"When Will All of This End?":

A 65-Year-Old Man With Amyotrophic Lateral Sclerosis and Psychiatric Distress

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Abstract

Patients with amyotrophic lateral sclerosis (ALS) are impacted both physically and psychiatrically during their illness. Emotional distress (ie, anxiety, depression, stress) is common in patients diagnosed with ALS, as prognosis is poor and there are very few effective treatments. The progression of symptoms is unpredictable, and all cases are terminal. Neuropsychiatric symptoms are also increasingly recognized as part of ALS symptomatology. There are currently no empirically supported interventions or best practices for adjustment to ALS. This case presents both the psychological and pharmacologic aspects of caring for a patient with ALS. Psychotherapy utilized a cognitive behavioral therapy–informed approach, and pharmacotherapy was tailored to the specific needs of the patient. We explore how these approaches impacted our patient, as well as how ALS-specific challenges presented throughout the course of treatment.

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Amyotrophic lateral sclerosis (ALS) is a rare, progressive, and incurable neurodegenerative disease affecting both upper motor neurons in the brain and lower motor neurons in the bulbar and spinal segments. Prevalence is higher in Western countries, with men affected more than women. Risk increases with age and reaches a peak between 60 and 79 years (age-adjusted prevalence: 6.6:100,000).[1] Approximately 15% of ALS cases are familial and linked to about 40 known genes (most commonly *C9orf72, TARDBP, SOD1,* and *FUS*), while the rest are sporadic mutations.

Although ALS is characterized by phenotypic heterogeneity, the most common forms comprise a bulbar or spinal onset, each accounting for about 30% of the cases. All phenotypic variants are characterized by progressive weakness of voluntary skeletal muscles, beginning in the limbs and extending to the trunk and later involving swallowing, speaking, and breathing, in the case of the spinal variant, or vice versa in the case of the bulbar variant, eventually leading to significant functional decline and respiratory failure.[2] Sphincter and extraocular muscles are typically spared, which allows for some individuals to communicate with computer assisted eye tracking devices in advanced phases of the disease. The prognosis for a patient diagnosed with ALS is on average 3–5 years.

Although the more traditional view of ALS has been that of a predominantly motor neurodegenerative disorder, clinicians and researchers recognize that cognitive and behavioral disturbances affect between 30% and 50% of ALS patients. Specifically, difficulty with executive function, apathy, irritability, changes in eating habits, and disregard for hygiene are commonly seen even in the absence of a diagnosis of frontotemporal dementia, which shares a common genetic background with ALS and can affect 15% of ALS patients. Moreover, depression, anxiety, sleep disturbances, and pseudobulbar affect causing emotional lability are commonly seen at different stages of ALS and are now considered part of the condition.

Given the complex clinical manifestations of ALS, treatment of individuals with this disease should involve a multidisciplinary team. Interventions are typically focused on slowing the disease process with riluzole and edaravone and on supporting adequate nutrition and respiratory care. Psychotropic medications are often used to treat depression and anxiety. There are no guidelines on the treatment of emotional and cognitive symptoms of ALS, and the choice of psychotropic drugs is based on individual factors including psychiatric history, comorbid conditions, and concomitant medications,

along with functional status. Additionally, no psychosocial interventions for ALS-specific adjustment have been validated with well-designed and controlled studies. The following case illustrates the psychiatric challenges patients with ALS face. The patient, "Michael," received both psychotherapy and psychopharmacology. We first introduce the patient and discuss his background, clinical presentation, and course of psychotherapy. Next, we discuss the treatments for Michael's neuropsychiatric symptoms and medication management strategies.

Neurological and Psychopharmacological Perspective

Dr Alice Flaherty

When treating depressed patients with neurodegenerative illness, it's natural to wonder whether the depression is reactive to the hardships of disease or an organic effect of neuronal death. In ALS, the answer is surprising: people with ALS are less likely to be depressed than those with other neurodegenerative diseases such as Parkinson disease and Alzheimer disease. Moreover, depression prevalence decreases with ALS progression.[3] Why?

