John the Rifleman and Other Stories

Casebook of a Consulting Psychiatrist

Hoyle Leigh

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SutroCrest Publishing

San Francisco

ISBN-9798988644545
Library of Congress Control Number: 2023917895
SutroCrest Publishing, San Francisco
Printed in the United States of America

Dedicated To

Vinnie, my Love and Life's Companion,

&

My Mentors, Colleagues, Students,

&

Especially Patients

From Whom I Learned So Much!

Preface

Growing up in South Korea during the chaotic, perilous years of the Korean War, reading mystery novels comforted me with the idea that rational reasoning will cut through any confusion and red herrings, solve the puzzle, identify the criminal, and let justice prevail. I then became enamored with Freud's writings and with psychodynamics which showed how the mysteries of the human mind could be solved through similar reasoning. These interests led me to psychiatry and medical school.

During medical school, I also became interested in physiology, which shows how the human body, as a whole, functions by adapting to new situations and challenges. Medicine is a direct application of physiology to pathological conditions, i.e., when the normal physiologic balance (homeostasis) goes out of kilter due to, for example, the invasion by infectious organisms (e.g., Covid 19, Flu), cancer (certain cells becoming abnormal and start

multiplying out of control), extreme stress (e.g., excessive, and prolonged release of adrenal hormones causing damage), etc. During my psychiatric training, I expanded my interest to integrate psychopharmacology and hypnosis with psychodynamics and physiology in understanding and helping patients.

I chose to be a Consultation-Liaison psychiatrist, a psychiatrist who works in the general medical setting of a medical center, where both psychiatry and medicine can be integrated around the medical patient with behavioral/emotional problems.

Practicing medicine and psychiatry is serious business, but it can also be fun! Each case is different, and almost always complex. Deductive skills, as with the detective in a mystery fiction, are needed to cut through the miasma of pathology, both physiological and psychological, and arrive at an explanation (formulation) leading to a rational management plan.

I enjoyed my more than half a century of practice, teaching, and research in Consultation-Liaison Psychiatry in various settings. I encountered many patients with interesting stories and outcomes. Here I present some illustrative cases. Some of the cases are those that left an impression on me during my early career, prior to the advent of computerized medical records for example. The last patient I present, John, the Rifleman, is a recent teaching case that illustrates how genes, early environment, and experience through life stages affect mental health and illness. For obvious reasons, the names are pseudonyms, and the cases are composites and fictionalized accounts, but the basic message should be clear: Patients are unique individuals and need individualized understanding and care.

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September 2023

What is a Consulting Psychiatrist

A consulting psychiatrist, otherwise known as a consultation-liaison (CL) psychiatrist, is a psychiatrist who works in a general hospital, and consults on medical and surgical patients who are referred for concurrent or co-existing emotional or behavioral problems. The patients may be hospitalized patients or outpatients. The problems may be situational anxiety or depression concerning impending surgery or diagnosis of a serious medical illness or may be related to a chronic psychiatric illness such as bipolar disorder or schizophrenia. After the consultation session(s), the patient may be referred back to the referring physician with recommendations for treatment, referred to a psychiatric outpatient or inpatient facility, or may become the consulting psychiatrist's outpatient for follow-up.

A consulting psychiatrist is usually board certified in general psychiatry as well as in consultation-liaison psychiatry. Some consulting psychiatrists, like myself, also use hypnosis as an adjunct therapy for relaxation, visualization, habit control such as smoking, as well as psychotherapy.

Contents

	Page
Chapter 1. This bed will kill me	3
Chapter 2. The Czar on 8-East	13
Chapter 3. I Shall Die on My Thirtieth Birthday	34
Chapter 4. Dr. VIP	46
Chapter 5. The Vampires in the Hospital	72
Chapter 6. The Case of the Sick Tarzan	80
Chapter 7. Leave Me Alone and Let Me Die	101
Chapter 8. I See Red, Then I Cut My Guts	119
Chapter 9. The Case of the Catatonic Patient with a Brain Cavity	127
Chapter 10. The Case of The Suicidal Terminal Cancer Patient	136
Chapter 11. When The Buddha Sings	151
Chapter 12. A Case of “Coin Lesion” in the Lung	156
Chapter 13. Nurse with Cardiac Arrest and Low Potassium	164
Chapter 14. Enjoy your Vacation	172
Chapter 15. Hear My Song – the Mental Health Blues	183

Chapter 16. When I Visit My Own Grave 191

Chapter 17. When Cultures Clash 202

Chapter 18. Is this Seizure Real or Psychogenic? 210

Chapter 19. The Medical Student with Fear of Blood 226

Chapter 20. John, the Rifle Man – How genetics and experiences through life stages affect mental health and illness 241

Bibliography 288

About the Author 291

Chapter 1. This Bed Will Kill Me

The Cardiac Care Unit is not a place where one expects to find much shouting. In fact, the sounds of shouting plainly audible from outside the glass door indicated that there was a major untoward event occurring in the unit.

"'Am I glad to see you, Dr. Lee " was the greeting by the head nurse as I approached the nursing station. "It's been like a zoo here since Mr. Smith came in."

Mr. Smith was a 48-year-old divorced man who was a small retail store owner. After developing severe chest pains in the store, he had called an ambulance and was brought to the hospital. Massive myocardial infarction (heart attack) was diagnosed, and he was transferred to the Cardiac Care Unit (CCU). The medical record noted that Mr. Smith was anxious but cooperative in the Emergency Room and had readily agreed to be hospitalized.

Upon entering the CCU, however, the patient became increasingly anxious, and when his gurney was about to be wheeled into his cubicle, he suddenly sat bolt upright, and screamed, " I am not going in there, let me go! I want to go home. " The patient then started to climb out of the gurney. Nurses hurried to restrain him, security guards were called to hold him down as he was placed in the cubicle, and he became mere and mere agitated and louder and louder.

" I want to go home, you bastards. You can't hold me here. You are trying to kill me! "

The intern, who was emergency-paged by the nurse, tried the authoritarian approach, "Mr. Smith, you know that you have to stay here so that we can treat you for the heart attack. You will die if you don't stay here and get medical treatment!"

" I' l1 die sooner if I stay here, you bastards . I am going - I am going to call my lawyer. You can't hold me here. You

are trying to kill me" screamed Mr. Smith, struggling against the restraining hands of the security guards.

An emergency psychiatric consultation had been called by the intern, with the specific request to declare the patient psychotic so that he might be held against his will.

In most states, people may be held against their will for psychiatric emergencies such as acutely suicidal or homicidal behavior under what is called "emergency psychiatric certificate."

In this patient, the intern pointed out the "'irrational behavior" of wanting to go home in the face of massive heart attack, and the obvious agitation, screaming, and the paranoid idea that "people are trying to kill him".

In fact, these behaviors were most definitely manifest as I approached the patient.

Nothing makes you feel as important in the hospital as an emergency that falls within your specialty. All the nurses, physicians, and security guards gathered around the

patient made way for me to approach, and their silence spoke loudly, " Now the psychiatrist is here, and everything will be OK'".

Note, however, that this expectation cannot be fulfilled by your simply declaring the patient psychotic (as the reason for consultation was originally presented). Something had to be done to calm the patient also. A knee jerk response to this type of situation would be to prescribe a tranquilizer, and, in fact, this is a common and often necessary practice. Talking skillfully to the patient, however, is often a good diagnostic tool as well as potentially a tranquilizing procedure.

As I overheard the screaming conversation between the patient and the staff, it seemed to me that they were talking at cross-purposes. The patient was insisting that he would die if he stayed, and the staff were insisting that the patient stay no matter what (of course, because he would

die if he did not stay). It was not clear why the patient insisted that he would die if he stayed, especially considering that he did call the ambulance. I therefore determined to try to speak with the patient to clarify this point.

Taking advantage of the silence imposed by the reverential look toward me by the medical staff, I said to the patient, " Hello, Mr. Smith, I am Doctor Lee. I am a psychiatrist, and I would like to speak with you for a few minutes."

"I am not crazy", snapped the patient.

"I understand that you are feeling nervous about being in the hospital", I said in a matter-of-fact tone.

"I want to go home, I will die here."

"I understand that you called the ambulance yourself and came to the hospital. It's a good thing you did, because the doctors found you had a heart attack, and they are treating

you with medicine. You also need bed rest and cardiac care" I said.

"'No, not here. I will die here! Let me go home."

At this point, I decided to ask the patient directly about his conviction that he would die. This may elicit elaborate paranoid delusion, for example, a criminal gang is running the hospital and is trying to kill him. "You seem to be convinced that you would die if you stayed here in the hospital. Could you tell me why you think that?"'

"I know I will die here. In this room here. Let me go home."

"What about this room?"

"This is the dying room, I know that. I will not stay here."

The patient looked at me directly for the first time, and his eyes were fearful and appealing rather than blind with anger or psychotic delusion. Yet, this idea of "dying room" sounded very much like a delusion, unless...

"You say this is a dying room- do you know of anyone who died in this room?'"

"Sure, my dad died in this room. And they killed him. I saw it"

"What did you see?"

"They were all over him in here, pounding him and hitting him - I saw it through the glass. I was coming in here to visit. He was doing OK a few hours before. Then they said he died suddenly. I didn't say anything about what I saw to my Mom because I didn't want to upset her."

"You say they were all over him. Whom do you mean?" I asked.

"All of them doctors and nurses. They were pounding him"

"When did this happen?"

"Last year, about this time."

Suddenly, the pieces of the puzzle fell into place. Apparently, the patient's father had been admitted to this

Cardiac Care Unit with a heart attack, just like the patient. Then, the father must have had a cardiac arrest, and the patient had witnessed an attempt at resuscitation by closed cardiac massage - the doctors "pounding" on his father. This was probably followed by the use of a defibrillator, which may also look threatening

How frightening this tableau must have been seen through the glass, partition, and then to be told that his father had died.

And now he finds himself in the same cubicle where his father had died! At about the same time of the year! The fact that he was assigned to the same cubicle was not itself unusual -there were only six cubicles in the Cardiac Care Unit, and the probability of being assigned to a particular unit was nearly 17 per cent. Yet, it is understandable that the patient should have qualms about being in the same cubicle where his father had died, especially when he does not understand exactly what had happened to his father

(No one explained to him that what he witnessed was an attempt at resuscitation, perhaps because the patient never really asked anyone about it).

The problem in this case was that no one took the trouble to try to understand why the patient suddenly decided that he could not stay in the cubicle. In fact, when he expressed his anxiety about the cubicle, it was immediately assumed that he wanted to leave the hospital. It seemed he tried to explain that he would die if he stayed in that cubicle, but he was immediately assumed to be delusional.

"Listen, Mr. Smith, I can certainly understand that you must have been frightened when they wheeled you into room!" I said.

"Are you telling me!" replied the patient. I then told the patient that he certainly would not have to stay in the room where his father died, and that what he had witnessed was a closed cardiac massage, which doctors perform when there is a cardiac arrest. The patient's

sigh of relief was as loud as his previous screams. He must have lived for a whole year not knowing, and wondering, and fearing, about what he had seen!

As I say, sometimes, the consulting psychiatrist can live up to the expectations of their colleagues in need. Even though I did not deliver what they had ostensibly wanted - certifying the patient to be psychotic and holding the patient against his will. Yet everyone was happy as the patient stayed and recovered fully in another cubicle, feeling at ease that his year-old unspoken fear was finally put to rest.

Chapter 2. The Czar on 8-East

The nurse on 8-East, a medical service, was frustrated and angry. "We call him the Czar." said the nurse tersely. "He gives orders to everyone - his wife, his sons, the doctor, us."

"He also insists on having his secretary in his room all the time, and he and his people do not care a hoot about the visiting hours, they just barge in! He brought in a typewriter (you can see that this case predates the computer age) - when we told him he couldn't plug in an electric typewriter, he brought in an old manual one - I didn't know that these things still existed - an old black Underwood, no less. He is likely to kill himself when he bangs away at the typewriter. Too much exertion. He had a big MI (myocardial infarction- heart attack), you know. He is not even supposed get out of bed yet."

"You mean he feels he has to work in the hospital?" I asked.

"Yup, and he doesn't have to work at all. He owns his business, but he has two sons who are his Vice-Presidents. They are perfectly able to take care of the business, but he insists that he has to run the whole show - writing letters., calling customers - he even wanted to have a board meeting in our conference room! "

When a person is ill, we expect them to behave in certain ways and not others. Talcott Parsons, a sociologist, called these society's expectations of the sick person the "sick role". One of the widely accepted sick role expectations is that one is relieved of one's normal responsibilities such as going to work or going to a dinner party when one is sick. When a person is ill enough to be hospitalized, they are, of course, expected to follow the directions of the doctors and nurses, and they are certainly not expected to work while in the hospital . But what happens when a patient insists on working in his hospital bed?

The consultation was requested by the attending physician. an internist, who wrote “ Mr. Carson is a 57-year-old man with massive MI. Patient is irresponsible and insists on exerting himself in the hospital . Please evaluate for possible psychosis or suicidality."

Patients who do not live up to the sick role expectations are usually branded as "problem patients". Such patients are perplexing and frustrating for the physicians and nursing staff. Why doesn’t the patient do the things they are supposed do in a hospital? They must be crazy! Or maybe they are simply being obnoxious, uncooperative - maybe self-destructive and therefore suicidal!

In fact, patients who do not comply with the sick role expectations often do not receive optimal care, and, in that sense, self-destructive. However, the patient is usually totally unaware of this self-destructiveness, and not at all

intentionally suicidal. On the other hand, patients who are indeed psychotic are often inappropriate in their behavior so that they may engage in behaviors that are bizarre. In the case of this "Czar", however, it seemed that the work he was engaged in was not bizarre, although his carrying out the full workload in the hospital was, if not bizarre, inappropriate.

The patient's room was impressively messy. The small private room was cluttered with piles of documents, crumpled-up paper, portable dictating machine, and several briefcases.

On the wheeled adjustable hospital tray that is usually used to put at most, a food tray and a water cup, was a large black manual typewriter, which made the whole tray sag. The Czar was on the phone speaking loudly and argumentatively, "I don’t care a damn what these guys say. I want them out by this evening, do you hear? “

As he was gesticulating, one of the electrodes that was attached to his chest fell off, causing an alarm to sound from the cardiac monitor at the bedside. A nurse rushed in, then, flustered, simply turned off the monitor and left the room.

A man in his thirties dressed in a dark suit was hovering over the patient with a note pad. Obviously, his secretary. In one of the two chairs in the room was another man, also in his thirties who seemed to be engrossed in studying a file folder, perhaps one of his sons who was also a Vice-President of his company. A bit further away was the other chair which was occupied by a middle-aged woman who was thumbing through a magazine. A large shopping bag was standing by her chair.

“ Hello, Mr. Carson, I am Dr. Lee, and I would like to speak with you for a few minutes ... "

I said, feeling somewhat like an intruder.

The patient impatiently held up his palm as he continued to talk loudly into the telephone. All the other people in the room stopped what they were doing and looked at me expectantly.

I said to them, " Would you mind stepping outside for a few minutes? I would like to speak with Mr. Carson privately. " The entourage stood up, without much reluctance and (perhaps with some relief) filed out of the room.

While it is in general a good idea to speak with the relatives and coworkers of patients to obtain collateral information, the first interview with a patient should be generally performed in a private setting. This is because in the presence of family, friends, or coworkers, many patients feel reticent to talk about private thoughts and feelings that psychiatrists must inquire about. After speaking with the patient alone, the consultant often

obtains permission from the patient to speak with the family or friends.

"Listen, there is a doctor or an intern who wants to talk to me. I will call you back within ten minutes."
Mr. Carson slammed the phone on the receiver and looked at me, shaking his head. He said,
"You didn't have to kick out my secretary. I had some important dictation to do, and I could have done it while talking to you! Anyway, how am I doing? You are new, aren't you? Are you an intern?"

A physician can assess a patient's personality to a considerable extent by the way he or she talks, especially to an authority figure like a doctor.
Mr. Carson's addressing me as an intern was probably an attempt to claim a dominant position over me, as

anyone knows that an intern is at the bottom of the medical totem pole.

I might say that I was, unfortunately, not young enough to be mistaken for an intern. His speech was also remarkable for its rapidity, and one got the impression of being generally speeded-up in his presence. This speeded-up feeling may be seen in persons who are, to varying degrees, manic, or in persons who have the Type A personality. Type A personality is common and not necessarily abnormal but is associated with a greater risk of coronary disease. Its characteristics include being in haste at all times, a sense of time urgency, functioning on the basis of deadlines, increased general activity level., among others. This patient's general frenetic activity level, together with the way he spoke and acted, clearly indicated that he had Type A personality.

I hypothesized that underlying this patient's need to be dominant and busy may be severe anxiety over the

hospitalization and insecurity over his role in his business. The best way to deal with such a patient is not to challenge these needs.

"No., I am a consulting psychiatrist. Dr. F., your cardiologist, asked me to see you, as you know."

In fact, I did not know whether Dr. F had told the patient that he was requesting a psychiatric consultation. I was hoping, however, he had. Otherwise, the patient may prove to be difficult even for a psychiatrist to handle.

"Psychiatrist? No, the doctor never told me that I would see a psychiatrist. I am not crazy, why would I need a psychiatrist?" was the patient's reply.

"As a consulting psychiatrist, I am often asked to see medical patients, not because they are crazy, but to help the medical staff in treating the patient so that the hospital stay may be more comfortable to the patient."

As many patients are not familiar with the role of the consultation- liaison psychiatrist, a bit of explanation of the role of psychiatry in the general hospital is something I often do. Some patients are not satisfied with this explanation, but this patient replied,

"Certainly, you can make the hospital more comfortable for me. You could tell the nurses not to interfere with my people coming to see me. Then, you could let me plug in my IBM Selectric (a dominant electric typewriter brand before the computer age) here and let my secretary bring my desk in here."

"Well, before we do anything, could you tell me something about why you are in the hospital?"

"I had an anterior wall myocardial infarction, didn't Dr .F tell you?

“I had angina pectoris for the past five years and have been taking nitroglycerin. When the nitro didn't work, and the pain was getting worse, at 11 AM on Tuesday, last week,

I drove myself to Dr. F's office, who admitted me to the hospital immediately. I 've been doing fine, though, or so they say. But I've lost four precious days in the Cardiac Care Unit with Morphine, and what not, that made me groggy as the dickens."

This piece of conversation told me a great deal more about the patient. He clearly had a good grasp of his medical condition and was very aware of the treatments he was receiving. On the other hand, there seems to be some dissatisfaction about the amount or quality of information he was receiving - "I've been doing fine, or so they say"

I said, "You really seem to know a great deal about your condition and treatment. "

Giving credit when credit is due is always a good practice in developing rapport with a patient.

"Sure, I always try to understand exactly what is going on."

"Have the doctors been helpful to you in telling you about exactly what is going on?'"

"Are you kidding? Of course, not. All they say is 'Everything is fine, Mr. Carson. As if I am a little kid. I had to pry some of the information out of the students, like whether the enzyme is going up or down. Only today, I spent twenty bucks to get a copy of the blood test results on the black market!"

I was becoming concerned about the "black market" . Is he delusional? Is there really a black market in this hospital? For what?

"Could you tell me some more about the black market?"

"No. I am not going to tell you whom I bribed to get the information. After all, I have a right to know about the results of tests about me! If you are wondering if there is a big black market here, no, that's not what I mean. I simply mean that I am paying money to get

a copy of my test results on the sly only because the doctors won’ t. "

"I see. It must be frustrating that the doctors are not telling you everything you want to know. Did you ask them directly? Why do you think they are not giving you the information you want?"

"I really don‘ t know, doctor. Maybe you doctors are too busy. Sure, I asked Dr. F. many times about how I am doing, and he keeps on saying 'OK, you are doing fine'. When I ask, 'how do you know?', he says, 'Because I have a lot of experience with heart disease. Don't worry, Chuck, I assure you that you are doing OK. What I want is evidence, not empty words! Besides, if I am doing fine, why are they telling me I shouldn't do my work here?"

A misfit between the personalities of the physician and the patient can result in an impasse in collaboration, and in

potentially dangerous behavior on the part of either party. Mr. Carson was clearly someone who goes on the basis of numbers and evidence, who mistrusts blanket reassurances. On the other hand, Dr. F, his cardiologist, whom I knew personally, was a "fatherly'" person who believed that the role of the physician was to relieve the patients' anxiety through repeated reassurances and an optimistic outlook. He also felt, rather strongly, that physicians should not burden their patients with unnecessary and often anxiety-provoking information about their disease unless absolutely necessary in making major decisions such as to have surgery or not.

Thus, the more anxious Mr. Carson was to '"pry"' information out of him, the more vaguely reassuring was Dr. F, at least from Mr. Carson's perspective.

Mr. Carson's frenetic activity was perhaps an attempt to be in control of this anxiety. At least he would know exactly what's happening with his business and all

associated details and numbers! He would also exert his authority over his family and employees in the context of work, even though he could not be always '"one up"' on the doctors and nurses.

With Mr. Carson's permission, I spoke with his wife and son, confirmed that the patient had always been a '"workaholic"', and that it did not surprise them that he had to bring his work to the hospital . He always took work with him even during his infrequent vacations.
It was also confirmed that he did not, in fact, have to be always in charge of the company, that others were quite capable of running it on a temporary basis. Mr. Carson had no previous hospitalizations and had no previous psychiatric contact. There was no family history of psychiatric illness.

It seemed unlikely, then, that the patient had a major psychiatric disorder such as mania.

As the patient had always been a “workaholic", perhaps attempting to relax in the anxiety-provoking hospital setting and not working might be mere stressful to him than doing some work. On the other hand, his insistence on working so much was potentially dangerous to himself, and certainly problematic to the nursing staff. Perhaps, the need to work so hard was nurtured by the anxiety generated by not knowing the exact progress of his condition! Reducing the impasse between Mr. Carson and Dr. F would probably result in a reduction in his need to be such a problematic patient.

The impasse was a result of a misfit in personalities. And personality is not easily amenable to change, either by coercion or by psychotherapy. While it is true that eventual modification of personality traits may occur

through psychotherapy, this usually requires years of intensive work and is certainly not practicable during an acute medical hospital stay.

How to approach this dilemma? I determined to approach Dr .F, not so much to change his personality but to convince him that there was an "absolute necessity" to share with the patient all the detailed information concerning his progress and treatment on psychiatric grounds . No, not to say that the patient was "psychotic" or "suicidal", as was asked by Dr. F. I would tell Dr. F that his patient has a Type A personality with obsessive features, and that he has a psychological need to know exactly what is happening with the aid of numbers and test results.

Physicians, as a group, are seriously committed to the work of helping patients, even if it means personal discomfort.

As long as they are convinced it will help the patient, they are willing to set aside their personal inclinations and behave in prescribed ways. Dr. F was no exception.

Once I met with him and explained to him about the patient's personality diagnosis, and that the patient had a need to know the daily progress of his recovery with the aid of test results in numbers, Dr. F agreed to do so readily.

"Well, if you think this patient's personality is such that he wouldn't get unduly upset by numbers he doesn't understand, I have no objections to letting him see his chart every day." This was more than I had expected. I then suggested to Dr. F that he let the patient know of his decision, putting it in the context of the patient's being a partner in treatment.

Dr. F said, "Chuck, I understand that you are interested in knowing exactly how you are progressing. As an intelligent person who is accustomed to managing things, I think you could be a valuable partner in managing your recovery at this point. So, each time I make rounds here, I will show you your medical chart and explain to you the changes in enzymes, EKG, and medications as they occur. There is one thing I want to ask you, though, and that is to engage in a little bit less activity just as yet - your heart does need some time to heal completely. For example, you could make as many phone calls as you like, but you should refrain from typing things yourself. You might dictate into the machine, if you like.

