

The effect of a life-threatening illness for the psychodynamic psychiatrist and her patients

Like a lot of my colleagues, I approached growing older as I faced my 70's with a degree of ambivalence about retiring (Ingram and Stine, 2016). I had already reduced my practice to seeing patients only three days a week, largely because I had taken on teaching at a local university. I had been thinking of starting the process of retiring gradually. I had number of patients whom I had seen for years, at this point periodically to renew stable medications. I had thought that in the summer I would suggest to these patients that they see another psychiatrist who would continue these medications, or I would suggest that their primary care physician would be willing to prescribe for them. I had five or six patients in intensive psychotherapy, and by the end of the year, I planned to see only those few patients who were actually involved in the intensive psychotherapy. Over the next four or five years I anticipated their terminations.

I believed I had choices in the process of relinquishing my identity as a psychodynamically oriented psychiatrist. However, one afternoon in April all those choices and my autonomy were shattered. While I was visiting a friend, I suddenly began to have focal seizures in the right side of my face. A CT scan revealed a tumor, most probably a glioblastoma. I knew enough to be terrified. Was I going to die? Was there any hope? What was going to happen to me? I know that a prominent politician was dealing with this diagnosis, but I was not sure that he was not dying. All at once I was becoming a patient to whom things happened, not a physician who made decisions. I had to wait for several hours to be transferred from the first hospital to another where they performed neurosurgery; the nurses and ambulance drivers could not answer questions. I tried to be polite and cheerful to the staff, but inside I was screaming. There was no one could address my concerns.

When I arrived at the second hospital, I was kept busy with CT scans and MRI's throughout the night. I met once with a neurosurgeon who told what he was going to do. I had no choice but to undergo brain surgery. It was all a blur as people came and went. After the surgery I was helpless. The hospital nurses came and went, came and went as their shifts changed like clockwork. A hospitalist physician checked in once a day.

Because of the location of the tumor, on the premotor cortex, my speech was drastically affected. Immediately after surgery I could barely speak one word at a time. The next few weeks my husband told me that I was "channeling Stephen Hawking." I sounded robotic and was mostly unintelligible. There was no possibility of my speaking to my patients. I could barely get my needs across to anyone even when I was tangled in the sheets and could not reach the "help" button.

There was nothing I could do about my practice while I was in the hospital. I recalled a day in the course of my own analysis when I was confronted by a note on the door of my analyst's office that he was ill

and there was “No time to inform.” The note was all I knew for four or five days, and my fantasies then covered all sorts of possibilities. Unfortunately, for a week or so after my surgery, there was nothing I could do but put a similar note on the door of my office.

In the hospital I did not have access to any list of my patients; my speech was so garbled that I could not have spoken to any of them. Eventually, when I got home, I wrote a form letter informing everyone that “It is with deep regret . . .” that I had to suspend my practice. I think I chose the word “suspend” because I secretly harbored a hope that I would recover and be able to resume seeing patients. I wanted to be able eventually resume my work, but I thought I knew inwardly that “suspend” meant “end.” At that time, however, I referred everyone to two of my colleagues who agreed to help my patients with refilling prescriptions and finding referrals. Despite my extreme speech impediments, I tried to answer phone calls.

Ellen Pinsky, who was confronted by the sudden death of her analyst, describes an “Olympian delusion” (2011) that analysts do not die. To some extent, unwittingly,, I had subscribed to that delusion. Although I had briefly discussed with one of my colleagues how she could access my records and how I could get to hers, I don’t think either of us took seriously the possibility that we would really need to get to each other’s records. Frankly,, I had not given a thought about the effect on my patients if I died suddenly as Pinsky’s analyst did. About six months earlier my own analyst had died after a prolonged battle with leukemia. He spent about a week in hospice care, and his family encouraged me and a few of his friends to spend time with him as he died. I was one of the suggested referrals for the few of his patients who had not made other arrangements as his illness progressed. However, most of his patients had already made arrangements or worked through some sort of termination. His death when it occurred was anticipated.

I think my patients shared with me the Olympian delusion that I would always be there for them. I know that I had never discussed with any of them the possibility that I could disappear; the closest to the topic were written instructions regarding who to contact when I was on vacations. Ellen Pinsky’s analyst died suddenly. My analyst prepared all of us, family, friends, colleagues, and patients, for his death. I was in different situation. I was not dead, but I was not available to see patients. My disappearance was sudden and unexpected, but I was not dead. My patients – and myself – were unsure whether I would recover and when I might be able to work with them again. However, over the next couple of months it did become clear to me that I would retire and I would not see patients again.

Patients reacted differently. A few went ahead and found sources that could renew their prescription and only asked me to prepare a summary for the new prescriber. One woman, even after I had repeatedly told her that she should find a new prescriber, told me that she expected to see me in October, after her summer vacation. I allowed some long-term patients to come for one visit so that they could see that I was alive and realize the extent of my disabilities. One long-term psychotherapy patient broke into tears and asked to visit me; I told him that I would be amenable to a visit in a few weeks. He never called back. A couple of patients who visited – in the living room of my house -- wanted to come again; I was concerned that they were essentially transforming the patient/therapist

relationship into a friendship. I chose to simply not be available to repeated requests. Some long-term patients repeatedly emailed me, again apparently wanting to transform our relationships.

Throughout the first couple of months, as I started the debilitating radiation and chemotherapy treatments, I was supported by my husband and friends. I was inundated by flowers and cards. Friends and colleagues called. My synagogue community sent so much food that we could never have eaten it all. A friend who is retired pediatric oncologist came along to consultations to be sure my husband and I asked all the questions we needed to. None of this support was connected to my professional identity, and all of it eased the decision for me to explore what my life would be like if it did not revolve around my seeing patients. Who would I be? I expect that new identities will emerge. I will take up my loom again and be a weaver and a lacemaker. I will write the papers I have kept in mind. I go walking with a girlfriend once a week, discussing theological questions as we circle our track. This month I will resume teaching a class on psychodynamic psychotherapy to the PGY-III residents at the hospital. In the meantime, there are speech therapy and physical therapy appointments. There is a schedule of blood tests and doctor's appointments. After all, I am a patient.

References

Ingram, D.H. and Stine, J., 2016, How senior psychodynamic psychiatrists regard retirement, *Psychodynamic Psychiatry* 44:211-237

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