Although ALS is primarily a disease of motor neurons, about 10% of ALS patients have temporal lobe cell death that causes frontotemporal dementia (FTD). FTD can protect against depression, at least in late stages, because it causes prominent apathy and lack of empathy. However, most patients with FTD are not apathetic. Could they have other protective personality traits? A study titled "Are People With ALS Particularly Nice?" showed that ALS patients are more agreeable and less neurotic than controls.[4]

We should consider whether ALS patients are less depressed because other people are nicer to them. ALS's status as a rare tragedy rather than a chronic disease protects patients from caregiver compassion fatigue, as does the fact that ALS patients are not prone to the psychosis and impulsivity of Alzheimer disease and late Parkinson disease. A cold numerical estimate of public sympathy might be the ratio of National Institutes of Health (NIH) research dollars to patient prevalence. In 2017, NIH research dollars per patient were $0.49 for dementia, $305 for Parkinson disease, and $2,053 for ALS.[5]

Whether it is ALS neurology or sociology that on average protects against depression, neither was enough to protect the subject of this case presentation from his fears and family stress. In any case, etiology's prime importance is to guide treatment, and both "reactive" and "organic" depression can benefit from both psychotherapy and antidepressants. ALS physical symptoms guide treatment more than cause does. The risk of respiratory suppression made benzodiazepines dangerous for this patient. Neuroleptics do not suppress respiration, but long-acting ones caused too much daytime sedation. The shorter half-life of quetiapine or risperidone might have been useful. Homebound ALS patients rarely see full daylight, so phototherapy can help both circadian dysregulation and mood. Slow letter-by-letter communication shrank the content of psychotherapy visits; emails gave him a freer voice. Treatment guidelines developed for groups work best when they are not boundaries, but heuristics to guide what approach to try first with each individual.

Existential and Palliative Care Perspective

Dr Yvan Beaussant

In the context of serious illness, an existential and palliative orientation can significantly impact patient care. The existential dimension of an individual's experience encompasses the concerns that arise when confronting the boundaries of life, leading to a renegotiation of the relationship with self, others, life, and death.[6] Michael, the patient in the presented case, embodies numerous existential themes such as meaning, purpose, values, self-identity, hope, time, and connection.[7] His experience with an incurable and progressive illness profoundly affects all aspects of his being, including his physicality, relationships, and existential reflections on the value and duration of his life.

Understanding and acknowledging the existential dimension of illness provides an alternative perspective to patients' distress, going beyond potentially pathologizing constructs such as depression, suicidality, and anxiety. By recognizing existential experiences as a process, health care professionals can foster growth, healing, and self-awareness.[8,9] Interestingly, data on psychedelic-assisted therapy to improve psycho-existential distress are promising, suggesting ways Michael's experience with psilocybin mushrooms might have been further integrated into his existential therapy.[10] Lastly, integrating the existential dimension highlights the importance of interdisciplinary care in addressing questions of meaning, purpose, dignity, and spirituality.

Turning to palliative care, it is essential to consider the role it played in this patient's case. The guidelines for ALS patient care recommend incorporating a palliative approach from the time of diagnosis.[11] This approach focuses on maximizing quality of life through relieving symptoms; providing emotional, psychological, and spiritual support; removing obstacles to a peaceful death; and supporting the family in bereavement. Although the case emphasizes optimal symptom control and psycho-existential support, it raises questions about end-of-life (EOL) discussions and the goals of care.

Understanding the extent of EOL conversations, advance care planning, and the management of impending life-threatening complications according to Michael's

Case History And Treatment Course

Dr Ethan G. Lester and Dr Ottavio V. Vitolo: Michael was a 65-year-old white male diagnosed with ALS 12 years ago. Michael was going through a divorce and had 3 children. He was well educated and had a successful career prior to leaving his job due to increased disability from ALS. Michael lived at home and had caregivers 24 hours a day. He had no voluntary muscle control and used long-term ventilation (BiPAP 24/7) for breathing. He could not communicate through his own speech and instead used eye-tracking software and text-to-speech technology. He was unable to control any parts of his body other than the eyes and was completely dependent on his caregivers for all activities of daily living. Michael managed his own care (ie, hiring, managing, paying his caregiver employees). In addition to ALS, he struggled with cardiac issues, hypothyroidism, restrictive lung disease, and chronic respiratory failure secondary to ALS.

Michael had a lifetime history of major depressive disorder (MDD; recurrent, moderate), which began in late childhood. He took psychotropic medications to manage these mood issues throughout his adult life. He also noted marital issues and work-related stress in middle adulthood. Michael had both passive and active suicidal ideation during treatment of his mood symptoms and thought about his death often, with no acts of furtherance. His family history of mental illness was remarkable for depression and alcohol use disorder (parents).

