

MEDICAL PSYCHOLOGY FORUM

PSYCHOTHERAPY OF A SUICIDAL, TERMINAL  
CANCER PATIENT

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**ABSTRACT**—Psychotherapy of a terminal cancer patient who had attempted suicide is described. The suicidal attempt occurred when she was unable to ventilate her sad feelings to either her doctors or family. Immediately after the suicidal attempt, psychotherapy while on the medical floor opened a channel of communication between the patient and the psychiatrist, resulting in a trusting relationship. Second phase, outpatient therapy, was characterized by the patient's insistence to find psychologic meanings of her illness, in addition to dealing with feelings of jealousy regarding healthy acquaintances and mourning over her health and youth. By identifying the cancer as an introjected bad mother, she began to see it as an alien object, thus gaining a sense of psychological control. The final phase was characterized by increasing signs of metastases and increasing efforts on her part to "psychologize" the illness, without neglecting medical treatment. There were few signs of "acceptance" of death in this patient who was once suicidal. Some terminal cancer patients can use exploratory psychotherapy to make remaining life more gratifying. This presupposes a close collaboration between the psychiatrist, oncologist, and the patient's family.

Although a large body of literature has recently accumulated concerning the dying patient, there are few case reports describing psychotherapy of patients with terminal cancer who attempt suicide. Since depression is present in almost all patients with terminal illness at least at some point [1-4], the possibility of suicidal attempt is ever-present in those patients. Reports of actual suicidal attempts by terminal cancer patients are, however, surprisingly rare.<sup>2</sup> The following case history illustrates how a terminally ill suicidal patient may derive gratification in life through psychotherapy.

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<sup>2</sup> The actual incidence of suicide in this population may be higher than expected from published accounts, especially if one considers covert suicides by refusing medical treatment. This author knows of at least one successful suicide (by jumping out of the window of a highrise) in a terminal cancer patient.

## CASE HISTORY

### *Background*

I was first called on to see G., a 35-year-old physician's wife and mother of three children, who had been admitted to the intensive care unit after a massive overdose of barbiturates. At the time of the consultation, her private physician informed me that the patient had terminal metastatic carcinoma of the breast, and that she was in considerable pain. Four years previously, a lump in her left breast detected on a routine physical examination was subsequently diagnosed as malignant. Two years following the radical mastectomy, another malignancy was detected in the right breast, necessitating another radical mastectomy. Approximately one year prior to the current admission, she developed metastasis to the orbit with proptosis. She received radiation treatment, chemotherapy, and underwent bilateral oophorectomy. After an initial good response, the patient developed back and leg pain, as well as jaundice, approximately one month prior to the suicidal attempt. On the day of the suicidal attempt, she was discovered by her husband, who came home from work to find her comatose in bed. No suicidal notes were found.

### *First Phase of Psychotherapy: As Medical Inpatient*

The first impression that G. conveyed to me was one of defeat. She was an attractive and intelligent young woman who felt guilty about the burden she had become to her family and to her husband. She expressed regrets about not having actually died, and a sense of exhaustion about the possibility of immobilization and of becoming a "vegetable" for a long time. Her husband had found a diary that she had begun about one month prior to her suicidal attempt in which she wrote, "In order to maintain my equilibrium and not to burden others, I'll try to be my own therapist and write down my feelings and thoughts about myself." In the diary she had expressed feelings of being "out of battle," and not being involved. She expressed occasional feelings of euphoria which she attributed to steroid therapy, and feelings of depression whenever she had pain. She wrote, "It is crazy to feel okay, but I am ready to take my exit pills tomorrow, if necessary." G., being a social worker, was accustomed to listening to other people and helping others, and she confided in the diary that she thought she ought to be able to help herself as well.

