Instructor’s Manual
for
DEATH, DYING
AND GRIEF IN
PSYCHOTHERAPY
VOLUME 2:
HOSPITAL
CONSULTATION
WITH MEDICALLY ILL
PATIENTS

with
MILTON VIEDERMAN, MD

Manual by
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psychotherapy.net
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Instructor’s Manual Death, Dying and Grief in Psychotherapy, Volume 2: Hospital Consultation with Medically Ill Patients with Milton Viederman, MD

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Instructor’s Manual for

DEATH, DYING AND GRIEF IN PSYCHOTHERAPY
VOLUME 2: HOSPITAL CONSULTATION WITH MEDICALLY ILL PATIENTS WITH MILTON VIEDERMAN, MD

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Tips for Making the Best Use of the DVD

1. USE THE TRANSCRIPTS
Make notes in the video Transcript for future reference; the next time you show the video you will have them available. Highlight or notate key moments in the video to better facilitate discussion during and after the video.

2. FACILITATE DISCUSSION
Pause the video at different points to elicit viewers’ observations and reactions to the concepts presented. The Discussion Questions provide ideas about key points that can stimulate rich discussions and learning.

3. LET IT FLOW
Consider playing the sessions all the way through at once, rather than hitting the pause button frequently, so viewers can appreciate the way they flow together. It is best to watch the video in its entirety since issues untouched in earlier parts often play out later. Encourage viewers to voice their opinions; no therapy is perfect! What are viewers’ impressions of what works and does not work in the sessions? We learn as much from our mistakes as our successes; it is crucial for students and therapists to develop the ability to effectively critique this work as well as their own.

4. SUGGEST READINGS TO ENRICH VIDEO MATERIAL
Assign readings from Suggestions for Further Readings and Websites prior to viewing. You can also schedule the video to coincide with other course or training materials on related topics.

5. ASSIGN A REACTION PAPER
See suggestions in Reaction Paper section.

6. CONDUCT ROLE PLAYS
After watching the video and reviewing Viederman’s Approach to Death, Dying and Grief in Psychotherapy in this manual, break participants into groups of two and have them role-play a hospital
consultation session following Viederman’s approach to working with medically ill patients. One person will start out as the therapist and the other person will be the patient; then the participants will switch roles. Patients may discuss actual issues around illness in their own lives, or may role-play a friend, acquaintance or a patient of their own.

Invite therapists to practice some of the techniques Viederman used in the video, such as:

- helping the patient develop awareness of his or her emotional state, by echoing the patient’s implicit affect;
- encouraging self-revelation by underlining the patient’s emotional responses and meanings;
- painting a picture of the patient’s experience;
- commenting tactfully on the therapeutic relationship;
- commenting on aspects of the patient’s personality (mostly supportive of self-esteem) to convey to the patient that he or she is recognized.

After the role-plays, have the pairs come together to discuss their experiences. First, have the patients talk about what it was like to role-play a medical patient (or discuss their own illnesses), and how they felt about the therapist’s interventions. Then have the therapists talk about their experiences; how did it feel to conduct a therapeutic session around these issues? Finally, open up a general discussion of the strengths and the challenges in applying Viederman’s approach to working with medically ill patients.

An alternative is to do this role-play in front of the whole group with one therapist and one patient; the entire group can observe, acting as the advising team to the therapist. Before the end of the session, have the therapist take a break, get feedback from the observation team, and bring it back into the session with the patient. Other observers might jump in if the therapist gets stuck. Follow up with a discussion on what participants learned about using Viederman’s approach to working with medically ill patients.
PERSPECTIVE ON VIDEOS AND THE PERSONALITY OF THE THERAPIST

Psychotherapy portrayed in videos is less off-the-cuff than therapy in practice. Therapists may feel put on the spot to offer a good demonstration, and clients can be self-conscious in front of a camera. Therapists often move more quickly than they would in everyday practice to demonstrate a particular technique. Despite these factors, therapists and clients on video can engage in a realistic session that conveys a wealth of information not contained in books or therapy transcripts: body language, tone of voice, facial expression, rhythm of the interaction, quality of the alliance—all aspects of the therapeutic relationship that are unique to an interpersonal encounter.

Psychotherapy is an intensely private matter. Unlike the training in other professions, students and practitioners rarely have an opportunity to see their mentors at work. But watching therapy on video is the next best thing.

One more note: Therapists’ personal styles are often as important as their techniques and theories. Therapists are usually drawn to approaches that mesh well with their own personality. Thus, while we can certainly pick up ideas from master therapists, students and trainees must make the best use of relevant theory, technique and research that fits their own personal style and the needs of their clients.

PRIVACY AND CONFIDENTIALITY

Because this video contains actual therapy sessions, please take care to protect the privacy and confidentiality of the client who has courageously shared her personal life with us.
Viederman’s Approach to Death, Dying and Grief in Psychotherapy

As can be seen in the cases on this video, each patient responds quite uniquely when faced with a life-threatening illness. Their responses are determined by a confluence of factors, including their own individual psychology, personal history, current support systems, and type and severity of illness. Given these factors, the consultant must quickly assess what the patient most urgently needs and what type of help is realistically possible.

There are no algorithms or manuals that can define Viederman’s therapeutic approach to death, dying and grief. Each clinician must develop his or her own style based on his or her experience. However, there are basic concepts and specific techniques that when illustrated can be integrated and learned.

An outline of some of the maneuvers utilized in this video may be useful:

A. Echoing the patient’s implicit affect or therapeutically developing the patient’s awareness of his or her emotional state.
B. Underlining the patient’s emotional responses and meanings, so as to encourage further revelation. This maneuver would include active clarification of aspects of his or her life experience pertinent to her current response.
C. Creating the climate of the patient’s experience when it has not been directly expressed. Painting a picture of the experience.
D. Commenting tactfully on the quality of the interaction with the consultant to relieve inhibitions in communication. Using observed qualities of the interaction to examine characteristic patterns of behavior with the patient.
E. Commenting on aspects of the patient’s personality (mostly supportive of self-esteem) to convey to the patient that he or she is recognized. These aspects include the patient’s basic perception of the world and attitude to the world.
Understanding the patient’s experience and communicating this understanding becomes the vehicle by which the clinician can reach the patient. Central to this approach is a dynamic view of behavior that implies that underlying desires, wishes, and fears and their accompanying fantasies condition experience. Actively engaging patients using this dynamic understanding can rapidly affect them. The mistaken notion that supportive engagements simply require being nice to a patient dominates the view of most physicians. Supportive interventions are truly effective when based on a dynamic understanding of the patient’s personality and major conflicts. The elucidation of the patient’s experience as a patient and the consultant’s communication of that understanding facilitate the establishment of a bond that relieves distress and acts as a catalyst for a future collaborative therapeutic relationship.

I speak of the doctor–patient relationship and physicians or consultants, not only for convenience of expression but because it is a paradigm for a special relationship with social and psychological implications. It is to be understood, however, that the teaching modules will be useful for all categories of health care professionals, whether they are attending physicians, house staff, medical students, chaplains, social workers, or nurses.
Reaction Paper for Classes and Training

Video: *Death, Dying and Grief in Psychotherapy Volume II: Hospital Consultation with Medically Ill Patients with Milton Viederman, M.D.*

- **Assignment:** Complete this reaction paper and return it by the date noted by the facilitator.
- **Suggestions for Viewers:** Take notes on these questions while viewing the video and complete the reaction paper afterwards. Respond to each question below.
- **Length and Style:** 2-4 pages double-spaced. Be concise. Do NOT provide a full synopsis of the video. This is meant to be a brief paper that you write soon after watching the video—we want your ideas and reactions.

**What to Write:** Respond to the following questions in your reaction paper:

1. **Key points:** What important points did you learn about hospital consultation with medically ill and dying patients? What stands out to you about how Viederman works?

2. **What I found most helpful:** As a therapist, what aspects of the model presented did you find most beneficial? What tools or perspectives did you find helpful, and what might you use in your own work? What challenged you to think about something in a new way?

3. **What does not make sense:** What principles, techniques, and/or interventions did not make sense to you? Did anything push your buttons or bring about a sense of resistance in you, or just not fit with your own style of working?

4. **How I would do it differently:** What might you have done differently than Viederman in the sessions in the video? Be specific about what different approaches, interventions and techniques you might have applied.

5. **Other Questions/Reactions:** What questions or reactions did you have as you viewed the therapy sessions with Viederman? Other comments, thoughts or feelings?
Related Websites, Videos and Further Reading

WEB RESOURCES

Faculty web page for Milton Viederman, MD
www.med.cornell.edu/research/mviederman/index.html

Association for Death Education and Counseling
www.adec.org

The Center for Thanatology
www.thanatology.org

RELATED VIDEOS AVAILABLE AT
WWW.PSYCHOTHERAPY.NET

Time Limited Dynamic Psychotherapy with Hanna Levenson, PhD
Psychotherapy with Medically Ill Children (Child Therapy with the Experts Series) with Gerald Koocher, PhD
Object Relations Therapy (Psychotherapy with the Experts Series) with Jill Savege Scharff, MD
Coping with the Suicide of a Loved One: An REBT Approach (REBT in Action Series) with Albert Ellis, PhD

RECOMMENDED READINGS


Discussion Questions

Professors, training directors and facilitators may use some or all of these discussion questions, depending on what aspects of the video are most relevant to the audience.

INTRODUCTION

1. **Hospital Consultation**: Have you ever worked with patients who are hospitalized? How has this been for you? What experiences have you had working with people with cancer? What are the rewards and challenges for you in working with this population?

2. **Denial**: What do you think about Viederman’s point that, for physically ill patients, denial is a useful defense mechanism for controlling stress, as long as it doesn’t interfere with the patient’s ability to accept proper treatment? What experiences have you had, in either your personal or professional life, with people who are physically ill and engaging denial as a defense mechanism?

