Finding a Way Home

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Palliative care is defined as the relief of pain, symptoms, and stress of a serious illness. One of us (J.S.) has had an ongoing medical interest in this area for years. The other (D.S.) was recently hired to work part-time on a geriatric unit of a general hospital, wherein he joined a palliative care team.

On this unit, the concept of "life stage" has a particular poignancy. While most of the patients have a variety of serious medical illnesses, many are also older and are often thrust into a new life stage upon admission. Their lives have not always been happy ones, and, too often, there is no caretaker to relieve the burden of constant isolation. Daily existence becomes dominated by staff and other residents, as well as the experiencing of symptoms relevant to their underlying medical circumstances and the treatments aimed at relieving them.

There is a need therefore for a medical physician to diagnose and treat patients admitted to a nursing home unit, along with a psychiatrist to provide brief psychotherapy focused on adjustment to this new life stage.

CASE PRESENTATION (Dr Schuyler)

Mr A was born in Boston, Massachusetts, to a family of 3 boys and 3 girls. This 70-year-old divorced man is a high school graduate. He spent his adult life working in the Navy and was stationed during his final work phase in Charleston, South Carolina. He supported 2 daughters and a son but derives little satisfaction from how they have turned out. He has no contact with either of his ex-wives. Prior to his admission to the hospital, he lived alone in a small apartment, in which he drank to intoxication and smoked cigarettes constantly. He had few friends, and there was little life activity.

His hospitalization was prompted by increasing difficulty breathing, as well as an unstructured and isolated lifestyle with little focus. When I met Mr A, he had already been an inpatient for 5 months. Alcohol and tobacco had each had their consequences on his life, but neither was a current habit. Periodically, he would cry, but vegetative symptoms of depression were absent. Rather, there was anxiety seemingly related to all he had lost control over and sadness largely related to feeling sorry for himself. My working *DSM-IV* diagnostic impression was of an adjustment disorder with depressed mood.

I planned to try to engage Mr A in brief cognitive therapy aimed at establishing a basis for this new life stage.

MEDICAL CHALLENGES (Dr Senseney)

Mr A came to us for end-of-life care after multiple hospitalizations over the past year for exacerbations of chronic obstructive pulmonary disease. He had used home oxygen for the past 4 years, living alone, without a caregiver. With minimal exertion, he would become so dyspneic that he thought he was "going to die."

When I met with Mr A, he was very guarded about allowing anyone to provide care for him. When the prognosis for his emphysema was discussed with him, he joked and was reluctant to talk about the end of his life. After several days of "thinking it over," he agreed to be admitted to our nursing home unit.

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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Over the first couple of months, Mr A required morphine to counter his difficulty breathing (40 mg every 15 minutes as needed). Morphine sulfate controlled release was added to help with his shortness of breath at rest. Since anxiety complicated his breathing problems, lorazepam was started and titrated to 1 mg 3 times per day. When left by himself, Mr A would sit alone and "watch the world go by."

After 3 months, our staff began noting comments from Mr A about someone stealing from him or wanting to kill him. Over a 3-week period, he began expressing more and more frequent paranoid ideas and finally struck out at staff members who he had previously been friendly with. I increased his morphine, morphine sulfate controlled release, and lorazepam and started haloperidol to counter his delusional thinking and psychotic behavior. I was concerned about his worsening dyspnea and anxiety, as well as the effect of his personality style and the consequences of his former coping behaviors (involving alcohol and tobacco). I believed that all were contributing to the onset of delirium. Perhaps also, his delirium was secondary to active metabolites of morphine or represented a paradoxical reaction to increasing doses of lorazepam. Mr A was aware of (and unhappy with) his bizarre behavior and wanted to "not feel this way."

I reduced his morphine and started hydromorphone hydrochloride that he could self-administer. I systematically reduced his dose of lorazepam and started small doses of alprazolam. Within 72 hours, his behavior improved and his mental status cleared. His dyspnea and anxiety were each now well controlled. When the hydromorphone hydrochloride pump was seen as "too confining," I replaced it with an equivalent amount of oxycodone. Haloperidol was tapered and discontinued; oxycodone was decreased.

I met with Mr A almost daily now, and although he continued to joke, he began to share glimpses of himself. I realized that fear of this stage of life was a huge contributor to the anxiety that worsened his breathing difficulty. He needed some perspective to help him adapt to his present situation. A psychiatrist (D.S.) had joined our team prior to the onset of Mr A's delirium. Their work together would now take center stage.

PSYCHOTHERAPY (Dr Schuyler)

After an intake visit, I was determined to speak with Mr A every other day for a while to see if there was a focus for this life stage that he would find worthwhile. The presence of daily crying and periodic sadness was in contrast to the absence of vegetative depressive symptoms. His energy seemed drained by his poor lung function and his constant need for oxygen. Respiratory difficulty limited his mobility, and, consequently, his activity level in the hospital was low. He saw life as having passed him by and found little that remained engaging. Before each session, I reviewed the nursing notes as well as any medical notes that had been written.

In our second session, Mr A focused on negative self-statements: "I can't. I'm not smart. I can't write," he said. I emphasized the concept of choice for him. I tried to separate what his disease (chronic obstructive pulmonary disease) imposed from that which he could reasonably take responsibility for. He wanted the initiative to come from staff members. I suggested that, more often, it would need to originate from him. Afterward, I met with his social worker to suggest the value of including Mr A in a problem-solving session related to a unit issue.

In session 3, I emphasized the excuses he typically offered to avoid an activity, followed by a complaint that there is "nothing to do." He noted looking forward to a daily visit from a volunteer. He had thought about a task that he might undertake with the occupational therapist. I determined to send the therapist a copy of my note and told Mr A.

Prior to session 4, Mr A had experienced paranoid and psychotic thinking and a bout of unusually aggressive behavior. Hypotheses to explain this behavior varied from the psychological to a pharmacologic drug interaction. Aware that this state had prompted some initial restrictions and then a rearrangement of medications, Mr A said, "I went crazy." He also said that he found dealing with large groups of people difficult, and, therefore, he avoided activities that he anticipated would involve many people. We discussed his recollection of the past 2 days in detail. He acknowledged feeling afraid but now felt more in control of himself and was glad to see me again.

Prior to session 5, I discussed medical management issues with his nurse and his internist. I found Mr A to be thinking logically. I emphasized the importance of re-establishing his self-control and encouraged him to be a self-advocate with staff. I promised to do my part to support him.

By session 6, the clearing of his thinking and the re-establishing of privileges to roam about the hospital had worked wonders for Mr A. I attributed the major etiology for his original mental changes to drug side effects. He focused our talk on "dying," what it would be like, and how it might happen. It was evident that this topic was on his mind and that he saw our sessions as an appropriate place to speak about death and dying.

In our seventh session, Mr A focused on how he believed he was seen by others, why people liked him so much, and how he joked to avoid dealing with some real issues. He expressed embarrassment at his brief episode of psychotic behavior. At an eighth session, he expressed remorse about his past behavior and "life." He was dissatisfied with what he saw as "earlier outcomes." Again, he emphasized his current social success. It seemed like he had made the residents and staff the centerpiece of his existence during this stage. Drinking and smoking were no longer his focus. An intellectual establishment of a new interest seemed quite unlikely.

However, an aspect of the "old Mr A" was back, and, for now, he was enjoying it. There was no longer any sign of his prior depressed mood. His adjustment to residing in the nursing home unit seemed transformed.