, because it involved changing the approach of the medical and nursing

staff to the patient and his wife. The psychiatrist consultant coordinated this educational task.

1. The primary physician was instructed how to be able to present the approach he used concerning "moving blood" (see above). The patient was offered pain medication regularly, but he could decline to take it if he had no pain (reverse p.r.n. schedule).

2. The patient's wife was mobilized to be a collaborator in management. For this reason, she was invited to sit down with the doctor and nurses and jointly discuss the patient's progress—and compliance with the regimen. If the patient seemed to become too active, such as tending to sit up or get out of bed, the wife would go to him and say, "You know that it's important for me that you are strong and well. It worries me a lot when the doctors get worried about you and your getting out of bed; please stay in bed for a few more days—for me." She turned out to be a good collaborator, not only in ensuring compliance with the treatment, but also in reporting to the doctors and nurses about any change in the patient's state, level of anxiety, and sedation, so that medications could be adjusted on the basis of her observations.

3. Taking into account the talkative, boastful aspect of the patient, the members of the nursing staff were encouraged to listen to him and communicate that they were impressed by his strength. The nurses were able to understand that he needed to feel extra strong because otherwise he would feel so weak and afraid. As the nurses listened to him, they found him to be a rather charming "tall-story" teller, with whom it was rather enjoyable to converse. When the nurses had to be firm with him, they asked him to comply because otherwise they would "get into trouble." He usually heeded this appeal, because it gave him a sense of masculine chivalry—to do things so that a nurse would not get into trouble.

As his medical condition improved, he was given as much control as possible over his activity, including setting his own schedule for shaving and bathing. He was allowed out of bed as soon as possible and transferred out of the coronary care unit as soon as his physical condition allowed. On transfer from the coronary care unit, the nurses on the medical ward were alerted to his unique needs, and he was prepared for the transfer carefully.

The concerted efforts by everyone concerned—doctors, nurses, and wife—were successful, and the remainder of his hospital stay was uneventful.

THE CASE OF THE CATATONIC PATIENT WITH ENLARGED VENTRICLES*

History and Course

This 27-year-old white married woman was admitted to the medical service for treatment of severe ulcerative colitis. She was a high school graduate and the mother of two children. On arrival at the hospital, she was mute and immobile.

The family stated that the patient had complained of "racing thoughts" and a feeling that she was going "crazy" beginning several weeks prior to admission. In fact, the patient had stopped taking prednisone (a synthetic cortisol-like drug) that was given her for the colitis, because she felt it was making her "crazy." It was restarted, however, and she was receiving relatively high doses (60 mg/day) of prednisone for three weeks prior to hospitalization. She had no previous psychiatric history.

In the hospital, she was mute and unresponsive and showed waxy flexibility; that is, her limbs would remain indefinitely in any position in which they were put. Her eyes were open, and she appeared vigilant, occasionally grimacing at people in her room. The physical examination on admission revealed an emaciated and diaphoretic young woman with labile hypertension (170-130/120-90 mm Hg), tachycardia (90-125/min), and fever (rectal temperature, 100-101 °F). Laboratory findings showed anemia (hematocrit, 29-27%), hypokalemia (2.2 mEq/liter), and hypomagnesemia (116 mEq/liter). All other values, including thyroid studies, were within normal limits.

On admission, she was placed on a regimen of hydrocortisone, 100 mg intravenously four times a day. Serum potassium and magnesium abnormalities were corrected by administration of potassium and magnesium without visible improvement in the patient's mental status. An automatic computerized tomographic axial scan (ACTA), which visualizes the brain structures on X ray, was performed on the second day of hospitalization and revealed "grossly enlarged lateral, third, and fourth ventricles with no evidence of cortical atrophy"; that is, a structural abnormality of the brain was found. A repeat ACTA scan three days later confirmed enlarged ventricles with no evidence of a tumor that might

*Originally published in a somewhat different form in Leigh H: Good outcome in a catatonic patient with enlarged ventricles. *J Nerv Ment Dis* 166(2):139-141, 1978. Copyright 1978 by Williams & Wilkins Co. Portions reprinted with permission from the publisher.

have caused this abnormality. An EEG revealed moderate, generalized, bilateral rhythmic slow-wave activity with no focal or epileptic features—an indication of generalized slowing of brain function. At this time, the most likely diagnosis was considered to be subacute sclerosing panencephalitis, a very grave condition for which there is no specific treatment.