MRS. STEWART: FIGHTING FOR HER LIFE

3. **Isolation and loneliness**: Viederman stated that the consultant is in a unique position to undo the isolation and loneliness that may result from suppression by offering patients an opportunity to reveal their most private concerns. Do you think Viederman was successful in undoing any of the isolation and loneliness that Mrs. Stewart may have been experiencing? If so, what particular interventions do you think contributed to his success? Was there anything you would have done differently to relieve some of Mrs. Stewart’s isolation and loneliness?

**Reaction to news of death**: What was your reaction when Viederman reported that Mrs. Stewart died some months after this session? Have you ever worked with a patient who died? How did that affect you? What kind of support is helpful for you when you work with patients who are dealing with death?
MR. SHAAN: LOVE AS COPING MECHANISM

4. **Unconscious hostility:** One of Viederman’s interpretations was that Mr. Shaan had unconscious hostility toward his parents. Did this align with your interpretation of what was going on for Mr. Shaan? Why or why not? What did you think of Viederman’s decision to not bring Mr. Shaan’s underlying hostility to his attention because it would increase the patient’s anxiety?

5. **Pushing the patient:** Viederman stated that he pushed Mr. Shaan to examine the roots of his behavior. Do you think this was helpful to Mr. Shaan? Why or why not? Do you think you would have pushed Mr. Shaan in a similar way if you had been in Viederman’s role? What factors do you take into account in deciding how much to push patients to examine the roots of their behaviors?

MRS. IRENOVA: REGRESSION, PANIC, UNRESOLVED GRIEF

6. **Language difficulty:** Viederman commented that, due to the language barrier, he spoke slowly, chose his words carefully, and echoed Mrs. Irenova to let her know she was understood. How successful do you think Viederman was in overcoming this barrier and conveying understanding to the patient? How has it been for you to work with patients when there is a language difficulty?

7. **Depression:** Mrs. Irenova told Viederman that he helped her because now she is able to relax. What do you think Viederman said or did that contributed to her relaxing? How else do you think he helped her with her depressive symptoms? Was there anything you would have done differently to help her depression?

MR. CALLAHAN: MOVING INTO ACTION

8. **Shock:** What was your reaction when Viederman described the emotions he assumed Mr. Callahan felt but did not reveal, such as when Viederman said, “God, what a shock. I mean, it was just dumped on you like nothing. There was no preparation or anything”? Do you think this comment was helpful to Mr. Callahan? Why or why not? Did you agree with Viederman’s
assessment that Mr. Callahan was numbed and in a state of shock? What did you observe that informs your assessment?

9. **Meaning:** How do you think it helped Mr. Callahan when Viederman asked him what it meant to him when the doctor told him he had leukemia? Why do you think Viederman engaged the patient in this exploration of meaning? How successful do you think Viederman was in conveying to Mr. Callahan that he understood the meaning he was making out of his situation?

**MRS. STEINER: MAINTAINING HOPE**

10. **Tell me about that:** What was your impression of Viederman’s phrase, “Tell me about that,” which he repeated throughout the session with Mrs. Steiner as well as other patients? What kind of impact do you think this phrase had on the session with Mrs. Steiner? Do you have any phrases you tend to use a lot with patients as a way to engage them?

11. **Understanding:** How well do you think Viederman conveyed empathy and understanding to Mrs. Steiner? What specific things did he say that you think contributed to her feeling seen and understood? What are some of the ways you convey understanding to your patients?

**DISCUSSION AND CONCLUSION**

12. **Patient reactions to illness:** What struck you about the different ways that the hospital patients responded to their illnesses? Did you find yourself more understanding or empathic towards some patient’s reactions than others? What about their reactions did you find easier or harder to relate to?

13. **Therapeutic Alliance:** How successful do you think Viederman was in developing a therapeutic alliance with each of the five patients in this video? Was it your impression that they each felt understood by Viederman? What do you think Viederman did or said that contributed to or impeded an alliance with each of them?

14. **Overall thoughts:** What are your overall thoughts about Viederman’s approach to working with hospitalized patients
with cancer? What aspects of his approach can you see yourself incorporating into your work? Are there some components of this approach that seem incompatible with how you work with patients?

15. **Personal Reaction:** How would you feel about having Viederman as your therapist if you were sick in the hospital? Do you think he could build a supportive therapeutic alliance with you? Why or why not?
INTRODUCTION

Viederman: My goal in this video is to illustrate the principles and techniques of psychologically engaging physically ill and dying patients. Edited interviews of five patients confronted with cancer in different stages of their illness will be discussed. By psychological engagement, I mean the development of a bond with the patient that results from his experience of being understood by the consultant at a moment in crisis. The consultant’s behavior must evolve during the consultation in response to his assessment of a patient’s personality and emotional state.

Individuals have varied responses to challenges. It is particularly important for the consultant to elucidate and communicate the specific meanings of a patient’s experience. In this way, the patient feels recognized and reciprocally experiences the consultant as a person aware of his plight. This is the essence of a supportive relationship.

Attention must be paid to the way in which patients defend themselves psychologically against life-threatening illness. Denial is a defense mechanism that has special pertinence to the threat of death. Since it protects against anxiety, it must be dealt with carefully. Among defense mechanisms, it is unique in that it is directed toward reality, toward the perception of the outside world. It is to be distinguished from repression, for example, which defends against inner fantasy, feelings and wishes.

Denial is viewed as a primitive defense, since a reasonably accurate perception of reality is ordinarily essential for an adaptive response. As applied to physical illness, however, denial is an especially useful
mechanism in controlling the stress if it does not interfere with the patient’s ability to accept proper treatment.

One must distinguish between denial and protective suppression of feelings and thoughts. Suppression is a conscious unwillingness to reveal what one’s thinking. Patients who suppress often believe they are protecting those close to them from pain. Suppression used this way disturbs the quality of communication with significant others and may create problems in personal relationships.

The consultant is in a unique position to undo the isolation and loneliness that may result from suppression by offering patients an opportunity to reveal their most private concerns.

The following interviews will illustrate how the consultant searches for and communicates meaning, and how he tailors his own responses to meet the special needs of each individual patient. The names of the patients have been changed.

**MRS. STEWART: FIGHTING FOR HER LIFE**

Viederman: The patient is a 54-year-old mother of two, married to an investment banker. She developed lung cancer some months ago and is currently in active treatment.

Viederman: You told me about that. I mean, that’s been what’s been going on with you right now.

Mrs. Stewart: I mean, I came in with the fluid around my lung and they drained that and then put me on some Percocet and things just went awry with my whole intestinal system and I think it has been going awry for awhile. Part of it is that seeing as many doctors as I am, somebody gives me this medicine, somebody gives me that medicine without any regard for somebody else’s giving me that medicine and no one is taking an overview of what all this is doing to my stomach.

Viederman: So it’s not integrated. There’s no chef d’orchestre.

Mrs. Stewart: No and it really should be. This is ridiculous.

Viederman: That’s discouraging, isn’t it? To have to deal with so many people and no one in charge.
Mrs. Stewart: It is extraordinarily discouraging and in fact, I have a good friend that’s on the board here and I happen to be speaking with her about it. There is a patient advocate, so they’re trying to get everything under control, which I’m confident that they will do.

Viederman: You’re really in this and you have a lot of confidence, don’t you?

Mrs. Stewart: I do. I mean, I am a doctor’s daughter.

Viederman: Are you?

Mrs. Stewart: I am more than a doctor’s daughter. My grandfather was a doctor. My mother was a doctor. My father was a doctor. My brother’s a doctor. I won’t even begin to tell you all the aunts, uncles and cousins.

Viederman: How did you avoid being a doctor?

Mrs. Stewart: Can’t stand the sight of blood…. And so, I mean, when you hear this, at least my feeling was, I wanted to start treatment yesterday. I wanted it out and so the next week was doing chemotherapy, which my first two treatments worked beautifully. The tumor shrunk in half, but then the tumor got smart and it then didn’t respond to the chemo so it started to grow again. Now I’m doing radiation and we’re going to zap it. It’s going to be a long road.

Viederman: How is that going, the radiation?

Mrs. Stewart: Fine. I mean, as far as all these procedures go.

Viederman: You’re a real trooper, aren’t you?

Mrs. Stewart: I mean, that’s a piece of cake.

Viederman: You’re a real trooper, aren’t you?

Mrs. Stewart: I mean, I don’t know if I am or not, but I mean, I have my moments, you know?

**Viederman Commentary:** In the first minutes of the interview, a picture of the patient’s personality emerges. She’s a strong, expressive woman who speaks calmly about her dissatisfaction in the absence of a single physician in charge of her treatment. I echo her communication using a language that I am certain this educated woman will
understand.

In the face of her dissatisfaction, she moves into action, as is characteristic of her, and speaks to a friend on the board of governors to discover that there are patient advocates.

The spontaneity and ease, the conversational tone of the interview continues. When she reveals that both of her parents and many of her relatives are physicians, I joking asked, how did you avoid this? She responds with a laugh, I cannot stand the sight of blood. I comment on the affective tone of discouragement to let her know that she has been heard, yet she remains basically optimistic and I acknowledge her strength as a real trooper and a fighter.

Her fighting attitude is revealed in her description of her adversary, the cancer, which she personifies. It got smart -- as if it is a person with whom she has been in battle. She knows how to deal with adversaries and by anthropomorphizing the cancer, she places it in the realm of the familiar, with which she can cope.

This discussion reveals that a dialogue has begun. We have developed a shared language, which includes humor. I respond to her as a person who is defined and knows herself. This stance facilitates the process in which the patient reveals herself. She is engaged, spontaneous and is motivated to communicate.

Viederman: You’re a real trooper, aren’t you?

Mrs. Stewart: I mean, I don’t know if I am or not, but I mean, I have my moments, you know?

Viederman: Tell me about them, those moments.

Mrs. Stewart: Well, you know, you got… or I…

Viederman: Don’t worry about that.

Mrs. Stewart: I think when it hurts most is not being able to be a mother to my kids. I hate how this debilitates me. I can’t go to my son’s wrestling matches. I can’t get up and have breakfast with them. I can’t be a mom.

Viederman: That’s been a central role for you.