Michael had a challenging childhood and home life, and he described his parents as emotionally distant and authoritarian. He noted receiving limited affection and praise for his accomplishments as a child, and often he and his sibling witnessed emotions in the household only when both parents had been drinking. Michael's 3 children primarily lived with their mother. He found it difficult to connect with his children and prioritized work responsibilities over time spent with them. He noted that issues in his family and marriage became more pronounced after his ALS diagnosis. He denied having significant friendships and noted that most of his social interactions were with his professional caregivers and through email exchanges with old work acquaintances. Michael had several hobbies, including music, art, and reading; however, he was less capable of engaging in these activities based on his limited functioning.

Initial Clinical Presentation

Michael was referred by the Massachusetts General Hospital (MGH) Department of Neurology for psychotherapy for his recurrent MDD and adjustment challenges related to his illness and stress due to his ongoing divorce. He attended his initial evaluation virtually with his live-in caregiver. He expressed experiencing anger and frustration related to his ongoing divorce and family situation and about his medical illness. He appeared calm, with labored breathing and drooling, wiped by the caregiver. His affect was mostly blunted, at times characterized by grimaces, mood congruent smiles, and sudden crying episodes, consistent with ALS—pseudobulbar affect. He could not move any other part of the body. His language, as assessed through his text-to-speech device, appeared grossly intact, with good vocabulary. There was no evidence of psychotic symptoms.

The patient's goals for attending therapy were to improve his mood and emotional functioning. He met *DSM-5* criteria for MDD, recurrent moderate; generalized anxiety disorder with panic attacks; and adjustment disorder with anxious and depressed mood. The treatment plan included assisting him in developing better emotion regulation strategies for interpersonal and medical illness stress. Psychotherapy sessions were planned for every 2 weeks for 45 minutes for 6 months. His evaluation was limited by the use of telemedicine and his reliance on a text-to-speech synthesizer.

Psychopharmacologically, Michael reported a history of poor response to psychotropic medications and was not interested in new medications. He had been taking venlafaxine 37.5 mg once a day for many years both because he could not discontinue it without withdrawal symptoms and because he could not tolerate higher and more therapeutic doses. He had recently been prescribed bupropion 100 mg twice a day and escitalopram (unknown dosage) but was not taking them. He recalled taking escitalopram for some time, although he could not remember treatment dose, duration, and response. He also had trials of stimulants for fatigue (eg, modafinil 200 mg/d). Michael had a long history of insomnia, which had been addressed with the use of both benzodiazepines and nonbenzodiazepine agents (eg, eszopiclone). His ALS medication regimen included riluzole and edaravone. He had tried dextromethorphan/quinidine for pseudobulbar affect but could not tolerate it.

Psychotherapy

Dr Lester: Michael was offered an integrated treatment of traditional cognitive behavioral therapy (CBT), dialectical behavior therapy (DBT), and acceptance and commitment therapy (ACT) to address challenges in managing mood and distress (anger, sadness, worry, rumination) and interpersonal functioning (conflict, communication issues, and interpersonal boundaries, and goal setting) and to increase vitality and meaning through mindfulness, behavioral commitments, and personal values work. The first several therapy sessions were focused on processing the feelings of anger and introducing and utilizing the cognitive model for understanding thoughts, feelings, and

behaviors. The patient's anger was often directed toward his wife, who had initiated the divorce proceedings after citing several grievances related to how he had changed drastically after ALS onset, becoming more depressed, less engaged with the family and his children, more irritable, and notably more self-focused than ever before. Despite his serious disability, Michael was still able to enjoy what was accessible to him, including seeing his family and friends, listening to music, and watching movies. He was an avid Netflix viewer.

Michael learned to identify several negative automatic thoughts that occurred when thinking about his wife and their divorce, including, "She is ruining my life…" and "I have wasted so much time…" These thoughts were challenged and reframed. Furthermore, core beliefs were identified, including themes of unfairness and the feeling of being deserving of terrible things (such as in the case of his ALS). Homework was adapted based on the patient's limited functioning, and he made a habit of sending an email prior to the beginning of the session identifying thoughts and stressors he experienced from week to week. We also incorporated cognitive defusion and acceptance techniques from ACT and DBT when reframing thoughts proved challenging.

Early in the course of therapy, he noted a recent use of psilocybin mushrooms, which he considered an incredibly powerful, spiritual experience. He shared his emotional experience of elation and euphoria, as well as a "realization" and "epiphany" of a strong infatuation he felt toward a caregiver under his employment. The patient denied any inappropriate interactions between him and this health care professional. He described an experience of being cared for by this caregiver in contrast to the current stress and distress he was feeling about his marriage.