She would occasionally manifest severe tremors of all her extremities that were sometimes mistaken for convulsions by the nursing staff. She was placed on small doses (2 mg) of perphenazine, an antipsychotic phenothiazine, three times a day, with some improvement. She would occasionally “wake up” from her stuporous, immobile state and converse with the staff, but would then lapse back into the catatonic state. During the lucid intervals, she was apparently responding to visual and, occasionally, auditory hallucinations.

Throughout her hospital course, she had stools positive for blood and developed episodes of frank gastrointestinal bleeding with marked evidence of toxicity. An emergency total colectomy was performed in the sixth week of hospitalization.

After the colectomy, all vital signs and laboratory findings returned to normal, and the hydrocortisone was gradually tapered off. Her mental status improved gradually such that five weeks after the colectomy, she was completely oriented and showed good recent and remote memory. She did serial 7s well, and her calculations and abstractions were within normal limits (see Chapter 13 for a discussion of the mental-status examination). Her judgment was good. Her affect was normal, and she related with the staff quite well. Tremors, waxy flexibility, and hallucinations were no longer present. She was eager to go home and return to her family and stated that she had no recollection of the events that had transpired during the period she was in the hospital until the time she recovered from the surgery. She did not remember any of the conversations she had with the physicians during her lucid periods, nor did she remember any of the hallucinations she had before surgery. A repeat ACTA scan performed at the time of discharge from the hospital, two and one half months after surgery, still showed enlarged ventricles of the same magnitude.

Comments

The PEG constructed shortly after admission is presented in Figure 35. The management plan for this patient involved discussing all aspects of the case with her husband, the important supportive person. This was especially important, because the patient, being mute and

27 yrs, ♀, white, married, housewife, 2 children

CONTEXTS			
DIMENSIONS	CURRENT (Current States)	RECENT (Recent Events and Changes)	BACKGROUND (Culture, Traits, Constitution)
BIOLOGICAL	Labile hypertension Tachycardia Fever Anemia Electrolyte imbalance Hypokalemia Hypomagnesemia Steroids ACTA—enlarged ventricles Ulcerative colitis	Ulcerative colitis for 3 yr Prednisone 60 mg (3 wk)	No family history of psychiatric illness
PERSONAL	Catatonic syndrome Mute	Racing thoughts (several weeks) Felt she was “going crazy” for a few weeks—stopped Prednisone Prednisone restarted (3 wk ago)	No past psychiatric history Pleasant, sociable person
ENVIRONMENTAL	Came in ambulance accompanied by husband	Married five years Two children Husband supportive	High school graduate Middle class Protestant Two siblings well Parents living and well No psychiatric history in family

Figure 35. PEG of the catatonic patient with enlarged ventricles.

immobile, could not sign any forms for hospitalization or surgery and was not in any state to discuss management plans with the physicians. Treatment of the catatonic syndrome involves first an evaluation and treatment of the possible causes (see Table 6 [Chapter 7]). Symptomatic treatment with antipsychotic medications (such as perphenazine) may be necessary. Possible causes of the catatonia included, in the biological dimension, hypokalemia, hypomagnesemia, steroids (hydrocortisone, prednisone), and the structural abnormality of the brain (enlarged ventricles on the ACTA scan). The toxicity from ulcerative colitis and fever may also contribute to this picture. The electrolytes (e.g., potassium, magnesium) were corrected, and the ulcerative colitis was initially treated with high doses of steroids without much change in the mental status. This left the possibility that (1) the steroids given to treat the colitis might be contributing to the mental state; (2) the structural abnormality of the brain on ACTA was indicative of a brain pathology that was causing the catatonic state, such as subacute sclerosing panencephalitis; or (3) the catatonic syndrome was primarily a psychiatric disorder, for example, schizophrenia, that might be only secondarily related to the biological abnormalities found.

In view of the negative family and past history of psychiatric disorder, and the outgoing, sociable personality of the patient, it seemed less likely that the patient had schizophrenia. Although the encephalitis was a possibility, no specific measures could be applied to treat it. In retrospect, and in view of the good outcome, this was probably not the cause of catatonia.

