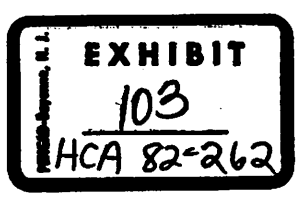
CASE OF R. O.

The patient is a 41-year-old physician who asks by phone if I will see him for "followup treatment" after he is discharged from Silver Hill Hospital. He is self-referred, having known me during a period of treatment for "anxiety" from 1967-1973. During evaluation September 28 and 29, 1979, he appears intense, pacing, frightened, and complains that what he has been through has been an "existential nightmare," referring to his seven-month hospitalization at Chestnut Lodge. He is taking 150 mg. amitriptyline HCl and 400 mg chlorpromazine daily. As the evaluation progresses he becomes calm, sits, and resumes his familiar expressive style of communicating.

The transformation which the patient has experienced in the months of August and September of 1979 are remarkable. He claims he is visiting me without suicide precautions, hundreds of miles away from his hospital. He is interested in resuming his medical practice. He wants to get rid of the "guardianship" which prevents him from visiting his three children. At this time he is purposeful, oriented, aware of what has happened to him. He plans what he now has to do to restore himself to the community.

He attributes this transformation to the care he has received: the staff did what they could to heighten his self-esteem, using attitude, milieu, food, activities, group therapy, individual therapy, and socialization. They also used appropriate medication.

Approximately three weeks after admission to Silver Hill the patient describes a change of feeling, a "burden" had been lifted



from him, a phenomenon beginning on a particular day. He gives credit to the antidepressant medication for this change.

PAST HISTORY

He was the only child of parents who lived in the Bronx, New York. Much beloved by his Mother, a school teacher, she devoted herself to this bright child, despite her observing, controlling, dominating, and demanding behavior.' Her attentiveness has continued throughout his life ameliorated somewhat when Mother went into treatment (patient was 8 years old), when the Mother returned to work (patient was 11), and when the Mother remarried.

Father was a nonpracticing lawyer who made his living working with the patient's paternal grandmother, a restaurateur. Patient has fond memories of Father before the age of four. However, after four the patient's memories are of his being abusive, rejecting, and scornful of the patient, reflecting the power struggle between Mother and Father, the patient being a won or rejected object. When the patient was 15, Father had his first "heart attack," from which he recovered. Patient remembers walking ahead of Father to prevent him from climbing stairs too fast, feeling loving and protective toward Father.

Earliest memories are of verbal fighting between Mother and Father. Patient has been told he could talk before he could walk, he was toilet trained before age one, and that his Father was uninvolved with household.

At times there was closeness, warmth, and understanding when he and his Father were alone, yet he knows that Father sent patient and Mother away on "vacations" regularly. Patient had an appendectomy performed; with his physician uncle in attendance, when he was 4 years old. He reports Father had a taxi sent for him and his Mother when he was discharged and ready to come home.

Father was only pleased with the patient's academic accomplishments. However, the patient longed for a closer, more fulfilling relationship with his Father and until adolescence, tried to please him. He had won and regretted his "oedipal victory" over his Father many times. His Father's death occurred when he was 17. His loss was great, later seen in the position transference and in the relationship with his oldest child, named after his Father. His two stepfathers from his Mother's subsequent marriages were never men he allowed similar closeness.

Following the patient's appendectomy, the patient identified with his uncle, the physician, and at ages six through eight would visit his uncle and go through his medical journals and books.

Performance skills, except for music, were underdeveloped at age eight, lagging far behind verbal skills. He was simply unable to play competitive sports or handle mathematics adequately. It is noteworthy that he was tutored in mathematics and that in NY High School of Music and Art he mastered the subject by perseverance.

Patient had friendships with boys which began early in life and has maintained them.

At age eight he "loved" a girl, courted her seriously, eventually was rejected, and suffered through a "depression" which he clearly remembers. Later at age 16, he lost a second girlfriend and experienced "depression and brooding." It was about this time that he observed his great capacity for self-starting and autonomy in whatever he undertook.

Errors of judgment and impulsiveness, great loves, scornful rejection of those he surpassed, self-criticism, and impatience marred his brilliance, creativeness, and appetite for achievement.

One conflict-free area of the ego has been his music, remarkable, in terms of self-discipline, creativeness, and capacity to express himself with multiple instruments and voice.

COURSE AND FLOW OF TREATMENT

The patient first came for treatment August 25, 1967. He was anxious and troubled, plagued with self-doubts. There had been a growing concern about himself from college on. He felt because he had not gone to a first-class medical school, his medical training was inadequate, his work would lead him nowhere, his wife who was an "angel" would leave him. Indeed, there had been no pregnancies and he believed he was sterile.

Patient might have been a candidate for psychoanalysis
1967 had it not been for money and time. Rapid development of a positive transference of this 30-year-old man occurred with twice-a-week, face-to-face, psychoanalytically oriented psychotherapy. His chief

concern was that I not become angry with him, as his Father had, and that he find ways to please me.