Michael's distress also increased due to insomnia, illness stress, stress related to managing his caregivers, and his ongoing divorce. He began to say phrases like, "It is too much to handle," "When will all of this end?" and "Do you know anything about physician assisted suicide?" Risk from these assessments was deemed low. He noted that, although he thought about death often, and sometimes even actively wished he were dead, he lacked a means to do so given his functional condition. When these topics were raised, we shared our concern for his safety. He understood and was appreciative of the care given to the matter.

Sessions continued, and at 6 months, the patient had completed 16 sessions. A new treatment plan was developed for monthly maintenance therapy, and an end date for therapy was left open-ended based on worsening of ALS progression and increased stress from his divorce. He had demonstrated some stability in his overall mental health, noting less anger and frustration overall, but still endorsed persistent sadness from his illness and diminishing relationship with his children. Michael felt like his adult children took little interest in him, which often led him to feel resentful and frustrated: "It's like they don't care about how I am doing…why don't they text me?" Despite feeling disconnected from his children, he often used guilt and passive aggression when communicating with his children. Skills of interpersonal effectiveness from DBT were emphasized when the patient was corresponding with his lawyers about divorce negotiations and interacting with his children. He identified goals of interpersonal effectiveness, noting practical, relational, and self-respect/integrity themes at the center of these difficult conversations he was attempting to have. Michael used these skills and wrote out thoughtful emails prior to the next scheduled session with the clinician and shared these emails with his children with positive outcomes, ultimately rebuilding the relationship with his children.

Michael completed 20 sessions and evinced improvements in his mood. We began discussing therapy termination given his stability but quickly became aware that this discussion activated fears of abandonment and rejection. His impression of therapy, despite the discussion of eventual termination at the outset of therapy, was that therapy would continue until his death. The patient was told that if he were to continue in therapy, we would need to identify further therapy goals. He elected to discuss caregiver management and values work.

Michael discussed finding another person to help manage his care. He recognized that much of his reason for continuing to manage his care on his own was due to a fear of losing control. Through several conversations with him, we were able to identify the value of "letting go" of some of the control and bringing on a care manager or lead caregiver who would be able to help with managing the employees delivering the care to him. He eventually hired a manager as part of his team, which allowed him to reengage in hobbies of listening to music and reading, as well as some experimenting with creative writing. However, the patient was experiencing a reemergence of low mood and distress as his ongoing divorce proceedings were triggering familiar feelings of anger and frustration. New compromises and legal decisions were made that threatened his financial security and his ability to keep his caregivers employed.

Over the next few weeks, Michael sent a series of emails canceling and rescheduling his psychotherapy appointments. He noted that his eyes were becoming drier and more strained, and that he often felt fatigued when trying to use his eyes for communicating. He wrote in an email, "I basically can't type for more than 20-30 min. Even then, frustratingly slow." And the following week, "Sorry, My eyes barely work. I don't know what to do about appointment. Have to cancel today." I assured him by saying, "It's okay, Michael—please reach out when you can and would

like to reschedule. Take your time and if I don't hear from you by end of month I will reach out again. Hang in there and save your energy." This was the last we heard from Michael.

Psychopharmacology

Dr Vitolo: Upon worsening of his mood and anxiety, venlafaxine was increased to 37.5 mg twice a day with significant improvement of his affective symptoms and good tolerability. The patient had also started taking alprazolam 0.25 mg 3 times a day prn for his anxiety and eszopiclone 3 mg at bedtime for insomnia. He shared ongoing fleeting death wishes, which never became too compelling.

Despite the use of benzodiazepines, his anxiety and poor sleep persisted. I initially recommended a trial of olanzapine at 2.5 mg at bedtime. The use of olanzapine could also help avoid high doses of benzodiazepines, which could further negatively affect the breathing drive of ALS patients. Michael communicated that although his mood benefited from olanzapine, he was unable to tolerate it even after cutting the dose in half.

I recommended switching olanzapine to aripiprazole 2 mg at bedtime, which could be less sedating; however, he discontinued this as well due to sedation. His insomnia had become more disruptive and affected daytime alertness. He reported waking up 5–6 times each night without reason. I recommended a trial of trazodone 50 mg at bedtime. Unfortunately, trazodone produced similar sedating effects and was discontinued.

Current Status

Dr Lester: Michael died a little less than 2 years after the initial referral. Records indicated he was admitted to the emergency room with new onset respiratory distress, and after rapid worsening and 20 minutes of resuscitation attempts, he was pronounced dead. I noticed a lack of closure to our work despite the clinically significant progress we made together over the 1.5 years. He will be missed, and I will think of him often as he taught me to be more mindful in the silence of my sessions, as when I was working with him there were many moments in which little was "said" but much was being processed.

