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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Passages

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In 1976, journalist Gail Sheehy[1] wrote a popular book detailing a series of "passages" in the life of an adult. I have written about retirement, stressing the need for an individual to craft a new adaptation to a major change in life circumstances.[2] Moving forward[3] may entail similar adaptational work.

When an incapacitating illness puts a clamp on one's usual pleasures, blocks mobility, and restricts activity, it can be said that passage into a new life stage is the patient's task.

A family physician treating an elderly man for colon cancer and emphysema was troubled by her patient's increasing withdrawal and sad mood. She feared that the patient was suffering from major depressive disorder and referred him to me for evaluation and treatment.

CASE PRESENTATION

Mr. A is an 80-year-old man, married for 52 years, with 3 adult daughters and 10 grandchildren. A pillar of the community in which he has lived nearly all of his life, Mr. A was the senior partner in a highly successful law firm until his 72nd birthday when he was diagnosed with colon cancer. Treated with surgery and then chemotherapy, he did not expect to live 5 years. A lifelong smoking habit had left him with emphysema, but otherwise, he had been quite healthy. When he retired at age 75 years, he continued to play tennis and to work out several times a week.

Mr. A and his wife had an active social life and frequently visited or were visited by their children, typically with the focus of spending time with their grandchildren. Mr. A regularly attended legal-society meetings and was an active member of his church.

At age 75 years, his cancer recurred, and he was beset with continual leg pain and had difficulty walking. Alcohol use had never been a habit for Mr. A, and it did not develop now. Instead, unable to play tennis or exercise, he withdrew to his house. Over time, he lost his usual interests and stopped seeing friends. He no longer went to professional meetings and rarely saw his children or grandchildren. He stopped going to church. A lifelong reader for work and pleasure, he no longer had books stacked by his bed.

Mr. A was now 80 years old, had outlived most of his friends, and awaited death, as his activity level dropped to near zero. Cancer, however, was not cooperating, and Mr. A continued to eat, sleep, and move his bowels relatively normally. He confessed to having near-normal energy and no problem with fatigue, despite his physical restrictions and pain. His memory remained excellent. His mood was mostly one of sadness related to his plight.

My DSM-IV diagnosis for Mr. A was adjustment disorder with depressed mood. I prescribed no medication but suggested a course of brief cognitive therapy. I conveyed my evaluation and plan to his family physician. Mr. A expressed "eagerness" for treatment.

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PSYCHOTHERAPY

In session 2, I taught Mr. A the cognitive model, emphasizing that cancer, emphysema, and aging might be beyond his control, but that he had many choices in other areas. We inventoried his pleasures and skills, noting how each was affected by his medical conditions. He discussed the friends (many were lawyers) who had died and how tennis had been a major sustainer for him, but that he could no longer play.

After our initial visit, Mr. A had resumed reading, effectively challenging his belief that he would get no pleasure from it. He discussed "not wanting to burden his children with his problems." I asked him how he might think about those relationships in other terms, and he acknowledged that the children might be a resource of ideas for him. Spontaneously, Mr. A brought up a social club in which he had been active and suggested that, if he resumed going to meetings, the interaction might be stimulating for him.

He described a project, abandoned years earlier, that sought to document an aspect of local legal history. I asked about the obstacle preventing him from returning to the project. Mr. A cited "age" and then said that he probably could do most of the work to complete the project at home on his computer if he "really tried." The session consisted largely of us both generating ideas for him and Mr. A finding ways to approach those ideas.

By our third meeting, Mr. A reported a doubling of his activity level. He described how he must appear to others, focusing on the word "nuisance." I asked him to think about a friend of his with similar achievements and interests. Would he see this friend as a nuisance? "Of course not," he said. I stressed identifying his conclusions to see if they met the tests of rationality and strategic worth typically applied to automatic thoughts when they are tested. Often, they did not.

Mr. A came for our fourth and final visit acknowledging that he had remained active and felt "stronger" and "more connected to others, and to life." He had joined a book club that met monthly. He and his wife had invited several younger couples over for dinner and had received return invitations. Mr. A and his wife found these evenings stimulating and worthwhile. "Cancer and emphysema didn't stop me," Mr. A concluded. "I stopped me. And if I chose to stop, I could choose to resume."

I couldn't have said it better myself.

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