Mrs. Stewart: Oh, yes.
**Viederman Commentary:** My comment on the patient’s strength and stoicism permits her to reveal her vulnerability. She describes the most disturbing aspect of her current situation and its special meaning to her. She is fearful that she will be unable to “be a mom to my children.” As she will put it, she is the doughnut lady at all of their games. Her current illness threatens that role.

Mrs. Stewart: I basically tell Weldon, you know, I’m going to be alright. It’s going to be a fight. I’m going to be sick. They’re going to make me sicker to make me well, but it’s going to be fine. I think it affects him in his own way. I said to my husband when I got in here, bring him over so he will know that I’m okay and he didn’t want to come. You know, I just…

Viederman: Was that hard for you?

Mrs. Stewart: Oh, no. No. I mean, he’s got to accept it in his own way. I don’t want to put any pressure on him. I’m not feeling sorry for myself.

Viederman: I hear that, but what I hear is that you very much want to protect them.

Mrs. Stewart: Yes, and if that’s his mechanism for protecting himself, that’s fine.

Viederman: Sure.

Mrs. Stewart: Which I kind of think maybe it is. He doesn’t want to see me in a hospital setting. I mean, I was kidding him about it. He says, I have this paper due. I said, in other words, you don’t want to come to the hospital. He goes, yes, mom. I said, fine. Why does anybody want to come to the hospital? I don’t blame him.

Viederman: Who wants to come to the hospital?

Mrs. Stewart. So no, it doesn’t…

Viederman: Right. So, how is he handling it?

Mrs. Stewart: Well, I mean, I think maybe he’s keeping some things to himself. I’ve asked him. I said, you know, if you feel that you need to talk to anybody, you could go talk to Doctor Clark. If you feel you need more, let me know. Sometimes it helps to talk these things out
and how you’re feeling. You want to scream. You have to realize, I’m the doughnut lady at the soccer games.

Viederman: You’re there all the time.

Mrs. Stewart: Heaven forbid that I’m not there and they don’t get their doughnuts.

Viederman: You’re the doughnut lady.

**Viederman Commentary:** This segment illustrates the patient’s method of dealing with her son’s concerns. She assures him that she will be fine, but prepares him for increasing debilitation, implying that the outcome may be difficult. In this, she shows great sensitivity. She gives her son the freedom to deal with her illness in his own way and has confidence in his ability to handle it.

When she jokes about his not coming to the hospital, I respond in kind, echoing her emotional state at the moment with laughter. Who wants to come to the hospital? We share an emotional moment as one would with a friend.

There is no self-pity or bitterness as she acknowledges smoking as the origin of her disease, stating that she enjoyed every minute of it.

Viederman: Where did that come from?

Mrs. Stewart: What?

Viederman: The intensity of your involvement with your kids.

Mrs. Stewart: I don’t know. Maybe it’s because --

Viederman: Off the top of your head, just tell me what comes to mind when you think of your earlier life.

Mrs. Stewart: I think it’s because I was raised just the opposite. That my father passed away when… or was in an automobile accident when I was four and my mother went back and did her residency and my father was also a doctor, but my mother was a doctor. Bu she was, she had to do a residency.

Viederman: Because she had stayed home with the kids before. Your father’s death sort of pushed her to become the breadwinner, you mean?
Mrs. Stewart: No choice, absolutely.

Viederman: So you were more on your own then, as a kid.

Mrs. Stewart: We stayed with my grandparents who were elderly. When I was about 12, my mother felt that we were old enough to come home with just, you know, servants.

Viederman: She had a very distinguished career then.

Mrs. Stewart: Yes. She was a very, very good doctor, but she was not involved. There was no going to the PTA meetings. There were no going to our games. There were…

Viederman: You were going to be sure it was different with your kids.

Mrs. Stewart: Absolutely. I think I missed it, I mean, and probably my kids wouldn’t have missed it, because times are changing. I mean, so many parents now are not there because it is a two career family. Back then it wasn’t. So no, I was at every single game of every one of my children, you know. That was my priority.

Viederman: When the patient reveals that her father had been killed in an automobile accident, I say, “Oh really,” in a low voice that does not interrupt the flow of her thoughts. It is not certain that she has clearly noticed what I said, yet this uncontrived interchange reflects the easy conversational tone that contributes to the process of engagement.

The patient elaborates the sources of her intense involvement with her children. As she describes her childhood, I comment, “So you were more on your own as a kid.” This reflects my participation and understanding as we construct the experience of her childhood. In spite of her involvement with her children, the patient is able to recognize that her children may well be able to manage without the degree of attention that she shows them, thereby revealing her capacity to take distance from her own needs.

Mrs. Stewart: I would go up for two seconds to listen to her recite a poem. It was god-awful, you know. And, you know, that’s what hurts.

Viederman: That’s what hurts.

Mrs. Stewart: I don’t know whether I’m being still presumptuous in thinking he still needs me. He may not, but I think he does, you
know, in his own way. He’s my child that’s always kind of held things in. I mean, just, Weldon is my child and he never tried to walk until he could get up and walk. He never tried to talk until he could say a full sentence. I mean, we never had any potty training with him. One morning I went into his room and he was all of two and a half and he had dressed himself. He had decided that this was big boy clothes and that was the end of it. It’s kind of like he kept things in until he went, “I can do this.” Whereas my daughter would get up and run and fall and laugh.

Viederman: You’re describing a sort of independence in him, then.

Mrs. Stewart: Oh, yes. Well, he’s a fighter. He was born three months early. I had placenta abruptio and he pulled his respirator out the first day. They couldn’t believe it.

Viederman: You’re proud of him.

Mrs. Stewart: I’m extraordinarily proud of him. I don’t think you, when you go through that with a baby and will him back to life and teach him to suck and will life into him, and, you know I remember the first time after he got out, we went to preemie clinic and they told me, he’s not tracking. So I walked out and I went to Mary Arnold Toys and I bought every single mobile they had. Then I went to another toy store and I bought every single mobile that I hadn’t bought at the first one. We had mobiles all over the place and I would take that bulls-eye with him every night. Well, at our next appointment, Weldon got an A+ in tracking.

Viederman: Will. That’s an important word for you, isn’t it?

Mrs. Stewart: Yes. There’s a closeness that you have when you have a baby that you can hold in the palm… although he was the bruiser of the neonatal intensive care unit at three and a half pounds. You still could hold him in the, you know, palm of your hand. He’s a fighter. He’s funny.

Viederman: I wonder where he got that.

Mrs. Stewart: I think from me.

Viederman: I’m teasing you. You’re a fighter too, aren’t you?
Mrs. Stewart: I am very much a fighter and that’s why I know I’m going to knock this. I’m bigger than it is.

**Viederman Commentary:** The patient and I have a very easy, comfortable conversational tone. There’s a playful quality as I tease her and she responds. We are immersed in a discussion of what she values in her life and are removed from the threatening experience of her hospitalization and illness.

The patient describes her own personality just as she describes the personality of her son. She will fight the disease as he fought the sequelae of prematurity and she will win.

Issues of identification and projection become intermeshed. The patient identifies with her son and describes her son as identifying with her. At the same time, she projects her will and sensitivity onto the son. She asks herself whether her view of his need for her is presumptuous. One might wonder whether this is part of the process of letting him go.

The patient returned home and continued outpatient treatment, but declined rapidly and died some months later.

**MR. SHAAN: LOVE AS COPING MECHANISM**

Viederman: The patient is a 40-year-old married father of two. He was hospitalized for chemotherapy for a malignant medulloblastoma in the chest wall. Consultation was requested for evaluation of hallucinations that occurred when the patient had been delirious on high doses of prednisone.

Mr. Shaan was initially seen in consultation during a resident conference. The tape shown is a second interview. During the first interview, I was particularly touched and impressed by this man’s intelligence, sensitivity, introspective capacity and ability to describe his situation in a rich and emotional way.

My effort to recreate the same atmosphere in the second interview presented a problem. Only as the interview proceeds did he discuss his early, formative experience in a poignant way.

Viederman: You told me that you’re very adept at… I mean, you’re very interested in finding out yourself.
Mr. Shaan: Yes.

Viederman: And that is important for you.

Mr. Shaan: I do a lot of research and I do a lot of studies on especially my type of cancer.

Viederman: Yes.

Mr. Shaan: And that keeps me going because it helps me to know beforehand what I should expect out of my sickness, out of medication, chemotherapy and also what I should feel psychologically and how to handle it properly.

**Viederman Commentary:** When confronted with an inappropriate recommendation for massive chest surgery, the patient had done research and sought a second opinion, which revealed that he had a medulloblastoma, best treated with chemotherapy.

In this segment, he reveals a highly adaptive and active coping response. Mr. Shaan speaks directly, without anxiety or hesitation, about his cancer. He knows what type of cancer he has, had integrated the information and though aware of the prognostic implications, maintains a hopeful attitude and an illusion of cure.

Viederman: We did talk about one thing that seemed quite important and that was your feeling about your children and how it related to your own experience. Do you remember that?

Mr. Shaan: Yes, I do remember because it’s very important to have children or a family, for that matter, to be very close to you at every point as possible. I think for every patient, I think they need that part of it because that is the only strong hold or a backbone to the sickness… love.

Viederman: You feel strongly about that.

Mr. Shaan: Yes. You have to have, somehow, you have to have a way where you can have backing because without love, nothing can survive.

Viederman: Tell me about the love in your life.

Mr. Shaan: I love everything.

Viederman: Everything?
Mr. Shaan: Almost. I guess if you have to give a lot of love to keep things going, I guess everybody’s nature is different, you know? If you’re happy, I think you can get through a lot of troubles.

Viederman Commentary: In response to my attempt to explore his love for his children, the patient has detached himself from the emotionality that emerged in the first interview.

Mr. Shaan: I would prefer not to have my children away from me now at this particular time, because I think they are the backbone for me and the more love I can give them, I think they can give it back to me and they need it from me right now, especially the family itself, which I did not have an opportunity before to get it from my parents. So that much, at least, I can give to my children.

Viederman: You’re aware very much of the importance of giving that to your children because you didn’t get it as a child.

Mr. Shaan: Yes, probably because I did not get it as much at that time and it is more intense for me to give it to them now. I feel very comfortable that I have good friends and family. And even good enemies?