It became clear during the evaluation that G. was a fighter, and activity and mastery were important for her, and that pain and prolonged suffering made her feel exhausted and defeated. I pointed out to her that in the presence of pain she had a tendency to think in terms of "all or none"—that is, when she did not have pain she felt completely healthy and when she had pain, she felt as if she were going to be immobilized immediately. She agreed and added that it was very

difficult for her to think rationally when she was in pain. I pointed out to her that although she had a serious illness, the least the medical profession could offer was relief of discomfort and that I would try my best to prevent the kind of prolonged suffering that she was afraid of. With these reassurances, she agreed to continue to see me daily while she was in the hospital, and also to continue therapy as an outpatient after discharge. I was reassured during this time by her oncologists that, although her cancer was terminal, the pain could be reduced considerably by irradiation and analgesics. During the time of the hospitalization, I also saw the patient's husband on frequent occasions to evaluate the home situation and also to relieve his guilt feelings concerning his inability to spend more time with her due to his busy schedule as a cardiologist.

In my sessions with G., she spent much time dealing with her feelings of shame over having to seek help, and having attempted suicide, which, parenthetically, she held in contempt—she had been quite serious about wanting to die, and she saw the survival from the attempt as another failure. She talked about the repeated disappointments she had whenever she dared to hope. Finally, she was able to see that the suicidal attempt was her own way of expressing a need for help as "I was determined to die because I wanted to live so badly." We agreed that she was rightfully concerned about the quality of life she would have before her final demise, and that many psychological factors might influence her feelings and outlook.

### *Second Phase: Outpatient Psychotherapy*

Upon discharge, we agreed on once-a-week psychotherapy. At first I decided that the treatment approach would be mainly supportive with clarifications of her feelings and thoughts. In addition, I placed her on amitriptyline 50 mg. at night because of her difficulty in falling asleep, frequent early morning awakenings, and depressive feelings. By the second week of outpatient therapy, she felt less depressed but quite sedated and groggy, which she attributed to the amitriptyline. She had stopped taking it herself for approximately three days before the second session. Thus, amitriptyline was discontinued.

Although my plan was to be more supportive than exploratory, she showed an eagerness to delve into her deep-seated feelings and symbolic meanings of her symptoms. 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 when she could get up, eat, and meet people. She sought relief from this unhappy relationship by going to college away from home. Her father, who died when she was in her teens, was to a large extent an ineffectual person who did not "count much" at home.

During the first month of outpatient psychotherapy, it became clear that this

patient wanted to have more than support and reassurances. She wanted to explore the meaning of the illness and her reactions to it. Thus, the therapy took on a more exploratory flavor. She realized during the course of therapy that she had developed an extremely controlling personality trait which she felt was a reaction to her mother's attempt to control her life. She had felt threatened by this and began to feel that she, herself, had to control any situation she encountered. Lack of control and lack of mastery meant being completely subservient to and dependent on her hated mother. As treatment progressed, she came to associate her cancer as an introjected bad object, namely, her mother. She recalled more experiences of rejection by her mother and how her mother had preferred her sister, two years younger than the patient. She expressed feelings of jealousy about her healthy acquaintances which feeling she associated to the jealousy she felt towards her sister. In her present situation, she felt that others were again being preferred by "fate" and that she was being rejected. She was able to assert her own mastery over herself from her mother by moving away from home, going to school, and choosing a career. But now, she felt that she was hopeless against cancer which was a part of herself.

Gradually, she began to see cancer as an "evil alien thing" that she was in struggle with. Then she began to regard it as an object she could fight. She felt a certain degree of relief in that she could mobilize her own strength, which had been helpful to her in the past, against this new challenge. As she began to regard cancer as an external enemy, she was able to shift her attitude toward it. In the past, she had felt that she would be entirely rid of the malignancy or that she would be completely inundated by it. Now, she saw her relationship to cancer as a continuing struggle and that there would be times when she would have an upper hand and at other times the cancer would. This did not immediately spell the end of conflict one way or the other. She had decided to think in terms of living for discrete periods of time such as for another month, another two months rather than in terms of all or none, live or die now. She felt a certain degree of control in *willing* herself to live for certain discrete intervals.