"Also, your secretary should be here only for two hours a day. And too many visitors tend to disturb other patients on the floor who are sicker than you are. Could you do something about this?"

Mr. Carson was greatly pleased with this approach, and readily volunteered to restrict his visitors to one at a time, and to have his secretary come to him only during the hours of 3:00-4:00 PM.

"We will make business rounds during that time!" said Mr. Carson.

When I visited Mr. Carson two days later, he was reading a popular book on Type A behavior, lying sedately in his bed. A dictating machine was on his side, but no one else was in the room.

"Hello, doctor, how are you? You are the psychiatrist, right? Notice that I am reading about how the mind and behavior affect the heart! I decided to take it easy a bit while recovering, you know. Now that I know exactly how I am doing every day, I want to help the old ticker of mine to get every chance there is. By the way, maybe I could learn some of what you call

relaxation techniques. Today, my LDH (lactic dehydrogenase, an enzyme that is elevated after heart attack) was completely normal and I want to keep it that way. Besides, last time you just asked me questions but didn't really do anything for me. Maybe you can earn your consultation fee for teaching me the relaxation technique!"

Chapter 3. I shall Die on My Thirtieth Birthday

I first saw Susan in a classroom when I gave an in-service lecture on depression to a group of nurses on the medical floor. My talk was on depression, and she asked some intelligent questions. She came to me after the lecture, and asked if she could make an appointment with me concerning a patient.

The patient turned out to be herself – she had been feeling depressed for a while, without any particular reason, and wondered about receiving psychotherapy. Susan was a single 28-year-old woman, who had worked as an RN for many years at the hospital. She had no romantic relationships and was still living with her widowed mother in an abusive relationship. She had considered having therapy for many years but never had the courage to seek it until my lecture, when she felt she had reached the end of

her rope as she felt certain she was headed for suicide. She gathered the energy to make an appointment.

She revealed that she had a very conflictual relationship with her mother, who seemed depressed herself in an abusive marriage to now deceased alcoholic husband and seemed to take her anger on Susan. Susan knew that she had to somehow break loose from her mother, who was financially and emotionally dependent on Susan. Susan felt she had no way out of her dilemma but felt a sense of relief when she decided that she would kill herself on her 30th birthday, two years from now!

In a sense, Susan was putting me, the potential therapist, in a bind. "Cure me within two years, or you will have a patient suicide on you – a failure!" I seriously considered not taking her on as a patient at that time. I was, however, young, ambitious, and inexperienced then, and I decided to take her on as a challenging patient.

I offered my routine therapeutic contract with depressed, suicidal patients – that I am unable to treat suicidality itself but can attempt to treat the underlying psychiatric condition such as depression that may impel the patient to think of suicide as the only option and that the patient is to report to me if he/she feels that, in spite of therapy, the urge to suicide is overwhelming.

Then, I proposed a course of antidepressant medication and psychotherapy for depression. Susan agreed and as for psychotherapy, she opted for exploratory therapy rather than cognitive-behavioral therapy as she wanted to know what developmental factors underlay her depression and suicidality.

Further history revealed that from Susan's childhood, her mother seemed to have identified Susan as her rival and villain vis a vis her abusive husband. She had been

physically and emotionally abusive toward Susan as if she, Susan, were her husband, which abuse Susan was forbidden to reveal to her father. Things did not improve after the death of her father from alcoholic liver failure, as her mother, who had not worked for years, became financially dependent on Susan, who was, in turn, in an inseparable love-hate relationship with her mother.

In childhood, Susan had severe classical symptoms of Posttraumatic Stress Disorder including flashbacks, nightmares, depression, and anxiety, which seemed to have subsided significantly as she grew older and more independent, at least financially. She did have episodes of cutting her wrist when stressed – she felt relief when she saw blood flowing from her wound. These cuttings were done surreptitiously and were never brought to medical attention, which were in contrast of "suicidal gestures by cutting" common in Borderline Personality Disorder patients. She had only a couple of stormy unsatisfactory

romantic relationships, probably related to severe self-esteem issues. She had an early interest in medicine – her mother was a nurse who stopped working when she married. Susan could not afford to go to medical school, but became a nurse, and worked to support her mother and herself. Her father, who was a truck driver, was an alcoholic and had left no money when he died. Susan, having witnessed her father's alcoholic behavior firsthand, never drank.

In terms of diagnosis, Susan clearly had childhood PTSD and Borderline Personality Traits, which are common in patients with childhood trauma. The fact that Susan did not use substances unlike many PTSD and Borderline patients, and that her wrist cuttings were done in secret as tension relief mechanisms, as well as her excellent work record were all good prognostic indicators.

The therapy progressed reasonably well, the antidepressant worked in reducing her symptoms, and Susan was able to

put together her traumatic experiences and how they affected her conflicted emotions regarding her mother, father, and subsequently toward others. She had one much older brother who was a rather distant figure who left home to join the military as soon as he could and was living out of state with no communication with his family. She felt envious of her brother's freedom, but also resented that she was left alone to deal with and care for her mother. Susan's family, in spite of her father's alcoholism, belonged to a tightly knit ethnic Catholic group. Susan was too shy to date, and her mother rejected any attempts by relatives or friends to introduce Susan to eligible young men. On two occasions, boys attempted to date her, but at the first touch of a boy's hand on her body, Susan recoiled and ran away. Susan did have erotic fantasies, often of a sadomasochistic ones about which she felt guilty, especially as she was too ashamed to confess them to a priest. When she was able to confide in me about these

fantasies, it was a milestone in her therapy as she was able to recognize that sexual fantasies were normal, and that she was unduly repressed in her exploration of new experiences in life. As therapy progressed, she was remarkably better in her mood, and even considered moving away from her mother's house, while still supporting her financially.

In about a year of therapy, she was making sufficient gains that we changed the frequency of sessions from weekly to monthly sessions for "just checking up". In one of the monthly sessions, I noticed immediately that something was wrong with Susan – she looked quite subdued and depressed.

"Susan, I notice that you are looking quite sad today" I said after the greetings were over.

"Yes, Doctor Lee. I do feel depressed. Do you remember your telling me, at our first session, that I should tell you if I felt a strong urge to commit suicide? I have it now."

“Can you tell me more about it, Susan?”

“I don’t know if you remember my telling you this or not, but I always knew that I would die of suicide on my 30th birthday. How do I know this, I don’t know. But I planned this ever since I can remember, maybe even at age 5. In a way, knowing that I would die when I reached age 30, it gave me relief from any pain or despair I had at the time. Susie, just wait till you reach your 30th birthday, and then, well, I will just fade away, away from all the pain, anxiety, depression. Just peace!”

“Do you still have that much pain and depression that dying would be a relief for you?”

“I didn’t think that until about a month ago, but if you didn’t know it, my 30th birthday is coming up on Friday! And yes, I know that I am going to kill myself on Friday – I know just how to do it, after all I am a nurse!”

I was torn between the desire to delve more into her "commitment" to kill herself on her 30th birthday, which might be a psychotherapeutic thing to do, and a desire to act to prevent her from contemplated actual suicide attempt, though it may be based on an irrational "commitment".

"Susan, I understand that you have this fixed idea of suicide on your 30th birthday, and we could try to understand it in therapy. But I think it is more important that we keep you alive through your 30th birthday, because the fixed idea may be too powerful, however irrational it may be. Until it's over past your 30th birthday."

"But Doctor Lee, I am convinced that I will die on coming Friday!"

"No, you won't. I am going to place you on a 72-hour emergency certificate and admit you to the psychiatric unit of the hospital."

Susan was devastated, and begged that she not be placed on emergency certificate as she was afraid of the stigma as a registered nurse. I empathized with her about the stigma (which existed then, now perhaps less so).

"Susan, I am determined to keep you alive past your 30th birthday one way or another. However, would you be willing to be hospitalized voluntarily on the medical service for evaluation of cardiac arrhythmia, which you told me you have from time to time? I might be able to arrange this through a colleague of mine, Dr. X, whom, of course, you know. I know that he will be very discreet."

Susan agreed to this plan, as she was clearly crying for help when she confided in me about the strong urge, in fact, a commitment to suicide on her 30th birthday.

Friday, Susan's 30th birthday, passed uneventfully. Susan was happy that it was just another day, if in a hospital bed on a medical service and thus deprived of any birthday

celebration. Actually, her birthdays had always been quiet, her mother barely noticing her birthday. Susan usually worked on her birthdays, or if it fell on a holiday, she still chose to work for the day.

She was discharged from the hospital on Saturday, the day after her 30th birthday. When I saw her that week, she was in good spirits, and we decided to resume her weekly psychotherapy sessions to explore and deal with her fixed idea of suicide on her 30th birthday, now in the past tense. The sessions were productive, and Susan was able to resume once a month check-ups within six months, then sessions on a "as needed basis."

Since then, I had moved to another city for a new job. The last I heard from Susan was some years later, on a postcard indicating she was promoted to head nurse, and that she was in a relationship with a man with whom she was in love.

Postscript: It seems improbable now to be able to admit a patient to a medical service with suicidality, but this happened at a time when it was possible to “bend the rules” for a medical colleague, in this case a nurse. Now, I would probably have held her under emergency certificate – at least the stigma is (hopefully) much less.

Chapter 4. Dr. VIP

"A private consultation for you, Dr. Lee", said the secretary. "The patient is a doctor, a graduate of this University. The attending himself called in the consultation. Please call Dr. James at extension 4571"

Dr. James said on the phone, "Yes, I would like you to see my patient, Dr. Samuelson, who was admitted yesterday with a GI (gastrointestinal) bleed. He is a really sad case, a graduate of our University and Hopkins medical school. A chronic alcoholic, lost his license in Pennsylvania. Now while passing through this town, developed GI bleed. He wants to have some alcohol treatment, confidentially, you know ... "

Unfortunately, physicians , like other health care professionals, have a high rate of drug and alcohol abuse. It is estimated that about 1-2 per cent of practicing physicians in the United States are known to be dependent

on drugs or alcohol, which is 30 to 100 times the rate of the general population. The stressful nature of doctors' work- reducing suffering and saving lives, the long hours, and the high risks involved in everyday decision-making about patients. Doctors are often taught during training to assume an attitude of confidence and invulnerability, which may contribute to a dilemma - an increasing need for an emotional outlet but an inability to seek comfort and help from others. Thus. many physicians may indulge in the solitary and ephemeral comfort of drugs, which are readily available to them.

Society places unrealistic moral and ethical expectations on physicians. making it even more difficult for them to admit to a problem like addiction. Thus, a drug dependent physician often has no recourse but to continue their reliance on drugs, which increases guilt feelings and may,

eventually, result in a decrease in functional level, leading to severe depression or suicide.

It is not surprising, then, that one of the most difficult tasks for a physician is dealing with a fellow physician who is a substance abuser. "But for the grace of God, go I" is often the hidden feeling when a physician is confronted with another physician who is forced to admit such a stigmatized problem and seek help. In fact, many physicians tend to minimize other physicians' substance abuse problems even when there is evidence of actual impairment. "What you need is a vacation!" But what if the physician patient has reached the point that they had to give up their practice, the point where dreaded medical complications have made them an invalid? Such was apparently the case with Dr. Samuelson, a fellow physician, graduate of this august University!

Dr .F seemed to be apologetic that he was requesting a psychiatric consultation on a fellow physician, but the patient was requesting to see a psychiatrist for treatment.

The patient was on a private service of the medical unit. I looked for his medical chart in the chart-rack as usual (yes, this was before medical records were computerized), but it was nowhere to be found.

"Uh, is Dr. Samuelson off to X-ray or something like that? The chart does not seem to be here‥, I said to the nurse.

"Oh, his chart is not in the rack, it's locked up in the head nurse's drawer. We don't keep our VIP charts out, you know." Yes, of course.

Dr. Samuelson room was the best private room in the hospital. It was clear that the medical and nursing staff giving him the VIP treatment (which was of course, usual for a physician patient then, as was the type of "sexist" conversation that follows.).

As I entered the room, the patient was conversing with two nurses about hospitals in Pennsylvania. "The Penn General is rather like this hospital in many ways, but you should see what the nurses are like! There is a former Israeli general in charge of the Nursing Department, and all the nurses are ready to combat anyone at the drop of a pin. Especially doctors. The way they are trained to eat up interns is something horrible.

And they must screen their nurse applicants on pictures alone - the good-looking need not apply. No, not like the nurses here at all!" The two nurses were obviously enjoying the conversation judging by their giggles.

"Hello, Dr. Samuelson, I am Dr .Lee.", then, turning to the nurses, I said, "Hello, I am sorry to interrupt a fun conversation. "

"Oh, no problem," said one of the nurses. "We should be out of here, anyway. But, Dr. Samuelson has so many interesting stories! "

Dr. Samuelson said to the nurses, "Goodbye, Jill, Goodbye, Sharon. Will see you soon."

Dr. Samuelson was in his fifties but looked much older. He was a thin man with a very wrinkled face which cracked into a wide grin as he extended his hand to greet me. His eyes , however, appeared sad and precatory. "Hello., Dr. Lee, nice meeting you. "

"Dr. Samuelson, I am a psychiatrist. I understand that you wished to see a psychiatrist." I said respectfully.

I confess feeling somewhat awkward when I introduced myself as a psychiatric consultant to a fellow physician, even though he may have requested the consultation. It would be very different, of course, if the physician showed up in my office. But there is a certain sense of invasion of privacy when I enter another physician's room, even a hospital room, in a professional capacity. Especially when it is for an "embarrassing" condition like alcoholism.

"Yes., Doctor Lee, I certainly did. I need help badly, doctor. I am at the end of my rope. I don't know what to do."

"Please tell me some more about yourself and your problems. " I said.

"Well, Doctor Lee, I had this massive GI bleed on my way to Boston. I was passing by this town where my alma mater is and decided to bring myself here to get help. If anyone could help me, doctor, I am sure you can! You see, I am an alcoholic, and manic depressive, too. I have been depressed quite a bit when I was young, but my colleagues would not take it seriously.

“I drank to ease the pain of depression till it was too late.I was, ironically, a gastroenterologist. A liver specialist. I taught at all the teaching hospitals in Philadelphia. Oh, yes, I was a good teacher, and even though my hands were shaking, I could still entrance all my students with my lectures.

"But it began to show more and more, my drinking problem, you know. Often, I had to drag myself out of the bed, and come to the hospital hours late. I started losing my patients as they got tired of waiting for me for hours while I was at home nursing a headache. Many days I simply didn't show up at mv office. Then, a few years ago, I had this terrible malpractice suit. You see, I did this liver biopsy - you know, the puncture biopsy, and my hands were just too shaky that morning - he, the patient almost died with the tear. Yes, I deserved to be sued. Fact is, doctor, I still didn't face the fact that I was an alcoholic. "I couldn't get any malpractice insurance after the company settled the suit out of court. I lost mv family during this period, too. My wife simply upped and left after twenty-three years of marriage. Later, I found out that she was having an affair with one of mv physician colleagues, and they both left for another state. "

"Do you have any children?" I asked.

"No, Dr. Lee, my wife couldn't have any children. Blocked tubes and endometriosis.

We both felt so sad about it. We had dreams of raising two kids, both of whom would become doctors . When I see the young doctors and medical students, I can't but think of what might have been"

"Was your wife a doctor, too?"

"Yes, she is a doctor, but not a physician. She used to work as a researcher in the lab at the hospital . I don't know what she is doing now."

"I see. Please go on. What happened after your wife left?"

"Well, mv practice was gone, too, by then. I got a job as an Emergency Room physician. Still, I didn't stop drinking. And one day, I killed a patient."

"What do you mean?"

"Well, I didn't take an X-ray on a patient who came in with a head injury and he died on the way home. I killed him. The hospital did a blood alcohol level on me, which was, of

course, high. I was suspended from the staff and was forced to go into an alcohol treatment program.

"Actually, the program worked very well. I was soon the leader of the patient group. I was off alcohol for three months after the program. But I was too proud to continue with the AA , and, I was lonely, since I had no friends left. I started drinking again. I had obtained a job as a school physician, but I lost the job when the school nurse smelled alcohol in mv breath. She reported me to the school administrator, who reported me to the medical board. My medical license was suspended, which I never got back.

"Doctor, you don't know what it is like to be a physician who can't practice. I have done all kinds of jobs - as an orderly, nurse's aide, ambulance attendant. They were hard jobs - if you think doctors work hard, you should try some of these 'paraprofessional' jobs. Then, I could never bring myself to accept the fact that I was not the doctor, the top

dog. I resented receiving orders from doctors, many of whom were barely dry behind their ears. My only consolation was alcohol, though I knew full well that my liver was rotting away."

"Did you get any medical help about your liver condition?"

"Yes, in fact I did. I was going to go on an experimental protocol for liver cell transplant at the University Hospital. There wasn't anything else that could be done except for this experiment, other than stopping drinking, of course. I always promised myself to stop drinking when I had to be admitted to the hospital , but as soon as I am home, I hit the bottle without fail."

"You were saying you were on an experimental protocol?"

"I was going to be, but guess what happened? Just before I was started on the protocol, the Institutional Committee decided to pull the protocol because it was considered too dangerous. Some papers came out from mice research that cast serious questions about the protocol just days before I

was placed on it. Doctor, I didn't know whether to cry or to laugh. My last hope was too dangerous for humans., even as an experiment!"

Needless to say, I was feeling very empathic, compassionate, and downright sorry for this patient. In spite of so many reverses, he seemed to maintain a certain dignity and a wry sense of humor.

"It’s been like a nightmare for the last several months – my drinking increased - I can no longer afford good stuff, so I've been drinking cheap liquor - the poisonous stuff. When I was fired from my last job, I was a courier for the pathology department. I was asked to bring a fresh brain to the annex. The brain was in a plastic bag. Rather than taking the tunnel, which I was supposed to do, I went through the main corridor because I was feeling so queasy with a hangover. I was sweaty, feeling faint, and my hands were so shaky that I dropped the bag on the hard floor -- it went "splat", and somehow the plastic bag opened, and the

whole squash got spilled on the floor, and a poor nurse rushing behind me slipped and fell on the mess - I tell you it was messy! Well, I was fired. Probably I deprived somebody of the Nobel prize, too, by losing the brain. Anyway, when I was fired, I decided to chuck it in Pennsylvania, and decided to go to Boston, where some of my old schoolmates live. but see where I landed. In the arms of my alma mater hospital!
"Well, perhaps, it is by Providence that I should find myself here. If anyone can help me, it must be you."

I had decided, by this time, that Dr. Samuelson deserved a better lot. I would treat him myself, during the medical hospitalization and then, after discharge, as an outpatient, even if I have to see him in late evenings after my office hours. True, treatment for alcoholism is usually best done on a specialized alcohol treatment unit. But this patient had

tried that before, only to return to drinking because he did not follow through with outpatient treatment.

Maybe I am the only one who can help him now. Disregard that he probably cannot pay you. After all, my Hippocratic Oath did say that I shall consider other physicians as my brothers! And I would somehow arrange for a place for him to live and maybe a job in the hospital; I am sure my boss Dr. James would be willing to help as long as Dr. Samuelson promises to stay sober.

I felt gratified that I was able to make the commitment to help this colleague. If anybody deserved better luck, he did. And I would be making a significant contribution to society by rehabilitating this man, who, in turn, could save lives of others.

Dr. Samuelson was gratitude itself when I told him that I would, indeed, treat him in psychotherapy. He readily agreed to stay away from alcohol as long as he was seeing

me as patient. “I am at the end of the rope, Dr. Lee, and you are my last chance. I will abide by what you say like the gospel itself. "

The next day, as usual, I sought the intern assigned to Dr. Samuelson to get an update of his medical condition before my visit with the patient. The nurse paged the intern, who happened to be in Dr. Samuelson's room. The intern’s first comment to me was, "I am glad you are seeing him, Dr. Lee. He is such a sad case, and such a good man, too. He is like a walking encyclopedia as far as experience in gastroenterology is concerned. In fact, he had so many fascinating complications of GI diseases himself.
“The hospitals in Philadelphia, though! They are something else. It's impossible to get any records from them. As Dr. Samuelson says, they are so disorganized that they routinely operate on the wrong patient, and I truly believe it."

The session with Dr. Samuelson went quite well. It turned out that the patient had been born to a poor family in the Appalachian mountains, his father was a laborer in the strip mines. He grew up in poverty but won a college scholarship through a spelling bee. His dreams of college had to be held in abeyance when World War II broke out. Being patriotic and eager, he joined the marines, and was injured in combat several times in the Pacific theatre. After the war, he was accepted by the prestigious college in this town largely on the basis of his excellent grades and his heroism during the war. He was the only one in his family to go to college. Having witnessed so many injuries and deaths during the war, he decided to become a physician. His father's death due to chronic lung disease which was probably caused by coal dust also contributed to his desire to be a doctor. He was accepted by the prestigious Hopkins medical school, having done very well in college and with the help of the GI bill.

He did very well in medical school, although he was distressed by the inequity in medical care the poor received. He had determined to practice, upon completion of his training, in an urban ghetto area to provide quality care for the poor and downtrodden.

"Practicing in the ghetto is very hard - even harder than being in training as an intern. You are all alone, because no one else wants to practice with you in such an area. The patients are sicker - and they come to you at the last minute with emergencies, often when there is not much you can do for them. And it is hard financially, too. Many patients simply didn't know they could get Medicaid. And many are undocumented patients who had no ability to pay medical bills. That's when I really took up drinking seriously "

Psychotherapy is a time consuming, '"labor-intensive"', and expensive procedure. Intensive psychotherapy, which I would be providing Dr. Samuelson usually involves 50-minute sessions at least once a week, and the total duration of such an undertaking is generally measured in years. Some critics have questioned the cost-benefit ratio of psychotherapy, claiming that the psychiatrist's time might be used more efficiently if more patients were to be treated for shorter periods of time.

I believe such intensive psychotherapy, which aims at the full development of the individual's potential, should be reserved for the select few patients for whom such an investment is likely to be cost-effective. I had no doubt whatever that Dr. Samuelson more than fulfilled this criterion. Clearly, there was much rapport between the patient and myself, and the patient is clearly highly intelligent and insightful.

I arrived at Dr. Samuelson's unit the following day with much anticipation.

As has become a routine with Dr. Samuelson, I went into the head nurse's office to retrieve the patient's medical chart from the drawer, taking the key from the hiding place that the nurses had shown me. For some reason, the chart was not there. I said to the secretary, "Oh, is Dr. Samuelson in X-ray of something? I don't seem to be able to locate his chart."

"Why, he is no longer here, didn't you know?", said the secretary.

"Not here? What do you mean?"

"Gone OUT, discharged!"

Stunned, I grabbed the head nurse as she was coming into the nursing station headed for her office. "Listen, Ms.

Brown, what is this I hear about Dr. Samuelson's being discharged?"

Ms. Brown, the head nurse, with whom I had a cordial relationship, seemed surprised at my question. "You mean you didn't know? There was a big bruhaha about him last night."

"No, I was out late last night. What happened?" I said.