Viederman: What do you mean by that?

Mr. Shaan: I don’t mean it that way, but….

Viederman: You said something.

Mr. Shaan: Also sometimes, you’ve got to love your enemies. Enemies are just people. They do something that you don’t know or they don’t know at that particular time why they do it to you with the perception of anger and you’ve got to forgive them.

Viederman: It’s very important to deal with your anger, to forgive. Do you feel angry often?

Mr. Shaan: No, I don’t feel that angry, not very often.

Viederman: See, I’m wondering about one thing. I’m wondering whether it’s difficult for you to allow yourself to experience anger toward other people.

Mr. Shaan: I used to feel anger at one particular point in life. When
you grow up, you are in a certain stage of your life where you think you know everything and you don’t want to listen to nobody -- no parents, no teachers. It’s a phase of life and that’s probably the time of your life where you grow up and then you are obnoxious about everything, but you grow.

Viederman: Did you go through such a period, where you were obnoxious?

Mr. Shaan: Everyone goes through it.

Viederman: Tell me about that period.

Mr. Shaan: I guess too much of friends and too much of entertainment and…

Viederman: Anger at your parents as well?

Mr. Shaan: I’m sorry?

Viederman: Anger at your parents as well?

Mr. Shaan: No, not so much anger at parents. Not as much… I don’t even think about any remorse towards them because as I said, if you can love your foes, you can always love your parents.

**Viederman Commentary:** After he expresses love for his children, certain features of the patient’s personality emerge. He reveals his organized defenses against aggression and anger and his need to repress anger toward his parents, explicit in his statement, if you can love your foes, you can love your parents. In stating that he wants to be near his children, it becomes clear that he does not wish them to experience the isolation and loneliness that he had with his parents.

Cancer threatens his relationship with his children and is, in this respect, a threat to him. One should not ignore the possible complimentary cultural factors that may influence this man’s discussion of love.

Mr. Shaan: You’re looking for habits -- looking to give and not to receive.

Viederman: Where was this developed, this… you know, when you think of it and you go back, it’s very strong in you. I heard it, this need
to keep people happy. When you think back to your childhood, what comes to mind about that? Anything. What comes to mind?

Mr. Shaan: I’m not very sure, but being very simple in life helps a lot, not to be too complicated.

Viederman: Does anything -- does it remind you of experiences in your childhood, the idea of keeping people happy? Feeling that you needed to keep people happy?

Mr. Shaan: As I explained to you at one time, that was most important thing that happened to me is as I was out not living with my parents and one important thing that happened was when I was almost four or five years old, I did see a lady who looked like my mother and I knew she’s my mother and I ran to her, ran, ran and I grabbed her by her dress and I said, mother. She turned around and she was not my mother and I did cry. I think that was a turning point, probably.

Viederman: A turning point.

Mr. Shaan: A turning point to be strong for love. I think maybe that was like a turning point for me, to be strong enough not to rely on people itself for emotional love. I presume maybe that was one of them.

Viederman: Because it made you vulnerable to rely on people.

Mr. Shaan: Yes, and that was -- it was heartbreaking.

Viederman: It was very painful.

Mr. Shaan: Yes, but I went through it and I got through it. After that, I decided it is time that you start living a normal life and be strong. When you’re young, you don’t know. You’re very vulnerable to everything, especially love, especially parents. That’s why maybe I am more interested in giving as much as possible to my children, my family and friends -- as much as possible.

Viederman: And not depending upon what you might get them from.

Mr. Shaan: Right.

Viederman: Because it’s fearful, you’re afraid to depend upon what you...
Mr. Shaan: It’s not worth it.

Viederman Commentary: The patient had been born in Kuwait, of Indian parents who sent him to an orphanage in Goa when he was six or seven, ostensibly to learn English. He describes an incident in which he sought his mother, only to discover a stranger. This incident speaks of his ungratified quest for love, a love denied him in childhood. He says this was a turning point in his life. This reveals his vulnerability and his reluctance to rely on people.

In this segment, the emotional expressiveness of the patient emerges. How did this come about? The patient describes his need to give and not to receive. This evokes in me a curiosity and a desire to understand the sources of this attitude. I reveal this curiosity and push him to examine the roots of this behavior. As he reveals himself, I echo the emotional aspects of the experience and its meaning to him. I note his vulnerability and I acknowledge the painful aspects of the experience that he describes.

In so doing, I create a climate that encourages the patient to more fully express himself.

Mr. Shaan: I don’t want my children to see me in a state of mind or in a state of body which is other than they see me normally, which I know that they would have impact for the rest of their life. I will try and avoid, but it is impossible to avoid in a situation like this. As I said, I would like to have them more happy than most people I make happy.

Viederman: Sure, I can understand that.

Mr. Shaan: I try to make them -- even if I cannot speak properly, I try to make them a different tone of speaking over the phone so they’ll be more comfortable with me. I don’t know how far I can avoid that, but eventually they will see me physically, now, especially. I hope they don’t get scared.

Viederman: It worries you, doesn’t it?

Mr. Shaan: It worries me. It does, it does make you feel good about it that they understand. I’m far away, but not too far away from them and I still do care for them.
Viederman: It struck me that the feeling that you actually conveyed about them, I’m sure they know even if at times you’re unable to really express it because you’re not feeling right.

Mr. Shaan: I did explain to them also about that and I told them it’s very important to understand that things can go wrong and you should expect things that can happen to people in general, especially people when they become old, like my parents, or their girlfriends or whatever like that, as well as people when they become sick. I did try to get across to them, to make them understand that it is very important to not to feel bad. If somebody has to leave, they’ll be in heaven...

Viederman: If somebody --

Mr. Shaan: If somebody has to leave them and go.

Viederman: Has to leave them and go -- because you’ve thought of that.

Mr. Shaan: I’ve thought of that. I did. It crosses your mind, when you go through something like this.

Viederman: Yes, of course it does.

Mr. Shaan: Even though even in business or anything else, you could have death any day.

Viederman Commentary: The patient speaks to his children of the possibility of his eventual death. He does not want them to experience this as an abandonment. In his words, “They should not feel bad if I were to die.” That it is very important to not feel bad even if somebody has to leave them, to go. He wishes to mute their possible guilt over anger at abandonment – something he must have felt when his parents sent him to the orphanage.

His concern about his children is an active love, designed to help them avoid the trauma of his early experience. I share my conviction that this man’s children experiences love. In so doing, I support him in a central area of concern. The patient continues by telling me that he has not told his parents that he is ill.

Mr. Shaan: They are emotionally dependent on the younger son, so in
a way it would be easier for them to know everything’s okay with me and with my family. If something could go wrong with me, it would be devastating to them.

Viederman: You think it might kill them?

Mr. Shaan: Yes.

Viederman: You’re terribly afraid of hurting them, aren’t you?

Mr. Shaan: Them especially. They are old. They are parents. You can’t hurt them. You can’t express to them. Let them be happy.

Viederman: Keep them happy.

Mr. Shaan: Why worry them?

Viederman: Keep them happy. That’s the same theme. You’ve always had to do that with people. Have you had to do that especially with them?

Mr. Shaan: Yes, I try. I try.

Viederman: The patient is unaware of the unconscious hostility implicit in his need to protect his parents by not telling them of his illness. This contrasts with the rich and truly protective communication that he has with his children.

My role in this segment is to state the unspeakable, that he is fearful of killing his parents. At the same time, I do not bring his attention to the underlying hostility. To interpret this would increase his anxiety, which is not my intent in a supportive engagement.

Viederman: There must have been moments when you were alone in that orphanage.

Mr. Shaan: Yes.

Viederman: When you wondered about their love.

Mr. Shaan: No, I never wondered about their love. In fact, they put me there because it was the only school that did teach English at that time and it was very important for them to give me a better education. I never doubted their love at that time -- or even now, for that matter. They did give me support of my brothers with me at that time so I had somebody with me all the time.
The life that I saw in that particular orphanage -- it’s unforgettable. It is so interesting to find, to see children without parents, without anybody in their lifetime, to say hello to them, to give them a piece of chocolate and think that is my daughter or my son or my child. I was fortunate enough that I had parents, good parents -- rich enough to take care of me, yet they wanted good things for me and that has made a lot of difference to me.

Viederman: The image of those children without parents is so sad.
Mr. Shaan: Very sad.

Viederman: Even as you think about it, you feel sad now.
Mr. Shaan: Yes. Very emotional at that time.

Viederman: You feel it now, don’t you too?
Mr. Shaan: Yes, sure. Not to have a father or a mother -- not to have anybody, for that matter.

Viederman: It’s touching, what you describe.
Mr. Shaan: Yes. It does. I had the opportunity to, after a couple of years, as I said, to go to the same orphanage and be a Father Christmas.

Viederman: To make them happy.
Mr. Shaan: And I was dressed up as a Father Christmas, all decked up and ho, ho, ho, all chocolates in my bag and putting a chocolate in each hand, shed me a thousand tears. Unbelievable experience.

Viederman: A what?
Mr. Shaan: Unbelievable experience.

Mr. Shaan: That is the experience of a lifetime.

Viederman: It was. That was a very important experience for you.
Mr. Shaan: Yes.

Viederman: Making these children happy -- that sounds like it has a lot to do with why you need to make people happy.
Mr. Shaan: Probably.

Viederman: Because you also must have experienced unhappiness and you knew what it was to be unhappy.

Mr. Shaan: I knew what it was to be hungry. At orphanages, you don’t get good food enough.

**Viederman Commentary:** The patient poignantly describes his experience in the orphanage. He is able to speak more easily and with feeling of the deprivation of others rather than of his own.

Initially, I asked him about moments when he was alone at the orphanage. He responds defensively, by distancing himself from the other children and by rationalizing this with a statement that he has parents. Yet as he continues, the atmosphere of the experience is conveyed and I comment on its sadness. He continues to describe the painful deprivation that characterized the experience and his empathetic resonance with the deprived children, reflecting his own sense of deprivation.