Although she was now content to plan for the immediate rather than the indefinite future which she might not see, she expressed feelings of being like a "geriatric patient," and felt sad for her lost youth. She also mourned for the loss of years she might have enjoyed in the future but which she probably couldn't. This would intensify her feelings of jealousy of the healthy young people who were able to do so many things that she could not do. She decided to start working again on a limited basis in order to maintain a sense of worth. In spite of her negative feelings toward her mother which had been associated to her feelings concerning cancer, she was able to visit with her on occasion. In a sense, this seemed to concretize the idea that cancer was an external, alien, destructive force not originating from herself.

During the seven month period of outpatient therapy, she seldom mentioned pain or physical discomfort and stayed away from prolonged discussions

concerning her medical treatment. In fact, she seemed to want to believe that whatever physical symptoms she felt had a psychogenic origin and could be dealt with in psychotherapy. When she described physical discomfort or symptoms, she would say, "Do you think this could be psychosomatic?" or "I was having anxiety when I had the symptom. What I was thinking about was . . .". During this time, she seldom used analgesics, although they were prescribed to her freely, and she was instructed to take as much pain medication as she needed. She stated that she did not want to take narcotic analgesics because she felt too sedated, as if she were out of control.

Although she had made a commitment not to look into distant future, she had to make a decision around whether she could plan on being at her son's bar mitzvah which was to occur in five months time. In therapy, it turned out that she very much wanted to plan the bar mitzvah and be there but she was afraid that if she hoped it too much, she would not "make it" because of the malevolent force (cancer) which was determined to have the upper hand. I pointed out that she could make plans, in any case, since that gave her a sense of participation at present, and even if she could not attend it, she would have the knowledge that it would go according to her plan. I also felt that her making this commitment to live for five months might be an important factor in preventing her from feelings of hopelessness and helplessness.

#### *Final Phase: Rapid Progression of Illness*

Approximately one month prior to the bar mitzvah of her son, she showed increasing signs of weakness and metastases. For example, she started showing proptosis again and an unmistakable limp as she walked. However, she continued to come to therapy on a once a week basis and seemed to be completely oblivious to the changes in the physical appearance. She was concomitantly seeing her radiologist and surgeon and receiving treatment for the malignancy.

It seemed as though she put more energy into psychotherapy as her physical condition deteriorated. She delved further into the unconscious conflict over her dependency needs on her mother and her feelings of being rejected by her. She went deeply into her early memories of being dominated by her mother and feeling helpless. She found consolation in that her own children were being reared to be independent and that she was not repeating any of the patterns that her own mother had shown. She also emphasized that she was being a good mother to her children even when she was suffering from cancer and even when she was feeling quite weak. She was quite unhappy when her husband talked of hiring a fulltime housekeeper for her because she felt that she, herself, should continue to take care of the children and the house.

On occasion, however, she would think about her terminal status, and express feelings of sadness over not being able to see her children growing up. On occasion she would be tearful about how her husband and children would

manage without her, adding quickly that she was tearful only during the sessions and that she normally did not cry at all. I pointed out that she could express any feelings including sadness during the session and this might temporarily relieve some of the pent-up feelings.

She began thinking about possible replacements for herself when she died, and hoped that her husband would remarry soon after her death. She found consolation in that her children were all past the age of five and thus had had the mothering experience by a good mother during the "important phases" of their lives. Approximately two weeks before the bar mitzvah of her son, she started having dizzy spells and blurry vision. She attributed these to anxiety and attempted to find the meaning of these symptoms. However, a brain scan performed at the recommendation of her surgeon and myself showed multiple metastases in the brain. At one time, she felt so dizzy after the session that she had to be carried home in a taxi-cab.