"Dr. Lee, you missed a big one. Jim Stein, the Chief Resident got so frustrated with the Philadelphia Hospital because they couldn't find their records on Dr. Samuelson that he contacted the Chief of Gastroenterology there. He said, 'Doctor, the patient used to be on the staff in your department, and they don't seem to be able to find his medical records. Dr. Samuelson is here with GI bleed, and we would very much like to consult with you in treating him. "

"And you would never guess what the Chief in Philadelphia said!" said Ms. Brown excitedly. "He said, according to Jim Stein, 'Dr. Samuelson? I don't know of any Dr. Samuelson who was on my staff or who was a patient of mine. Could you describe him?' Jim Stein described him on the phone, and, then, this Chief said, 'Aha, now I know whom you are talking about. Dr. Samuelson, indeed! He is known to us as Dr. Richardson, and he is not a doctor at all . He is a Munchausen patient, who claims to be a doctor, and fabricates horrendous symptoms, comes in the hospital and gets a million-dollar workup. Don't feel too bad about it though because he had taken us for a ride for a long time, too, before we found out. He has excellent medical knowledge, so that he was actually one of the best teachers of medical students we had. Did he tell you that he was in the war, got through medical school with the GI bill, et cetera? Uh-hum. None of that is true, of course. He did

work as a nurses' aide at one time, though. What he needs really is a shrink, but whenever we sic one on him, he signs out against medical advice. Well, good luck to you'"

Ms. Brown continued, "Well, Jim Stein was dumbfounded, of course. He called the attending, Dr. James, but couldn't get hold of him but got his associate Dr. Fisher, who called Philadelphia himself and confirmed the conversation. Then he let Jim Stein confront the patient about what he heard, whereupon the patient promptly signed out against medical advice. I think Dr. Stein tried to reach you, but you were unavailable, so he spoke with the psychiatrist on call, who didn't think the patient should be committed. So, that's the end of Dr. Samuelson! "

Apparently, the patient left in a huff, without leaving any address or phone number. Any attempts by the medical staff to persuade him to stay to receive psychiatric care were met with "Now that you are one of them, and don't

believe me, I can't really be helped by you. I am not a liar, what I told you is true. But the people in Philadelphia have blacklisted me and are trying to get me because they feel guilty. I must leave to protect myself!"

Munchausen's syndrome is named after Baron Hieronymus Karl Friedrich von Munchhausen who lived in Europe in the 1700s telling grand tales of adventure. Rudolph Erich Raspe popularized this character by publishing a book on the adventures of Baron von Munchausen. In 1951, Asher proposed the term "Munchausen's syndrome" to describe patients who wander from hospital to hospital with fantastic fictitious symptoms and medical histories. Munchausen's syndrome is not uncommon, patients usually present themselves with dramatic and serious-sounding symptoms, including seizures, bloody urine, severe pains, etc. The bloody urine the patient brought may be actually water containing red dye, but, at

times, Munchausen patients have induced serious injuries such as inserting a pin into the urethra to produce bloody urine. The cause of this syndrome is not well understood, although the fact of being in the hospital, and receiving medical care, seems to have a special meaning for the afflicted patients . The syndrome is different from malingering in that there is usually no obvious gain (and usually much pain and discomfort) in being hospitalized and receiving diagnostic tests and medical treatment. Somatic symptoms disorder including conversion disorder (the older term, “hysteria” included many of these) lacks the conscious and intentional acts associated with Munchausen’s and involves recognizable unconscious conflict.

I was familiar with this syndrome, and even reported a new kind of Munchausen' s syndrome in the medical literature. That Dr. Samuelson was a case of

Munchausen' s syndrome, was , however, a startling news for me. Why, he seemed so genuine, and caring, and, yes, pathetic. True, many Munchausen patients have a history of exposure to hospitals, often they were in hospital-related occupations such as nursing, physical therapy, etc. But I had never encountered a Munchausen's, patient who was a physician! Or someone who claimed to be a physician. No question, I felt very empathic, well, even sympathetic, to Dr. Samuelson. Did my sympathy interfere with my diagnostic acumen, my index of suspicion?

I had very mixed emotions when I learned of this revelation. Some of it was embarrassment for not recognizing that he was a phony. I also felt anger - both at him for deceiving me, and at myself for being "taken in". I also felt a sense of regret on not being able to continue the therapy I had started with him! Perhaps, I could have

helped him. He did not bolt, as he usually did, when he saw a psychiatrist! On the contrary, he was very pleased when I agreed to treat him. I thought, wistfully, that maybe I could have helped him, knowing full well that this probably was not true, his wanting to see a psychiatrist was probably a more evolved elaboration of his masterful Munchausen's syndrome.

And yet, as art condenses and re-presents reality, could a medical syndrome like Munchausen's re-present a medical reality? In his career as Munchausen's patient, could the patient have observed and introjected the concerns, pains, and dilemmas of physicians (his victims who were essential for his existence) ? Could he have represented in the too human a person of Dr. Samuelson, an alter ego (denied and shunned, but easily ernpathizable nonetheless) of all physicians? Perhaps, then, we could help him by understanding and helping ourselves.

Chapter 5. The Vampires in the Hospital

Heather was a 67-year-old woman who suffered a fall and broke her hip (fracture of the femur). She was hospitalized four days prior, had hip repair surgery the next day, and was now recovering on the surgical ward. She tolerated the procedure well, but last night, she began to see vampires in the room, some hanging from the ceiling, others flying about trying to land on her jugular vein. She was agitated and screaming and had to be restrained and sedated intravenously. A psychiatric consultation was requested.

Her medical record revealed that she was in reasonably good health until the fall she suffered inside her house when she fell from a step ladder while trying to change a light bulb. She called 911 from her cell phone and was rushed to the hospital. She was widowed about a year ago and lived alone at home. She was on several medications for hypertension and arthritis. She had hysterectomy in her

30's for fibromas. She had no known psychiatric history. There was no family history of psychiatric disorders.

Heather was a petite elderly woman lying in bed with soft restraints on her wrists. She seemed to be sedated with eyes closed when I approached her and called her name.

"Hi, I am Dr. Lee, and I am a psychiatrist. I understand that you have been seeing some frightening things?"

Heather opened her eyes, looked at me with frightened eyes, and replied,

"Bats! Vampires! Flying about, trying to attack me – suck blood! I saw them – I am not crazy! They are here in the hospital!"

"Could you describe the vampires for me? Are they black? How big?" I asked.

"They are huge for bats, almost like an eagle! They are black, and I know they are vampires 'cause they got

hungry eyes, and they grin at me when they come after me! Meaning 'I'll get ya'"

"Do they actually say things to you?"

"No, not really. I don't hear them say things, but I know what they have in mind. Suck me dry!"

"Have you seen vampires before?"

"No, not really. I think I saw one or two when I was in the hospital for a couple of days a few months ago. There are bats in this hospital!! Wait till I tell the local TV station reporters about the bats here!"

"A few months ago? Why were you in the hospital?"

"I had some heart problems. Had 24-hour cardiac monitoring. Turned out to be OK, though. Except for the bats, the vampires! I signed out as soon as I saw them. Good thinking, I said to myself."

“I see. So, after leaving the hospital, did you see any more bats or vampires?”

“Yeah, when I got home, I thought there might be one or two in the attic but there weren’t.”

“Sounds good! It must have been harrowing seeing these vampires in the hospital. So, what did you do when you got home?”

“Yeah, running away from the vampires was harrowing, indeed. When I got home, I wanted to relax. I got a glass of wine and was about to turn on the TV when I heard some sounds, like bats you know, in the attic. So, I went up there with a broom to shoo them away, but there weren’t any bats. I thought – there, I scared them away. Actually, I slept well that night – surprising.”

“I am glad the bats were not there, and you slept well. Sounds like the glass of wine helped too. Do you usually drink a glass or two every night at home?”

“Yeah, wine helps me relax. I usually have a glass or two with dinner. I heard that some hospitals serve wine with dinner – why don’t you do that?”

“Yes, I heard that, too. Maybe this hospital is not yet that modern. How about since then, have you seen any bats at all before coming back in this hospital?”

“No, never. I tell you, it’s this hospital that attracts vampires.”

That Heather seems to have experienced frightening visual hallucinations only during hospitalizations suggested to me that the hallucinations were not the result of a chronic psychiatric condition but rather associated with her being in the hospital. Incidentally, I tell my students, “ Visual hallucinations are secondary to delirium, intoxication or withdrawal from substances including alcohol, or to other medical, not psychiatric, conditions unless proven otherwise!”

Being in the hospital entails many changes in both physical and interpersonal environment, in physiology, changes in diet, and medications, and substances. New medications may be given, which may be hallucinogens for sensitive people (e.g., morphine and other opioid pain medications). There is also the withdrawal from certain substances – e.g., alcohol, opioids, stimulants. If one is used to imbibing 2-4 glasses of wine as with Heather (often, the actual amount may be at least double of what the patient reports), the sudden withdrawal as in acute hospitalization can precipitate a serious withdrawal syndrome (delirium tremens), which are characterized by frightening visual hallucinations and agitation. This acute withdrawal from alcohol is a medical emergency requiring immediate treatment with a sedative and Vitamin B1 (Thiamin). The history of having had the beginnings of visual hallucinations a few months prior, again when she was in the hospital for a couple of days while she had to abstain

from alcohol tends to confirm the diagnosis of acute alcohol withdrawal. Further history revealed that Heather was one of a small group of elderly women, who were all neighbors and drinking buddies. They would often get together over wine and snacks and gossip, which was “a lot of fun” according to Heather.

Heather had been, fortunately, given intravenous sedatives that calmed her down from the acute agitation. I also felt that she needed high-dose Vitamin B1. Then she should be counseled about her alcohol use, perhaps some reduction so that acute withdrawal would be unlikely, and education for her (as well as her drinking buddies) concerning acute withdrawal so that she can prevent it and also to diagnose the onset herself.

I discussed my findings with the primary care physician, who implemented the recommendations. Heather was provided with education concerning alcohol withdrawal, an

opportunity for counselling, and prescriptions for pain medications as well as a Vitamin B complex.

Chapter 6. The Case of the Sick Tarzan[1]

Mr. Frank T. or "Tarzan" a nickname that the hospital staff used only among themselves, was a 59-year-old married owner of a small family-owned business . He was admitted to the intensive care unit with nausea and severe chest pain radiating to the left arm that had developed suddenly in the morning following a hot bath. He was immediately rushed to the hospital. Electrocardiograms (EKGs) and enzyme studies on admission confirmed the diagnosis of a massive heart attack (myocardial infarction, MI). This was the patient's first admission to a hospital, and there was no past history of serious illness. Family history was not significant except that his father had died of MI at age 72. His mother had died of pulmonary edema at age 75.

[1] If the reader is lucky enough to be too young to remember Tarzan, read books or see Tarzan movies (still entertaining) on YouTube, Amazon, etc.

On admission to the intensive care unit, absolute bed rest was prescribed, and continuous monitoring of the EKG was instituted. Orders were written for administration of strong sedatives and pain medications. He was also treated for an irregularity (arrhythmia) of the heartbeat that is common after MI and indicates hyperirritability of the heart muscle.

On the day of admission, he posed no problem for the doctors and nurses. His complaints were confined to the “gas pain” in his upper abdomen. On the second day, however, he was found sitting up in a chair beside the bed, despite the doctor's orders to stay in bed. He appeared agitated at night and asked for large doses of Valium to make him relax. The nurse wrote, “Patient is very arrogant but easily subdued with firmness.” On the fourth day after admission, he became agitated and refused to have his blood drawn for laboratory tests. He screamed to the nurses that he wanted to sign out on the same day and was found exerting himself trying to lift up his bed. He was reproached by the nurse with no effect. He

refused to cooperate in measuring his fluid intake and output and poured urine on the floor. The next day, he said to the nurse, “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.” He was again observed lifting up his bed. He told the nurse that he wanted to exercise by lifting up his bed 40 times a day. He was flushed and sweaty, and multiple irregular heartbeat occurred. Finally, the nurses persuaded the cardiologist to ask for psychiatric consultation.

When I went to see the patient, he was being helped by the nurse to get back in bed after another attempt to lift up his bed.

(The interview below is based on an audio recording which was obtained with the patient’s consent. The recording was suggested by the hospital administration in view of the risky activity such as lifting up the bed. Permission for reproduction of the transcription was obtained on the condition of anonymity.)

After introducing myself, I asked,

“Well, Mr. T, can you tell me what’s going on?”

Half sitting up in bed, he responded rather rapidly and loudly,

“ Doc, when I came here, I was sick. . . . I admit I was sick, and I wanted to be helped. Now after the first stages are over, I get impatient. I can stay in bed for a certain amount of time. You know, the first day I was here, I was jumping out of bed every two seconds. I didn't know why, but I'm accustomed to sleeping on a flat board, and the bed was at an angle and my back just broke on me. I couldn't sleep. The second night, they gave me sleeping pills, so I was able to take it. Do you understand?

“Yes. I think so. Let's backtrack a little bit. Could you tell me what happened in the first place that brought you to the hospital?”

“ You mean the heart attack? You want me to tell you something? I laid my wife that morning, let's be frank. And

instead of resting a minute, I jumped into a hot tub of water, boiling hot water. I didn't give my heart a chance to rest, and it was a little too much for me. If I had rested just one minute, you know, lay alongside her and relaxed a minute, nothing woulda happened. In the beginning, I came downstairs, and I sorta felt squeamish, so I said to myself, ‘You know, I oughta stand in front of the open window and breathe deeply.’ I've got a big chest so I can take in a lot of air. Then, I had a drink of pineapple juice. You know, I don't drink small amounts of anything! I guzzled that, I am telling you, and when I guzzled that, all of a sudden, she gave me a bang in the heart. And I knew right away I had a heart attack.

No, I don't get frightened at nothing, nothing scares me. All I did was holler up to my wife. I've got a bull voice. You understand, I got a powerful chest, so it comes out strong. So, she came down, and I says, ‘Call the doctor, tell him I had a heart attack.’ As I said, in the hospital, I got uncomfortable

staying in bed. They had my bed raised, and I couldn't sleep. So, I got up and walked around.

You want to know something, Doc? Nothing bothers me. I am just telling you. I am an impatient guy. I don't let nothing bother me. I found that a long time ago, that if you don't let nothing bother you, you're the happiest guy in the world. Let them call you a dope, let them call you anything, but you got peace of mind."

"I see, peace of mind is very important for you." I said.

Mr. T continued,

"Doc, at age 37, I had pains in my head, and I had diarrhea for years, and my family, every one of my aunts and uncles died of cancer, and I took an X ray and I figured, 'Gee, I got cancer, too.' Let's be frank. I had a cousin at 31 die of cancer, too. He died of leukemia, so I figure it was me too. But when they told me it was all from nerves, I says, 'You see this book. It's open right now. This book is closed. If you ever see

me get excited again, you can insult me from morning to night, you can call me anything you want, and I will look at you and I don't give a damn.' And you want to know something - from that day on, I don't give a damn about anything. I learned one thing. If you got a calm mind, nothing is gonna hurt you. You know, a lot of doctors don't realize it.

My wife? In earlier years, we used to fight like hell. Now, I love her so much I could kiss her. And she knows it. And I let her do what she wants. She likes folk dancing, I let her folk dance. She wants me to stay home with her on Saturdays, I stay home with her."

"I understand your wife called the ambulance."

"Oh, she was very shocked when she heard me hollering with pain. The thought of me, me being sick. She couldn't take it, you know. I'm imperishable. That's the way she looks at me. You want to know why? Because I look at myself that way. I

looked at myself as imperishable. In other words, nothing could hurt me.

In my youth, I was so strong that in order to get any satisfaction, I had to wrestle with four or five fellows at one time. I used to wade into a gang of fellows, 14, 15 fellows, just for the excitement of a little exercise. I had muscles like this here; I had two calves under here, like watermelons. I was what they called a natural strong man . . . but today I feel sorta weak, not full of pep, if you know what I mean.

I think it's because they don't let me move my blood in the hospital.

Yeah. I'll explain it another way. Do you remember, years ago, they had a couple of operations in the African veldt? Now, these operations that they had in the fields, everyone survived, yet the ones they had in the hospital, those guys died. You want to know why? Those guys had to get off the bed and pull themselves along to get home. They moved their

blood. I am convinced that moving the blood is the most important thing to stay alive. Once you start laying in bed without moving and letting your blood move, you might as well bury yourself. That's how I feel. I tell you the honest truth, doctor. And, someday, you fellas are going to come to the same conclusion, that moving the blood is the most important thing of all."

The case of the sick Tarzan constituted a medical emergency. In the early phase of MI, maximal myocardial rest is essential. His insistence on lifting the bed to "move his blood" was seriously jeopardizing his life. In fact, there were increasing signs of myocardial distress, as evidenced by increasing cardiac arrhythmia.

How to manage such a patient? It became clear that there was a discrepancy in the model of illness between the patient and the doctors. 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 this 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 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 their 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 became 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.

I called for a meeting with the patient’s medical care team, the attending physician, trainees, and senior nursing staff. I explained my findings and impression and invited a

discussion on how to manage this patient. The team 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 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. 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 damage to his heart. 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 the 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.

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 sedatives.

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.

I proposed in my book, The Patient, authored with my mentor, Morton F. Reiser, MD, three-dimensional evaluation and management model of patients (See Refs). The three dimensions are biological, personal (including psychological), and environmental (social) dimensions, intersected by current state, recent changes, and background factors (including genetic and early interaction with environment)

A three-dimensional management plans outlined below were worked out and put into practice:

Biological Dimension

1. Adequate pain relief with narcotic analgesics. Pain relief is necessary for myocardial rest and gives the patient a sense of control.

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

3. Other necessary treatment of MI and arrhythmias.

Personal Dimension

1. Treatment of pain with narcotic analgesics as above.

2. The patient was to be offered pain medication regularly, but he could decline to take it if he had no pain, which would allow him to have more sense of control.

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 by the senior attending physician:

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 – your toes will pump your blood all the way up and down. 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.

Environmental/Social 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. I, as the consulting psychiatrist, coordinated this task.

1. 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 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 - doctors, nurses, and wife were successful, and the remainder of his hospital stay was uneventful.

Some months later, in the doctors’ lounge, I saw one of the medical residents who was a member of the management

team I coordinated around Mr. T. She approached me and said, “Dr. Lee, do you remember ‘Sick Tarzan?’ I am now seeing him in my clinic as an outpatient. He is doing quite well. In fact, I used the approach you taught us, making use of his strong man image and presenting him with challenges he can master! I challenged him to stop smoking to get rid of the poison which makes him weak so that he can continue to be strong and take care of his family. It worked! He stopped smoking cold turkey more than six months ago! Very proud of it."

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(This case was presented in a somewhat different form in The Patient: Biological, Psychological, and Social Dimensions of Medical Practice, Hoyle Leigh & Morton F. Reiser, Springer, 1980, 1985, & 1992).

Chapter 7. Leave Me Alone and Let Me Die

Mr. Conklin was a 67-year-old widowed man who was admitted to the medical service with congestive heart failure, a condition that causes swelling of the legs and difficulty in breathing. Several days after admission, I was called to see him because the nurses felt that he was depressed.

As usual, I spoke with the nursing staff before seeing the patient in question. "I am here to see Mr. Conklin. I understand that he seems to be depressed."

"Yes, he is usually lying down in bed with the sheets over his head. When we try to speak with him, he keeps on saying, 'Leave me alone and let me die. I would be better off dead. Often, he gets quite hostile, too, and swears at us." said Ms. Sanders, the primary nurse for Mr. Conklin.

She continued, "He has been eating practically nothing since he came in - his trays are always untouched. He also has a

lot of trouble with sleep - waking up other patients at three o'clock in the morning with moans, groans, and all kinds of noises."

Ms. Sanders was one of the exceptionally competent nurses in my past experience, and I was very grateful for her astute observation. She knew that appetite and sleep patterns were extremely important data in assessing depression. Objective observational data such as those given by Ms. Sanders are invaluable in getting a comprehensive picture of a clinical situation like depression.

Reviewing the medical records, I determined that Mr. Conklin was not on any drugs that might cause depression. The congestive heart failure seemed to be on the way to being under control. I then proceeded to the patient’s bedside.

Mr. Conklin was, in fact, completely covered with the bed sheets. This presented a somewhat comic picture, as his

upper body was elevated (which is the most comfortable position for patients with congestive heart failure), and where you would expect to see the head, one saw only the pillow partially sticking out as the head was completely under the sheet - reminding one of a half-folded mummy.

"Hello, Mr. Conklin" I called to him as I drew the bedside curtain around the bed. Mr. Conklin did not stir. I approached the top of the bundled form and gently tugged on the sheet covering what must have been the face. "Hello, I am Dr. Lee. I want to speak with you for a few minutes."

"Leave me alone", a voice answered from the bundle, but there was no stirring under the sheet except the rapid rising and falling of one side of the top sheet indicating shallow breathing. I decided that a little "force" was necessary, and gently but firmly pulled up the corner of the sheet covering his face and said, " I need to talk with you for a few minutes!"

The face that was exposed was painful to look at. An old, dejected face with deep furrows, sallow complexion, with eyes that were closed tightly as though to shut out all light. The head was sparsely covered with gray unkempt hair. I said firmly, "Mr. Conklin, would you look at me please. I need to speak with you."

I almost expected him not to respond or respond by closing his eyes even tighter. But he did open his eyes partially, as though it took too much energy either to resist or to comply with my command.

"Mr. Conklin, how are you feeling now?", I asked.

In a barely audible voice, he said, "Fine." No, this would not do. I should have said, "I understand that you are feeling depressed" instead. Better late than never.

"Mr. Conklin, I understand you have been feeling depressed."

Surprisingly, he said, "Yes." He had said, in a matter of a few seconds, that he was feeling both fine and depressed! There are several possibilities when a patient contradicts himself so blatantly. They are: 1) The patient is too confused to know that the answers are contradictory, 2) The patient does not understand the question, 3) The patient is taking the path of least resistance, that is, the least energy consuming answer is given because he lacks the energy to give a thoughtful answer. I felt that the last was the most likely possibility. Could you tell me some more about your depression?", I asked.

Mr. Conklin, however, simply closed his eyes without answering. Many patients who are mildly or moderately depressed will answer questions like those I asked, but very seriously depressed patients may be unable to answer an open-ended question like it because it may feel to them to require monumental energy to devise answers that are not

Yes or No. Thus, I asked, "Mr. Conklin, do you feel very sad?" The patient merely shook his head.

While most patients feel sad and blue when they are depressed, very seriously depressed patients may not actually feel sad - they are, so to speak, past feeling sad to the point of apathy. Mr. Conklin certainly looked apathetic - past caring. "Do you feel as though you don't care about anything?"

He did not answer. "Could you look at me once again, please. Do you feel as though you don't care about anything?"

He opened his eyes slightly, and said, "Yes" in a faint voice.

"Do you feel like there is no hope?", I asked. The patient nodded.

"Do you feel like giving up?" Once again, he nodded.

"Do you have thoughts of hurting yourself or suicide?" This is a question that even physicians often feel uncomfortable

in asking their patients. It is, however, a crucial question to ask of any patients who are suspected of being depressed.

"Yes", answered the patient.

"Do you have any plans of hurting yourself?"

The patient merely shook his head to this question. I decided to change the topic a bit and assess whether he was confused.

"Mr. Conklin, let me ask you some other routine questions. Could you tell me where you are?"

"Hospital"

"Yes, could you tell me the name of the hospital?" He whispered the correct name.

"Good, now what day is today?" The patient whispered, "I don't know."

"Who is the President of the United States?"

"I don't know"

"How much is fifteen plus seventeen?"

"I don't know"

"How about two plus five?"

"I don't know"

By this time, it was clear that he was going to say "I don't know" to all my questions. While this may seem to be a sign of dementia or uncooperativeness of the patient, many depressed patients actually do not have enough energy to do even simple mental exercises, such as remembering things and doing calculations. This inability to think and concentrate in depression is well recognized and has been named pseudodementia of depression. Unlike most true dementias, pseudodementia responds to antidepressant therapy.