I say that it is touching. He goes further in describing the importance of making these children happy. I underline this as a major theme in his relationships with everyone. The scene of his playing Father Christmas moves him greatly and he poetically speaks of shedding me a thousand tears. Affected by the poetry of the expression, I repeat it with feeling.

He speaks of the unhappiness of the other children. I ask him if he too had been unhappy and he is able now to acknowledge the unhappiness. The patient and I are sharing a formative experience in his life.

*Currently, the patient is in a state of remission.*

**MRS. IRENOVA: REGRESSION, PANIC, UNRESOLVED GRIEF**

Viederman: The patient is a 44-year-old widow who emigrated from Russia seven years ago with her family of two siblings and three children after her husband’s death.

Two years ago, an enlargement in her neck led to a diagnosis of thyroid cancer that was treated surgically. Currently, she is debilitated with
metastases to the lungs. Abdominal pain troubled her at different moments during the interview.

The patient’s life has been disrupted by loss, migration and illness. Consultation was requested for depression. A psychiatric resident had done an initial evaluation.

Viederman: I’ve spoken to Doctor Klagsburn and so I know something about what you’re going through, but of course I want to hear about it from you. How old are you?

Mrs. Irenova: Forty-four.

Viederman: 44, right. Dr. Klagsburn told me that was it helpful to talk to her.

Mrs. Irenova: Yes.

Viederman: Tell me about that. How is it helpful

Mrs. Irenova: He spoke to me -- I am a little bit cry, a little bit normal cry, but she told me, don’t worry. Everything is good. Don’t worry. I am not crying more. After two times, I spoke with her.

Viederman: You felt reassured, then? Is that what you’re saying?

Mrs. Irenova: Yes. I know what I am speaking. I know what I am doing. I know what I am speaking.

Viederman: But it was reassuring to talk to her then.

Mrs. Irenova: Yes. I love talk to her.

Viederman: Right, and are you depressed?

Mrs. Irenova: Yes.

Viederman: Were you less depressed after you spoke to her?

Mrs. Irenova: A little bit good.

Viederman: A little bit good. You felt a little better.

Mrs. Irenova: Yes.

Viederman Commentary: I begin the interview by discussing her experience with the psychiatric resident. Because of the language difficulty, I speak slowly, choose my words carefully and articulate them.
At times I echo her language to let her know that I understand her. The patient is in a regressed state and seeks reassurance from a comforting and benevolent authority figure. My stance is solicitous, as I tailor my responses to her needs.

Mrs. Irenova: Every time, I want to die.

Viederman: You want to die? Tell me about that.

Mrs. Irenova: I -- when I am not walk -- I wonder why I am sick, why I have cancer. Is everything after my husband died. I have throat surgery, but I think I am not better.

Viederman: You’re not better, you think?

Mrs. Irenova: After I spoke with him, I am a little bit good, but again, I am thinking about this.

Viederman: You think about dying then? Is that it? And you say you want to die. Tell me about that. Why is that?

Mrs. Irenova: I don’t know. Because I am not better. I have pain all times, but my leg is good.

Viederman: Your what is good?

Mrs. Irenova: Leg is good.

Viederman: Your leg is better.

Mrs. Irenova: Yes, better.

Viederman: That’s good, right. But you feel sick now?

Mrs. Irenova: Yes.

Viederman: And that’s what makes you so miserable.

Mrs. Irenova: No, no. I am not miserable. I am sick.

Viederman: You’re just sick.

Mrs. Irenova: I don’t want to die, but I think about this.

Viederman: You think about dying -- so you don’t want to die.

Mrs. Irenova: No, no, because I have thee children. What do my three children I am die? My son tell me, “You die momy, I also die.” He’s 15 years old.
Viederman: So you worry about him, then.


**Viederman Commentary:** The patient’s acknowledgement that she has cancer is devastating. It means death to her. Death is an invincible foe that has pursued her, beginning with her husband’s demise, followed by her sickness and expected death and the fear that her son will follow her. She reveals a pathological relationship with her 15-year-old son who wants to die if she dies. She is burdened with the sense that his existence is entirely dependent upon hers. My therapeutic stance becomes refined in the form of a nurturant responsiveness. I offer her a tissue. When she speaks of her son, I echo her implicit concern by saying, “So you worry, don’t you?”

Mrs. Irenova: I am live in Russia, Uzbekistan.

Viederman: Yes, that’s right, and when did you come to this country?

Mrs. Irenova: After husband died.

Viederman: That was eight years ago.

Mrs. Irenova: Seven years ago.

Viederman: Seven years ago.

Mrs. Irenova: After husband died, everybody come here, but I am not staying alone in my country.

Viederman: You came because the whole family came? I see. How did your husband die?

Mrs. Irenova: One day.

Viederman: What happened? The heart? The heart?

Mrs. Irenova: Yes.

Viederman: That must have been a terrible blow for you. Do you remember that clearly?

Mrs. Irenova: Yes, clearly.

Viederman: Tell me what happened.

Mrs. Irenova: I am not done.
Viederman: You don’t want to talk about it? It’s still too painful for you?

Mrs. Irenova: Eight years am I in pain. I remember this. I know I am depressed because my oncologist doctor said to me you need a psychologist because I cry every time.

Viederman: Yes. Do you feel depressed? Did you feel depressed?

Mrs. Irenova: I am crying.

Viederman: When you first got sick, how were you sick? Why did you go to the doctor? What told you…?

Mrs. Irenova: Big.

Viederman: You noticed something?

Mrs. Irenova: Big. But no hurt me.

Viederman: It didn’t hurt and when he told you that you had cancer, how did you react to that?

Mrs. Irenova: My sister, my brother not told me. Only after two years I know I have cancer, but I got radiation treatment alone. My doctor say me.

Viederman: So in other words, they knew, but you didn’t know? The doctor told them, but didn’t tell you?

Mrs. Irenova: Yes.

Viederman: How do you feel about that?

Mrs. Irenova: I am trust my sister, my brother.

Viederman: You trust -- did you prefer that it was that way? That you didn’t want to know?

Mrs. Irenova: No, it’s good.

Viederman: It’s better not to know.

Mrs. Irenova: Yes.

Viederman: Is that the way you feel in general, that it’s better not to know?
**Viederman Commentary**: The patient is suffering from unresolved grief related to her husband’s death seven years before. The thought of his death is too painful to contemplate and she waves it away. Characteristically, she uses suppression and not denial as she tries to push out of mind painful feelings and thoughts, although she is unsuccessful in this effort.

Striking was her ability to remain ignorant of the diagnosis for two years in spite of extensive treatment. She delegates knowledge of and responsibility for her medical condition to her siblings and maintains a dependent relationship with them. My therapeutic stance echoes her preferred relationship with her siblings.

The patient illustrates a behavioral pattern called alexithymia. She is unaware of her inner state of feeling and devoid of fantasy. She treats events in a concrete way, making inferences about the way she feels from observations of her own behavior. She states that she must be depressed because her oncologist told her so and because she is crying, not because she recognizes depression as a feeling state.

Viederman: Is there anything that you want to ask me?

Mrs. Irenova: No, thank you, Doctor. You helped me. You speak with me. You help me.

Viederman: How did it help for me to speak with you?

Mrs. Irenova: I am able to relax.

Viederman: It helps you to relax.

Mrs. Irenova: Yes.

Viederman: You seem more relaxed than you were before, you know?

Mrs. Irenova: Yes.

**Viederman Commentary**: The patient experienced temporary relief in the context of a nurturant supportive, directly reassuring and comforting stance. She died some weeks later.

**MR. CALLAHAN: MOVING INTO ACTION**

Viederman: The patient is a fireman, the father of two children, diagnosed six weeks before with acute myelogenous leukemia.
The interview begins with his description of the onset of his illness. He had gone to a dermatologist for treatment of boils and was sent to an oncologist.

Mr. Callahan: So when I got through, when I got to the door, it said oncologist. I knew it had to do with cancer.

Viederman: Had you thought of cancer before?

Mr. Callahan: No.

Viederman: Not really. This came as a huge shock then. This was all in December?

Mr. Callahan: This was all year.

Viederman: December, just last year, December.

Mr. Callahan: Yes.

Viederman: All of a sudden, I mean, as far as you knew, you had just a couple of boils and the next thing you know, you’re seeing an oncologist. What was your reaction to the oncologist?

Mr. Callahan: He was blunt, straight to the point and made up my mind as what the hell it is. As soon as I got in there, he said, how you doing? He goes, I looked over your blood work and I’ll tell you what I think you got right now. You know, we only said like four words together. He said, I think you got leukemia.

Viederman: Good God.

Mr. Callahan: I said, oh shit. I don’t think I got leukemia. I think I got something else, not leukemia. He said, no, 70 percent chance it’s that. He said, get up onto that table and we’ll give you bone marrow, take some bone marrow out of you. When I take the bone marrow out of you, instead of being 70 percent, it could be 100 percent that it’s leukemia. So he started taking it out. He was so sure. I was just crying while he was doing it because he was so sure that I had it.

Viederman: God, what a shock. I mean, it just was dumped on you like nothing. There was no preparation or anything.

Mr. Callahan: I just thought, I got it and then he took some blood. He starts with that, and then I stood up to get out of this place.
Viederman Commentary: This patient describes a brutally insensitive presentation of a diagnosis by the oncologist, who speaks in statistical and clinical terms. He is ill-prepared for the possibility that he has leukemia, which he interprets as a death sentence. The bone marrow biopsy is recommended and performed without psychological preparation. His response was to get out of this place. The patient is numbed and in a state of shock. I recognize the traumatic aspect of the experience and describe the emotions that I assume he felt, but does not reveal. In so doing, I attempt to convey a sense that I can understand how painful the experience has been for him.

Pat: I’m meeting her this afternoon at 4 to have the afternoon and dinner with her tonight. So, we are really working and now the guard is down a little bit. And that’s huge. That’s really wonderful. But for me to realize how I literally blocked what she had to say and turned it into something negative I thought, “I wonder if you do that all the time with her? The kid doesn’t have a chance.” So that’s not good.

Mr. Callahan: When I walked out of there. I was so exhausted. I was the most tired I’ve ever been.

Viederman: Had you been tired like that when you walked in?