Dr Vitolo: Although Michael was always very appreciative, I also had the impression that he, and I, were both becoming increasingly frustrated by the failed attempts to relieve his insomnia and other symptoms. As a neuropsychiatrist, I am constantly facing my own personal and the field's at large limitations in treating many complex and often devastating conditions. Nonetheless, few conditions bring both the patient and the health care professional to face and interrogate our own human nature and mortality so powerfully over such a short period of time.

Summary

In addition to the physical decline experienced, people with ALS often struggle simultaneously with other psychosocial issues throughout the course of their illness (eg, personal, financial, social/relational, spiritual). The utility of both a multidisciplinary team (often standard in ALS care) and an embedded team of interdisciplinary mental health providers (psychologist and psychiatrist) can make these issues that patients with ALS face more manageable throughout the course of their illness.

preferences is crucial. As his functional capacity declines, decisions regarding life-sustaining measures such as non-invasive ventilation and G-tube feeding become increasingly complex. Anticipating the decline of his ability to communicate and entertain himself via assistive technology raises questions about the ethical limits of sustaining his life and the potential use of interventions like terminal sedation or medical assistance in dying.[12] The importance of preserving his sense of control for Michael suggests that engaging in these discussions and establishing a plan aligning with his definition of a reasonable life might have been empowering for him.

Psychodynamic Perspective

Dr Margaret Cramer

Physical loss. Freud states that, "The ego is first and foremost a bodily ego."[13] With his existential and phenomenological focus, Binswanger considered that we don't just have a body; we are a body.[14] Physicality is integral to identity, so understanding Michael's previous relationship to his body could be useful.

Personality loss. Catastrophic illness can be a catalyst for either growth or regression. This patient's self-absorption and need to control others may be an artifact of illness, psychological adaptation, or exacerbation of character style. A family meeting might elucidate his premorbid relational functioning.

Past loss in the present. Michael's concerns are both contemporary worries and proxies for grievances of a painful past. His complaint that his children are not interested in him refers to his own childhood. His early life suggested enduring experiences of "unfairness" and emotional abandonment, proving that he was unworthy of attention on the basis of an affectional bond alone. He used guilt induction, financial control, and passive aggression to keep people close. Caregivers had to be paid or manipulated. His increasing disability and the prospect of dying likely reawakened yearnings for maternal care and love, emerging in the love/infatuation

for a caregiver. Although the target of his feelings might not have been appropriate, the tender affects associated with it were entirely relevant to treatment.

Ambivalence. When Michael says, "It is too much to handle" and "When will all of this end?" he expresses his desire for/fear of death. Exploring this might have created an experience of being deeply understood by a caring other. Candid discussions about the desire for death can help patients feel less alone, make life-as-it-is feel more possible, and actually undermine the desire to die. For providers, becoming better acquainted with defenses against mortality becomes a treatment imperative.

Termination. When death is imminent, the concept of "short-term treatment" requires redefinition. Holding the certainty of the patient's death within the treatment relationship could lead to greater frankness about provider availability. Michael's initial goal for treatment was to find "a space to talk about what I'm going through." Of all the things he meant by this, facing the end of his life was at the heart of the matter.

Clinical Points

- Patients with progressive, terminal neurodegenerative diseases like amyotrophic lateral sclerosis (ALS) are at increased risk for emotional distress secondary to their illness. Many interventions for these patients are primarily biomedical, and comparatively less attention has been paid to interventions addressing co-occurring psychological and psychiatric impacts of the illness.
- In addition to the physical toll ALS takes on patients and families, complex psychosocial factors (eg, family dynamics, occupational stress) can pose additional burdens for patients and produce more rapid and devastating health declines for patients with ALS.
- By taking an integrated, multidisciplinary approach to ALS care, and by prioritizing mental health, we can begin to address the additional challenges that patients with ALS face as part of their illness experience.

Dialectical Behavior Therapy Perspective

Dr Rebecca Harley

One of the "calling cards" of DBT is its versatile skills toolbox, teaching mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness (IE) skills in language that patients and treaters tend to like. We hear Dr Lester use DBT skills throughout this case—the IE work, for instance, when Dr Lester and Michael clarify the patient's interpersonal goals and then craft more effective communications to his children, leading to a much-needed sense of rebuilding in those relationships.