In formulating a diagnosis and treatment plan, speaking with the family would have provided invaluable information. For example, whether or not the patient had previous episodes of

depression, what medication if any was effective, and whether there is any family history of depression and, if so, what the course and treatment was. Unfortunately, Mr. Conklin did not have any visitors, and could not or would not give the staff any names of family. He was living alone in a rooming house.

Depressive mood is a normal reaction to loss and most people experience it at one time or another. The depth of depression varies from transient feeling blue to mild to moderate depressive mood to the extreme form, major depression or depressive syndrome.

Major depression is a serious illness that is often accompanied by apathy rather than feeling sad, and changes in physiologic functions such as loss of appetite, weight loss, insomnia, and a general loss of interest in all things that used to give pleasure. This is an illness that requires evaluation and treatment by a specialist. In addition to situational factors such as loss, many medical diseases and drugs can

cause depression which is indistinguishable from major depression. An important function of the consulting psychiatrist is to determine the degree and nature of depression in a medical patient, and to recommend appropriate treatment.

Although the information I had was meager, I decided that the patient's depression was serious enough to warrant the diagnosis of Major Depression and decided on suicide precautions and antidepressant therapy. In consultation with the cardiology staff, an antidepressant drug least likely to cause complications to his heart condition was decided upon. Suicide precaution was ordered, which meant that the patient would be with a member of the nursing staff at all times to prevent him from attempting suicide.

In a matter of days, there seemed to be some improvement in the patient's state. He was eating a little more and seemed to sleep better. Also, he seemed to be somewhat more energetic and was able to think and remember a little better.

His medical condition, however, still required careful and intensive treatment. The staff were quite excited about Mr. Conklin's response to the antidepressant and remarked that perhaps antidepressants should be used more often on medical services.

When I saw Mr. Conklin about a week after my first visit with him, he was actually sitting up in bed. His expression was still one of dejection, but there also seemed to be an element of anger. But he smiled at me when I asked him, "How do you feel today?"

He said, "All right under the circumstances."

"Could you tell me more about the circumstances?"

"Being sick, trouble breathing, can't go home."

"Yes, it must be very uncomfortable for you", I sympathized.

"How would you know? You are healthy." I decided to ignore this.

"Well, do you feel very depressed?", I asked.

"No. Not as bad as before. Just discouraged."

"Do you still feel like hurting yourself?"

"No. Not anymore", he answered quickly. Not having suicidal thoughts is often a sign of lifting depression but experienced psychiatrists know that this can be tricky. A patient may be too apathetic and without energy to attempt suicide during the nadir of depression but as they regain energy, they may become actually suicidal and seriously plan it.

I asked the routine mental status questions to see whether he could pay attention, do calculations, etc. He now knew the date, presidents, and was able to do simple calculations. These supported the idea that his previous difficulties were due to pseudodementia of depression.

"Mr. Conklin, do you have any relatives or family?"

"No. I am all alone in the world. My wife died many years ago, we had no children. My parents are dead. I was an only child." I did not like the way he said this - angry, sad, and proud? As I was finishing the interview, the patient asked, "By the way, do you still have to have me babysat?

"What do you mean?"

"I mean the sitter - you know the babysitter who watches me all the time so that I won't hang myself. As you see, I am much better now. And I can promise you that I won't hang myself."

While it was true that his depression was improving, I decided not to discontinue suicide precautions. His rather sudden denial of suicidal ideation, his talking about hanging himself which indicated that he was thinking of the concrete means of suicide, and his increased energy levels and angry feelings, if anything, increased my concerns about his

suicidality. But as long as he had a constant companion, suicide would be impossible.

"No. Not quite yet. But I am glad that you are feeling better. If you would like to speak with me before I come up next time, just ask the nurse to call me. My office is only five flights down."

The following Monday, four days after I had seen Mr. Conklin, I was sitting at my desk looking out of my window. Through my window, I saw the concrete pathway with flower beds. Spring. Bright yellow forsythias were in bloom. Somehow, I felt sad looking out the window. April is a cruel month, so wrote T.S. Eliot. It isn't even April yet, but Spring is a sad season for so many of my patients. Why do revival and rebirth only add to the burdens of the depressed?

Suddenly, I was shocked out of my reverie as I saw an object falling on the concrete pavement next to the forsythias. It

took me a moment to realize that the form that had hit the concrete with a thud and crack was actually a man in a johnny coat. Then I heard shouting and screaming through my window and realized with horror that a patient had fallen or probably plunged from a ward above my window. A pool of blood was forming under the motionless heap on the pavement, and slowly expanding into the gray of the concrete. He must have landed on the head!

It occurred to me then that I should do something - what? call an ambulance? Silly, you are in a hospital. Call an emergency code. I picked up the phone, my eyes still looking out the window, when a group of white-clad people with a stretcher rushed to the body out my window. I put the phone back, eyes still fastened on the scene outside. I could see clearly the face of the man as the emergency squad lifted him onto the stretcher - the sallow, dejected face of Mr. Conklin, now bloodied and smashed, but still recognizable.

The forsythias were no longer in bloom when all the windows of the hospital were changed so that none could be opened from the inside at all. But Mr. Conklin had not simply opened his window and jumped out of his room. The "babysitter" made that impossible. And the old windows which could be opened from inside, did have sturdy wire mesh outside, so that no one could just open the window and jump. How did he do it then?

Suicide precaution involves nursing staff, usually a nurse's aide being with the patient at all times and accompanying him or her wherever the patient goes. I had felt secure, having ordered suicide precautions, that Mr. Conklin would always be with someone. I was mistaken. He was able to persuade his "babysitters" to let him stay in the bathroom with the door closed by pleading modesty. True enough, the staff was just outside the bathroom door, but she could not observe that Mr. Conklin was always opening the bathroom window, and systematically cutting the wire-mesh outside

with a dinner knife. Then, on that Monday, he opened the window for the last time, made the final cut, pulled off the mesh, and jumped!

Hospital policy concerning suicide precautions was rewritten to be specific - the staff must stay within an arm's length of the patient and in constant visual contact at all times. But too late for Mr. Conklin.

"But shouldn't a very determined patient have the right to autonomy, even to the point of suicide?" asked a medical student when I discussed Mr. Conklin's case in a seminar.

"Surely, he was uncomfortable, very ill, and was all alone in the world. Why should he not be able to determine his own future?" agreed another student.

"Yes, a patient has a right to autonomy, except when he or she is in an altered state - such as being confused, psychotic or in a depressed state." I answered.

"And the only reason I feel we are justified in denying that autonomy is because confusion or depression interferes with the decision-making process. When these conditions are adequately treated, then the patient would be in a position to be fully autonomous."

Yes, Mr. Conklin's depression was improving, and given two or three more weeks of therapy in a protected setting, he might have been able to say, "Dr. Lee, I am glad that you had the babysitter with me all the time. I was seriously planning suicide, but now I do not feel like that at all. I still have a lot to live for."

But then, I had a fleeting memory of Mr. Conklin's proud and, yes, defiant face as he said, "I am all alone in the world".

Was his defiant, successful suicide, in the protected setting of a hospital, literally under the nose of the psychiatrist, a full exercise of autonomy?

Chapter 8. I see Red, then I cut My Guts

"I see red, then I cut" said the haggard-looking middle-aged woman lying in bed, with an IV line hanging beside her bed.

"Yes, I know, and you are back again," said I.

Indeed, Deb was a familiar patient to me, as well as to the staff of the surgical service, especially the nursing staff. In fact, when I received the consult request from the surgical resident caring for the patient, she said, "Well, Dr. Lee, your old friend, Deb, is back again, with you know what."

"Again, with an abdominal dissection? Pretty bad as usual, I am sure." I replied almost automatically.

Everybody associated the patient, Deb, with "abdominal dissection" and "geographical abdomen".

“Geographical abdomen” refers to a condition of the surface of an abdomen that is characterized by mountains, hills, valleys, and rivers – scars looking like a topographical map caused by repeated cutting. Yes, Deb was an expert in cutting herself in the abdomen with a sharp knife – a surgical scalpel that she purchased specifically for that purpose. Her geographical abdomen was indeed a masterpiece, almost worthy of being included in a textbook. With each fresh new cut, however, the landscape would be drenched in blood.

One might wonder how dangerous such repeated cutting must be! Indeed, it is dangerous, and Deb has come to the hospital on numerous occasions with such blood loss that she needed transfusion. She, however, was an expert and precise cutter, so she dissected her abdomen to reach deep structures without actually cutting through a major blood vessel or bowel which could have resulted in almost instant death. She used to cut her gut in such a way that the blood

vessels would be damaged, but not the lumen. Her aim was to see blood coming out from her open abdomen, with her gut sticking out.

Deb stated that she invariably sees a vision, a vision of "Red – Red Blood welling out of my abdomen, almost like giving birth!" Then, Deb enters a state of altered consciousness where she feels detached from everything, with only the idea of "cutting myself, causing blood – red blood well out of the cut in my stomach".

Then, she invariably isolates herself in the bedroom, and places a clean sheet around her abdomen, and then commences the incision. As she sees the blood oozing out of the incision, she feels a certain sense of calm, some sharp, pricking sensation but not unbearable pain. She then begins to feel excited but continues to cut her abdominal tissue as if doing a delicate dissection. As the blood wells out of the abdominal wound, and she begins to feel faint, she calls the VA Hospital operator.

Yes, she was a veteran, and a very frequent customer of the VA Hospital's surgery department.

When I was consulted on the patient, I was very intrigued with her on many levels. How was it possible to cut oneself so much without feeling excruciating pain? What motivated her to do such painful self-mutilation? How did her veteran status affect her condition? Many questions.

Deb was cooperative with her interview with me, but it was obvious she wanted to provide me with only minimal necessary information:

Deb grew up in a rural small town, her father was a farmhand, and her mother was a housewife who tended to her three children, a son and two older daughters, and some chickens. She described her childhood as being rather deprived, having to do housework and walk miles to school. She felt her parents doted on the younger son, and neglected their daughters, especially Deb who was the

oldest. She was a rather shy girl, but she surprised everyone when she signed up for the army soon after graduation from high school.

She was vague about her military career, but it seemed that she had some traumatic experiences, perhaps a sexual assault, during her deployment and she received a medical discharge following a suicide attempt by cutting her wrist. She had received a diagnosis of Posttraumatic Stress Disorder with service connection.

Since her discharge from the service, she lived by herself and had some part time jobs in retail and in a beauty salon. She seemed to have had some unsteady and fleeting relationships with men, but no lasting relationships.

She did admit that her serious cutting behavior involving her abdomen began when she had a falling out with a boyfriend for whom she had strong affection, almost as a punishment for the falling out. She also admitted to having

some sense of excitement when she sees the blood welling out, almost of a sexual nature. She admitted that she was able to do the "surgery" because she was in an altered state, that she could not possibly do it in a normal state. She denied using any substances that might cause the altered state.

I saw Deb on consultation at least once every three months or so, each time for the same reason- cutting, for at least a couple of years while I was part-time employed by the VA Hospital. Then, Deb disappeared from my life for at least two years while I was still involved with the VA Hospital. I sometimes wondered what happened to Deb – could she have actually accidentally killed herself during one of her "surgery"?

"Hey, Dr. Lee, don't you even say 'hello' to me?"

called a female voice. I looked for the source of the voice and found an attractive blonde young woman smiling at me.

“It’s me, Deb, the ‘geographic abdomen’. Don’t you remember me?”

I was dumbfounded. The woman smiling at me had some resemblance to what I remembered of Deb, but Deb was always in hospital garb, with disheveled brown hair, and rather tired, sickly face. However, now she was much younger looking, and smiling and vivacious!

“Well, Deb, I certainly didn’t recognize you. You look so much younger and healthier!”

“Yes, Dr. Lee, I am now much healthier if not younger. I haven’t ‘seen Red’ for at least two years, since I got married. Oh, didn’t I tell you I got married two years ago to Bill, who is also a veteran and ten years older than me.

In fact, I am here with him – he is seeing his eye doctor for a new prescription."

"Well, Congratulations, Deb. It seems marriage certainly agrees with you!"

"Yes, it does, Dr. Lee. Bill takes very good care of me."

Deb's case is dramatic but not unique. Deb's condition, traumas especially from childhood resulting in Borderline Personality traits including unstable relationships, cutting, depression, and PTSD due to later sexual trauma, can be effectively treated by psychotherapy, especially Dialectical Behavioral Therapy, OR at times by developing a stable relationship with a partner. It seems Deb was fortunate enough to find a husband who was able to meet her difficult needs and allow her to grow out of the need for the elaborate cutting with all its implications.

Chapter 9. The Case of the Catatonic Patient with a Brain Cavity

A 27-year-old 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, a condition called catatonia, which may be a symptom of several serious medical and psychiatric conditions including brain infection and schizophrenia.

Referral for psychiatric consultation was made on the first day of admission though the patient was unable to speak at all.

The family stated that, Emily, the patient had complained of “racing thoughts” and a feeling that she was going “crazy” beginning several weeks prior to admission. In fact, Emily

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 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 (sweaty) young woman with unstable hypertension, tachycardia (rapid heart beat), and fever. Laboratory findings showed anemia, low potassium, and magnesium. All other values, including thyroid studies, were within normal limits.

On admission, Emily was placed on a regimen of cortisone intravenously to treat her ulcerative colitis. Serum

potassium and magnesium abnormalities were corrected by administration of potassium and magnesium without visible improvement in the patient's mental status. CAT scan of the head 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, normally small cavities in the brain were enlarged to look like big holes. A repeat CAT scan three days later confirmed enlarged ventricles with no evidence of a tumor that might have caused this abnormality. An EEG showed no epileptic focus but evidence 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. At this point, it was felt that the brain abnormality, the enlarged ventricles, were probably responsible for the catatonia, which would be unlikely to improve at all.

Emily would occasionally manifest severe tremors of all her extremities that were sometimes mistaken for convulsions by the nursing staff. She would, however, occasionally “wake up” from her catatonic 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.

At our recommendation, Emily was given small doses of antipsychotic medications which seemed to help some. Her ulcerative colitis, however, continued to worsen with episodes of frank gastrointestinal bleeding and marked toxicity. An emergency total colectomy was performed.

Remarkably, all vital signs and laboratory findings returned to normal after the colectomy, and the cortisone was tapered off. Concurrently, her mental status improved gradually such that, eventually, Emily was completely oriented and showed good recent and remote memory. She showed good concentration. Her judgment was good.

At this point, she felt “ normal”, and she related with the staff quite well. Tremors, waxy flexibility, and hallucinations were no longer present.

Emily 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 CAT scan at this point showed enlarged ventricles in the brain of the same magnitude as previously.

The successful management of this patient involved discussing all aspects of the case with her husband, the important supportive person from the outset. This was especially important, because the patient, being mute and

immobile, could not sign any forms for hospitalization or surgery and was not in any state to discuss management plans with the physicians. Approach to catatonia involves first an evaluation of the possible causes, e.g., low potassium and magnesium levels, medically administered steroids, and the enlarged ventricles on the CAT scan. The toxicity from ulcerative colitis and fever may also have contributed to this picture. The electrolytes (i.e., 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 CAT 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 and/or

depression 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 reported Emily's outgoing, sociable personality, it seemed less likely that she had schizophrenia or depression. Although encephalitis was a possibility, no specific measures could be applied to treat it.

In retrospect, and in view of the good outcome, encephalitis was probably not the cause of catatonia.

Following colectomy for ulcerative colitis, Emily 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, up to a point, psychosis can be symptomatically treated with antipsychotics.

Thus, in situations where 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 Emily 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 with psychotic symptoms.

As Emily no longer showed any psychiatric symptoms, e.g., catatonia, hallucinations, depression, no formal psychiatric follow-up was needed other than a phone number to call should any symptoms arise, e.g., in case she developed any symptoms possibly secondary to steroids or other medications. She, of course, needed appointments for postop care and medical follow-up.

The last time I saw Emily, she and her husband were happily preparing for discharge from the hospital.

(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)

Chapter 10. The Case of the Suicidal Terminal Cancer Patient

Sarah, a 35-year-old 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 Sarah 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.

Sarah 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 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.

Sarah 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.”

Interviews with her and her husband confirmed the initial impression that Sarah 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. Sarah's mother lived in a city some distance away. Sarah 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 homemaker 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.

Sarah 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.

Sarah's immediate need was, of course, treatment of the overdose during the hospitalization, evaluation of her 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: metastatic cancer and the depression and suffering of the patient and family. In the social dimension, the husband's guilt feelings about not spending enough time with his wife 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. Sarah was not a religious person and did not wish the involvement of clergy.

Psychologically, 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.

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, antidepressant medication should be considered for this patient.

In terms of treating her cancer, as much information as possible about the expected effect of the treatments and the progress should be shared with the patient.

Course of Management

Sarah 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 me, the psychiatrist, in collaboration with the primary

physician. 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 her concerns. Thus, with improved communications and psychotherapy, she might cease to be suicidal. Considerable amount of depression was present, and antidepressant therapy was instituted.

I evaluated the family and decided that I would see Sarah regularly daily while in the hospital and once a week after discharge and that her husband would also be seen by another psychiatrist I would recommend on a biweekly basis to discuss his own feelings of despair and guilt. This would also provide him with the opportunity to discuss his various concerns including the preparation of their children for the eventual loss of their mother.

As these plans were set in motion, Sarah was discharged from the hospital as the acute medical condition resolved. She kept her appointments with me diligently. I 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.

With the support of her primary physician and oncologist, I 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 antidepressant medication 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 Sarah 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, Sarah 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, Sarah 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. I 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, Sarah 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 myself, the psychiatrist. As spread of the cancer to the brain was discovered, Sarah 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 my office, Sarah's care was left primarily to her family. She chose not to be hospitalized during the final phase of the illness. I talked with her regularly on the phone, and she would tell me 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 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. Sarah 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.

(Originally published in a somewhat different form in Leigh H: Psychotherapy of a suicidal, terminal cancer patient. Int J Psychiatry Med **5:**173<F128M>-<F255D>182, 1974.)

Chapter 11. When The Buddha Sings

Anya was a 45-year-old widow who came to the U.S. at age 20 with her merchant husband who died of heart disease five years prior to Anya's current hospitalization. She was in the hospital with congestive heart failure and was referred for psychiatric consultation because she was having visual hallucinations.

Visual hallucinations are quite commonly due to non-psychiatric medical conditions such as drug toxicity, side effects, low blood pressure or chemical imbalance of the blood, lack of oxygen, recreational drug use, alcohol withdrawal, etc., etc. Careful chart review did not indicate any obvious causes of visual hallucination in this patient.

When I came to see the patient at bedside, she was comfortably resting in bed staring into space. The TV was on, but she did not seem to be watching. Anya was a petite Asian woman who appeared to be in good mood. When I

introduced myself, she greeted me enthusiastically and invited me to sit in the bedside chair. I explained to her that I was a psychiatrist, and that I was asked to see her because she seemed to be "seeing things that weren't there."

She said, "Oh, you mean my Buddha! I see him all the time."

"All the time?" I inquired.

"Yes, all the time, since I was a child."

"Can you describe what you see?"

"Well, I see, you know, a fat Budha, sitting down and smiling at me."

"Well, how do you feel when you see the Buddha?"

"I feel good! He also sings to me! I like it very much."

"He sings? Do you actually hear him sing? "

“Yes, very softly, but I can hear him very well. He sings very well, too.”

“What songs does he sing?”

“Mostly Thai popular songs, you know the kind you hear on the radio. Also, some children’s songs I used to sing when in school.”

“Really? What are some of the words of the songs?”

“Well, I am embarrassed. Some of the songs are real love songs, you know, passionate words. Others are like folk songs.”

“Did you actually hear any Budha sing before, I mean in reality?” I asked.

“Of course not, doctor. Buddhas are made of wood or stone, they do not sing! It’s only when I see them in imagination they sing!”

“So, you know that the Buddhas that sing are not real?”

“Of course, not. They are hallucinations. I know that!”

I was rather intrigued. So, she knew that they were hallucinations, and moreover, she seems to be enjoying them. Hallucinations are generally frightening or at least puzzling to patients, not enjoyable. But then, I remembered that there are certain hallucinations that are quite enjoyable for children – imaginary companions. Is Anya’s Buddha an imaginary companion?

Indeed, history revealed that Anya started seeing her “fat Buddha that sings” since the age of 4-5. That was a particularly stressful time for her as she was left alone for prolonged periods of time with a distant relative when her parents were away. Then, she would see the Buddha whenever she was under stress, whose sight and songs comforted her. When she couldn’t sleep, the Buddha would sing a familiar lullaby and she would fall asleep content and happy.

What came to Anya's mind when she thought about the fat Buddha now? She thought of her father, who used to be a kind and jolly man when he was around, and also her deceased husband, whom she loved deeply.

Yes, reality can sometimes be augmented with creations our mind conjures up for comfort that we may lack in reality. Aside from her hallucinations, Anya did not have any symptoms or signs of any major psychiatric disorder such as depression or delusions. I determined that Anya was having healthy, adaptive hallucinations, and that there was no need to try to "treat" it.

Chapter 12. A Case of "Coin Lesion" in the Lung

Joe was a 48-year-old single male was referred to me for consultation concerning a "coin lesion" in the lung. "Coin lesion" usually refers to X-ray findings of coin-like shadows that may indicate serious conditions such as lung cancer or serious infection. They may also be caused by relatively benign processes like cysts. In this case, however, there was actually a coin, a dime to be exact, that was lodged in the right bronchus of the patient. Psychiatric consultation was requested as Joe denied any knowledge of how the dime might have gotten into his lung, and Joe also carried the diagnosis of chronic schizophrenia.

Chronic psychiatric illnesses tend to take a toll on patient's appearance, especially if the patient is not well looked after, lacking a family or similar supportive setting. Joe, who was homeless, was no exception. He looked unkempt with long hair, sallow complexion, and sunken eyes. In spite of the rather prominent "coin lesion" Joe was not in

any acute distress; he had a rather wooden expression and did not make eye contact when I introduced myself.

Joe did respond to my questions concretely without volunteering any information. He did state that he came to the hospital because he developed a “boil” in his left foot that made it difficult for him to walk. On admission, he was observed to be dyspneic (short of breath), and a chest X-ray showed a “coin in his lung” – the shadow of an actual metallic coin! Joe stated that he had no idea how it got there. Yes, he was diagnosed with schizophrenia during his teenage years, has been in and out of psychiatric hospitals most of his life. His mother apparently also had schizophrenia and was in a psychiatric hospital during most of Joe’s childhood. Joe grew up in foster homes and group homes, had many behavioral problems including fights and being bullied in school. He was apparently paranoid and having auditory hallucinations (hearing voices) when he was first hospitalized around age 16. Joe apparently had no

friends or family with whom he related. After most of his psychiatric hospitalizations, he was placed in board and care, but he usually ran away after a while, preferring to live on the streets, sometimes making money by "recycling". He was erratic in keeping outpatient appointments and with medication regimen. He had been tried on monthly depot antipsychotic injections, but he was usually non-compliant.

Joe was apparently quite disruptive during his youth and had a number of police records though no actual prison time. In more recent years, however, Joe seemed to have calmed down somewhat, with relatively regular outpatient appointments and better compliance with his antipsychotic medications.

