Keeping Hope Alive

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American society has been through significant changes in our lifetime. Recent events have focused people on the stability of their employment and the continuity of their income flow. When the situation is global and affects many people, multiple others are available to counsel an individual seeking to adapt to change. However, when the change relates to illness in a given person, it is often easier to lose perspective, fail to adapt, and to "give in" to the consequences of the disease.

The typical patient one sees while working on a geriatric nursing home unit in a Veterans Administration hospital is elderly, suffers from multiple physical illnesses, and at times is demented as well. There is only the occasional female patient and the infrequent younger person.

Mr A was diagnosed with multiple sclerosis in his 20s. The disease was stable with few changes requiring adaptation until 3 years before his admission to our hospital at age 35 years. Prior to that time, he continued to work and live a productive life within his family and community.

Then, symptoms and dysfunction had a sudden onset and a rapid progression. The man I met was bedridden, had seriously impaired mobility and speech, and had a horizon that appeared bleak. It would be his task to find a mindset that allowed for hope for the future and to modify his thinking to take into consideration the physical changes brought about by his disease. He would be asked to accomplish this while living alongside a decidedly older (and often unavailable) population of men. There would seem to be an ample agenda for the unit psychiatrist to address.

CASE PRESENTATION

Mr A was a 35-year-old man born in North Carolina, separated from his wife with 2 teenaged daughters, who had worked as a chemical engineer. His father suffered from multiple sclerosis as well, but had gained significant benefit from an experimental drug treatment 30 years earlier. Mr A was the eldest of 3 children, having 2 younger sisters. His admission was prompted by an inability to care for himself at home. He was wheelchair bound and had spasmodic movements, as well as moderate dysarthria and ataxia.

Three years earlier, when his disease began to progress rapidly, he suffered a period of acute depression that resolved (perhaps with the aid of prescribed citalopram). When his acute disease-related problems were solved on the general wards of the hospital, he was transferred to our nursing home unit. It was anticipated that he would subsequently be transferred to a private nursing home facility for end-of-life care. But, life doesn't always work out as planned.

Medical Course

Having served his country during Desert Storm, this young veteran was admitted to the Veterans Administration general hospital when his disease had progressed to the point that he required more help at home than could be provided by the home health services. He had dermatologic problems that required intravenous antibiotic treatment, but there was no current plan of attack for his progressive disease. His skin conditions were

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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Prim Care Companion CNS Disord 2011;13(1):e1-e2

(doi:10.4088/PCC.10f01131).

cleared up 1 month later, and the focus then was to find a nursing home that could provide end-of-life care.

After a diligent search by social services, it was decided to admit him to our skilled nursing home unit. After several months, a consultation with the neurology staff offered the suggestion of a chemotherapy trial that conceivably could slow or reverse the progress of multiple sclerosis. It was not entirely coincidence that the drug chosen had been administered successfully to the patient's father many years earlier. However, the protocol would be different. Instead of daily dosing, he would receive monthly intravenous treatments for 6 months, with the dose continuously increased. This would be followed by similar treatments administered every other month for the following 6 months. Then, a functional reevaluation would be done.

Psychotherapy

The internal medicine team thought that Mr A could benefit from a relationship with the team psychiatrist. I met him after he had been an inpatient on our unit for 6 months. He could no longer transfer from one position to another without help and could not support himself on his legs. One year before, he had sustained a significant (30 lb) weight loss. There was a question of some short-term memory loss. During our intake evaluation, there was little anxiety evident and no depression. There was no indication of psychosis. His thinking was goal directed. His current adjustment seemed remarkably good. His speech was "thickened," but easily understood. I noted his past history of depression. He had just begun a protocol of monthly chemotherapy with cyclophosphamide. Other than fatigue for several days following an intravenous chemotherapy dose, there were no discernible side effects. The plan, however, called for a substantial increase in dose each month.

My task was to monitor his emotional reaction to treatment and to provide a sounding board for him to discuss his thoughts about his disease. He focused on the periods of depression, which he related to hopelessness about any chance for regaining lost function. He expressed low expectations for the future because, "Nothing has yet made a difference for me." I focused his attention on the importance of his role as a self-observer. In light of the protocol treatment, he would continually be asked whether he saw any changes that he could relate to treatment. We discussed reasonable expectations for the initial 6-month treatment.

In our second session, Mr A mentioned that his father, too, had entered the hospital in a wheelchair but that he had left walking on his own. I suggested that he ask the administering neurologist how she would measure his progress. I also cautioned him that the side effects of treatment he observed after 1 month might not predict future effects.

When he demonstrated a dramatically increased ease in walking down the hallway, I asked him to explain his progress. He responded that his expectational system would likely be central to any success he had. He allowed that his newfound ease might be attributable to the treatment. In our fourth session, Mr A focused on his thoughts about his marriage. He wanted his wife to "move on" and not tie down her life to his disease and its course. But also, he wanted his wife to remain committed to him. He hoped that he would recover one day and reconstitute his marriage. He also spoke about, and correctly defined, demoralization as a loss of effectiveness. He acknowledged that he worried about this and that it affected his mood. For his treatment to succeed, he felt that it was necessary to maintain his sense of competence.

After several months of meetings, Mr A revealed that he planned to write a book about his illness. Earlier, he had written (and published) poetry. We discussed precontemplative, contemplative, and active writing stages in creating a manuscript. I consistently encouraged this project. He emphasized the importance of his day trips out of the hospital, accompanied by a good friend, and sometimes, by his wife. "I've learned that people can see me as someone other than a patient with multiple sclerosis," he said. Asked how he viewed our relationship, he said, "I know that you are serving as my guide."

The interval between his monthly treatments allowed too much time for him to think. These periods frequently resulted in his periodic depressions. My attempt during these times was to reorient him to the ways in which he could reconfigure his expectations.

We discussed alcohol and its interaction with chemotherapy as well as with depression. We discussed his view of his wife in detail. But, mostly, we focused on his view of himself in its varied components. He made real progress in reworking his self-esteem, incorporating his experiences outside the hospital as well as his relationships with staff and patients on the unit.

CONCLUSION

It is my opinion that Mr A made continual good use of our sessions together. With time, he shared more and more detail about his thinking and emotions related to his life and future. Now, in the midst of chemotherapy with regular dose increases, his commitment and perseverance have been remarkable. As to the effectiveness of the treatment, only time will tell.