Underpinning the skills toolbox, DBT is rooted in dialectical philosophy, a basic tenet of which is that two (or more) opposing things can be true simultaneously. This is a problem for us humans, however, because oftentimes we struggle to reconcile opposing thoughts, feelings, needs, or points of view. Rather than siding with one side and minimizing the opposing side, or vacillating between the two polarities, the challenge of dialectical awareness is to hold the truth of both sides. Applied to a therapy context, we as clinicians must hold contradiction and tolerate how that feels. We invite our patients to hold contradiction with us, along with the accompanying feelings we both have. It can feel deeply uncomfortable and, when it works, also deeply relieving.

Michael's case is full of dialectics—many true, often painful things for which there is no one answer: his intense present-moment concerns about physical symptoms and caregiver and family relationships on the one hand, and looming awareness of his mortality on the other. The wish to live and the wish to hurry death along. Hope and hopelessness. I don't see these polarities as problematic, although of course they pain us deeply. It makes sense to hope for that which is possible—in Michael's case, things like connecting to the in-the-moment pleasure of watching Netflix or feeling supported by his care providers as they patiently wait for him to type his thoughts with his eyes. Equally valid is the co-occurring experience of hopelessness and its companion, sorrow, in response to that which is not possible: Michael will not survive ALS. While he lives, he will never use his voice to speak again, and he literally cannot lift a finger on his own behalf.

DBT points to validation as a core therapeutic tool for difficult, dialectical situations. When we offer our patients validation, we communicate that we are listening, that we see them, and that their reactions are understandable. We say, "Yes and Yes. It makes sense that you would feel *this* and also that you would feel *that*. I am interested in taking the journey with you as we work together to hold awareness of all of it." I suspect that, to this patient, validation of his concerns, both large and small, felt precious. Isolated and alone inside an unmoving body, the experience of being seen and understood was almost certainly a lifeline.

Integrative Perspective

Dr Jonah N. Cohen

Drs Lester and Vitolo present the case of Michael, a man with ALS who struggled to adjust to the disease. This case reminds us of the varied considerations when working with someone at the end of their life, including the importance of developmental history, psychological and existential distress, medical complications, and grief. Moreover, this case emphasizes

the essential role of a multidisciplinary approach over and above any particular theoretical modality.

Dr Flaherty allows us to zoom out of an intrapsychic lens and consider more societal, cultural, and psychopharmacological factors. ALS patients are treated differently and, on average, have lower levels of depression than their counterparts. Perhaps there is something about being locked-in our own bodies that forges stronger feelings of empathy in others, including therapists, psychiatrists, and caregivers. Moreover, despite the acknowledgment of social factors, Dr Flaherty also emphasizes the real suffering inside this patient's symptoms and the need for optimized pharmacologic management.

Dr Beaussant discusses the case from an existential and palliative care perspective. Dr Beaussant reminds us how Michael's case needs to be thought about beyond symptoms and to consider meaning, purpose, and identity. Of course, this is hard to do when our patients are exhibiting acute symptoms, but perhaps even more important in these moments so as to not over-pathologize. Finally, Dr Beaussant emphasizes the importance of a multidisciplinary approach in involving palliative care.

Dr Cramer discusses the role of dialectics by another name: conflict. In psychodynamic theory, unconscious conflict leads to compromises that can cause suffering. Dr Cramer discusses how this patient's experience of unfairness and emotional abandonment led him to use guilt and passive aggression. Psychodynamic therapy might have helped Michael understand that these strategies were not actually likely to engender the love he wanted. We needed to help him think of other ways to find the love he desired, which might have meant working toward better tolerating his vulnerability. Furthermore, Dr Cramer discusses ways—largely inside the therapeutic relationship—that might have helped Michael feel less alone and more understood by another, things he lacked developmentally.

Finally, Dr Harley discusses the idea of dialectics—that two things that are opposite can be true simultaneously. In life, suffering often occurs in the denial of simultaneous and opposite truths—that we can love and hate the same person, that we can think we do not need help but yearn for it at the same time, and that we can both want to die and want to live. Dr Harley offers us a frame that not only acknowledges these contradictions but also reminds us that inside contradiction is something not just permissible but beautifully human. Michael faced some of these contradictions and struggled to try to reconcile them. He wanted to live but also wanted to know when his suffering would end; he was aggressive and sometimes controlling of others but longed for more connections with his family, friends, and caregivers.

This case illustrates the importance of working together in a multidisciplinary effort to provide the highest quality care (medical, psychological, social) to our patients most in need. Conversations such as these are essential to this work.

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