What was more prominent with Joe at this time were the so called "negative" symptoms of schizophrenia – noted absence of certain mental functions one expects of "normal" people, such as expression of affect or emotions,

being able to have a fluent stream of thought and speech and reasoning. In contrast, the “positive symptoms” are those that you do not expect to be present in a “normal” person, such as delusions including paranoia, hallucinations, and disruptive or bizarre behavior due to the loss of normal social and moral inhibition, a frontal lobe function.

During the interview, Joe manifested, as previously mentioned, a lack of affect and emotion, having a wooden facial expression. He also showed some “thought blocking”, sudden blanking of thought, which might contribute to his tendency to monosyllabic answers to questions. When he spoke for more than one sentence, the next sentence often did not logically follow the previous sentence. These negative symptoms are not always present in patients with schizophrenia, but if present, tend to persist and treatment resistant.

How to explain the “coin lesion”? Joe was at a loss, he does not remember inhaling or swallowing a dime or any other coin. Could he have accidentally done so unawares? He does not know but cannot think of why he would have done so. He does not generally have coins in his possession.

Foreign body ingestion does occur in some patients with psychosis and/or in dissociative states such as in the Borderline Personality Disorder, PTSD, intoxication, and other conditions. In fact, I have seen some patients who swallowed razor blades, safety pins, and even scissors. One patient had to have surgery on her stomach to remove hundreds of open safety pins.

Inhaling a dime into the bronchus, however, is another matter – it will invariably cause violent reflex coughing, retching, - an extreme discomfort.

If Joe had relatives or friends, I could have obtained some collateral information that might shed some light on the coin in Joe's bronchus. For example, did he snort any substances? Like many patients with schizophrenia, Joe smoked cigarettes, but he denied any snorting of any substance. It is believed that some patients who are on antipsychotics that tend to block dopamine transmission attempt to compensate for it by using nicotine.

How was Joe able to tolerate the coin in his bronchus, for probably months or even years! There is some evidence that patients who have chronic schizophrenia may have decreased sensitivity to chronic pain, perhaps related to a hyperactive endorphin system in the brain. Was Joe able to tolerate the discomfort because of this mechanism? Schizophrenic patients, however, may be more, not less, sensitive to acute pain, so how was he able to tolerate the acute pain and discomfort when the coin first lodged on his bronchus?

Joe's case illustrates that patients with chronic schizophrenia may minimize or be unaware of conditions that would normally cause severe pain or discomfort, and that we should not lightly dismiss their minor complaints. In fact, reviewing the chart, besides the foot abscess, the only physical complaint Joe had on admission was a slight cough.

The coin in Joe's bronchus was finally removed surgically, and he was discharged, again, to a board and care facility. The mystery of how the dime got in was never solved.

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Chapter 13. The Nurse with Cardiac Arrest and Low Potassium

Jill, a 22-year-old divorced woman was admitted to the ICU in a comatose state following cardiac arrest. Immediate labs in the Emergency Room showed severely reduced serum potassium levels and she was immediately revived by intracardiac potassium injection. Physical examination showed. a slender young woman without any gross abnormalities. Repeat laboratory findings confirmed severe hypokalemia. There were no endocrine (hormonal) abnormalities. The medical staff was puzzled about the cause of the hypokalemia, performed a urinalysis, and found the presence of hydrochlorothiazide, a diuretic (medication that causes increase in urination and lowers potassium levels in the blood). The patient had denied any ingestion of drugs, but a search of her bedside table yielded a large bottle containing hydrochlorothiazide, a diuretic.

Psychiatric consultation was requested.

Jill had initially told the nursing staff that she did not want to see a psychiatrist, but I decided to introduce myself anyway. I decided to use her being a nurse as a common ground for collaboration.

“Hi, Jill, I am Dr. Lee. I understand that you are in the medical field, too, as a nurse?” Jill seemed to be a little taken aback.

“Yes, Dr. Lee, how did you know I was a nurse? Oh, I guess the chart must say that.” She replied with a hint of a smile.

“Yup, the chart says that you are an ICU nurse at the other hospital. You must have had a scare with your own cardiac arrest!”

Jill agreed that it was a quite frightening experience, just “passing out like that!”

“But I don’t know why I have to see a psychiatrist! I don’t know how a bottle of hydrochlorothiazide got into my bedside table. I certainly didn’t take it.”

“Well, I am more concerned about your hypokalemia and the frightening experience you had. Have you had cardiac arrest before?”

“No, never. I saw many patients who had it, but I never have.”

“Good that you do not have a chronic condition. By the way, since I am a psychiatrist, I need to get some history from you. Would it be OK?”

Jill must have been on guard that I might accuse her of inducing her hypokalemia but became more relaxed as I did not take an accusatory approach. She readily consented to the psychiatric interview.

Her history revealed that she had been abandoned as a baby, was raised in a number of foster homes.

She was told that she had gastrointestinal problems since the age of 2. She had been hospitalized many times during her childhood for these problems. During adolescence, she had the first of many episodes of urinary tract infection and diarrhea around the time of stressful event. Nevertheless, she graduated from a nursing school and worked at two jobs.

She had married a "mamm's boy" two years prior to her current hospitalization but was soon involved in a power struggle with her mother- in-law. She also developed severe dyspareunia. On her first wedding anniversary, she was in a local hospital. Eventually the marriage broke up.

"Mamma won!" She said bitterly.

Her history has features in common with other reported "Munchausen" cases - early rejection, dependent relationship to health care facility, and her health care occupation (nurse). Factitious disorders are often a manifestation of “sick role addiction” – an unconscious expression to be cared for in a hospital, especially to escape stressful situations. Why did she induce hypokalemia with a diuretic? Perhaps, as a nurse, she knew the potential serious condition a diuretic could cause and also that it had seldom been implicated as a method of causing a factitious illness. Some women used to use diuretics as a weight-loss tool – could she have tried this and found that it caused hypokalemia and symptoms?

Jill, however, denied ever having used a diuretic, for whatever reason, weight loss included.

“I know quite a few women who do use hydrochlorothiazide to lose weight, maybe one of them put a bottle in my bedside table. I also see a lot of cardiac

patients who need the diuretic, really sick old people! No, I would never use it!"

"I know you would never consciously use it, but sometimes people wind up doing very strange things in an altered state of consciousness, especially if one is under stress and/or with severe lack of sleep. Have you had any stress or lack of sleep lately?" I inquired. Some truly painful self-inflicted or factitious injuries can occur in a state of altered consciousness or dissociation. Further, this idea provides an excuse for factitious injuries even if they occurred in a conscious or semi-conscious state.

Jill did admit that she was under much stress at work and with personal relationships and had considerable lack of sleep. She admitted that she might at times have altered states of consciousness, but adamantly denied that she consciously possessed or used the diuretic for whatever purpose.

At the conclusion of my interview, I offered Jill an outpatient referral for her work and personal stress. Unfortunately, as with many patients with factitious disorder, this patient did not follow through with outpatient therapy and was lost to follow up when she eventually moved out of town.

Regardless of the underlying dynamics, this case raises important points. Factitious at it was, her illness was life-threatening and as a nurse, she must have known how dangerous it was! She was comatose this time with cardiac arrest. Even if the medical staff knew that her clinical problem was an instance of Munchausen's syndrome, immediate psychiatric referral or refusal of medical hospitalization would have been inappropriate. Prompt, rapid treatment of the self-induced hypokalemia was lifesaving.

(This case was published in a somewhat different form; Leigh H: Factitious Hypokalemia - A Case Report. Annals of Internal Medicine, 80:111-112, 1974)

Chapter 14. Enjoy your Vacation

My first real vacation since graduation from medical school – the first-year internship went in a whirl, the two weeks of vacation I had then was mostly spent making up the lost sleep. Now as a psychiatric resident, I had whole four weeks of vacation coming up – to be spent with my fiancée in New York City, across the continent!

I had announced my four-week vacation to all my patients at least a week ahead to my patients on the Veterans Hospital inpatient service to which I was assigned as a junior resident. This was during the Vietnam War era, and the average length of stay for a psychiatric inpatient was about one month, much longer than current 3-4 days. It was possible to do real psychotherapy with inpatients then!

Most of the VA hospital inpatients were middle aged World War II veterans or young Vietnam War veterans with PTSD (posttraumatic stress disorder), schizophrenia,

or bipolar disorder (mostly with depression). Many also had substance use problems and co-morbid medical problems such as heart disease and hypertension. Each resident was assigned about 5-7 patients at a time on a twenty-bed unit. There were three junior residents supervised by one attending psychiatrist on the unit. I had been on the service for three months of total six months' rotation, and felt I was making good progress with my therapeutic skills.

One young patient, Duane, was particularly promising. He was only 22 years old, having been discharged from the army only last year. He had been raised in a rural farming community, a high school graduate, who was drafted into service, had seen combat in Vietnam, had used various substances as was common in the military at the time, apparently had some visual and auditory hallucinations, was diagnosed with schizophrenia, and was subsequently discharged. He had returned to his home on the farm, felt

lonely and depressed, had taken a bottle of unspecified "pills" with alcohol, and was admitted to the hospital.

When Duane was assigned to me, I felt some anxiety as he appeared so young, almost like a teenager! And he had such an awkward and pained expression and behavior. This being his first VA hospital admission, although he did have experience with army field hospitals, he seemed uncomfortable especially with the middle to advanced aged patients who could easily be his father or even grandfather. I was also young then, in my 20s, and I empathized with his discomfort being on the unit.

Duane clearly liked me, and I was able to engage him in a rather in-depth psychotherapy in spite of the VA inpatient setting. I saw all my six to seven patients at morning rounds, and then attempted more in-depth sessions with them at least once or twice a week. With Duane, I had daily sessions as he seemed to make such good progress!

Duane was an ambitious and inquisitive child growing up and felt rather stifled in his farming community – his parents were “simple folks” who eked out a living from their small farm. Both his parents were high school drop--outs, who preferred “growing things” to schooling. Duane’s older sister took after her parents, dropped out of high school, and worked with her parents. Duane was an excellent student and graduated from high school of which he was proud. Duane was also in the soccer team in school. Duane had dreams of leaving the area and going to college, a first among the “simple folks”. He welcomed being drafted as it provided him with an opportunity to “see the world” He also hoped to go to college eventually with the GI Bill. Little did he realize that he would be swept into a maelstrom of carnage, drug use to escape unbearable turmoil, and eventually being labeled as a “mental” patient.

After an arduous basic training period in which Duane was exposed to unaccustomed discipline, both physical and

mental, he was deployed to Vietnam where he saw brutal killings and injuries, both of the enemy and his own buddies. While in service, Duane formed a close friendship with his buddy, Bobby, who came from an entirely different background, from Brooklyn, New York. Bobby was also from a different ethnic background – his parents were Puerto Rican, though Bobby himself was born in Brooklyn. Duane felt attracted to Bobby's Big City ways, and his worldliness and felt very secure in their friendship.

One day, however, Duane's secure island of stable relationship collapsed when Bobby, intoxicated with rum, made sexual advances to Duane. Duane, being a "simple farm boy" had never encountered a sexual advance from a male – his sexual experience hitherto was only with a few high school flings with girls ending in a demure kiss, never any real intimate physical contact (this was prior to the real "sexual revolution"). Duane never revealed Bobby's sexual advances to anyone but requested a transfer from his

unit and had never spoken to Bobby again. To Duane, this incident with Bobby was more traumatic than even the worst combat he encountered during his military service.

After the breakup with Bobby, Duane became despondent, his use of substances increased, and he became careless in his combat duties. He also started hearing accusatory voices, telling him that he was a "faggot" and he deserved to die. He also saw visions of Bobby coming to attack him or engaged in bizarre sexual practices. At times Duane would wake up from sleep screaming, having dreamt of Bobby forcing himself on him. As Duane's behavior became more erratic, and the substance use and hallucinations increased, he was admitted to an army field hospital in Vietnam, was diagnosed with Schizophrenia and Combat Neurosis (the diagnosis of PTSD was not formalized until 1980 when it was included in the Diagnostic and Statistical Manual of the American

Psychiatric Association) and was subsequently discharged from the military.

Being at his childhood home after the tumultuous period in the military, Duane did not find peace and acceptance as might have been hoped. He found himself emotionally isolated from his family's "simple folk" ways and felt estranged from others in the community "after having seen what I saw, and experienced what I did, with killings and all, and all the drugs", life on the farm was stiflingly depressing! So, Duane got drunk and took a whole bottle of unidentified pills.

During the daily psychotherapy sessions, I conducted with Duane, it became clear that he had major conflicts with his confined situation and his exploratory drives. He also had major attachment issues, both a wish and fear of attachment, and conflicted sexuality. He had been attracted to Bobby, for his worldly (from New York!) and exotic (Puerto Rican!) ways, and in fact, sexuality ("Latin you

know!"). During the course of therapy, he came to realize that he could tolerate these diverse desires and drives within himself, and "pick and choose what I really want." He also realized that being on an all-male psychiatric inpatient service was an uncomfortable setting for him, and that he needed to have an opportunity to "decompress" by being in the country. We decided that he could have a pass on weekends to drive to his farm and "say hello to the chickens."

It was in the midst of these intense and gratifying psychotherapy sessions that I found my long-anticipated vacation will start in three days- this weekend!

As I mentioned earlier, I prepared my patients in advance about my vacation of one month. Some of my patients would be discharged before I came back – I discussed their follow-up plans and ensured that their medications would be prescribed on time. Most patients would still be there when I came back – my fellow colleagues would care for

them during my absence. While they would not have as intensive therapy as with me during my absence, we could certainly pick it up when I return. I felt sorry that there would be a hiatus in therapy for Duane, which was progressing so satisfactorily. Now he was even handling his weekend passes well, having been very friendly with his parents and sister as well as neighbors. In fact, he was looking into a job at a hardware store in town preparing for his discharge from the hospital, probably shortly after my return.

On the day prior to my departure on vacation, Duane handed me a card as the session ended:

Dear Dr. Lee,

You are truly wonderful! I believe I have gained much insight into my personality with all its conflicts and defects and your healing hand has been most tender but powerful! I will be forever grateful.

Have a Wonderful, Well-Deserved Vacation!

Duane

When I returned from my wonderful, enjoyable, well-deserved vacation with my fiancée in New York, I looked for all my patients, but Duane was not there.

Duane had died in a single car accident during his weekend pass last week. His car had a head-on collision with a concrete column on the highway.

Deaths from single car accidents are often suicides. Duane had left no note, and he did not have any indication that he was depressed or contemplating suicide. In fact, everyone on the service felt that he was making good progress even during my absence, and he was handling his weekend passes well. Until the last one, the weekend prior to my return.

Was it suicide? I do not know. I learned, however, that I should perhaps prepare my patients more fully, more carefully, for any absences from therapy. Attachment is powerful.

Chapter 15. Hear My Song – The Mental Health Blues

Josh, age 23, was referred to me from the medical floor following a suicide attempt by driving a car into a tree. The collision resulted in multiple contusions but no life-threatening injury as he was wearing the seat belt. The medical records also revealed that he had a diagnosis of schizophrenia and had multiple psychiatric hospital admissions since his teens, mostly for psychotic episodes when he became paranoid and often suicidal, fearing enemies capturing and torturing him. He also had auditory hallucinations – hearing voices that threatened to get him.

When I met Josh in his hospital room, he had bandages on the head and left knee, and clearly seemed to be attending to internal stimuli, probably voices that only he heard. He also struck me as having flat affect.

Upon hearing my introduction as a psychiatrist, Josh declared, rather in a matter-of- fact voice,

“ No psychiatrist can help me “.

“Well, it seems you were rather depressed, and it seems you were hearing voices that upset you?”

“Yeah, so what if I heard….” Josh seemed to lose track of his thought, then he blurted out,

“ had enough of Zyprexa, made me fat, can’t stand Abilify -made me angry, Haldol, that makes me stiff! Why don’t you just leave me alone?”

“I see that you had a bunch of medications that caused side effects. Have you had any other meds, like injections? And how about some therapy or counselling?” I asked.

“I’ve tried all the meds known to man, and therapy sucks! I am afraid of needles. I don’t need any of that shit!”

“OK, let’s talk about treatments later. Let me get some basic information about you. How much education did you have?”

He did graduate from high school but has been unable to find any stable employment, and lived with his parents who owned and operated a gift shop. Josh sometimes helped with the store, but mostly stayed in his room listening to music and playing video games.

I was rather impressed during the interview that Josh seemed to have many of the "negative symptoms" of schizophrenia (See Chapter 12, the "Coin Lesion" patient for further discussion on schizophrenia) and apparent auditory hallucinations. When I asked him directly if he was hearing voices during the interview, he did reply, "No, Yeah, I hear voices, none of your business, 'No you shut up!', I mean the voice!" Clearly, he was responding to auditory hallucinations.

A review of his medical records did indicate that he had indeed been on most antipsychotic medications that were discontinued or not taken because of side effects. Some of the medications were given in suboptimal doses and others

in “heroic” doses, most with some effectiveness but discontinued for one reason or another. I noticed, however, that one medication that I felt would be very helpful for this patient had not been tried at all – the medication I had in mind was clozapine. The use of clozapine requires some formal training and certification because it has one not uncommon serious side effect – agranulocytosis or deficiency of specific white blood cells necessary to ward of infections. Patients who are placed on this medication therefore need to have weekly to monthly blood draws to ensure that the white count does not drop below a certain level. I did have this certification but many psychiatrists in the community did not.

In spite of this possible serious adverse effect, clozapine has some rather unique effects which might be especially helpful for Josh – it was the only antipsychotic medication to date that effectively treated the “negative symptoms” of schizophrenia, and compliance to taking this medication

was higher than to other medications, perhaps related to the frequent contact the patient has with the lab staff for blood draw in addition to seeing the psychiatrist.

I determined that a trial of clozapine was indicated for Josh in view of the negative symptoms and the disruptiveness of his auditory hallucinations, a positive symptom. If clozapine did not work, then I would consider using a monthly injection regimen, attempting to overcome Josh's fear of needles. I have done hypnosis and de-sensitization for fear of needles in the past with good results in motivated patients.

To be able to "sell" clozapine, however, I would need to develop a better rapport with Josh and emphasize clozapine's uniqueness. To build a better rapport, I inquired about Josh's sources of pleasure and his aspirations, what he wished to accomplish in his life. Not surprisingly, his current source of pleasure was playing video games and listening to new music. It turned out that

Josh had gained some expertise in composing songs and playing them for himself. His aspiration was to become a musician/singer of his own songs.

As I enjoy music myself, I was genuinely interested in knowing what kind of music/songs Josh composed and he gave me the You Tube link to one of his songs, which I played on my iPhone.

It was amateurish but pretty good, in fact his voice and the composition were both quite promising. As I expressed my enjoyment, I felt that a clear rapport was forming between us. Then, I raised the question about the potential new medication, clozapine, its advantages, the one potentially serious side effect, and the need for regular blood draws at the lab. I offered to see Josh as an outpatient following his discharge from the hospital as I felt that if anything could possibly ensure his compliance with clozapine, it would be the rapport I built with Josh through music.

In fact, Josh did show up for his follow-up appointments and was compliant with clozapine as well as with the regular blood-draws. He also agreed to attend a Living Skills class offered by the mental health clinic. In about six months' treatment with clozapine, there was marked improvement with all of Josh's positive (i.e.- voices) and negative (flat affect, etc.) symptoms of schizophrenia. In fact, Josh's face showed full affect and he had very little auditory hallucinations – the voices were much less frequent, and even when present, were of such low volume that he could easily ignore them.

Josh also became much more productive. He published a number of his songs, and with the money he made, he purchased more professional equipment to compose and produce more professional music. He was being noticed by the musical community of his genre, such that the local radio station broadcast his songs.

I continued to see Josh regularly at monthly intervals, review his progress, enquire about his accomplishments, and renew his clozapine and lab orders. In about 2 years, however, the therapy with Josh had to be discontinued as I was moving to a distant city, transferring all my patients to another psychiatrist. Having prepared for my departure for months, Josh felt ready to embark on his "relationship" with a new psychiatrist, who will continue to prescribe him exactly the same regimen of clozapine, blood-draws, and Living Skills Group.

At the end of our last session, Josh gave me a little paper bag. It contained a DVD with Josh's name with the title, " Hear My Song – The Mental Health Blues"

Chapter 16. When I Visit My Own Grave

A consulting psychiatrist endeavors to learn, maintain, and practice a variety of psychotherapeutic, behavioral, pharmacological, and medical skills as they deal with many psychiatric, medical, and behavioral problems that often bridge the boundaries of psychiatry, medicine, psychology, and sociology.

One such skill is hypnosis, which is not usually a part of regular curriculum of psychiatric training. In the past, hypnosis was mainly used in psychotherapy to explore the patient's unconscious memories and conflicts. At one time, some unscrupulous lay hypnotists pressured patients to create "false memories" to support the hypnotists' false claim of "ritual abuse of the child", which gave a bad name to hypnosis and psychotherapy. Obviously, the professional hypnotherapist must be careful not to engage in such unethical practices.

I learned hypnosis by attending a course given by Dr. Herbert Spiegel of Columbia University while I was an Assistant Professor of Psychiatry at Yale.

Contrary to popular notions, hypnosis is a brain state ("trance") characterized by varying degrees of enhanced and focused attention and suggestibility. The depth of the trance state that can be induced depends on the individual's hypnotizability, which seems to be determined by many factors including genetic as well as exposure to early stress. In medical hypnosis, it can induce a state of concentrated attention and altered perception which may be used to control pain and undesirable habits such as smoking. For example, perception such as heat or cold may be suggested to replace pain. The concentrated attention can be used to learn strategies to control smoking, such as making a strong commitment to protect the health of the body and practicing under hypnosis substitute behaviors to smoking. Patients also learn to use hypnotic techniques to reinforce

the commitment not to harm the body by smoking and reward themselves with relaxing scenery (self-hypnosis).

Karen was a 25-year-old single woman who sought me out as a psychiatrist practicing hypnosis. She was a college graduate now working for a pharmaceutical company. She had recently moved out of her parents' house and obtained a studio apartment in the city. She had started smoking in college. In appearance, Karen was an attractive young woman who was neatly dressed. She seemed somewhat reserved but eager.

She had heard about hypnosis as being useful in stopping smoking and she was very eager to try it. She was smoking about a pack of cigarettes a day, and at that time did not experience any physical side effects of smoking other than some cough at times. As it is a good idea to stop smoking

in early stages, I agreed to evaluate her for hypnotherapy, the first step of which is a test for hypnotizability.

Karen's hypnotizability was outstanding – she was not only able to get into a deep trance, but she was also able to imagine herself gently flying among the clouds while vividly hallucinating different colors of the clouds which were not even suggested, "Oh, now I see pink clouds against the setting sun, and now there is an orange one!"

She was like an Olympic star in terms of hypnotizability. She went through the smoking cessation protocol and vowed that she will use the technique to kick the smoking habit. Hypnotic procedure for smoking cessation usually involves two sessions, the treatment, and a follow-up. During the follow-up session, she clearly showed that she was successful with the treatment including the self-hypnosis routine for smoking cessation. She wondered, however, if she could continue a few more sessions with me, "just to make sure that I got this right"

I was so impressed with her hypnotizability that I was eager to try hypnotic time regression and progression. I told Karen, “You are such a wonderful hypnotic subject. Would you be willing to try something that is not exactly smoking control, but suggesting to you going back in age into the past, or maybe some future events?” “This might help us understand your need to smoke and desire to quit better, as well as perhaps your being able to use self-hypnosis for various other purposes.”

Karen readily agreed.

The next session:

Karen appeared somewhat somber when she came into the office. “I think I may need some more hypnosis. I did use self-hypnosis and it did work OK, but I continue to have this urge to smoke. I am even deliberately getting near

people who are smoking just to get a whiff of the second-hand smoke!"

