Live Until You Die

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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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I have been working for over a decade now helping people with serious illness "live until they die." My work focuses on the cognitive model of therapy, which points to the thoughts that people have and the response people make to them. When an event like a serious medical illness strikes, I believe that we all have catastrophic thoughts: "Uh, oh, this could take my life," or something similar. The story, however, does not end here. Rather, it begins here. If an individual focuses on, magnifies, or thinks more about this thought, it can dominate cognition. If, however, the individual disputes this thought and applies his or her energies elsewhere, the thought often has little effect.

I believe that this approach can be taught to a person suffering from serious illness. By applying the cognitive model at the proper time, he or she can avoid the cognitive consequences of focusing on an undesirable outcome. I pair this with consideration of one's life stage. I believe that a diagnosis of cancer (as one example) can usher in a new life stage. It is typical of a new life stage that a person spends time thinking about what he or she can and cannot do at this time. Once again, if the focus is set on what one can no longer do, there are negative consequences. A healthy focus considers what an individual can do now.

The usual emphasis on avoiding cognitive errors remains a part of any cognitive therapy: polarization, personalization, and overgeneralization. Does the individual think typically in terms of black and white? Does he or she always put himself/herself in the center of the screen? Does one (often) correct assumption lead to a whole raft of related ideas, many of which have no validity?

The person confronting serious medical illness, and many people dealing with the changes wrought by increasing age, retain an identity that relates to an earlier time of life. They do not update that "identity pie" to reflect their current reality. Doctors and lawyers, for example, continue this view of themselves long after they have retired from doctoring and lawyering.

For many people, this approach lends itself to a brief therapy interaction. Many patients want this interaction to take place with their providers. However, many providers either do not talk much with their patients or do not see this aspect of doctoring as one of their roles. This lack of physician-patient interaction has made room for a psychiatrist with a specific task as a member of a treatment team. Typically, the therapy is short-term and complements the interaction of the patient and his or her physician.

At times, however, the relationship is long-lasting, the patient's personality is unyielding, and the transaction continues for quite a while. I met Mr A more than 3 years ago. We continue to meet regularly, and we each believe that benefit continues to accrue.

CASE PRESENTATION

Mr A is a 77-year-old Chinese man, married to his wife for 58 years. They have 4 grown children and multiple grandchildren and great grandchildren. His care was being managed by a hospice when he called the local Veterans Affairs hospital. "Is there anyone there that I can talk to," he asked? "I can't seem to talk with anyone at the hospice." I agreed to meet with him and his wife and see if I could help. Medically, he suffered from coronary artery disease, chronic obstructive pulmonary disease, hypertension, gout, and depression. He used daily oxygen at home.

Born in New York City, Mr A was raised in Washington, DC. He was the eldest of 3 children. His mother died when she was nearly 90 years old; his father died of a heart attack when Mr A was quite young. Mr A graduated from high school in Washington, DC, and attended several years of college before he began selling insurance. By age 40, he started his own insurance company. He and his wife married in 1956. They moved to Charleston in 1982.

Mr A was healthy until chest pain led to a triple bypass in 1999. Gout and hypertension followed soon thereafter. A lifetime of cigarette smoking led to chronic obstructive pulmonary disease. When we met, Mr A fulfilled the criteria for a diagnosis of major depressive disorder (*DSM-IV/5*). His personality structure was obsessive compulsive, he was controlling, and he dominated the relationship with his wife.

PSYCHOTHERAPY

In our second session, Mr A told me of his intention to stop all medications. He described periods of being suicidal. Shortly thereafter, he did indeed stop all his medications. A gout flare-up followed, and he became clearly more depressed. After discussing his plan, Mr A agreed to resume his antigout drug and to begin taking escitalopram 10 mg. I invited his wife to join us, and she faithfully attended every session thereafter. After 3 weeks, I increased Mr A's escitalopram dose to 20 mg/d. Two days after the increase, his depression lifted. His wife noted that she often got even more from these sessions than her husband did!

Mr A spent a lot of time talking about what he used to be able to do and what he could not do now. He illustrated on multiple occasions the process of black or white thinking. I would constantly ask him to choose a "gray" somewhere between black and white. He often spoke in a "perfectionistic" fashion, and I constantly pointed this out. After a lengthy period, he resumed most of his prescribed medications. He described what he thought he should do, including mowing the lawn and washing dishes, as "part of my DNA." The concept of life stage frequently lost out to "what is right and proper for me to do." He often jumped to conclusions. Being fatigued meant that death was "closing in." It turned out that a diagnosis of bronchitis proved to be a better explanation.

Mr A began to allow reading to dominate his existence. For a time, he was clearly doing better. Our visits were set at 1-month intervals. Then, his wife had a serious accident, and he decided that it was "a husband's job to care for his wife." Despite his role as a patient whom his wife cared for, now he began to ignore his needs and to take care of his wife. After 2 years of care, the hospice summarily dropped him because he had "outlived his contract." He continued to show remarkable energy in his care for his wife's needs. "When your wife has a need, it is up to the husband to provide care," he said.

His primary care doctor took over his medical care from the hospice. His wife had a lengthy recovery and finally needed surgery to align her bones. The couple moved in with a son. Mr A had 2 carotid surgeries to deal with bilateral blockage, and he had a heart attack while in the hospital, but he recovered completely from both operations. While breathing remained an ongoing problem (exacerbated by the summer weather), he began to further define this life stage! He started cooking meals for himself and his wife. He continued his dominant activity of reading. His depression did not recur. He managed to remain active in church, despite no longer physically making the trip. He learned that "different people see things differently."

Mr A asked me if I thought that he and his wife should stop coming to these monthly sessions. I told him that I looked forward to seeing them both. He responded "then we will continue to come, because these sessions have been quite helpful to us." His wife described our time together as "life-saving for my husband."

I see Mr A (and his wife) as having made significant gains during our 3-plus years together. They have taught me a lot, and our continuing relationship has served as a prod as well as a support for them. I believe fervently that how a medically ill patient thinks affects his or her functioning. It makes sense, therefore, to provide an opportunity for the patient to speak with a provider to help with the process of adapting to illness.