At this point, the patient and I decided that she could not come for therapy for the time being and that we would keep contact on the telephone as she lived some distance away from my office. In the meanwhile, I kept contact with her husband, who was supportive to her despite his busy schedule. He had also discussed with me how to prepare his children for their mother's eventual death. When I called her on the phone, she would tell me how she was able to muster up strength to do various chores and how her family, including her children, were able to help her. She told me she would resume therapy as soon as she regained her strength. Her husband was with her almost constantly during the final weeks of her life. She did attend the bar mitzvah of her son although she felt quite weak and dizzy. She died suddenly one week afterwards.

## DISCUSSION

This patient came to my attention after a suicidal attempt which was clearly a cry for help. She was in a state of "moratorium on candid communications" [5]. She refrained from discussing her feelings with the family for fear of burdening them. The well-meaning cheerfulness of her doctors was perceived by her as a discouragement of any expression of feelings that were not optimistic and cheerful. As she wrote in her diary, she attempted to become her own therapist, but when she was in pain she was unable to "think rationally" and be effective as a therapist for herself.

Until recently, most physicians have not told their cancer patients the exact nature of the illness and prognosis [6], but the pendulum seems to have swung to the other end of late in that almost all patients are told of the diagnosis of cancer and the exact progression of the illness. For instance, this patient was told about the various metastases in exact detail. In a sense she appreciated the information, but she felt unable to work through the feelings about her illness with the physicians because she felt that she had to "always be smiling" in order

to please her doctors. A physician who assumes the responsibility to inform his patient about a serious illness should also assume the responsibility to work through the patient's feelings concerning the illness [7]. Physicians dealing with terminal patients should also consider the possibility of psychiatric referral when they feel that the patient cannot communicate openly to them because of their personality make-up. Even though the physicians may try to open up a channel of communication, some patients cannot really express their pessimistic feelings to the doctors because of their need to see the medical doctors as omnipotent figures. For these patients, the omnipotent surgeon or internist is the only hope for their cancer. Isaacs et al. [8] proposed the concept of pre-death, concerning elderly patients in the terminal phase. During the time when she had pain, this young patient was also "unable to care for myself" because of the fear of immobilization, and inability to express her pent-up feelings about dying, creating a state similar to "pre-death."

The psychotherapy of this patient took different emphases according to the phase of therapy. During the first phase, while on the medical floor, the foremost task for the psychiatrist was to establish a trusting relationship with the patient. This was achieved by allowing her to talk freely about anything, including pessimistic thoughts and feelings of being an inadequate and worthless person—the feelings she was unable to express to others close to her. Another task was to allow her to mourn for her lost health, youth, and the life that she would probably not be able to lead. Ventilation was the major modality of psychotherapeutic process used.

As she entered the second phase of treatment as an outpatient, the therapeutic approach also changed according to the patient's wishes. Although initially I planned a continuation of supportive treatment as in the first phase, she showed an eagerness to look into the psychological meaning of cancer and her early experiences in depth. By identifying the psychological meaning of cancer, she was able to see the cancer growing in her as an alien object, an introjection of the bad mother, and disavow it as a part of herself. By refusing to accept cancer as a part of herself, she was able to struggle with it as if it were an alien being. During this process, she gained a sense of control over this alien object, which gave her hope. This kind of "psychologizing" in patients who have serious illnesses is relatively common. I have seen quite a few inexperienced psychiatrists who are perplexed by patients with serious illness who do not talk about the illness but rather about psychological difficulties which seem relatively minor. On close examination, almost all these patients are attempting to deny (or not pay attention to) their physical problem by putting emphasis on the psychological issues which they hope could be resolved by psychotherapy.