"Well, it seems you could use a 'booster' Would you mind doing what we talked about last session, age regression and progression, as well as the smoking 'booster?'"

"Yes, of course. Anything I can do to get over this urge!"

After a "strong dose" of "booster" consisting of repeated suggestions of the health commitment and relaxation techniques, I began the age regression and progression.

"Now, Karen, I am going to ask you to go back in time, I'll count to 5 and at the count of 5, you will be your 5th birthday! Ready? One….Two…." At the count of five, the patient felt to be age 5, "saw the birthday cake", and saw her parents and relatives gathered at the birthday party. She felt happy but was annoyed by her uncle who always had a cigarette in his mouth and was blowing smoke in her direction.

She was obviously able to age-regress and hallucinate her fifth birthday party. Now, what about the future? "Karen, now I am going to count to five once again, and this time, at the count of five, it will be your twenty-seventh birthday, two years from now. Ready?

One….Two…. Three….Four….FIVE… Karen, today is your twenty-seventh birthday! Happy Birthday! Tell me what you are seeing"

Karen was silent for a minute, then spoke in a faltering voice, " I see people – my parents, my sister, and Jim, my ex-boyfriend. They are gathered in some kind or a park. No, a cemetery. They are putting flowers in front of a tombstone while talking hushed among themselves. 'I miss her very much, still', 'I loved her truly'…." Karen started sobbing. "I see the tombstone clearly now and it has my name on it…. "

This was quite unexpected. I quickly brought her back to here and now from the hypnotic trance.

"Karen, do you remember what you experienced just now?"

"Yes, doctor. I attended a gathering at my own grave."

"How did you die in that scenario?"

"Of course, I killed myself. I didn't know they would miss me that much two years from now!"

"Karen, are you planning suicide?"

It turned out that Karen had indeed concrete plans of suicide which she was going to put to action within weeks. On questioning, she admitted to feeling depressed for some time, but she had to keep up a good front in her new job, smiling all the time. She felt lonely, rejected by her parents, her relationship with her boyfriend Jim became rocky, and

she became more and more isolated, started to smoke more, and drank large amounts of wine to fall asleep. She became increasingly preoccupied with death and suicide, and seeking help for smoking cessation was a means of getting help without admitting to depression, a way to see a psychiatrist for a “garden variety request”.

A careful psychiatric exam revealed that she had depressive episodes that began in her teens and a family history of bipolar depression with two suicides in her close relatives. I have to admit that I neglected to do a thorough psychiatric examination because I had believed, as Karen presented, this was a “garden variety request for hypnotherapy for smoking cessation”. Karen taught me a lesson that I now practice always - Do a thorough evaluation of any patient regardless of the “presenting” complaints/requests.

I discussed with Karen about treatment options for her depression – immediate inpatient treatment, or weekly

sessions with me with antidepressant medications with the proviso that she would call me or my answering service day or night if she felt strong suicidal urges. Karen was intelligent and insightful enough to be able to articulate her degree of suicidality and depression once they were permitted (in her mind) to be discussed. One mitigating factor for immediate hospitalization was that although she had concrete plans (specific drugs) for suicide, she had not yet obtained the drugs and instead sought help from a psychiatrist (me).

Karen did well with antidepressant therapy and psychotherapy, which was aided by hypnosis at which she was a superstar. In a year's time, she was well enough to discontinue regular therapy, but was maintained on antidepressant medications which were now prescribed by her primary care physician, who consulted with me when needed.

Yes, she did stop smoking largely on her own, aided with self-hypnosis.

Two years after the first encounter with Karen, I received a postcard from her:

Thought I should let you know that I am alive and well and just celebrated my twenty-seventh birthday. I am now happily married to Jim, my boyfriend whom 'I saw at my gravesite'. My career is going well- I was just promoted to an executive position. Thanks for all you did for me!

Chapter 17. When Cultures Clash

An urgent consultation request came requesting that a patient be declared incompetent so that an emergency operation could be performed. The patient, Mr. Xong, was a 32-year-old diabetic Hmong speaking male who developed severe infection of his left leg with necrosis (tissue dying) which was rapidly spreading. He was at risk of developing whole body infection and dying. His medical doctor told me, however, that he refused to have an emergency amputation of his leg "because of cultural reasons."

When I went to see Mr. Xong, I found a rather frail-looking Asian man who seemed to be sedated but in pain. An Asian woman, presumably his wife, was beside the bed wiping sweat off his forehead with a towel.

When I tried to speak to the patient and wife, it became clear that they understood very little English. The nurse

attending the patient informed me that the patient spoke very little English, and that communication was mostly done with the telephone interpreter system, i.e., through a speaker phone that is connected to a remote Foreign Language Translation service.

I was now connected to the service and could speak with the patient and wife.

Mr. Xong, told me through the phone translator that he was in the hospital because of leg pain caused by his diabetes, and that he would be OK with medications in the hospital, as had happened many times in the past. The patient did show some waxing and waning of alertness during the interview but did not show any signs of severe confusion. When asked about the amputation proposed by the medical team, he said, “No, I won’t have part of my body cut off. My ancestors would never allow it.”

When asked, the wife said she tried to persuade him to get the surgery so that he would get better but her husband was adamant in his refusal as the head of the household. No amount of explanation by the doctors that the amputation was necessary to save his life had an impact. So, the medical team asked the psychiatrist, me, to declare him incompetent so that the amputation could be done over his objections.

I felt that it would be life-saving tor him to get the amputation, but the reason he gave for refusing it was not based on confusion or a delusion but his cultural belief about maintaining bodily integrity. However maladaptive his refusal of surgery may be, I could not consider the patient to lack the capacity to make medical decisions on the basis of confusion or psychiatric illness. But my refusal to force him to have the surgery, which was within my power (abuse as it may be), would most probably condemn him to impending death. This is a dilemma that consulting

psychiatrists often encounter in dealing with seriously ill patients with strong beliefs falling short of psychiatric delusion, e.g., cultural, religious, philosophical, personal, etc.

Telephone translation services serve an important function in medical and psychiatric practices and were essential in evaluating this patient. I, however, felt that the physical presence of an actual human being could be helpful, who can not only translate the spoken words but also interpret the unspoken meanings and significance of the doctor-patient interaction. Failing that, I wondered if we could bring into the conversation someone, even if by phone, who could serve the role of interpreting and bridging the impasse between the patient and the medical team.

Is there someone who could play this role in the case of Mr. Xong?

I asked Mr. Xong if I could speak with the wife privately after my interview, which he consented to.

I asked the wife, “It seems both you and the medical team want to help him get better and prevent dying, but your husband has his own belief that a mutilation of the body is never acceptable.”

She replied, “Yes, I know. I know the cultural belief – it is disrespectful to mutilate one’s body, but I want him to live!”

“Is there anyone whom your husband trusts who might be able to talk with him in an unbiased way?”

“Yes, he has an elder brother who lives out of state and works for a communications company. He is almost ten years older than my husband, and he is considered to be the patriarch of the family. I could call him and tell him about my husband.”

"I think it would be a great idea. Would it be OK if I joined your conversation with him when you call him?"

The wife agreed, and the wife, husband's brother, and I had a three-way conversation, again with a speaker phone in the nurse's office, away from the patient. It turned out that the husband's brother actually worked as a Hmong translator and often dealt with medical patients. When the wife and I explained the current situation concerning leg amputation, the brother readily consented to speak with the patient. The brother was an educated man, and readily understood the cultural impasse between the patient's wish to preserve his body intact and the medical need to amputate the diseased limb.

At the appointed time that evening, another conference call was made among the brother, the patient, his wife, and myself. The patient had consented to talking with his elder brother, the patriarch of the family, but stated that he would not change his mind about not having the amputation. The

brother listened to the patient about what was going on, and what was being proposed for treatment of his medical condition. The brother empathized with the patient about his wish to maintain his body intact, and not mutilate it by amputation. He asked the patient, however, what he felt about the diseased, dead tissue of his leg. The patient expressed his loathing about the pain and the ugly appearance of his once healthy leg. The brother wondered whether the patient could really maintain his bodily integrity when that part of the body was no longer really a part of his healthy body. Would the ancestors really want him to join them with the painful, foul-smelling, dead limb? It turned out that one of the patient's unspoken worries was whether he would be able to walk at all when the leg was "cut off". I was able to tell him that from my experience, many people with leg amputations can walk well with prostheses, and that I would arrange for him to

talk with appropriate orthopedic personnel concerning post-amputation care and rehabilitation.

The patient finally decided that he would rather have a healthy body without one leg (the function of which can be substituted with a prosthesis) rather than present his ancestors with a body that has an already-dead limb.

A consulting psychiatrist is ultimately a manager of the interface between the patient as a person with their biological, psychological, and environmental (social, cultural, experiential) components and the health care system (doctors, nurses, administrators; legal, ethical considerations, etc.) A consulting psychiatrist can be aided greatly by a “cultural broker”, someone who is familiar with the culture of the health care system as well as the (sub) cultural influences on specific patients (e.g., indigenous beliefs, practices, etc.) The cultural broker can often bridge the gap.

Chapter 18. Is this Seizure Real or Psychogenic?

A frequent reason given for psychiatric consultation is to determine if an epileptic seizure is “real” or “psychogenic”. Obviously, the implication is that “psychogenic seizures” are “fake, imaginary, hysterical, or feigned,” and thus unreal, with derogatory implications such as the waste of valuable resources in attempting to find a physical cause.

The medical resident’s referral note for the patient, Gwen, was one phrase, “psychogenic seizures”

I decided to call the resident to find out more about what was going on. The medical resident indicated that Gwen was a “frequent flyer” on the unit, that she was repeatedly admitted with seizures, at times classical seizures but much of the time incomplete seizures that were not typical. Electroencephalograms (EEG) were negative. The patient had moved from another state a few years before and no previous medical records were available. Gwen had at least

a dozen admissions to this hospital in the last three years or so for seizures. It was noted that she was already on seizure medications when she came to the current hospital for the first time.

Neurology consultation was equivocal. No significant neurologic deficits were found but some of the seizures described were not incompatible with partial complex seizures and seizure medications were continued.

There was clearly a sense of frustration on the medical resident's part when he recounted the history. "Dr. Lee, aren't psychogenic seizures treatable with psychotherapy or hypnosis?"

In fact, psychotherapy and/or hypnosis can be useful not only in treating "psychogenic" seizures, but also in "real" seizures as well. Before embarking on any psychiatric intervention, however, I had to understand the nature of the condition.

So called hysterical seizures have been described since the time of Hippocrates when hysteria was considered to be caused by a “wandering uterus”. Later, Sigmund Freud attributed hysteria, including hysterical seizures, to repressed sexuality. As may seem clear, hysteria was considered to be a “female” condition, but now we know that significant number of males also have symptoms formerly attributable to hysteria. Be it in males or females, “psychogenic” “hysterical” or more modern terminologies such as “conversion” “somatoform” ”somatization” disorders, including seizures, must have a psychological (“psychogenic”) *reason* or *pathogenetic formulation* to merit such a diagnosis. This is to say that “psychogenic seizure” qualifying for a psychiatric diagnosis is not one of exclusion. The absence of proof of an organic disease does not make a psychiatric diagnosis, there must be proof of a plausible psychiatric diagnosis.

An important objective of my interview with Gwen was to see if I could find proof of a plausible psychiatric diagnosis as well as an absence of proof of a neurological seizure disorder.

When I approached the patient's bed in the semi-private room, what caught my attention was a very large bouquet of beautiful flowers in a vase next to her bed. There was a large photo of a family on the bulletin board next to her bed. There was also a large box of chocolates on her bedside table.

The patient, Gwen, was a 37-year-old attractive woman lying in bed reading a book. She was of average build, neatly dressed, and pleasant in demeanor.

She smiled at me when I introduced myself as a psychiatrist and said, "Yes, they told me you would come to see me. I know they think I am crazy!"

“I am not sure that’s why they asked me to see you. But you do have seizures, and I wonder if there might be some psychological factors contributing to it.” I responded.

“But doctor, of course I am a psychological wreck! Being in and out of the hospital all the time, and the seizures coming at the most inopportune time!”

“Most inopportune time? Could you tell me more about that?”

“Yeah, right now for example. My Mom’s birthday is tomorrow, and I should be there, but I am in the hospital!” said Gwen.

“Well, that puts you in a bind, doesn’t it? You feel you should be at your Mom’s side, but you need to take care of your seizure here in the hospital. A lot of stress it must be!”

“Yes, doctor. In fact, I think stress has something to do with some of my seizures.”

In spite of Freud's original formulation that repressed sexuality underlay certain seizures by converting the psychological conflict into a physical symptom (*conversion disorder*), now we know that *psychological stress in general* is often a precipitating factor not only of the official diagnosis of *Psychogenic Non-Epileptic Seizure (PNES)*[2] but also of many medical conditions such as heart attacks and neurological conditions including seizures. It seemed Gwen had the insight that psychological stress seemed to predispose her to her seizures.

"You say *some* of your seizures – do you mean you have different kinds of seizures?"

"Yes, I think I can tell when stress is causing my seizures, it begins with a knot in the stomach, and then I seem to lose control of my arms and legs that start twitching and

[2] DSM 5 (Diagnostic and Statistical Manual of American Psychiatric Association) – I prefer to use the term *Stress Induced Seizures* or *Conversion Seizures.*

contracting…but usually I am awake. Then at other times, I just feel weird all over, like maybe not myself, and then I just pass out. People say I'd been twitching all over. When I wake up, I feel dazed, confused, you know, like where am I?"

"It does sound like you experience two kinds of seizures, and that you think one kind is related to being psychologically stressed?"

"Yes, that's true. When I begin to feel a knot in my stomach, I know that I'm going to have a seizure, and in a matter of seconds to a minute or so, I begin to feel my arms and legs twitching. But I really don't know when the passing out happens – it comes so quickly after the weird feeling…"

It is not uncommon for patients to have *both* psychologically *and* neurologically determined seizures, especially in patients who already have neurologic seizures

demonstrable by EEG. EEG's show abnormal patterns of spikes with seizures *during* seizures, but the EEG may be completely normal when the patient is not having a seizure. Only a 24-hour video EEG can determine the presence or absence of an electrical seizure activity when the patient is experiencing it. A review of medical records revealed that Gwen had numerous EEGs but never during a seizure. There was no record of a 24-hour video EEG. I discussed this with the consulting neurologist who promptly ordered a 24-hour video EEG.

The findings were unequivocal – Gwen had *both* "electrical" or "neurological" seizures of the temporal lobe variety (partial complex seizures) *and* "stress-induced non-electrical seizures"

A delayed correspondence from an earlier hospitalization in the city Gwen used to live confirmed that electrical seizure activity was observed during a seizure in that hospital at

one time, which further confirmed the presence of *electrical* or "real" seizures.

I called a meeting with the attending neurologist who ordered the 24-hour video EEG and the medical resident who made the referral, and the medical attending on the case. The medical resident who initially asked if Gwen's seizures were "psychogenic" was quite impressed that she actually had *both electrical and non-electrical seizures, both genuine and explainable.* The medicine attending indicated that she had encountered similar patients, and that all patients' experiences of symptoms must be taken seriously. It was agreed that Gwen would be followed by both the medicine and neurology services, and that the seizure medications would be adjusted and controlled by the neurology service. Gwen was to be offered psychiatric follow-up if she wished.

The day after the "definitive diagnosis" of both *electrical and non-electrical seizures,* I spent some time with Gwen

discussing the results. It is of note that Gwen herself volunteered the information that there were two *differently experienced* seizures, one related to stress, the other, not. It was no wonder that she was attuned to such fine distinctions as she was a freelance writer aware of subtle personal bodily and emotional experiences. On further discussion, she revealed that much stress arose from her relationship with her tech worker husband, who seemed over-concerned about her health and insisted on calling the emergency number 911 whenever she had any kind of seizure-like activity. She often felt that she could somehow control her now-named "stress-induced" seizures, but her husband would call 911 in any case, and she would wind up in the hospital, which tended to increase her stress level.

"So, it seems you feel stressed because you are now in the hospital rather than being with your Mom for her birthday?" I inquired.

“Yes, a lot, because I should be there. My brother and I used to be there to celebrate her birthday almost every year until I moved here. I called her on the phone to wish her a happy birthday - she misses me, though she understands.”

“You seem to be close to your Mom?”

It turned out that Gwen had a close but complex relationship with her mother. She felt her mother loved her but was overprotective when she was growing up. Gwen was also often on her toes because her Mom had many ailments including seizures. Seizures! This information was important because family history of the same disease often indicates a genetic component to the illness and/or a subculture concerning illness. Children often learn from their parents and other significant adults about the role of being ill – how one expresses or communicates one’s illness, and in turn, how one is cared for when ill.

Being ill with an established disease such as seizure disorder can be stressful to family members, and by being ill, the family member requires attention and care. This repeated attention and loving care by family members may lead to the unconscious induction of symptoms of the illness when the patient feels, again unconsciously or semi-consciously, in need of attention and loving care. This unconscious and not deliberate induction of symptoms of a physical illness when under stress is a common "psychogenic" cause of physical symptoms without concurrent underlying physical pathology, and if the symptoms are seizures, "psychogenic seizures" without concurrent corresponding changes on EEG. In some families, this learning process, which is an example of *Operant Conditioning* is widespread, so that all the family members *know* how to express stress (or depression/sadness) – by having physical symptoms, e.g.,

headache, stomach upsets, diarrhea, hyperventilation, seizures!

In Gwen's case, it turned out that her Mom probably also had both *electrical* and *non-electrical seizures.* Gwen felt that her Mom got sick with various symptoms including seizures when she was under stress arising especially in her marital relationship. Gwen recalled how her parents would have a fight, and her father would leave the house and her Mom would have seizures, get hospitalized, and her father would become loving and solicitous again.

"Yeah, I guess just like what happens with me – I have a stress-induced seizure and my husband calls 911, I am rushed to the hospital, and I get flowers and sweets! Of course, the stress in my case is usually with my daughters and with work, but that's another story. Anyway, my husband is a dear, loving man, but he is overprotective! He was here during the visiting hours just before you came in."

Two different pathways for management suggest themselves at this point in addition to the neurological management of the "electrical seizures", i.e.,

1. Explore and treat the underlying causes of the *stress-induced seizures* with (time consuming) psychotherapy
2. Use immediate behavioral techniques and medications if needed to treat the *stress-induced seizures*

Or possibly both.

I discussed these options with Gwen, and jointly decided to use Option 2.

During the same session which I extended, I taught her stress-management techniques including self-hypnosis and Mindfulness meditation. These techniques were to be utilized at the first sign of *stress-induced seizures* which often began with a "knot in the stomach."

The next day, I had my final session with Gwen.

“Doctor, I am so glad to see you. It worked! I used self-hypnosis you taught me when I felt a knot in my stomach last evening, and this was just after my husband left after visiting hours, I felt the knot melting away, and no seizures! Afterwards, I did the Mindfulness, and it was really calming. In fact, I did it again this morning.”

“Great! I am glad you were able to prevent and control the seizure, and that Mindfulness is helping you. Have you thought about whether you might want to have psychotherapy as we discussed?”

Gwen decided that she would continue self-hypnosis and Mindfulness for the time being and see if she needed any further help. She also told me that she shared with her husband during his visit that day her feelings of being overprotected with his 911 calls, and he agreed to let her “treat myself with preventive behavioral techniques first” before calling 911.

I gave her the contact information of a psychiatrist colleague in case of need. She was discharged from the hospital that day.

To my knowledge, she has not been referred for psychiatric consultation since.

Chapter 19. The Medical Student with Fear of Blood

The referral note from the University Health was brief:

This 22-year-old medical student is being referred to you for hypnosis treatment for erythrophobia. The patient seems impatient to receive treatment as he will be in clinical rotations soon.

Hypnosis for erythrophobia? Erythrophobia means fear of blushing – what does blushing have to do with clinical rotations? It turned out that "erythrophobia" was a term that the patient had used idiosyncratically to mean fear of blood rather than blushing.

Fear of blood in a medical student who will be inserting needles to and drawing blood from patients? While I had used hypnosis as an adjunct in treating various conditions including phobias, fear of blood in a medical student tweaked my curiosity. From what I could glean from the

records, the patient, Steve, was a first-year medical student who was doing well in his studies but was apprehensive of advancing to clinical years because of his phobia.

Steve was a very clean-cut young man who seemed quite anxious when we met. He said, “Doctor Lee, I am very anxious about my erythrophobia because I’ll be assigned patients in the clinic beginning next month, and I know that I have to draw blood on some of these patients because of the clinic setup. But the thought of being exposed to blood frightens me! I’ve always had this fear of blood. I did some research and found that hypnosis can treat all kinds of phobias, and that you are one of the few people in this medical center who does hypnosis. Could we get started today?”

“Well, Steve, hypnosis is certainly possible, but let’s get acquainted first. So, you had this ‘erythrophobia’ for a long time?”

It is important to obtain a comprehensive history of any patient, even if the patient is interested in a particular procedure, such as hypnosis. I learned this the hard way (See “When I visit my own grave” chapter 16). Though Steve was very eager to cut to the chase, I obtained a rather detailed history of his “erythrophobia”.

Steve was the son of a distinguished cardiologist in a nearby city, and it was expected that he would become a cardiologist like his father and eventually take over the practice. So, from ever since he could remember, he was studying to be a doctor. When he was in the fifth grade in the private school for talented students, the biology class had a lab in which frogs were dissected to study the circulatory system among others. At the sight of blood during the dissection, Steve felt light-headed and had to excuse himself from the session. Ever since, he found excuses not to attend lab sessions where dissections were scheduled.

As Steve was an exceptionally bright and talented student who excelled in all subjects, his non-attendance of some lab sessions did not impair his obtaining the highest grades in all schools including high school and college. In addition to academics, he also excelled in tennis and musical instruments, being excellent both in piano and violin. He had no difficulty in being accepted to all the medical schools to which he applied and chose this medical school because it was his Dad's alma mater, and also because of its reputation for a culture that valued liberal arts as well as science.

"So, it seems you are a young man of many talents! You could have chosen almost any career you wanted, including in the liberal and performing arts?"

"Yes, but I always knew that I would be a doctor, a cardiologist like my Dad. I really love medicine, the idea of curing disease and helping people! Can we begin hypnosis soon?"

“As we discussed, we need to complete an evaluation first. Concerning your fear of blood, it seems like you have been able to complete all the pre-med courses including labs with flying colors! Why is it becoming such a problem now?”

“I have been able to avoid being exposed to blood by skipping labs with excuses for another important activity or faking participation when actually I had a classmate do most of the dissecting or other blood work. But I’ll be actually working in a clinic and lab next month, and actually drawing blood and dealing with blood specimens! I need help!”

I agreed to begin evaluation for hypnosis the following week provided I obtained further background information:

Steve’s father was a cardiologist in his late fifties who had a very busy solo practice. Steve’s mother was a social worker with a counselling practice. Steve had a younger

sister who was in pre-med program at a prestigious University. Steve had a few girlfriends in the past and is now in a rather serious relationship with a girlfriend who was in another medical school out of town. They got together whenever they could, perhaps every several months. They communicated frequently. Steve spent his leisure time playing his musical instruments, particularly violin, which he loved. But he had very little free time and it was going to get even scarcer with clinical rotations. He said, wistfully, that at one time, he thought of being a musician, but he knew that he had to become a doctor, just like his father, with whom he hoped to work eventually. Music, after all, was for his own pleasure, while medicine was a noble calling.

