Establishing a Therapeutic Focus

Dean Schuyler, MD, and Donald L. Courtney, MD

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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For a doctor working with an older-aged population, meeting patients with severe medical illness is an everyday occurrence. Some symptoms can be treated and some must be borne by the patient and family. In every case, however, the problem of establishing a psychotherapeutic focus must be dealt with by the patient.

When the diagnosis is cancer, when the problem is heart disease, or when the cause of distress is emphysema, often much is known medically about the patient's situation. However, when the diagnosis is obscure and the problem is a rarity, there may be no accepted treatment to prescribe. The management issues may be more complicated; however, the patient's task of "where to focus" remains largely the same as that of someone with a more common problem.

CASE PRESENTATION

Mr A was a 50-year-old black man with 2 teenaged daughters. Born and raised in New York City, he was the middle child in a large family of 10 children. Mr A had 4 older brothers and 5 younger sisters. After graduating from high school in Manhattan, Mr A's family moved to Charleston, South Carolina, where his father worked as an engineer. Mr A attended college at the University of South Carolina, Columbia, studying to be an elementary school teacher.

At age 22 years, Mr A enlisted in the Army, serving for 15 years before returning to Charleston. He then taught third-grade children for the following 12 years. During his childhood, Mr A recalled having frequent skin infections and rashes that were never diagnosed. There were recurrent skin pustules resulting in scarring and hair loss. While in the Army, Mr A experienced a severe lung infection that required hospitalization. There was a history of juvenile and adult asthma.

By age 49 years, and after a second puzzling bone fracture had occurred, a surprising diagnosis was made: hyperimmunoglobulin E (Job's) syndrome. The syndrome name derives from the Old Testament character from the *Bible* who was beset with boils and various afflictions as a test of faith. Mr A had the coarse facies—prominent forehead, deep-set eyes, and broad nasal bridge—typical of these patients. This autosomal dominant syndrome is rare (1 per million; 250 cases reported in the world literature). Typically, the skin abscesses are sterile, but secondary infection is common. Other characteristic findings include asthma, recurrent skin pustules, spinal scoliosis, recurrent pneumonia, and a variety of bone and teeth abnormalities. Laboratory values confirmed an immunoglobulin E level that was over 130 times the upper limit of normal.

Immunoglobulin E is a mediator of allergic reactions. Receptors for immunoglobulin E are found on mast cells. When activated, immunoglobulin E attaches to mast cells, and they release several factors, chiefly histamine. This histamine is a principal mediator for the asthma, skin problems, and pneumonia as well as for some of the skeletal abnormalities associated with the disorder. Mr A's history revealed a progression of the complications of Job's syndrome. The diagnosis was finally made during the treatment of his cervical spondylosis. At that time, he was having problems with upper and lower extremity weakness, and he had a radicular pain syndrome. For the progressive spinal problems, Mr A had a C3–C7 posterior decompression and spinal fusion. Afterward, he was sent to a rehabilitation facility for 2 months. At that point, it was apparent that Mr A would need long-term skilled nursing care, and he was transferred to our nursing home facility.

Medical Management (Dr Courtney)

Mr A's physical examination was remarkable for the scarring and saddle nose deformity common to Job's syndrome. Proximal upper extremity strength was graded at 2/5. He could not dress himself or do personal hygiene. Distal upper extremity strength (wrist and hands) was rated 4/5, with some clumsiness, but no cerebellar signs. There was evidence of the chronic pruritus commonly seen in the syndrome, along with more intense itching of the trunk, with a new macular skin rash. A drug reaction to metformin was suspected, and when the drug was stopped, the rash resolved.

Since antihistamines diminish the impact of histamine, Mr A was started on both classes of antihistamine: the H_1-receptor blocker loratadine and the H_2-receptor blocker ranitidine. Mr A reported significant reduction in his chronic pruritus, as well as decreased heartburn.

During 4 months following admission to the community living center, Mr A showed modest improvements in function. These improvements were related to his adaptation to (and learning to work around) his limitations, but only in small part due to increased strength. His skin problems gradually improved. Mr A had become actively engaged in managing his illness and disabilities.

Psychotherapy (Dr Schuyler)

I was asked by Dr Courtney to play an active role in the treatment of Mr A. I started off our relationship by introducing myself and stating my purpose: to help him adjust to his illness, its treatment, and his new surroundings. He told me about his 2 teenaged daughters and his earlier life in New York City, as well as his lengthy Army stint. Mr A described his (12-year) occupation as a third-grade teacher, before he "got sick." His diagnosis was made in 2010, and he was given a medical retirement and a pension.

After taking a history and establishing "engagement," it was important for me to ascertain Mr A's goals for care. He wanted to build up his strength, to become more independent, and, if possible, to find a new companion. Mr A revealed himself to be a person of faith, and he expected to be able to regain some lost function. Clearly, he was intelligent, thoughtful, well-educated, and well-spoken.

We spoke at our next meeting about a program designed to increase his diminished arm and leg strength. He noted recurring thoughts that he would be dependent for the rest of his life. We discussed the strategic implications of this thought and that how he handled it was up to him. Mr A compared the process to prayer. "It's always easier to do it for someone else than it is for yourself, but it's the same process," he said.

In our third session, Mr A emphasized how important caretaking was for him (he had cared for an ailing grandfather for years) and how hard it was for him to allow others to take care of him. I responded that this statement neatly captured the caretaking patient's dilemma and told him how often I had heard it before. Mr A expressed some feelings of loneliness and ended with a declaration of the need to remind himself how important it was for him to be able to rely on himself.

At our next meeting, Mr A emphasized his need to get outside the nursing home unit each day. He described a routine that included twice-weekly physical therapy sessions, daily exercise, and frequent trips outside. At our fifth meeting, Mr A complained about oversedation, and I reviewed his medications with him, pointing out which ones might be contributing to his sleepiness. He spoke also about his parental expectations for his daughters and his role as a single parent. I agreed with his observations about adolescence. I also underscored the importance of his physical therapy.

At our next meeting, Mr A brought up his career teaching children and its significance to him. He spoke about how he saw his students' world changed by social media technology and how he had tried to relate to their world. He told me a joke, and was, in general, much more spontaneous. Later on, he focused on how his daughters "thought" and how often this differed from the way that he thought. He emphasized the need for his children to be "accountable, responsible, and to own what they do." He spoke too about establishing the habit of monitoring his own thoughts and being selective about what he chose to dwell on. I told him that, for a cognitive therapist, this habit validated much of what I hoped to accomplish with him.

While reading the nursing notes before our next meeting, I learned that Mr A was found to be feeling sorry for himself. His morale had been up and down, and his activity level had varied with it. I planned a "moralizing session" with him, aimed at a period of demoralization. Consistent with this goal, I asked him what he was now able to do. He enumerated his gains, and I emphasized his role and responsibility for his progress.

SUMMARY (Dr Schuyler)

The initial task was to engage Mr A in planning for this stage of his life. Then, I endeavored to establish with him his goals of care. I tried to be an effective conduit between the treatment team and the patient, answering Mr A's questions when I could and directing him to relevant members of the team when appropriate. We discussed his parenting role as well as the painful absence of his educational job. Overall, he succeeded in making a good adaptation to the life stage that began with his admission to the nursing home unit.