Mr. Callahan: No.

Viederman: You must’ve been emotionally drained, you know.

Mr. Callahan: You know, I was anxious to find out what I had. I didn’t think he was going to say that. He took a little bit of blood. He took bone marrow. Between the two, I was drained. I was walking down the hallway like the whole world was moving with me -- really slow. I felt, I’m a sick guy, you know, even though right up to then I didn’t feel like a sick guy. I went home, told my wife. The next day, we got my family together. I got a big family.

Viederman: You got what?

Mr. Callahan: A big family.

Viederman: Yes.

Mr. Callahan: We told everybody, one by one. Told them that we might need donors for a transplant so I started telling everybody. The next day, I seen the doctor. He said, I’ve got good news and bad
news. The bad news is, you got leukemia. The good news is, it’s AML. He said, it’s most treatable. Out of all the leukemias, it’s the most common for kids between 30-40 years old. He said, it’s going to be tough work, about six months. He said, you’re young and should be able to beat it.

Viederman: How did you react to that? That’s a big load there.
Mr. Callahan: I wanted to go into the program.
Viederman: Get treated.
Mr. Callahan: Stop thinking about it.
Viederman: Just move into action.
Mr. Callahan: Yeah, because, the more I thought about it, the more I didn’t understand what to do.

**Viederman Commentary:** The initial experience with the oncologist changed this man’s perception of himself. He left with a fatigue that he had never felt before. For the first time, he experienced himself as a sick man. His mode of coping is to take flight from feelings and thoughts about his illness. This makes it difficult to engage him.

He moves into action immediately by bringing his family together and informs them that he needs a bone marrow transplant. He accepts a treatment about which he knows very little. Movement to action and ignoring danger may be congruent with his occupation as a fireman.

Viederman: What did it mean to you when he said you had leukemia?
Mr. Callahan: I always thought it was something that you die from, you know.
Viederman: It seemed grim then, in any case.
Mr. Callahan: I remember that movie Brian’s Song.
Viederman: Which one was it?
Mr. Callahan: Brian’s Song, with Gayle Sayers.
Viederman: I guess I didn’t see it. What happened in the movie?
Mr. Callahan: Brian Piccolo -- these two football players, this was in the ‘60s or something -- one of them got cancer. He died by the end
of the season. I could’ve sworn he had leukemia. This was before they had all the treatment that they have for it now.

Viederman: Sure. So it was like a death sentence to you when he said leukemia.

Mr. Callahan: When they told me it’s 80 percent beatable, I started feeling better.

**Viederman Commentary:** The diagnosis of leukemia was a death sentence. He identifies with a ball player who died of leukemia in a film. He is careful to emphasize that this man died at a time before current treatment were available.

Although he does not deny the fact that he has leukemia nor that leukemia may kill, he emphasizes that new treatments make this information personally irrelevant. He responds to simple reassurance that it is beatable, ignoring the uncertainty of his future.

Viederman: So you told her she had to be strong for them.

Mr. Callahan: Everybody’s telling her I ain’t gonna be around.

Viederman: Everyone’s telling her what?

Mr. Callahan: That she’s got to be because I won’t be around.

Viederman: Meaning what?

Mr. Callahan: I’m going to be here for about a month and a half.

Viederman: I see.

**Viederman Commentary:** The patient informed his wife by phone that he had leukemia. He indicates that she has to be strong with the children. The implication is that he will not be available for them. He is unable to consider the impact of the news of his illness on others. He can cope with only one overwhelming stress at a time.

My response to his statement that he will not be around is surprise. I move closer to him and ask him what he means. He responds concretely by stating that he will be in the hospital for a month and a half. I conclude that the specter of imminent death threatens him, but I do not challenge his defensive avoidance.
Mr. Callahan: I don’t know if I’m going to go back to being a fireman, or....

Viederman: This has changed your view, has it?

Mr. Callahan: As far as work.

Viederman: Pardon me?

Mr. Callahan: As far as work.

Viederman: Why is that? What’s changed it?

Mr. Callahan: It’s doing all this shit now. It’s going to be six months of this. I don’t want to predispose myself to more cancer.

Viederman: I see. Do you think that it was being a fireman that caused this?

Mr. Callahan: No. I have reasons to belief why I came about it. Doctors told me that it doesn’t come about for stress reasons. It comes about out of the blue.

Viederman: But you had your own idea. What were the ideas?

Mr. Callahan: I had a major accident in... December 31st, ‘97. I was coming down the street. An ambulance was coming down another street also. As we were coming down the two streets, we hit dead even, full speed in the middle of Sixth Street. So then, I hit the guy dead in the middle. He went flying until we started pushing him. The truck crashed into a building, a laundromat. Half the truck was in the building, half the truck was out. So then everybody got out. The ambulance got crushed, went into the wall. There was two guys in there bleeding. They had to cut them out. That day, I think something in my body just stopped.

Viederman: Were you driving?

Mr. Callahan: Yeah.

Viederman: Do you feel guilty?

Mr. Callahan: Yes and no. I had the light. I had the light. They should’ve been in the slow-down mode, not to push mode.

Viederman: The ambulance, you mean?
Mr. Callahan: Yes. They were catching the lights supposedly. They were catching speed because they were just catching lights. And then they were coming up this and they caught up with us too early.

Viederman: I see.

Mr. Callahan: So then that happened and a month later I had this thing called perirectal abscess on my anus. It’s almost like a boil. On the bottom of the ass. They cut that out. I had a few other things on my hand as time went on.

Viederman: Do you think things started then?

Mr. Callahan: According to these guys, they think those were all signs, those were all things, things not healing. Your AVCs, or whatever would have attacked it and fought it off. For the first day, for the first even five minutes, I got out of the truck and I was hoping it would happen. I feel something just stopped in my body. These doctors told me here that’s all bullshit. It didn’t happen that way.

Viederman: But it still affects you a great deal, doesn’t it, that accident? Did the guys die?

Mr. Callahan: No. All mild injuries.

Viederman: What’s that?

Mr. Callahan: All mild injuries.

Viederman: Mild injuries, even the two of them.

Mr. Callahan: There was a lady in the back too.

Viederman: Really, jesus. That was lucky then. Tell me, do you have nightmares about the accident?

Mr. Callahan: No.

Viederman: Do you have thoughts about it intruding in your head, coming in sometimes when you don’t expect it?

Mr. Callahan: Not no more.

Viederman: You did initially?

Mr. Callahan: Not really, I just had trouble sleeping.

Viederman: You did?
Mr. Callahan: Yes.

Viederman: But you wouldn’t dream about the accident?

Mr. Callahan: No.

Viederman: That really shook you up, didn’t it?

Mr. Callahan: Yes, worst day of the fire department.

Viederman: What’s that?

Mr. Callahan: Worst day of the fire department for me.

Viederman: Really? I bet you had some other hairy experiences too, and this was the worst.

Mr. Callahan: I could have killed six people plus anybody standing on the street. It was 12 at night, same night, the next night, New Year’s Eve.

Viederman: It really burdens you, doesn’t it? It’s really on your mind, that accident?

Mr. Callahan: It’s one of the reasons I transferred. In the long run.

Viederman: One of the reasons you?

Mr. Callahan: Transferred.

**Viederman Commentary:** I inquire about his experience as a fireman. He reveals that he is unsure whether he will return to this work. What emerges is his fantasy about the cause of the cancer. His emotional tone grows as he develops this story of the accident. When he saw the crushed ambulance, something in my body snapped, he says. He has never felt the same since.

I inquire about intrusive thoughts or nightmares, which might suggest a post-traumatic stress disorder. He maintains his belief that the cause of the cancer was traumatic and sees himself as liable to develop new cancers. He will no longer return to stressful work as a fireman.

*The patient is currently in remission.*

**MRS. STEINER: MAINTAINING HOPE**

Viederman: The patient is a 67-year-old married mother of two who,
five years before, had been diagnosed with renal cell carcinoma. After a nephrectomy, she had been told that she did not require further treatment.

Upon her return from a European trip, she developed pneumonia and was found to have metastases to the lungs. When I saw her first at that time, she was depressed and in considerable distress. The importance of our initial meeting is revealed in the interview that followed some months later.

Viederman: Good. So, what brings you here this time?

Mrs. Steiner: Well, I think I am much, much better and I wanted to thank you for your help. I don’t know how I would have done without it, so here I am. Any questions, whatever you have, I’ll try to answer.

Viederman: You look wonderful.

Mrs. Steiner: Thank you. I gained quite a bit of weight. The doctors are thrilled. I am not. The oncologist is very happy because I lost it very -- quite extensive amount of pounds because of the treatment.

Viederman: Yes, I do understand.

Mrs. Steiner: I think I lost like 15 pounds and I gained it all back.

Viederman: That’s wonderful. I mean, I gather you don’t like it. That’s the usual vanity I suppose.

Mrs. Steiner: That’s right.

Viederman: But you decided to see me at this time. Is there any problem in particular you want to talk about or did you want to sort of have the opportunity for us to have a follow-up on our previous....

Mrs. Steiner: I think just to follow-up on what happened and hopefully it won’t happen again, but in case...

Viederman: I think it’ll be useful then to re-examine things. Was there something that pushed you to make the decision to come at this particular time, you know?

Mrs. Steiner: I’m going away. I hope to go away, with the doctor’s permission, for close to two months. So, I thought that would be good to do it before I go away.
Viederman: I see. But it had been in the back of your mind that we would meet again, I guess.

Mrs. Steiner: Oh, yes. I just wanted for you to see me and to judge me the way you did the first time and see what you think.

Viederman: I think to see the person you were before you got sick -- is that what we’re talking about?

Mrs. Steiner: Yes.

**Viederman Commentary:** This is a follow-up interview. *My engagement of the patient extends the relationship that we had already established. I comment openly on the fact that she looks wonderful. We move into a free and easy exchange that involves playful teasing about feminine vanity. The patient enjoys this. The tone of our engagement is established.*

*In initiating this meeting, she is preparing the terrain for future difficulties. By dealing with the present, she is also managing her anticipated future. She has confidence in me and asks me what I want of her. This is an assertive act and not regressive dependency.*

Viederman: When we saw one another last time, you were at times very discouraged and very depressed and you felt that life wasn’t worth living.