“But if you had to, it seems you would not be too unhappy being a musician?”

“No, in fact, I have a standing invitation from Julliard with scholarship if I wanted it. But no, I really want to be a doctor, a cardiologist like my father and save lives!”

I determined that it would be important to support Steve’s wish to overcome his “erythrophobia”, in his case, fear of blood, rather than the common usage “fear of blushing”. It seemed strange that a medical student who looked up many medical terms, and was obviously very knowledgeable, would misuse the term. I scheduled a session for hypnosis for the following week.

“Steve, we will try hypnosis and self-hypnosis for your fear of blood next session. However, it is important that we have follow-up sessions for reinforcement, as well as a certain amount of psychotherapy as needed.’

Steve readily agreed to having weekly sessions after the hypnosis session. I thought that Steve’s fear of blood was not a simple phobia but was a result of psychological

conflicts which were just under the surface, which might be amenable to relatively brief psychotherapy.

The hypnotic session went well – Steve was moderately hypnotizable and was able to use imagery for relaxation and mastery of fear. For subsequent weeks, I assigned homework such as peeling a blood orange, withdrawing the juice with a syringe, and going to the ER and observing some injuries that came in. Steve was able to perform these well and seemed ready for the "real deal".

One week after Steve's actual work at the clinic including blood drawing, he was rather subdued during the session. "Yeah, I did use self-hypnosis and relaxation, detached myself from what I was doing-drawing blood, didn't faint or anything. They said I did a fine job. Seemed to like my work with the primary care patients."

I made a note, however, that maybe hypnosis was not quite what Steve expected it to be, a magical solution to his problem.

In subsequent weeks, Steve confided in me that he really did not like his clinical work with patients. While patients themselves were interesting, he was bored with the routine part of medical workup, and especially with the paperwork. He was also anxious about his performance, and fearful that his patients might get worse.

“Steve, it sounds like you have some doubts about clinical medicine?”

“Yes, Dr. Lee, I was wondering if clinical medicine is exactly right for me…”

“Well, anything else that attracts you?”

“Music, of course. When I am playing the violin or the piano, I lose myself – I get so absorbed that there is nothing

but music! I do not feel the same kind of passion with medicine."

"But it seemed you were determined to be a cardiologist, like your father!"

"Yes, I thought so. It was a given in my family that I would be a cardiologist, join my father's practice, and eventually inherit it and make it even more distinguished and prosperous! I was the heir designate, and obviously I had the brains to do it."

"Did you say you have a sister who is pre-med?"

"Yes, Leslie, my sister is three years younger than me. I always thought she might want to be a psychiatrist, but I am not sure. She is almost as smart as I am."

At this point, I considered calling a family meeting with Steve's consent, either in person or on a conference call. I could, then, let Steve express his ambivalence about his career choice, and help the family discuss their feelings and

options. However, I decided to encourage Steve to take the initiative in speaking with his family privately as I felt it was important for him to be the active mover in solving his problem.

"Does anyone in your family know that you have some ambivalent feelings about medicine? Is there anyone with whom you feel comfortable talking about it?"

"No, I have never told anyone in the family that I have any doubts about my trajectory – become a cardiologist and join Dad. I could talk with my Mom, who is into counselling as you know, a social worker. She is usually supportive of me whatever I do."

We agreed that Steve might talk with his mother about his ambivalence about medicine, but that he would continue with his clinical rotation with good cheer and continue sessions with me.

Steve and I explored his “erythrophobia” further. Surprisingly, he had simply made up the term “erythrophobia” for his fear of erythrocytes, red blood cells, as the term seemed to make sense. He had never even looked up the term in the dictionary to see if it had another meaning. This might be an indication of his self-confidence, or possibly creativity. Many made-up words wind up being widely accepted, including “OK or Okay”. It also turned out that Steve was so successful in avoiding the sight of blood up to the medical school that the one-time exposure to blood in his fifth grade caused the fear of the *idea* of exposure to blood and, in fact, fortified with hypnotic relaxation, he was able to tolerate his actual exposure to human blood in his rotation without much anxiety.

Several weeks later, Steve reported to me during our session that he had talked with his mother, who was surprised that he had doubts about his career choice to be a

doctor but was understanding of his love of music. She offered to talk with his father with Steve's consent. The father was, according to Mom, quite upset, but was able to understand his son's wish to be a musician rather than a doctor.

As it turned out, the father had also considered a career in music as he was an avid guitar player in his youth, but as he grew up during the Great Depression, his desire to be financially independent was paramount, thus he chose medicine. In a way, he felt envious of Steve, who had the talent and the means to aspire to be a successful musician. Of course, he would help in any way he can toward that goal!

Leslie, the sister, was also contacted by Steve's parents, and as it happened, Leslie was very interested in potentially becoming a cardiologist and working with her father.

Steve decided to take a leave of absence from medical school the following year and explore a career in music. He could return to medical school without any problems should he decide to do so. With this decision, we terminated the regular therapy sessions.

A number of years later, I received a letter:

Dear Dr. Lee,

You may be surprised to hear from an ex-patient after such a long time, but I wanted to let you know that I graduated from Julliard with a master's degree and now I am beginning my first national tour with my violin (Wish me luck!). I still do use the hypnotic relaxation techniques you taught me whenever I need. My sister, Leslie, is now a resident in Cardiology at Mass General and hopes to join my Dad's practice when she finishes.

I just want to let you know that our work together gave me the insight that my problem was not just “erythrophobia” but my career choice, between what I was expected to do and what I wanted to do. Hypnosis certainly helped, but your guidance was priceless!

Wishing you joy!

Steve

Chapter 20. John, the Rifle Man -How genes, early environment, and experience through life stages affect mental health and illness

This chapter is presented as a lecture for an educated lay audience.

Greetings,

The Case of John, the Paranoid Rifle Man, was presented to me during one of my teaching rounds:

John was a 41-year-old man was brought to the hospital by the police in handcuffs. He had been pointing an assault-weapon style rifle out his second story apartment window. The emergency call was made by his father with whom he lives. The patient, was apparently hallucinating – muttering about people following him, and threatening to kill him.

At this point, what questions would you ask?

I then ask my trainees to fill in the blanks, “Major psychiatric disorders are by and large ( ) and ( ). What would you answer?

Of course, there are not just two but many correct answers, but what I have in mind are “familial” and “chronic.” A third important answer is “stress related.”

What does familial mean? It means that there is most likely genetic and/or memetic contribution to the illness. By memetic, I mean *absorbed information* in general, including unconscious imitation, the way distress is expressed in the early environment of the patient, for example, did mom or dad complain of pain such as headaches or stomach aches when under stress? Did they habitually use alcohol or other substances to alleviate anxiety? And, of course, genes as possibly manifested by family history of major mental illness such as schizophrenia and bipolar disorder.

“Chronic” means that major psychiatric disorders tend to manifest in relatively young age – in their teens or twenties if not younger. Thus, asking about when it first began – the onset of the symptoms is important.

Now, let’s consider John. His family history was negative for major psychiatric disorders such as schizophrenia, but both his parents were heavy users of alcohol and were engaged in frequent fights. John had an older brother who

habitually used alcohol and marijuana. Thus, there is reason to suspect that there may be genetic and memetic, i.e., familial cultural, predisposition for alcohol and substance use. John was using alcohol and had started using methamphetamine around age 16 and has continued to use it though not enough to have been incarcerated. John did have a DUI arrest several times beginning with late teens, and alcohol withdrawal seizure twice. Since the last seizure about fifteen years ago, he confined his drinking to three beers and two shots of tequila a day and has been seizure free since. So, there seems to be a relatively early onset of alcohol use, and at around age 16, of methamphetamine use. According to his father, the patient had been drinking more and using methamphetamine more heavily in the last month.

At this point, what questions come to mind?

Of course, what's been happening during last month, September, when his substance use increased. Also, what was happening around age 16 when John was using both alcohol and methamphetamine? The patient is living with his father at age 41? Why?

But before we continue on this case, we will consider the general development of mental health or illness to adulthood.

The state of a person's mental health or illness is largely determined on foundations built in early stages of human life largely prior to adulthood.

Some degrees of anxiety, depression, and flight from reality in the form of depersonalization and derealization are normal and adaptive human experiences.

Imagine a child, let's say a girl, with genetic mutations such that she has no anxiety at all.

What would become of her? Without anxiety, she might have no fear of jumping from a high place or rushing into oncoming traffic – life itself would be threatened!

If you had no anxiety at all, would you have achieved your current station in life?

In certain extreme human conditions, psychotic experiences such as hallucinations and delusions may be adaptive.

What we call mental illnesses or psychiatric syndromes, such as Anxiety Disorders, Bipolar and Unipolar

depression, Substance Use Disorders, Psychotic disorders including Schizophrenia, PTSD and Personality Disorders, among others, are all extremes of normal experiences the susceptibility of which is determined by a person's genetic constitution and how it has interacted with environment.

There is recognition in the psychiatric literature that the model for psychiatric disorder is shifting from a paradigm of silos of risk factors for specific psychiatric disorders such as schizophrenia or bipolar disorder to a model of many common risk factors such as genes and their epigenetic changes interacting in a pluripotential brain especially in the early stages of development. The result may be symptoms of differing severities or no symptoms at all due to protective factors. (Arango 2019)

This lecture emphasizes the role of epigenetics – the interaction of genes with environment which may result in turning on or off of the genes. Fine brain connections and thus structure is constantly modified by information - which I call memes[3] – replicating bits of information, which can be stored in many containers including books,

[3] Richard Dawkins coined the term *meme* in his book, *The Selfish Gene.* For more discussion of memes in psychiatry, see *Leigh H: Genes, Memes, Culture and Mental Illness: An Integrative Approach, Springer, 2010.*

electronic media, and the brain. The memes may enter the brain from the outside or arise from within the brain as in "insight", may influence the environment and enter other brains, which in turn may be modified by the receiving individual's already existing memes. Thus, I hope that the memes or information contained in this lecture will enter your brains and replicate and change your brain to be more enlightened than before the experiencing of this lecture.

It is of note that our brains interact with culture through the exchange and processing of memes contained in various media, e.g., lectures, books, and through activities such as political movements as well as expressive art such as literature, music, painting. For example, what memes does Picasso's painting, Guernica, elicit in our brains? Probably of a sense of terror as expressed in the cubist faces in the painting, leading to an abhorrence of war in the informed brain that connects the painting to the Nazi Garman planes bombing the city of Guernica during the Spanish Civil War.

Stress showers the brain with memes (information) that interact with genes and pre-existing memes in either strengthening the individual to heroism, or to give in to post-traumatic stress disorder or PTSD. The outcome

would be the result of the interaction among genetic influences, influences of existing memes or information, representing the memories of past experiences with stressful events and whether they made the person stronger or weaker. At any given moment, a person is the sum of interactions among their genes and the memories (memes) of their experiences, both in interaction with their social and physical environment.

So, let's begin from the beginning. When does the life of a person begin?

One might say that the precursors of the seeds of a life began long before a person is formed, in the form of a pool of DNA's of the gonads (ovaries and testicles) of the parents of the person-to-be. A human cell contains 46 strands of chromosome, the thread made of DNA's. In the gonads, cells undergo divisions such that each sperm or egg contains 23, exactly one half of the parental chromosomes. The DNA's contained within each of the egg or sperm are subject to influence by the internal environment of the parents' bodies, which are, in turn, influenced by such factors as available nutrition, stress levels, and physical

environment such as temperature and presence or absence of infectious organisms and toxins.

I would divide a life's journey in the following stages:

1. Pre-Person Events including fertilization, intrauterine development of fetus,
2. Birth and beginnings of personhood,
3. Childhood, subdivided into a. Infancy and Early Childhood, b. Middle Childhood,
4. Adolescence,
5. Adulthood, subdivided into a. Early Adulthood, b. Middle Adulthood, c. Late Adulthood and Old Age, and Death.

We will discuss each stage of this journey:

1. Pre-Person Events:

a. Conception

Following ejaculation into the vagina, a lucky (or heroic) sperm with a random mixture of half of father's genes, among millions of fellow sperms, outruns the others up the Fallopian tube, meets and penetrates the egg, which contains a random mixture of half of mother's genes. Now the egg has the full complement of 46 chromosomes containing a mixture of half of father's and mother's genes. The egg is fertilized! Next, the fertilized egg flows

down the tube and becomes implanted in the soft inside lining of the uterus, the endometrium. Conception has occurred.

b. Sex Determination

Among the total 46 human chromosomes is a pair of sex chromosomes, X and Y. X and Y are different in size; X, the female chromosome, is lager in size, and Y, the male chromosome, is much smaller. Females have two X chromosomes, i.e., XX, while males have one X and one Y chromosome, i.e., XY. When the reproductive cell divides into eggs or sperms, the sex chromosome pair separates. Thus, the female's XX divides into two eggs both containing one X chromosome. The male XY divides into one sperm containing the X and the other, containing the Y. Thus, all eggs have an X chromosome, and about half of the sperms have an Y chromosome while the other half, an X chromosome. Thus, depending on whether the lucky sperm carries an X or a Y chromosome, the egg that already contains X would become XX (female) or XY (male). Half of all individual's genes come from the father' sperm and depending on whether that sperm contained X or Y chromosome, the individual's sex would be female or male. The mitochondrial DNA, on

the other hand, are all from the mother as the egg always contains maternal cytoplasm.

The Y chromosome is responsible for determining the morphological development of the fetus into a male, in the absence of Y, X chromosome determines the development into a female.

In the case of our patient, John the Rifle Man, the one sperm which outran all the other thousands of sperms and was victorious in penetrating the egg to fertilize it happened to carry his father's Y rather than X chromosome and thus made him a male. The other thousands of sperms, each carrying an X or Y chromosome, lost the race to enter the egg would be left to die. Had an X chromosome carrying sperm had been victorious and the fertilized egg eventually grew up to be Joan, would she be in the hospital now?

c. Implantation and Pregnancy

After conception, i.e., after the fertilized egg digs itself into the soft endometrium of the uterus (womb), it has to secure feeding and breathing (Oxygen!) source – from what else but the blood within the uterus? But when exposed to the blood from the mother, the egg could be discovered by the mother's immune system as a foreign body and be killed. Evolution naturally provided the egg with a barrier that sucks oxygen and nutrients from the blood of the mother without causing an immunologic attack – the placenta.

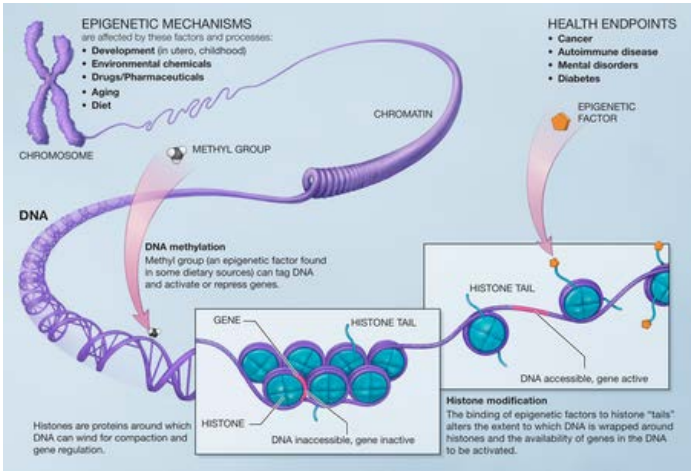
During early pregnancy, fetal organs appear and develop in an unfolding manner based on the schematics of the genes, but which genes get turned on or off (Epigenetics) is largely influenced by the intrauterine environment – oxygen, nutrients, and invasion by foreign bodies to mother and possibly to the fetus (e.g., German Measles). Fetal endocrine organs including the gonads also play a role in this process by secreting hormones, including sex hormones.

Genes are turned on or off through chemical changes in the DNA, for example, methylation, or by cutting access

to the gene through mechanical barriers such as molecules of the chemical, histone, surrounding the DNA.

Mechanisms of genes being turned off or on include **methylation and histone wrapping of the gene (DNA)**

Through such changes in the genetic makeup of



brain cells, the brain may become more or less susceptible to later responses to stress and environmental factors, determining the susceptibility to anxiety, depression, dissociation, reality-testing, as well as attention.

In John's case, we do not have exact information concerning any intrauterine stressors, although we found, later on, that John's mother was a moderate drinker and was consuming alcohol during her pregnancy with John. Fetal alcohol syndrome can cause problems in learning,

social relationships, and aggression. John, however, did not have the facial features of severe fetal alcohol syndrome.

2. Birth and the Beginnings of Personhood

The Birthing Process

Some psychoanalysts such as Otto Rank posited that the human birthing process through which a fetus becomes a baby is the first TRAUMATIC experience that may contribute to mental illness. The fetus is involuntarily forced (literally, squeezed) to pass through a dark and narrow canal to be dropped into a gigantic, cold, and unfamiliar, real world!

Whether it results in mental illness or not, the birthing process is certainly a great environmental change experience for the fetus, a shocking change from the comfort of the warm, familiar, secure environment of the womb where everything was provided. No wonder the baby starts to cry!

Change in Demand in Changed Environment after Birth

The baby is now forced to move their chest and abdominal muscles to breathe the cold and smelly (what is this sensation that I never had in the womb?) AIR to get measly amounts of oxygen. Then the baby must use their MOUTH. What is this thing they are sticking into my mouth? I have to open it to suck on this soft thing to get nutrients called MILK? I never had to EAT or DRINK in the womb, whatever I needed was just there! And I have to PEE and POOP? I never used these parts of the body before.

Epigenetic Changes occur with Birth

The genes of the baby-to-be first underwent epigenetic changes while in the womb depending on the womb's environment – nutritional and oxygen levels, sounds, pressure, potentially toxic substances including drugs and alcohol, foreign body invasions (infections), and illness or health of the mother. Now with the stress of the birthing process and neonatal environment, major epigenetic changes are superimposed on the genes in the brain cells which may lead to changes in the volume of specific areas

of the brain such as the hippocampus and amygdala, structures concerned with fear, relaxation, stress sensitivity, resilience, withdrawal, and exploratory drive. These are the paths for potential emotional dysregulation at the brain level for such disorders as anxiety and depression.

In the case of the Paranoid Rifle Man, John, there were no gross abnormalities on head X-ray, but a more precise imaging, such as an MRI, was not done.

3. Childhood

Having endured the universal stress of the birthing process, the newborn begins their journey of personal development. Biological development is an unfolding process of the genetic information contained in the DNA which occurs in interaction with the microenvironment of the cells. The microenvironment of the cells is in turn influenced by the macroenvironment of the organism, human body and its brain, the command center. The macroenvironment contains both social interactions with other human beings which includes information transfer and learning (that changes the brain) as well as the physical environment such as environmental toxins and weather.

Human development occurs as an interaction among the biological development initiated by genetic unfolding, including changes in weight, height, and brain maturation, and psychological (memetic) development influenced by social interaction, expectations, and learning.

A widely used model of human development is **Erik Erikson' Eight Stages of Human Development** (1959). This model posits specific psychosocial tasks to be mastered in each stage, the failure of which resulting in distress and dysfunction.

> The stages and the psychosocial tasks to be mastered versus the consequences of failure are:

Stage 1. infancy, Trust versus Mistrust.

Stage 2. toddlerhood, Autonomy versus Shame and Doubt

Stage 3. preschool years, Initiative versus Guilt

Stage 4. early school years, Industry versus Inferiority

Stage 5. Adolescence, Identity versus Identity confusion

Stage 6. young adulthood, Intimacy versus Isolation

Stage 7. middle adulthood, Generativity versus Stagnation

Stage 8. late adulthood, Integrity versus Despair

1) Early Childhood (Infancy, Toddlerhood, Pre-school years)

In this talk, I'll lump infancy, toddlerhood, and pre-school years as early childhood.

During this period, in Eriksonian terms, the child has to learn to trust, develop a sense of autonomy (e.g., bladder & bowel control), initiative (exploration, 'can do' feeling). Failing these, the person develops a sense of mistrust , shame and doubt, and guilt feelings.

What in the brain underlies personal development?

The brain grows in size through childhood caused by the growth of the neurons as well as of the supporting glial cells. While *some neurogenesis occurs after birth, much of the growth occurs through the growth of neuronal connections and their intensification through use.* This process may be shaped through new connections and elimination of old, no longer useful connections as will be discussed next. Thus, the process of personal development through learning, an interaction with the environment in the form of influx of information, reward and punishment,

would be a reflection of changes in the brain and neural connections.

A major mechanism of learning that results in brain changes is **synaptic pruning**, a process of shedding synaptic connections of neurons that occurs from around the time of birth, peaking around age 2 to 10, but continuing through adolescence and late 20's. By age 10 or so, about 50% of the neural synapses have been pruned. The process of pruning is influenced by genetic expressions as well as through the learning process of "use it or lose it." In schizophrenic brains, there may be an abnormal increase in the pruning process and consequent reduction in neural connections while in autism there may be a reduction in the pruning process and thus an abnormally large number of synapses.

The pruning that occurs later up to age 20's seems to be more concentrated in the prefrontal lobes of the brain, perhaps facilitating the higher cortical function such as decision making. Synaptic pruning is clearly a process determined by genetic, epigenetic, and personal psychological factors (pleasure, pain, fear, anticipation) that are in turn determined by environmental and biological

factors. For example, consider a 2–4-year-old child, in the peak of pruning process, was neglected and often punished, which enhanced neural transmission of stimuli to the amygdalae and caused their hypertrophy and enhanced fear/anxiety response, and at the same time resulted in the pruning of unused synapses that would have resulted in pleasure in nucleus accombens. The child would thus have developed a biological neural structure susceptible to *chronic anxiety and depression*, among other psychiatric syndromes, in adolescence and adulthood. Others would include, again among others, PTSD and Substance Use Disorder.

In our patient, John's case, considering heavy parental drug use and frequent fights, it is likely that there was neglect and possible abuse resulting in John's proneness for anxiety and depression as well as problems in attention and learning in later life.

A. Role of Parental Figures and Education

The enhancement or reduction in neural connections of specific brain areas will result in differences in cognitive ability and emotional experience and expression, which are at the same time also influenced by the child's immediate

physical and social environment, mainly comprising of parents, siblings and peers, and teachers and the educational system. You deal with the demands of the present with the equipment you got! And with experience, you learn!

Learning occurs mostly through *conditioning, and imitation.* There are two types of conditioning, Classical conditioning, otherwise known as Pavlovian, and Operant conditioning, otherwise known as Skinnerian conditioning. Pavlovian conditioning occurs when there is a repeated close temporal association between two stimuli. If you ring a bell at the same time, you give food to a dog, eventually the dog will salivate at the sound of a bell even when no food is presented. Repeated exposure to witnessing adults fighting when going through a particular street may cause fear response to a child when crossing that street. This type of conditioning is automatic. *In John's case, it turned out that his parents fought with each other mostly at dinner time, which made him hate, or he learned to have anxiety and fear associated with being with his parents at dinner time.*

Operant or Skinnerian Conditioning is based on reward or punishment after a behavior has occurred. For example, a dog retrieves a ball and brings it to the owner and gets a treat for reward. A student gets detention at school after bullying another student. *With operant conditioning, behaviors can be shaped by rewarding a progression of more complex desired behaviors, for example, an elephant is taught to dance.* Operant conditioning shapes speech, what to say, how to say it. How certain words/babble are received- a smile or a frown?

In John's case, he was punished often in school for his disruptive behavior, which may have been an early symptom of Attention Deficit Disorder, for which maternal alcohol and drug consumption might have been a factor. Because of ADHD, however, he may not have been successfully conditioned not to be disruptive, especially if he had not been rewarded for being not disruptive (which was rare), and for academic achievements, which were also rare. The lack of reward or reinforcement may have led to low self-esteem and tendency for depression, also contributed by his underlying tendency for anxiety and attention deficit.