Clearly, this patient gained a sense of control over her cancer by seeing it as a psychological entity, which, in her mind, might be resolved by psychotherapy. It should be emphasized that she did not actually believe that the cancer would melt away miraculously by psychotherapy, but she had an added sense of "doing

something" in psychotherapy, at least a harmless procedure, which, unlike radiation or chemotherapy, did not destroy her tissue or change her body. This did not result in an attempt to avoid medical treatment. Another important event during the second phase of psychotherapy was the development on the patient's part of a new attitude concerning cancer. When she began to see cancer as an alien object, which was identified to her mother, from whom she had finally gained independence, she was again able to see the process of her struggle with cancer as a prolonged process, which would not necessarily result in complete defeat or victory in a short period of time. She began to plan ahead for short periods of time and began to "will" herself to live for these periods which finally extended to a major event in her life, the bar mitzvah of her son. It is interesting that this patient did live to attend it. Janis Norton also describes a similar situation where her patient with terminal cancer lived until her son started school [1].

The third phase of psychotherapy coincided with the rapid progression of the illness, the very terminal phase. During this time, the patient showed an ever-increasing eagerness to "psychologize" her symptoms and to attribute almost all her symptoms to psychogenic causes. She seldom talked about dying during this period and there was little sign of "acceptance" of death. Unfortunately, I was unable to follow her progress first-hand when she could not come to my office. She had chosen to stay home rather than be admitted to the hospital during this time. Her husband was able to stay with her constantly now and nobody would have been a substitute for him, myself included.

The psychiatrist's role for this patient, in addition to being a primary psychotherapist, was that of a facilitator of communication between her and the family, and an educator of the family concerning how they could inform the children about their mother's serious illness, and also what psychological needs the patient would have at the very terminal phase of the illness. I believe that psychotherapy was instrumental in opening the communication barrier which had contributed to her suicidal attempt. Because of the patient's personality style, she was unable to communicate her sad feelings to people who were close. Eissler [9] emphasizes the importance of a "gift situation" that the psychiatrist creates for the dying patient. The "gift" of the psychiatrist in this particular case was the gift of opportunity—the opportunity for her to intellectualize and "psychologize" her cancer and thereby gain a sense of control. Then, also the important opportunity to be able to talk to someone without the fear of burdening or offending him. The regular appointments probably also conveyed the therapist's expectation that she would still be alive till the next visit [10].

Eissler also states that the trust that a dying patient can develop through transference toward the psychiatrist may help patients in extreme pain [9]. This patient needed analgesics little, although she was in considerable pain. Perhaps this was also helped by the understanding between the patient and the therapist

that she would not be allowed to suffer needlessly, and that she would receive as much pain medication as she wanted. She also understood that the medical staff would not prolong her life unnecessarily when she would have no further gratification, and be like a "vegetable." In the beginning, when she was in pain, "everything looked black." Later, she preferred to be clear-headed rather than sedated even when she was in more pain.

Some authors emphasize the role of acceptance in the terminal phase of illness [3, 9]. This patient, at least until the time she was completely unable to ambulate, showed few signs of acceptance of death. Rather, she increased her attempt to control the cancer, at least psychologically, and tried to find "psychogenic" causes for the symptoms. This approach might be non-adaptive in patients who do not seek medical help for the symptoms by "psychologizing" them, but this particular patient continued medical therapy while attempting to "analyze" these symptoms. I don't know if the patient finally accepted death after she had attended the bar mitzvah of her son, the date until which she willed herself to live, but it is my impression that she did not, even to the last minute. In a controlling and "fighting" personality like hers, perhaps the right to "die in one's boots," fighting rather than accepting death, should be respected.

This may be, for this kind of individual, an "appropriate death" [11], which I feel is a *way of dying that is most congruous with the individual's life style*, and which occurs *after exhaustion of all gratification* in the person's life. A psychiatrist does not have to be an "unpsychiatric psychiatrist" [1] for all dying patients, but can maintain his psychotherapeutic stance and yet help some patients effectively. This approach clearly requires close collaboration between the psychiatrist, the patient's family, and the internist or surgeon in charge of the medical treatment. The "analysis" of the serious illness should be to provide hope through a psychological sense of control over the illness and its psychological meaning.

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*Manuscript received August 2, 1973*