Mrs. Steiner: Correct.

Viederman: Tell me about that.

Mrs. Steiner: Well, I was very scared because they found it all of a sudden, out of the blue and I’d never -- I was not prepared for it, let’s put it this way. When they took out the kidney five years ago, the doctor said, we’ll check on you every year. We’ll give you an extra chest x-ray and after five years, you’re free. So I really -- and there was no treatment, nothing, after surgery so somehow I was very optimistic. I never even -- if someone asked me, did you have cancer? I wouldn’t say yes. I didn’t know what to say.

Viederman: Yes.

Mrs. Steiner: So when I came from my European trip and I had pneumonia, I thought, okay, so I have pneumonia. But then the doctor
discovered that it had spread and that was a terrible shock and I really was preparing a funeral.

Viederman: Preparing to die.

Mrs. Steiner: Yes, yes.

Viederman: You were hopeless then.

Mrs. Steiner: Completely. My husband was heartbroken. My children, they still said, there is hope. There is every day new medication. I just made up my mind that this will be it and I said to them, I had a very good life, great family. Everybody is bound to go and I am going. I just didn’t think that I will pull through. I said several times to my husband, I said, put me out of it. I don’t want it. It’s not worth it and he kept screaming and telling me off, et cetera, et cetera. You have a family. You have grandchildren. So, but I was very low, my spirits were very low. I couldn’t read a book and I’m a tremendous reader. I couldn’t read. I couldn’t look at a book. I love opera. I couldn’t put on a tape. I couldn’t stand it. I didn’t watch television. There was nothing that really interested me and that’s when they were so frightened, my whole family, that I had given up on everything. Then it came back normal. Right now, I go to the opera.

Viederman: That’s wonderful.

**Viederman Commentary:** The patient had believed that she had been cured. The news that she had metastases shocked and depressed her. She felt hopeless and said that she was ready to die. Yet there was no bitterness as she anticipated her end because her experience of life had been good. One might speculate that she would have chosen death rather than allowed death to overcome her.

The authenticity and intensity of her family’s response is striking. They refused to accept her death and were frightened at the fact that she had given up. They remained committed to her life and struggled with her to choose life over death.

Viederman: I gather our encounter was important for you. Tell me about it.

Mrs. Steiner: Yes. You told me when we met the first time that I had
a joie de vivre and that really pulled me up, feeling, yes, I do have that and I must go on. That lasted for awhile, until of course I got very sick from the treatment and I think the way that you said I am normal, that there is nothing really wrong with me made me feel that I am normal and that I am not mentally -- have any problems and that made me feel very good. Made me feel that now it’s up to me to pull myself through.

Viederman: I have this sense that what was important was I recognized in you the person you had experienced yourself as being even though the outside and the sickness was there.

Mrs. Steiner: Exactly.

Viederman: Do you know what I mean?

Mrs. Steiner: Exactly.

Viederman: I saw you for the person you valued.

Mrs. Steiner: Yes. You didn’t see the sickness. You just saw the person.

Viederman: Is that right?

Mrs. Steiner: You are absolutely right and that made me feel -- when I walked out of here and I talked to my husband, I said to my husband, you know, I do have joie de vivre. He said, you do, right now? I said, yes, even right now, I do. I would like to go, you know, to see a movie or something.

_Viederman Commentary:_ As we examine the impact of our previous encounter, she affirms the fact that it was my recognition of the person that she was that had been so helpful to her. Her face brightens as I comment on this. She needed to know that she was normal, that she had no mental problem. As she put it, you didn’t see the illness. You saw the person. It was the affirmation that she was normal, without mental problems. She concluded that it was her role to fight the illness and to overcome it.

She then recounts the amusing incident of leaving my office and telling her astonished husband that she had joie de vivre and would like to go to a movie.

Mrs. Steiner: I don’t wish it on anybody. I still don’t know how I did it. I mean, when I think about it, what did I do?
Viederman: That’s it. That’s it.

Mrs. Steiner: I was pushing myself. The drive.

Viederman: Tell me about that.

Mrs. Steiner: I don’t give up anything easily. I’m a war child. I survived the war and I lost everybody so I already went through an awful lot and I can go through a lot and I pick up. I am low and then I go back.

Viederman: You have enormous strength, don’t you?

Mrs. Steiner: I think so. I think so. That’s what pulled me through this whole sickness. I am many times in fear, no question about it. Sometimes I think such horrible thoughts, but then I talk to myself.

Viederman: Tell me about that. What specifically?

Mrs. Steiner: Well, when I can’t sleep, I would say, is it worth it? Do I have a few months? Do I have a year? What should I do? Then I shake it off and I say, what is good? What’s coming up now? You’re going away, you’re going to see your friends, you’re going to be at the sea. I reverse it and I see the immediate future. I don’t -- and my younger daughter is now expecting twins so I’m so excited because May or June I’m going to be a grandmother again. Sometimes I stop and I say, will I be here? Then I say, of course I’ll be there. There’s no question about it. I’ll be here. Will I be here when they are a year old? I don’t know, but I will be here when they will be born and that’s how I look at it.

Viederman: Moreover, you’re here now. You’re here now and here fully.

Mrs. Steiner: Yes.

Viederman: You’re here.

Mrs. Steiner: Yes.

**Viederman Commentary:** The patient emerges as a strong, vigorous woman in control of her life. I define for her my view of her special traits -- her drive, her strength. She replies by indicating that she is a war child and has learned to overcome adversity. She acknowledges the uncertainty of the future in the long run, but characteristically deals with problems as they emerge. The warmth and attractiveness of her
personality draws people to her. A complicity has developed in our relationship.

The dialogue appears like a conversation between two friends. I define and sculpt the patient’s personality, convey to her that I have recognized the person she is. I play with the patient’s sense of humor. In underlining the fact that she is here, I am conveying to her not only my awareness of her attachment to life, but of her presence in our relationship at that moment. She understands the communication’s metaphor and responds in a tone that echoes the intensity of my own.

My stance is of active engagement. We share a common language, a similar vocabulary and we each understand what the other is communicating.

Viederman: Tell me this strength -- and I noticed this in you when we first met, you know. What thoughts do you have about where this comes from? Don’t figure it out. When you think of your early life, what thoughts come to mind about that?

Mrs. Steiner: Well, I think, as I said, a child of war, what I went through made me stronger. Some people get depressed about it and get… I feel I got more strength from all that. I lost my father when I was a young kid. My mother remarried. He was very good to me. And, I lost all, I have absolutely no family. I am an only child and I have absolutely no cousins, no uncles, no aunts, nothing, nobody. I lost everybody during the war and I guess each time I had to adjust myself to a new way of life, like we went to Paris. I was a kid. I had to become more or less French and French schools and then we came here. I had to start all over again going to school, to college here and trying to become more Americanized and this required a lot of very hard work.

Viederman: But the will was there. You’re quite right. Some people became depressed and sort of gave up and lived the life of the Holocaust here.

Mrs. Steiner: Yeah.

Viederman: Obviously you’ve not done this.

Mrs. Steiner: I was an only child and very much loved and spoiled by
the family. My father was much, much older than my mother and I was like the gift of God. So that was only a few years because the war broke out, but I was protected by my father and my mother even during the war, even during the worst of times I always came first. I always felt so much love coming from my mother and my stepfather even. I could do no wrong. If I didn’t do well in school on a test, they would say the teacher is guilty, not my Alice. There was so much love and affection. I think that was probably the beginning. That was what gave me the strength. Then I got a marvelous family and married for 41 years and I have the best of husbands and marvelous children. When I was sick, my older one was at my bedside every single day just to talk to me and try to cheer me up and talk to me. It was... I’m lucky. I’m very, very fortunate. Some people go through the war and come out with nothing. I have a lot.

Viederman: You had a lot that you brought with you inside you.

Mrs. Steiner: I guess so.

Viederman Commentary: The patient tells a story of a loving and nurturing primary family that protected her from the horrors of exile and war. This environment helped her to establish a world of confidence and optimism, of life over death. She speaks with particular warmth of her current family and the network of friends that she has created. The patient is never alone. The safety of her inner world is mirrored in her perception of the outer world. Mrs. Steiner’s capacity for abstract thinking enriches our discussion. When I speak of her not having brought the Holocaust with her, she understands this as a comment on her inner world. When she speaks of the nurturant world that she lives in, I remark that she brought this with her.

Viederman: I have the sense from what you’ve described that your life has been mostly happy.

Mrs. Steiner: Yes, yes. I have no complaints. If only I could be well.

Viederman: Yeah, I understand. But you are entitled to some complaints, even if you’re mostly happy. Do you have any complaints?

Mrs. Steiner: I really don’t. I’m not -- I’m not unhappy about anything because I have such beautiful things to look forward to, like having
twin grandchildren and then going away to Florida. I’m just, once in awhile -- more than once in awhile -- afraid of this cancer.

Viederman: Let’s talk about that, that fear, when that happens.

Mrs. Steiner: I cannot make -- people ask me, are you going to go for Passover to California, which we always did. I said, that’s April. I can’t think of April. I don’t know. I only live two months at a time, when I get a CAT scan. Because if it spreads, then…

Viederman: The future seems different to you.

Mrs. Steiner: Oh yes.

Viederman: That’s one thing that’s quite different.

Mrs. Steiner: I never thought about death. I never thought about sickness. Maybe I was too optimistic, but somehow I never really took anything seriously. Even if a child of mine was sick, I wouldn’t go frantic. She’ll be all right. She’ll be fine. Now it makes a big difference. Now I can’t think of months in advance -- years, forget it -- but even months.

Viederman: It’s a question of trusting the future, isn’t it?

Mrs. Steiner: I guess that’s what it is.

Viederman: I mean, that’s one way of describing what you’re describing. There’s some degree of distrust of the future.

Mrs. Steiner: True, absolutely true. Because, I know that sooner or later this will spread someplace.