Another important phenomenon for humans and humanoids is *imitation*. A behavior that seems beneficial may be imitated by the observer, e.g., a chimp learning to use a rock to crack open a nut through observation.

Even when no immediate benefit is apparent, imitation of persons in close proximity comes naturally. A child often imitates and therefore acquires the mannerisms as well as their "way of doing things" from parental figures and teachers. Modes of emotional expression may also be imitated. For example, how is affection expressed? Through physical contact, such as embracing and kissing? By texting? How is aggression expressed? By physical fighting ? By "silent treatment?"

In John's case, there did not seem to have been much expression of affection by parents, and they expressed aggression by fighting, both physically and verbally. The parents seemed to have resorted to alcohol when feeling stressed, dysphoric, which may have been imitated by John.

Related to imitation is *information (or meme) transfer*. Through language development new methods of cracking nuts or cans can be transferred from one individual to others through word of mouth, and with written language

and pictorial representation, they can be preserved and transferred to other humans in distant lands and distant times. Written language is a means of telepathy – evoking both emotions and knowledge across the expanse of space and time. A child who is encouraged to read, has access to books and reads widely has a brain that has potentially absorbed a huge amount of accumulated knowledge and empathy with a variety of hues and colors of human emotions.

B. Race/Nationality/Ethnicity, Cultural Memes, Socioeconomic Class

A child grows up in the context of relationships formed with parents, family, friends, and the media which exist in interaction with the culture or meme pool determined by nationality, ethnicity, and race to varying degrees. Socioeconomic class has a universal effect in influencing the limits of exposure to enrichment in the child's physical and informational (memetic) milieu.

A child thus absorbs the norms of behavior and emotional expression, speech, and preference for food, clothing, entertainment, and arts, including types of music, etc. of their subculture.

Did the child grow up with parents shouting at each other all the time, and streets with loud noises and even the sound of gunfire? Or in a quiet suburb where the parents listened to classical music and took the child to art museums?

Information availability both in and outside of school environment plays a crucial role in a child's intellectual and emotional development. The availability of the *internet*, the modern source of practically all information available to humans, is often determined by socioeconomic class.

The child is exposed to pools of bits of information of all sorts of varying veracity and often quite false or misleading. Developing the skill of **reasoning and critical thinking** is an absolute necessity to successfully navigate such meme pools. While the school system should provide standardized curriculum in critical thinking, parents play an important role. Can the child observe that the parents are using reason in evaluating the news? Does the mother explain why something is believable and another is not, and why some things advertised in the media are good, and others not? Do the parents seek information from a reliable source such as an encyclopedia or dictionary? Does the

family belong to a fanatical religious sect that does not "believe in" science?

The *critical thinking and reasoning "muscles"* a child develops from childhood will determine the degree of resistance or susceptibility to fads, disinformation, and delusions. Without the tools to recognize facts and falsehoods, the child may grow up to be more and more confused in the ocean of surrounding memes, which may cause extreme stress and precipitate mental illness. Alternatively, they may be "brainwashed" to join cults or delusional, fanatical, violent sects.

After being ejected from the comfort of the womb, the infant feels either secure and develops a sense of trust or fails to do so, then in toddlerhood or the Freudian Oedipal Stage of age three to six or so, as the child starts to explore and feel competitive with parents, with encouragement and support, they will develop Eriksonian initiative, or guilt in a punitive environment. A lack of the sense of trust of others and pervasive sense of guilt is likely to lead to vulnerability to later stress resulting in anxiety and depression.

There is not much we can do to ameliorate the "trauma" of the birthing process, but in early childhood, there is much we can do to reduce the risk factors that cut across different

disorders. Reducing child abuse and bullying is likely to reduce the incidence or severity of mental disorders

Now, how about our patient, John the Paranoid Rifle Man? We know that his parents frequently fought at dinner time. John was disruptive in school and often punished and seldom rewarded . How about at home? We learn that John's parents seldom reasoned with John but set strict rules, such as being there for dinner every day. Why? Because I told you so. The father would threaten John with a slap in the face or by being thrown out into the streets. John's family's ethnicity was Mexican Hispanic. His father was an immigrant, mother was native born in the U.S. They were both Catholic, but early in their marriage, they converted into an evangelical Christian sect which had many prohibitions including alcohol. Nevertheless, the parents drank tequila to relieve tension, but drinking may have contributed to their frequent arguments and fights. John's family was lower middle class - John's father worked as a guard in a construction firm, and his mother worked in a supermarket. John felt closer to his mom, who seemed to understand his learning disability, and cut him some slack, John felt angry at his father for being "dictatorial", unreasonable, and violent. It is clear that John had major problems with his "Oedipal phase" or "

Stage of Initiative vs. Guilt" during which John would have exercised initiative and do new things and feel competitive with father. The "dictatorial" father slapped down John's competitiveness and/or initiative, so that John kept on feeling rebellious and angry toward his father, with attendant guilt feelings and low self-esteem.

They did not attend church regularly; the only times he went he was rather horrified by the attendees having what seemed to be convulsions and speaking in "tongue" during service. His mother had frequent meetings with other members of the sect, which seemed to have believed in many conspiracy theories, including being persecuted by certain unknown groups. The only books available at home were pamphlets left by mom's friend churchgoers, which John was encouraged to read but did NOT read. John had access to very few outside books other than school textbooks, which he seldom studied. It seems clear that home was not a place where John was encouraged to read widely, absorb human knowledge or to empathize with other human beings, real or fictional, across time and space. Home was not where John could develop rational and critical thinking to be able to distinguish reality from delusions such as conspiracy theories not founded on facts.

Considering John's already present symptoms of ADHD, it is no wonder that he was not learning much in school, was disruptive, and, ostracized, feeling despondent and depressed. John was also bullied in school, Hispanics were a minority in the school, and John was not very strong or athletic. John hated going to school, which did not help with his learning the basic skills for future development.

2) Middle Childhood – the School Years

The period between the Freudian Oedipal period and the onset of puberty, the Freudian latency period, represents the Eriksonian stage of industry vs. inferiority.

This is a period of learning, learning of basic interpersonal skills such as social interactions, cooperation, "just getting along", competition, conflict resolution, etc. The skills also include internal psychological ones, including analyzing, planning, delayed gratification, and "letting go", and emotional ones, such as how to become "hepped up", to relax, what to do when feeling sad, how to express anger constructively, how to enjoy pleasure. This is a period when serious academic learning or infusion of memes (information) into the brain begins, with increasing formal competition with peers for better grades, etc., leading to

better opportunities for better colleges, etc. Pride in accomplishments and feelings of inferiority and low self-esteem in failures enter into the formation of personality and identity in the next stage of adolescence.

How do the parents and/or the school encourage fair competition? Is defeat or failure in an exam treated as humiliation or an opportunity to learn? To what type of social group or clique does the child belong? Is the child afraid of social interaction? Isolated? Are there gangs?Is there exposure to drugs and drug culture?

Has the child been abused or traumatized psychologically, physically, and/or sexually by anyone including parents, relatives, peers, or strangers? Were the traumas discovered? Has there been support, evaluation and treatment of the effects of the trauma(s) or were they ignored or neglected?

Childhood Traumas and Primary Prevention of Mental Illness.

Many mental disorders including anxiety, depression, bipolar disorder, and schizophrenia have been shown to share common genetic and experiential risk factors such as bullying or child abuse. (Arango 2019, Cross-Disorder

Group, 2013, Brain Consortium et al 2018, Teicher 2013). Childhood abuse and trauma are also strong risk factors of Borderline Personality disorder.

Bullying is associated with severe symptoms of mental health problems, including self-harm and suicidality. Bullying was shown to have detrimental effects that persist into late adolescence and contribute independently to mental health problems.

For our patient John, the downward spiral continued through middle childhood. He continued to be bullied in school and absorbed very little skills in either home or school. He did poorly academically, and learned few social skills, being isolated much of the time. At home, the role models for any disagreement were loud arguments and physical violence and alcohol use. John's middle childhood only contributed further to his feelings of inferiority and despair, and he secretly started using alcohol which tended to ameliorate some of his anxiety and depression.

3) Adolescence

There are certain periods in one's life when major changes in outlook, attitudes to life and lifestyle, and relationships are possible (mutagenic periods). These periods include 1. Early childhood, 2. Adolescence, 3. Marriage and/or Birth of a Child, 3. Bereavement, 4. Retirement.

Among these periods, Adolescence is perhaps the most dramatic and often involves the development, preoccupation with, and fluxes and changes in body image, sexuality, sense of self, core beliefs, and career choice, among others.

Adolescence is initiated by a genetic unfolding process of puberty determined by the sex chromosomes. The appearance of secondary sex characteristics actually brings on changes in the physical appearance. With increasing physiologically determined sexual drive, romantic and sexual attraction and activity with others affect the person's sense of self, sexual identity, self-esteem, and expectations concerning others including attractiveness, self-confidence, assertiveness, or their opposites. Sexual identity may be questioned, experimented, and then firmed up, e.g., straight, gay, bi, cis, trans, etc.

With maturing brain, the adolescent may experiment with different political or religious ideologies and romantic partners. Sudden changes to previously held beliefs may occur, including frank rejection and adoption of new beliefs or ideologies. Previously held ideas about future careers may change, e.g., from wanting to be a fire person to wanting to be a climate change activist.

In Eriksonian terms, a sense of stable identity may emerge, and the turmoil would subside, or a failure may lead to identity confusion, leading to continuing insecurity and turmoil into adulthood.

The role of available information or meme pools in the environment – family, school, peers, organizations, media, and especially social media, fads, and prevailing youth culture – is of utmost importance in this process of identity formation and re-formation. Availability of recreational substances may play a major role in influencing and potentially inhibiting or altering the brain – meme interaction, i.e., how absorbed information is processed by synaptic changes – enhancement, pruning, etc.

To many adolescents, schools may provide a supportive environment for socialization and learning, but some adolescents may experience bullying which may have

serious consequences. In a recent Swedish study of all school age children ages 11 to 15, having been bullied was significantly associated with detriment in mental health, i.e., mental health problems were four times higher among boys who had been bullied compared to those not bullied. The corresponding figure for girls was 2.4 times higher (Kallman & Hallgren, 2021).

A stable sense of self identity formed during adolescence in spheres such as sexual, cultural, political and ideological, would lead to stable romantic and social relationships, a reasoned career path, and mental health.

Adolescence is also a period during which the unfolding of epigenetically determined risk genes may find phenotypic expression in interaction with permissive environment. For example, substances such as methamphetamine are known to cause paranoia with prolonged use even in normal people. Cannabis is known to precipitate psychosis in susceptible individuals. If an adolescent with risk genes for psychosis uses both substances, of course, the adolescent is likely to exhibit symptoms of psychosis, which may then be diagnosed as, depending on the phenomenology of the

symptoms and family history, drug induced psychosis, schizophrenia, or bipolar disorder.

Even without the risk genes, an unresolved sense of identity in adolescence may lead to future instability and diagnoses such as anxiety, depression, borderline personality, PTSD, and substance use disorders.

In John's case, it was reported that he was using alcohol in his teens and started using methamphetamine around age 16, at the height of adolescence. It was noted that being a shy loner, John felt unattractive and had very few dates with girls. He felt insecure in his sexuality. On further inquiry, it turned out that John's mother became ill with cancer of the uterus when John was around age 15 but had not sought medical help because she was suspicious of doctors, a belief fueled by John's parents' conspiracy-minded religious sect. It was only when she was terminally ill that she sought help, too late. She died in September, five days before John's 16th birthday John lost the only parent to whom he felt some love. After his wife died, the father drank more and became more abusive. John and his brother did the housekeeping for the household, and both indulged in methamphetamine heavily. Clearly, John's

adolescence was characterized by social isolation, stress of mother's illness and death, identity confusion, and substances known to contribute to emergence of psychotic symptoms. Indeed, John seemed to have developed increasing irritability and social isolation. He skipped school often, and when he did attend, he had more frequent bullying and fights. He dropped out at 11th grade.

After dropping out of school, he got odd jobs in fast food joints and supermarkets but was soon fired for using methamphetamine and cannabis at work. Adolescence is a time when epigenetic pathology often manifests itself – in John's case, intrauterine exposure to alcohol, early childhood maltreatment, lack of learning-conducive environment, parents' conspiracy-minded religious beliefs, being bullied, mother's illness and death, exposure to heavy alcohol and methamphetamine and cannabis use, likely have all contributed to his psychotic symptoms and depression, which he tried to ameliorate with more substance use resulting in a vicious cycle.

John's brother Victor, who shared with John many genes and childhood experiences including alcohol and drug use, had a divergent life in adolescence. Victor was four years

older than John and his intrauterine environment might have been different, perhaps less alcohol and substances. Victor was bigger and was more outgoing than John. Victor was not bullied, did moderately well in high school despite his drug use, and graduated from school shortly after their mother's death about the same time John dropped out of school. Victor and his girlfriend had applied to a state college out of town, were both accepted, and left home for college. Victor apparently reduced his substance use in college. Victor navigated his adolescence much more successfully than John in developing a firmer sense of identity. Unlike John, Victor had no Attention Deficit Disorder and was not bullied and was able to develop better social and academic skills which led to a healthier life course divergent from his brother John.

4) Adulthood Stages at a Glance

If an adolescent develops a stable sense of identity which forms stable foundations for adult personality, they would be prepared to successfully navigate themselves through the adult stages with appropriate constructive responses to stress. This would further consolidate their coping skills and a sense of competence. On the other hand, without a

stable foundation, there may be uncertainty and rapid fluctuations of the sense of identity, and an inability to deal with even minor stresses resulting in deficiencies in adaptive coping responses including autonomic nervous system and endocrine activation. These changes may trip the individual into a psychiatric syndrome including anxiety and/or depressive disorders, PTSD, and psychosis, with or without substances which may have been used in an attempt to alleviate the psychological pain.

Early Adulthood

In early adulthood, it is important to remember that synaptic pruning still occurs and that a more stable personality may yet to be formed. This may be especially true in persons with epigenetic risk for attention deficit disorder. In early adulthood, the Eriksonian stage of intimacy vs. isolation, social, study, and work skills learned and practiced in previous stages form the basis of stable intimate relationships as well as career. The life skills of cooperation and competition are tested here. Success in the expanding areas of endeavor may consolidate self-esteem

and a sense of competence; failures may result in isolation, low self-esteem, anxiety and depression.

Patienthood, being identified as a patient which may lead to a "career as a mental patient" may begin in early adulthood if it had not begun even earlier. The degree of acceptance of such "patienthood" may determine the patient's sense of self, their help seeking behavior, course of illness, and the outcome, e.g., remain working and receive treatment, unable to work due to frequent or continuing serious symptoms and/or hospitalizations, be partially disabled, or permanently and severely disabled.

Middle Adulthood

Middle Adulthood, the Eriksonian stage of generativity vs. stagnation, is ideally a stable period of "settling down", having formed a stable intimate relationship and perhaps marriage and child(ren), with a stable and satisfactory career. Failing these tasks, mostly due to less than satisfactory attainment of the foundations of earlier stages of life, e.g., industry (learning), identity formation, and intimacy, the person may feel left behind compared to peers, without a sense of stability. There may be continual stresses with unsatisfactory relationships, work, and life

itself. Anxiety and despair may be omnipresent, and for those with epigenetic vulnerability, mental illness may ensue. Substance use may be frequent and contribute to the descent into illness.

John the Rifleman's Adulthood

Our patient, John, was age 41 when he came to our attention, when he was observed pointing an assault rifle out his window. The father had called the police and he was brought to the psychiatric emergency room. John claimed he was trying to protect himself from the gang members who were following him and planning to attack him and kidnap him. He also said he would shoot himself rather than be kidnapped by the gang members. He was clearly delusional and had both visual and auditory hallucinations. We know that John had some early symptoms of depression and psychosis in adolescence. What happened since then?

As previously stated, John dropped out of school at 11th grade, shortly after his mother's death from cancer. He lived with his father and brother for a while, used alcohol, cannabis, and methamphetamine regularly, had a number of odd jobs but no stable employment. John had two DUIs in

his late teens and early twenties. When he attempted to reduce alcohol consumption after a DUI, he had withdrawal seizures.

Things changed considerably when John was around age 25 when he met a man some 20 years older. This man, Bill, "adopted" John as he missed his deceased son who was about the same age as John. Bill was divorced, lived alone and worked as a custodian of a storage company. Bill invited John to live with him and helped him get a job as a night custodian in the same company he worked for. It seems for the next ten years or so, John had a relatively stable, if still reclusive, life with Bill. Bill seemed to have been a "good" father figure to John though they did not see each other that much because Bill worked the day shift and John worked the night shift. During the day, John would do the housekeeping- cooking, laundry, etc. On weekends, they would go to the movies or ball games. They used alcohol and cannabis but not to excess. After John had an alcohol withdrawal seizure, Bill imposed a routine of alcohol use for both of them – each would confine his drinking to 3 cans of beer and two shots of tequila a day, to which they strictly adhered. They seldom used methamphetamine.

This relatively stable period came to an end in September six years ago when Bill died suddenly of an MI, a heart attack at age 55. Grief-stricken, John quit his job and moved back to his father's house. His brother, Victor, had long left the house, married, and was living out of town. His aging father was still working in his old job as a guard. Having moved back to his old surroundings, John began to drink heavily again, and used cannabis and methamphetamine heavily. Probably out of loneliness, and missing his mother in his old home, he was heavily involved in the social media of the conspiracy-theory oriented religious sect to which his mother had belonged. During the last month, September, John's father, age 63, started having some chest pains, and was placed on heart medications. So, what may have contributed to John's increased drinking and drug use during the past month, September? Of course, an anniversary reaction, i.e., the emergence, often unconsciously, of emotions attached to an event that happened during a particular month, day, or even a season, can underlie unexplained dysphoria leading to increased drug use. In John's case, his mother and his father substitute Bill, died in September, and September was also the month of John's birthday! And during the last month, John's father's health became worrisome!

John had a relatively stable period ages 25-35 or so when he was with a stable father figure- Bill. Although John never achieved a stable sense of identity (adolescence), intimacy (early adulthood), and generativity (middle adulthood), his life was stabilized for some ten years in adulthood through adaptation in his own way, given a supportive figure, Bill. It is unknown if John's relationship with Bill had a sexual component – one wishes it did as it would have provided some sense of intimacy for John. Whatever stability John experienced during this period crumbled with Bill's death, and thus the descent to mental illness. Methamphetamine is known to cause psychosis, especially paranoid psychosis, even in normal individuals with prolonged use. Furthermore, the social media that John devoured was conspiracy oriented, bordering on paranoid. John, who had so many risk and precipitating factors, finally developed frank paranoid psychosis requiring emergency hospitalization. Without question, John the Rifle Man was an immediate danger to others as well as to self. In addition to all the other factors, the ready availability of a lethal weapon in the environment was an additional factor in exacerbating the situation.

John is still in his middle adult life at age 41. And now, he is starting his psychiatric patienthood with the diagnoses of

Psychosis, unspecified, with substance use, Delusional Disorder, Depressive disorder, unspecified, Methamphetamine Use Disorder, Alcohol Use Disorder, Attention Deficit Disorder, Paranoid Personality Disorder. What would have happened if he had not been apprehended and brought to the hospital when he was pointing his assault rifle out the window? How dangerous was he really?

John the Paranoid Rifle Man was very dangerous! An unmarried, unemployed, socially isolated man who is paranoid, delusional, actively hallucinating, and using methamphetamine, with a deadly weapon and a declared intent to kill!

What should be the treatment approach for this patient?

Obviously, he needs emergency inpatient care and treatment for his active psychosis with antipsychotics. Then his methamphetamine use has to be managed as well as the use of cannabis and alcohol. Considering his chronic sense of isolation, loneliness, and addiction to conspiracy-oriented social media, the management plans must include outpatient psychotherapy and possible group therapy.

What is the prognosis for John? Clearly, the immediate acute psychotic symptoms can be treated and depression, managed, but intervening in the stunted personality development may be an insurmountable challenge. They include, from early childhood, the effects of bullying, lack of acquisition of social and academic skills, ADHD, inferiority feelings, identity diffusion, lack of intimacy, and isolation in early adulthood. That there was a relatively stable period while John was living with Bill for about ten years prior to Bill's death does provide some clue that there may be some hope. If the resources are available, John may be able to achieve some stability with a comprehensive and flexible management plan. Otherwise, John the Paranoid Rifle Man may rise again with unfortunate consequences.

John's brother, Victor, on the other hand, graduated from the out-of- town college, married his girlfriend and begam a career in the health care field as a first responder. Victor seems to have navigated his adolescence very differently from John in spite of his substance use, developed a sense of identity, and achieved Eriksonian intimacy during early adulthood, which formed a basis for a career as an emergency health technician. His middle adulthood achieved generativity: he eventually became a physician's

assistant together with his wife, and they had a daughter who is now a medical student.

Late Adulthood and Old Age

According to Erikson, in late adulthood or Old Age, the attainment of a sense of integrity of a life well lived would be the goal. Without this sense of integrity, there may be despair – regrets over life slipping by. With increasing age, there is an increased incidence and prevalence of chronic diseases such as heart disease and stroke, with attendant disability further contributing to despair. Even for those seniors who attained a sense of integrity, there may be social isolation due to the death of friends and family as well as the onset of physical or mental disability resulting in incapacity or physical dependence on caregivers.

An important task of advancing age, beginning during middle age but especially in old age, is adaptation to a general decrease in physical and mental functional capacity. "What I used to be able to do easily in my 20's, like climbing up five flights of stairs, I cannot do today, I run out of breath on the second floor!" "I used to be able to remember exactly what I did a week ago, but now, I have trouble remembering what I did yesterday!"

Continuing to be physically active within limits, and developing new ways of helping memory function, such as voice memos on the cell phone or writing down things to remember, these and other activities to compensate for age-related decline in function can help maintain a sense of integrity.

Despair in old age may be largely situational as well as epigenetic. Such despair may naturally lead to depression, substance use, or suicide. Suicide rate generally increases with age, especially with men, while women's suicide rate tends to peak around age 65. Significant number of older persons in despair may have suicidal ideation without the physical or mental ability to carry it out.

Contemplation of the end of life and how one faces it is a prominent consideration in old age, though such contemplation is appropriate at any stage of life as when an individual's life will end is quite unpredictable. Advance directives, wills, and other legal and financial considerations toward the end of life can be a source of comfort. Supportive figures in the face of dwindling numbers of family and friends due to infirmity and death become ever more precious and necessary. Provision of

some support system, be it a companion or a nursing home may become necessary.

As many persons are in medical care or nursing home settings at end of life, death with dignity and medically assisted suicide or euthanasia are issues to be considered. Achieving and maintaining integrity at the end of life requires the collaboration with significant others including the family, the community (social, legal, spiritual, etc.), and the medical team.

The Ninth Stage of Joan Erikson- Psychosocial Crises in Reverse Order

Joan Erikson, Erik Erikson's wife, wrote the last chapter, the 9th Stage of Life when Erik was 93 years old in their book, Life Cycle Completed, Extended Version (1997). She wrote in that chapter that in the 8th and 9th decades of life, the life challenges encountered in life occur in reverse order with declining capacities and function and increasing dependence on others. Reaching and completing this 9th stage of life with a sense of integrity and trust would be an ultimate challenge and accomplishment for us all.

Carpe diem!

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