EDITOR'S NOTE

Through this column, we hope that practitioners in general medical settings will gain a more complete knowledge of the many patients who are likely to benefit from brief psychotherapeutic interventions. A close working relationship between primary care and psychiatry can serve to enhance patient outcome.

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Midlife Crisis

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If you follow these articles, it will come as no surprise to you that I'm a big fan of the concept of life stages. For me, this concept is a useful way to think about the transitions we all go through in life: starting a new school, finding a life partner, embarking on a career, having a child, moving to a new place, beginning a new job, children leaving home, retirement, death of a spouse. I could go on and on.

This concept of beginning a new life stage can be effectively applied, as well, to a person told by a physician that he or she has been diagnosed with a major illness (e.g., cancer). In each case, the task requires an adjustment to the changes (or restrictions) imposed by the new stage in life. In each situation, the person affected is also vulnerable to assumptions that may or may not stand up to scrutiny, particularly in regard to whatever precipitated the new stage. For example, a patient facing a critical illness might blame a doctor who delivered the diagnosis.

Examining these (often faulty) assumptions and aiding a successful adjustment frame the task for brief psychotherapy. Cognitive therapy is well-suited to this problem.

CASE PRESENTATION

I was consulted recently by a 40-year-old, successful attorney. He had followed a somewhat circuitous path to his profession, but in the past 5 years he had found a career niche that satisfied most of his goals. He was working hard for a small law firm that focused on employment law and building a reputation as a trustworthy and effective professional. His parents were alive, healthy, and living nearby. He was involved to his satisfaction with several local charitable organizations. A skilled craftsman, he had a hobby of creating and building, designing and remodeling around his house, which he managed to find time to pursue.

He was a middle child, with one older and one younger sister, each married with her own children. He doted on his nieces, having a real presence in each of their lives. He had some friends, and occasionally went out with them, but his life lacked a committed relationship. Jack was gay and had come out over 5 years ago.

Lately, he noticed, he would periodically cry for no reason, and at times become "too easily upset." However, he slept well, ate well, and maintained a stable weight. He had energy, did not suffer easy fatigue, and could focus his attention. Jack had an excellent memory. He would not describe himself as an anxious person. Rather, he had the sense that something in his life was missing.

A friend in whom he had confided suggested the model of cognitive therapy to him and suggested that he contact me. My DSM-IV diagnosis was adjustment disorder, with mild depressed mood.

PSYCHOTHERAPY

Jack returned for session 2, feeling satisfied that he had successfully conveyed his situation and now "needed a plan." He wanted to "better

identify what he was looking for" and to learn "how to get from A to B." We examined his social activity and his accessibility to meeting people. "I put myself in socially limiting situations," he said.

We discussed his view of himself and the traits of a man he might find attractive. The cognitive model, with its emphasis on the here and now and on his personal meanings, suggested *action* to him, as opposed to *reflection*.

He reported for session 3, having thought a lot about what he wanted and what he was or wasn't doing about it. "I'm putting some new behaviors into play," he said. He believed that he needed to expand his social contacts, and that could only happen with some initiative on his part. He saw himself as having been too critical of people he met in the past. We defined options and talked about possible consequences.

Our last meeting came about one month after the first. "I've done well," Jack said. "A lot has changed for me." He had made major changes in his routine: when he went out, where he went, and with whom. The telephone was ringing much more often now. He felt he was being more open with people and much more conversational.

There were fewer chores to occupy the weekends, allowing more time and accessibility for relationship. He was noticeably happier with himself. His focus now was on "what he could do" rather than "what life was doing to him." He felt that he had "turned a major corner."

Cognitive therapy, for Jack, had been like lighting the pilot light in the grill. It had triggered a significant reorganization and resulted in his taking responsibility for working toward a goal. Once the grill was lit, there was no immediate further need for the pilot light.

I told Jack that he had made excellent use of our time together. I would remain available to him in the future, should he decide that more sessions would be useful. He had arrived in my office and defined a type of midlife crisis. He left with a sense of direction and purpose. Mission accomplished. ◆