**Viederman Commentary:** The patient reveals a change in her perspective on life. Her trust in the future has been shaken. There is a change in her time sense as she searches for pleasure in the immediate future. She now maintains hope by truncating her expectations.

Viederman: So you’ve been talking about the fear of death.

Mrs. Steiner: Yes.

Viederman: This may seem strange, but what does death mean to you?

Mrs. Steiner: I’m not exactly afraid of closing my eyes and going. Ff being sick, of being incapacitated. That’s one point. And then I feel it’s
too soon not to see my children, my grandchildren grow up. We are planning a bat mitzvah for my oldest one in a year and a half. I want to be here. I want to see her. This is a grandchild that somehow we have a good chemistry. We love each other very much. And when I think that I may not be here, I get scared. I get very scared.

Viederman: Of course, the sense of loss -- the loss of things that you value -- your family, your children, all of that.

Mrs. Steiner: I would just hate to go so soon and not to see them live. They are little and my children are young. To see the joy, to be with them… and my husband, I mean. I just don’t want to leave him. The greatest…

Viederman: He really is very special.

**Viederman Commentary:** The threat of death relates to the sense of loss, and in particular, the loss of the relationship with the family and the joy she experiences with them.

Mrs. Steiner: He doesn’t have a selfish bone in him. He doesn’t know what it means -- me, I -- no, it’s all for me and I’m very fortunate because when I went through the six months -- without him, I don’t think I would be able to take it. He would just shake me and tell me, you have no right to say what you are saying. You must go on -- and he kept it on and on and on, and screaming even at me. He pulled me through.

Viederman: He was committed to your living.

Mrs. Steiner: Exactly. He pulled me through. He has such strength that it’s unbelievable.

Viederman: It evokes for me as I think about it, the picture of your parents, also committed to you.

Mrs. Steiner: Yes, yes, yes, yes.

**Viederman Commentary:** The patient describes her husband’s unselfishness and commitment to her in words similar to those she used to describe her relationship with her parents. I recognize the parallel and comment on it. This is not an interpretation of conflict. It reminds the patient that I am listening carefully to her story.
Mrs. Steiner: We were not giver-upper, like they say.
Viederman: None of you in your family were, I guess.
Mrs. Steiner: No, no. We struggled, pulled out of Siberia, pulled out of Europe. Nobody ever gave up. Always trying and trying.
Viederman: What’s happening now?
Mrs. Steiner: Nothing. I’m just thinking about my parents.
Viederman: Tell me what you’re thinking.
Mrs. Steiner: I just feel that they are gone too soon, especially my mother. My mother was 69 when she died of a heart attack and there was so much love and affection that she was giving. She would see me now being sick, she would probably jump off the roof so maybe it’s better she’s not here, but I miss the family -- mother, father.
Viederman: It’s interesting what you say now about missing her and having her go too soon. That’s exactly what you said about your children, grandchildren, husband -- that’s exactly the same sense that you don’t want to go too soon.
Mrs. Steiner: Exactly.
Viederman: Just as your mother, for you, went too soon.
Mrs. Steiner: Exactly, exactly. She went much too soon. She didn’t even see a grandchild married off and then within a short time, both were married and she wanted so badly to see them married. She wasn’t here, but I guess that’s life.
Viederman: But it evokes a little sadness as you think about it now.
Mrs. Steiner: Of course, of course. Now I am the older generation. That’s how I look at it.
Viederman: I see. Of course, of course.
Mrs. Steiner: Yes.

**Viederman Commentary:** When asked about her thoughts during a period of silence, the patient speaks of her family, now dead, and in particular of her mother, who died when she was 69. The patient is 67 and the parallel between her own anticipated death and the pain
of her mother’s death is evident. She regrets that she, like her mother, will be deprived of the joy of a new generation. The parallel is pointed out to her. She responds with sadness, recognizing she is now the older generation. Currently the patient is in remission.

CONCLUSION

Viederman: In these interviews, I’ve illustrated aspects of the psychological engagement of the physically ill patient. What emerges vividly is the diversity of responses and experiences of these patients, each of which calls forth a different therapeutic stance by the consultant.

These are not formal psychotherapeutic sessions. There are no interpretations of unconscious fantasies, thoughts or feelings. These are consultations intended to support and relieve distress. Clarification is a useful part of this process. This involves the ordering of thoughts, feelings and experiences of which the patient is aware but has not put together. It may involve the labeling of an emotional response or the definition of a particular meaning attached to an experience.

The establishment of a connection between an important theme in the patient’s current life and past life can be a useful clarification. For example, it is helpful for Mrs. Stewart and Mr. Shaan to understand how their very different experiences of early deprivation have affected their need to develop the type of relationship with their children that they established. This connection was made by defining important themes in the patients’ current lives -- namely, their concerns about their children and then asking for associative connections to their early lives.

In the case of Mrs. Steiner, the patient’s fear of missing the pleasure of her grandchildren was related to the fact that her mother’s premature death at roughly her own age had deprived the mother of this experience. Such clarifications enrich the patient’s understanding of important concerns and values in his current life and serve the additional purpose of conveying to the patient that they have been listened to attentively by the consultant.
The subtle emotional interchanges that occur through the course of the interview and the communication of empathetic awareness of the patient’s state as well as establishing meanings are part of the fabric of the therapeutic consultation -- to note the patient’s affect, to reflect the emotional climate of an experience that a patient is describing creates the sense that it is a shared experience. This is exemplified by my response to Mr. Shaan’s deprivation and his pain in reaching up for a woman who turned out not to be his mother. By revealing how touched I was when he said so poetically, and so I shed me a thousand tears, I hoped to forge a sense of intimacy that decreased his isolation and loneliness.

The task is to recognize the person behind the patient. Patients who lend themselves to this interaction are most alive and benefit most from the encounter. There are definable differences in my therapeutic stance with different patients. Dialogue with Mrs. Stewart and Mrs. Steiner involves humor and easy conversational tone and the use of metaphor.

With Mr. Shaan, the tone is subdued. I reassure him directly when I convey my belief that his children are aware of his love, this based on what he told me of his attitude and discussion with them.

Mrs. Irenova is in acute crisis and in a regressed state. She is dependent and needs the support of a benevolent, nurturing and reassuring authority. Unlike Mrs. Stewart and Mr. Shaan, who are also intensely involved with their children, Mrs. Irenova is in a pathological and enmeshed dependent relationship with her 15-year-old son.

Mr. Callahan presents a different problem. He is in a state of numb shock and has a significant depression. Engagement is more difficult as I attempt to make contact with him by providing the emotional climate that I presume he experienced at the traumatic presentation of his diagnosis. Consultation with Mrs. Irenova and Mr. Callahan lead to recommendations for therapeutic interventions.

The patients revealed differences in the way they integrate concerns and the way they define themselves. Mrs. Stewart, Mr. Shaan and Mrs. Steiner recognized the cancer, maintained a hopeful attitude but
were aware of the potential dangers and ultimate death. Mr. Shaan in particular prepares his children for this possibility and attempts to alleviate guilt that they might feel about his death. Mrs. Stewart recognizes that her inclination to view her children as especially needy at this time may be a projection of her own view and that they may be more independent than she imagines.

Mrs. Irenova and Mr. Callahan are immediately threatened by their illness. Mrs. Irenova defends herself poorly against the immediate danger and is in a state of incipient panic. She speaks ambiguously about wanting to die. Mr. Callahan, on the other hand, defends himself with denial while at the same time communicating his view of the shortened life span by indicating that he might not be around.

Mrs. Steiner, in acknowledging the danger of cancer, has adjusted to a recognition of a shortening of her life by looking forward to pleasures in an abbreviated timeframe.

The therapeutic consultation is a supportive one, designed to reduce anxiety. No attempt is made to interpret defense. When Mr. Shaan states, if you love your foes, you can love your parents, I do not point out the implicit hostility toward them. I do not confront Mr. Callahan with his denial of his fear of death.

The wide variety of responses of patients to life-threatening illness and the resultant demand they place on the consultant makes this a challenging experience. There are no algorithms or manuals that can be used as guides for engagement. Each patient brings his personal and idiosyncratic life experience to the encounter.

One must understand how his particular perception of the new experience molds his needs and how the consultant evaluates and tailors his interventions to these needs. One approaches each patient with the flexibility, humility and curiosity necessary to find the patient behind the illness and to let him know that he has been recognized.
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About the Contributors

**Milton Viederman, MD**, is Emeritus Professor of Psychiatry at the Weill Medical College of Cornell University and until recently directed the Consultation-Liaison Service at the New York Presbyterian Hospital. Among the institutions at which Dr. Viederman has lectured are Oxford University, Harvard University, Duke University Medical School, University of Chicago, and UCLA School of Medicine. His honors include four Outstanding Teacher Awards at Cornell and two at the Columbia Psychoanalytic Center for Training and Research, the Ruth Easer Memorial Lecture at Mt. Sinai Hospital in Toronto, Ontario, Outstanding Lifetime Achievement Award from the Society for Liaison Psychiatry, the Robert Liebert Award in Applied Psychoanalysis, the Dr. Nathan Seidel Lecture on the Art of Medicine at the Beth Israel Hospital in Boston, among others.

A psychodynamic perspective and an interest in the narrative structure of people’s lives formed his Consultation-Liaison experience. Many of his publications address therapeutic change in the psychoanalytic situation and therapeutic possibilities during consultation. His recent publications include: *George Seurat: A Life Divided*, *Active Engagement During the Consultation Process, Presence and Enactment in the process of Psychotherapeutic Change, The Uses of the Past and the Actualization of a Family Romance, Metaphor and Meaning in Conversion Disorder, The Therapeutic Consultation: Finding the Patient, and A Model for Interpretative Supportive Dynamic Psychotherapy.*

**Ali Miller, MA, MFT**, is a psychotherapist in private practice in San Francisco and Berkeley, CA. She works with individuals and couples and facilitates therapy groups for women. You can learn more about her practice at www.AliMillerMFT.com.
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Group Therapy

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Narrative Therapy
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Positive Psychology
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Psychodrama Therapy
REBT
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Experts

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Scott Miller
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Peter Levine  
Rollo May  
...and more

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Suicidality  
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