There was a corresponding loss of symptomatology and emergence of self-confidence. He impregnated his wife, practiced internal medicine with enthusiasm, and decided to take further training
1968 in nephrology at a prestigious institution in Boston one year after we had started treatment.

I saw him twice during the next two years. He complained how repetitive and senseless many of the requirements for his training were. However, he decided to do the job so that he could qualify for the Specialty Boards.

1970 After a two-year departure, he resumed treatment, and he began to establish his nephrology practice in a nearby area. He began with transportable equipment, performing dialysis when and where it was needed. He opened an office for consultations, the design of which employed his artistic originality. He diligently pursued all referrals, and as his practice increased in size, he increased his staff to maintain the dialysis unit. His mood was positive. He was functioning well in his profession, providing services badly needed in the area he had chosen. Many physicians became friends and responded to him, his professional endeavors, and his social activities. It was during this period his second son was born.

It was following this success and birth his wife became
1972 "depressed," entered with the patient in couples' group therapy, and while I cannot reveal confidential material about her, the record has it they were eventually divorced.

The patient was left with much of the care of one infant boy and one three-year-old boy. He did well to manage his practice, get these boys breakfast, take them to their caretakers, have dinner with them, put them to bed if their mother was not present after dinner. He exhibited devotion and love to them and they to him.

The patient met an attractive woman physician who was impressed by the love the patient showed to his children. They fell in love, he bringing "poetry" to her drab life and she bringing beauty, companionship, and love to his life. He was happy, prosperous, surrounded by those who loved him, and looked on his future optimistically. When he decided to marry her, we discontinued therapy.

I saw the patient intermittently over the next three years, usually when he was perplexed, anxious, in doubt, or troubled over his profession, marriage, or children.

Then when I saw the patient early in 1977, he was in trouble. There were major threats from within and from without. He was tearful and depressed. An associate of his was aggressively threatening to disrupt his organization. This associate had been recommended by his wife, and she was cool to the patient's anger over this man's behavior. More important was his wife's position about his two boys by his former marriage. She was in favor of the former wife having custody so that the boys could leave the country and be out of their life. She was angry because the patient took little interest in their newborn son, he being preoccupied with the departure of the older boys, and gave her little support. She was in favor of the patient

seeing a different therapist. Externally, a National Kidney Foundation wanted to buy the patient's dialysis unit, and his wife was in favor of his selling.

I did not see the patient again for almost two years. When I did see him, he was deeply depressed, agitated, in a state of mourning over his losses, hopeless, with suicidal references. His therapist was talking about hospitalization, had given him some amounts of medication, the patient had called the suicide "hot line," and had been medicated at one point with Doxepin by Dr. Nathan Kline.

1979 For the next nine months, I heard nothing from or about the patient except for the poem which was mailed anonymously; however, I recognized the author and his love for his children.

Then I received his phone call, saw him for evaluation, and we began our work in November 1979 three times a week, supportive psychotherapy. Initially the patient was taking, besides amitriptyline 150 mg., 400 mg. of chlorpromazine. The chlorpromazine was increased to 600 mg. as he reintroduced himself to his work environment. As he employed his plans, directing his efforts and energy into the difficult task of rehabilitating himself, the need for chlorpromazine diminished and ceased, as did all signs of agitation. It has not been used since. The amitriptyline was continued until Spring 1980 when it was discontinued for a trial period. It was my feeling that the patient needed resumption of antidepressant treatment on maintenance dose for a longer period of time because of a return of early morning awakening, black moods (other than grief, regret, and normal misery),

weight change, and suicidal ideation. Treatment with the amitriptyline was used initially as a maintenance dose of 100 mg.; later it was increased to 225 mg. for more than a year. The subsequent administration of amitriptyline has varied according to circumstances.

As can be imagined, the world to which a mental patient is returned is a formidable arena. Everything is familiar, but nothing feels the same way it was remembered. In this patient's case, his world had changed radically, not because of distorted perception or memory; it had changed in reality. His house was empty of people and things. The furniture had been taken – his wife initiating separation and divorce proceedings.

The staff at the dialysis unit treated him with disdain, avoidance, and insubordination, refusing to comply with his requests and failing to respond to his orders. The associate with whom the patient had left his practice "in trust" indicated directly and indirectly that he was not going to allow the patient to resume his position of Medical Director!

After great anxiety and consultation with the Director of the National Foundation, owner of the unit, the patient dismissed his associate.

The associate retaliated (1) by arranging to have the patient's "privileges" suspended at the hospital where the patient saw patients from his dialysis unit who had deteriorated and needed hospital care; (2) by using records and staff to take patients away from the dialysis unit, (3) and by taking a number of the members

of the staff away. These rapidly developing events involving move and countermove by the ex-associate and the patient are too numerous to describe. But the final outcome was to leave the patient as director of an "empty" dialysis unit, attending physician with reinstated "privileges" at the hospital, a nephrologist with a cloud over his reputation, and referrals of new patients at a very low level, almost zero.