Following colectomy for the ulcerative colitis, the patient was withdrawn from the steroids. Simultaneously, her mental status improved. Thus, most likely, the steroid medications given to treat her medical disease contributed significantly to her abnormal mental status.

The patient's limited response to antipsychotic medication illustrates the nonspecific nature of antipsychotic treatment; that is, regardless of the etiology, psychosis can be symptomatically treated with these medications. In certain situations in which steroid medications are lifesaving, the psychiatric side effects may have to be treated with antipsychotic drugs while the steroid medications are maintained.

Many physicians felt initially that this patient had an irreversible process in the brain. Such thinking led some clinicians to despair of effective therapy and even to suggest the futility of colectomy in "such an obviously brain-damaged patient." The subsequent course of this patient indicates, however, the value of correcting any treatable source of a multifactorial problem.

While the structural brain abnormality might have been associated with the brain's vulnerability to catatonia, it could not have been the major "cause" of the problem. This case draws our attention to the fact that every effort should be made to identify and treat *all* possible etiological and contributing factors in a seriously ill patient.

THE CASE OF THE SUICIDAL TERMINAL CANCER PATIENT*

History

This 35-year-old white woman, a physician's wife and the mother of three children, was admitted to the intensive care unit of the hospital. She was found comatose in her bed by her husband when he came home from work late at night. An empty bottle that contained secobarbital, a sleeping medication, was found next to her bed. Prior to the suicide attempt, the patient was being treated with radiation and chemotherapy for a cancer of the breast with widespread metastases.

Four years prior to the present admission, a lump in her left breast was detected on a routine physical examination and was subsequently diagnosed as malignant. Two years following the radical mastectomy, another cancer was detected in the right breast, necessitating another radical mastectomy. Approximately one year prior to the current admission, there was evidence of spreading of the cancer to the bone and behind the eyes. The spreading cancer was treated with chemotherapy, radiation therapy, and removal of both ovaries, since breast cancer tends to spread less when female hormones are absent. She also received steroids and pain medications for the severe pain she developed in her back and legs due to the spreading of cancer to the bones. The side effects of these treatments were grogginess, baldness, and facial puffiness, and there was growth of a moustache due to the absence of female hormones and the masculinizing effect of steroid hormones. The steroids also made her feel "high" and euphoric sometimes.

She was a young woman who was intelligent and attractive (despite the bodily changes of late), but felt defeated and depressed. With the appearance of signs of spread of the cancer, she progressively withdrew from her social activities and her work as a social worker. She was feeling

*Originally published in a somewhat different form in Leigh H: Psychotherapy of a suicidal, terminal cancer patient. *Int J Psychiatry Med* 5:173-182, 1974. Copyright 1974 by Baywood Publishing Co. Portions reprinted with permission from the publisher.

guilty about being a burden to her family and frightened about the possibility of being a "vegetable." For fear of burdening her family, she did not discuss her feelings of frustration and sadness. She wrote in her diary, which was found by her husband when she attempted suicide, "In order to maintain my equilibrium and not burden others, I'll try to be my own therapist and write down my feelings and thoughts about myself." In it, she expressed feelings of being "out of battle" and of not being involved. She had feelings of depression whenever she had pain, but occasional euphoria due to steroids and pain medications: "It is crazy to feel okay with what I have, but I am ready to take my exit pills tomorrow, if necessary."

Evaluation of the environmental-interpersonal dimension through interviews with her and her husband confirmed the initial impression that she had a supportive and concerned family. Her husband, however, had guilty and conflictual feelings because he could not spend as much time as he felt he needed to with his wife because of his busy schedule as a cardiologist. He was also uncertain about how to prepare his children for the eventual death of their mother. The suicide attempt was a great shock to him and increased his guilt feelings. The patient's mother lived in a city some distance away. The patient saw her occasionally, but had a very ambivalent relationship with her. Her father, described as an ineffectual person, died as the result of an accident when the patient was in her teens. She had a younger sister who was a housewife in another town.

Her oncologists were highly competent and empathic, but tended to expect their patients to deny the serious nature of the disease. They were very proud, for example, that all their patients with terminal cancer had a bright emotional outlook and "smiled at everybody." Of course, this patient's suicidal attempt belied this notion and came as a great shock to them.