To emphasize how well the patient was functioning, I will point out that overlapping these events was the struggle to gain access to his three children. Having been in mental hospitals is excuse enough for mothers to ipso facto declare the patient is not suitable to have around children. Added to this is the fact that a "legal guardian" had been appointed by the court, and this guardian had been of the opinion that the patient was too sick to see his children (before antidepressants were used). So it meant that the patient had to demonstrate to the court his competency not only as a sane person but as a sane father, even though the guardianship had been ended November 1, 1979.

The patient had to be persistent to overcome these obstacles, legal and domestic, to be with his youngest child, then three years old. In his characteristic style, he was gentle, warm, and understanding, making his visits short initially, until the visits were looked forward to by both father and son as a mutual loving experience.

At this time, the older boys lived in an inaccessible location which took an overnight train trip and car travel. The atmosphere when the patient visited the boys was controlled, and hostile,

made so by an angry ex-wife and her new husband. This has been ameliorated because of the court actions the patient arranged. These boys now feel free to express their love for their father. His love for them had never been absent, even in deepest despair and melancholy.

It should be noted that the patient's enjoyment of music returned. And it was a conflict-free area where he could not only take lessons, improve his skills, but also be with others who had similar interests, perform in public, and encourage and teach those who could benefit. One child, a 10-year-old boy, was interested in playing a brass instrument; however, he had but one arm (congenital malformation). The patient formed a nonintrusive relationship, met with him, taught him how to support and finger the instrument, practiced with him, encouraged him to a point where the boy eventually performed in public. The parents were understandably pleased and grateful, to say nothing of this child's love for the patient. Friendships with others in the field of music have continued to grow, including other doctors who are interested in music, instruments, bands, and performances.

During my work with this patient, I observed from the beginning frequent repetitive phrases such as: "existential nightmare; crazy on the inside, sane on the outside; not tragic, pitiful; lost concept, of myself; narcissistic; and alienate others." The patient had had the idea of writing about his experience as a mental patient, and I encouraged him to write all that he could remember chronologically, in order to integrate these repetitive, emotionally-laden phrases.

(Refer to patient's reproduced and circulated manuscript entitled "A Symbolic Death.")

COMMENTS

Patient initially complained of neurotic and character problems which subjectively caused him considerable psychological pain. Because of the positive transference, he was able to give up his symptoms, continue his emotional and professional growth, and deal realistically with obstacles of some magnitude in a way which was not self-defeating. Some time following termination of the initial period of treatment, the patient turned to his wife for a dependent, mother-son relationship. It was in this state that he felt unable to stand up to those who would take from him, leaving him regressed, overpowered, and depressed. At this point he complied with demands from those around him, hospitalized himself at an institution well-known for its orientation of avoiding biological treatment (electroshock or medication) of patients. Here he was treated, not for depression but for a "narcissistic personality disorder." After seven months of regression, his mother and stepfather transferred him to a hospital where supportive therapy and medication (an antidepressant and major tranquilizer) was used. His response was good enough to return him home in three months. During the second period of treatment with me, which was supportive, the patient has attempted, with moderate success, to regain that which was his, restore himself in an alien environment.

Impression Axis I 296.23 Major Depression, Single Episode (DSM II 298.0 Psychotic depressive reaction, agitated type.) One must bear in mind that with another depression, the Axis I Dx must become 296.53 V71.09.

Axis II Difficulty with women, not to be construed as Narcissistic, Borderline or Dependent Personality Disorder, but an expectation of protective, supportive, nurturing devotion, a product of an only child with an oedipal victory.

Axis III Hiatus hernia produces intermittent distress and esophageal ulcer under stress.

Axis IV Hostile, untrustworthy environment without benefit of "significant-other" persons.

Axis V (1973) Highest level of adaptive function was that of a respected physician, loving father, and devoted husband.

ANALYSIS OF DIFFICULTY WITH CL

Proper diagnosis was made but therapeutic program and intervention ignored the importance of treating this illness.

Importance of following the Biological-Psychological-Social Model of Medicine is demonstrated by Dr. O's case. Here the proper diagnosis was made at time of admission, confirmed by the psychologist, and again at time of discharge, but the therapeutic plan, interventions, and program ignored the diagnosis except for suicidal precautions. During the past 30 years, psychotic depression, whether unipolar or bipolar, has been established as biological-psychological-social illness whether it generates from within (endogenous) or develops as a reaction to external forces (reactive). Like Hypertension, Thyrotoxicosis, Coronary Heart Disease, Bowel Obstruction,

Noncommunicating Hydrocephalus, the Major Affective Disorders must be treated aggressively or the consequences are disastrous for the patient.

This failure to treat appropriately indicates a more serious problem at C.L:; namely, administrative psychopathology and employment of the mechanism of defense of hierarchy. This has produced a breakdown of communication between members of administration, therapist, staff, and patients. Stanton and Schwartz in "The Mental Hospital" point out that communication between all members of the hospital, including administrators, therapists, residents, nurses, aides, and patients was one of the strengths of C.L. The persistent difference in diagnosis between the ward administrator and the therapist remains unresolved. Nurses' and aides' observations were ignored, or not communicated. Clinical director indicates he agrees with the therapist, leaving unanswered the ward administrators' conclusions. Such a health delivery system results in grave consequences for the patient.