The patient characterized herself as having been a fighter, for whom activity and mastery were very important. She had a full-time job and was a skillful tennis player. Pain and prolonged suffering, however, made her feel exhausted, weak, and defeated. She seemed to have used the defenses of activity and intellectualization successfully in the past, but of late, they seemed to be less effective in the face of pain and continuing progression of disease. She found that trying to smile and deny the presence of the serious illness, as her doctors seemed to want her to do, was more depressing to her. She wished that she could talk about her pessimistic thoughts with her doctor, but felt that this would be a burden to the doctor.

Evaluation

On the basis of information available at the time of evaluation, a PEG was formulated (Figure 36). The immediate need of the patient was, of course, treatment of the overdose during the hospitalization, evaluation of the patient's suicide potential and prevention of suicide, and evaluation of the family situation and mobilization of support.

In terms of relatively long-term management, two problems had to be considered: the metastatic cancer and the depression and suffering of the patient and family. In the environmental dimension, the husband's guilt feelings about not spending enough time with his wife (recent context) had to be dealt with. In view of her ambivalent feelings about her mother and sister, these family members were not considered to be a great resource for interpersonal support. She was not a religious person and did not wish the involvement of clergy.

In the personal dimension, encouraging activity and intellectualization within the limits of physical capacity would be useful in view of her personality style, coping style, and defense mechanisms. A plan of collaborative treatment of her illness would be more likely to succeed than blanket reassurances with a "trust me" attitude. Her occupation as a social worker and her diary indicated that she would probably use and benefit from psychotherapy, although she had not yet sought it. In the recent context, the presence of pain was an important factor in making her feel out of control, defeated, and discouraged. A regimen of adequate pain medication was planned. If the disfiguring side effects of treatment were put in the context of tangible signs of a fight against cancer, they might be less depressing given this patient's personality, somewhat like the combat scars of old and proud veterans. Also, anti-depressant medication should be considered for this patient.

In the biological dimension, treatment of the cancer should, of course, continue. As much information as possible about the expected effect of the treatments and the progress should be shared with the patient.

Course of Management

The patient was initially managed in the hospital until she recovered fully from the effects of the overdose. During this period, her suicide potential and depression were evaluated by the psychiatrist in collaboration with the primary physician. It was decided that although the suicide attempt was serious, it was a reaction to the patient's feeling out of control and at an impasse with the oncologists about communicating

35 yrs, ♀, married (to an M.D.), social worker, 3 children

DIMENSIONS	CONTEXTS		
	CURRENT (Current States)	RECENT (Recent Events and Changes)	BACKGROUND (Culture, Traits, Constitution)
BIOLOGICAL	Massive overdose of barbiturates Terminal metastatic breast cancer Steroids Pain medications	Lump in breast 4 yr ago — radical mastectomy Recurrence in remaining breast— radiation, then mastectomy 2 yr ago Metastases to orbit & bones (1 yr) Chemotherapy, radiation, steroids, ophorectomy — (within last yr)	Family history of cancer — aunt
PERSONAL	Suicidal attempt Fear of immobilization	Pain ↑ 1 yr Boldness, appearance change, jaundice (about 6 mo) Feeling defeated in recent mos Fatigue over recurrent disease Fear of burdening family and doctor — recent mos	Social worker Attractive, intelligent A fighter, activity & mastery important Orderly, controlling type Intellectualization Counterphobic maneuvers
ENVIRONMENTAL	Husband & 3 children are supportive No suicide note Oncologists	Husband — busy physician feels guilty for not spending more time Oncologists expect patient to be cheerful	Father died when patient in teens Controlling and ambivalently experienced mother Mother preferred sister (who lives in another town) Jewish, middle class

Figure 36. PEG of the suicidal terminal cancer patient.

her concerns. Thus, with improved communications and psychotherapy, she might cease to be suicidal. A considerable amount of depression was present, and amitriptyline therapy was instituted. Her family was evaluated by the psychiatrist, and it was decided that the psychiatrist would see the patient regularly—daily while in the hospital and once a week after discharge—and that her husband would also be seen by the psychiatrist on a biweekly basis to discuss his own feelings of guilt. This would also provide him with the opportunity to discuss various concerns of his including the preparation of their children for the eventual loss of their mother.

As these plans were set in motion, the patient was discharged from the hospital as the acute medical condition resolved. She kept her appointments with the psychiatrist diligently. The psychiatrist maintained close contact with the primary physician and the oncologist, discussed with the patient any new symptoms and plans of therapy, and encouraged her to communicate directly with the oncologists. She no longer felt that she had to always smile at them.

The psychiatrist, with the support of her primary physician and oncologist, encouraged her to return to work as much as she could tolerate (which was about half-time) and also to write down her experiences in fighting cancer. Writing this chronicle was a substitute activity for a more strenuous one, like playing tennis, and also served the function of being a record of her valiant fight against this serious disease.

She wanted to discontinue the amitriptyline soon after it was begun because of its side effects, especially sedation—she felt more out of control when she was groggy. It was discontinued, and the patient's depression lifted without medication as she gained a greater sense of control.

Psychotherapy was initially aimed at increasing her coping ability through discussing how she might cope with possible stressful events, such as increasing side effects from treatment (e.g., baldness). The idea that the side effects might be seen as something like battle scars was accepted by the patient with relief and determination. Soon, however, she wanted to explore her unconscious conflicts and meanings concerning her disease, cancer. She discussed in detail her ambivalent relationship with her mother, who had always been inconsistent and inconsiderate of her. She remembered experiences of being reprimanded by her mother for any independent activity and her mother's attempts to control her every activity, including what time in the morning she could get up and what she should eat. She sought relief from this unhappy relationship by going to college away from home. Her father was ineffectual and did not interfere with her mother's controlling attitude.

In the course of psychotherapy, the meaning of the cancer became clear to her—it represented an alien, evil force that was attempting to control her life, change it, and, ultimately, extinguish it. In many ways, she saw her cancer as a symbol of the kind of overwhelming force that, like her mother, seemed to want to control her and subjugate her completely. As she began to see cancer as an alien object, she was able to feel that she might be able to win over it, as she had been able to gain her independence from her mother. The process of gaining independence from her mother was a protracted one in which, at times, she had to give in, but, at other times, she was able to achieve greater independence. She began to see her struggle with the cancer in a similar vein. She resolved not to feel completely defeated by one or two setbacks.

She decided to live and plan for relatively short and discrete periods—a few months at a time. She felt a certain degree of mastery in *willing* herself to live for the discrete intervals.

During the seven-month period of outpatient psychotherapy, she seldom mentioned pain or physical discomfort and stayed away from prolonged discussions concerning her medical treatment. In fact, she seemed to want to believe that whatever physical symptoms she felt had a psychogenic origin and could be dealt with in psychotherapy. However, she recognized this as wishful thinking and did not neglect to take medications and treatments for the disease. The psychiatrist was in close contact with the oncologists throughout this period and made sure that the patient was complying with the medical regimen. Although she had free use of narcotic analgesics, she used them very sparingly, because she did not like their sedating side effects.

The disease progressed relentlessly despite the combined efforts of the primary physician, surgeon, oncologists, and psychiatrist. As spread of the cancer to the brain was discovered, she began to feel dizzy and had constant nausea. She still continued psychotherapy and was able to talk about her sadness over her disappearing youth and mourn for her unfinished plans, but then she hoped that her husband would remarry soon after her death—almost as though to continue her happy marriage.

As she became too ill to come to the psychiatrist's office, her care was left primarily to her family. She chose not to be hospitalized during the final phase of the illness. The psychiatrist talked with her regularly on the telephone, and she would tell him about the amount of work she was able to do at home despite the symptoms. During the final weeks of her life, her husband was almost constantly with her, having taken partial leave from his work. He continued to see the psychiatrist regularly and several times after her death, for support, discussion of plans, and sharing his thoughts and feelings.

Comments

This case illustrates how a terminal cancer patient found herself unable to communicate with her caretakers. As a result of complex interactions among her personality, her disease, its symbolic meaning, physical and emotional pain, and the effects and side effects of treatment modalities, she was driven to a suicide attempt.

Management plans based on a systematic evaluation of the patient were three-dimensional and effective. The patient's life was prolonged, and she died of her disease, not as a suicide—but above all, the eight and one half months of life she lived after the suicide attempt were *gratifying* to her. She died like the fighter that she had always been, and she died feeling that she had fought well to the very end, fighting as a team with her doctors and her family.