Preparing for the Next Stage

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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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As I have gotten older, my career has taken several twists and turns. Each turn has brought new colleagues and new opportunities to learn. During my "peak" years, I had a 30-hour outpatient practice of adult psychiatry, informed by the cognitive therapy model that I learned from Aaron Beck, MD. When I left Washington, DC, for Charleston, South Carolina, I took an academic job. I taught the cognitive model and supervised psychiatric resident psychotherapy, worked for the first time in an adult primary care clinic, and worked alongside an oncologist, seeing his patients once a week with him.

During this 3-year oncology outpatient experience, the value of the cognitive model for helping cancer patients adjust to their disease became apparent. I left the university in 2003. For the next 7 years, I had a small private practice, did some speaking, and worked in an outpatient oncology practice for 18 months. In 2010, I was hired by the Department of Medicine of the Veterans Administration hospital to work part-time on a palliative care geriatric team. I continued my private office time, but at a reduced level.

It was at the Veterans Administration hospital, when I applied the cognitive model to newly admitted nursing home veterans, that I found the most use for the concept of life stage. Elderly male patients admitted to a nursing home unit on an "end-of-life contract" often lived longer and did better than expected. There was an often unanticipated need for them to focus on this life stage to determine their plan for it. I worked with several men (and a few female veterans) to help them do this.

I did not expect this life stage work, however, to be relevant to my office practice, which represented a more heterogeneous group of patients. Then, one day, an internist colleague referred Mr A to me for cognitive therapy.

CASE PRESENTATION

Mr A is a 70-year-old married white man who retired at 60 years of age after a busy, productive work life. Born and raised in Chicago, Illinois, his parents died young, but 3 siblings survived along with him. He pursued a master's degree and then a PhD, qualifying to teach and finally to head the department in which he worked at the University of California.

At the age of 40 years, Mr A left the university to take the helm of a management consulting firm, which he led for the next 20 years. His life mostly revolved around his work. His wife, herself an academic, supported him and pursued her own career. They never had any children.

Soon after Mr A retired, however, health problems began to dominate his life. He moved back to Chicago. The next 9 years brought colon cancer, heart disease, cardiac arrhythmia, and a series of small strokes. Mr A's time was spent intoxicated with alcohol ("to forget") and seeing doctors for treatment. During his work life, alcohol had played no part.

Mr A was "not prepared to retire" and had never determined how he would spend this phase of his life. When he and his wife decided to move to Charleston (1 year before we met), he found the internist who would eventually direct him to me. He was referred to a variety of specialists for the purpose of streamlining his care. I was one of them.

PSYCHOTHERAPY

Mr A expressed immediately that he needed to curb his alcohol habit. His major focus was centered on his medical illnesses and their treatment. His work achievements were relegated to the distant past. Mr A spoke about colon cancer and its treatment, heart disease and its treatment, his difficulties with balance, and the strokes he had suffered, revealing a significant degree of narcissism. He was depressed, and his internist had prescribed and titrated the dose of an antidepressant for several months, but to little avail.

After I took a history and established engagement, we discussed the cognitive model, his personal strategies, his identity, and the need for a plan for this life stage of retirement. I asked Mr A to consider what could continue and what needed to be changed. He spoke about "living in the past" and needing to "reinvent" himself. He noted that he would need to respect the restrictions imposed by his medical conditions. Mr A was mostly housebound, and his wife provided a significant amount of care for him.

Mr A then revealed the substantial time and energy that he devoted to his medical conditions. Some of his thoughts were "Will cancer recur? Will there be another stroke? What could I really do if it was too difficult to leave the house?" I questioned the value of his attempts to predict the future, comparing them to my grandmother's strategy of dealing with her advanced age and medical illnesses. "When you have a problem, by all means try to problem solve," I told him. "However, when you do not have an active problem, is it a good strategy to focus on potential outcomes?" He agreed that it probably was not.

In the last of our 4 sessions, Mr A spoke of regaining some balance and strength. He emphasized the need to find some work that he could do at home and said that what he selected would have to be his own rather than a joint project with his wife. He was clearly now less depressed and had begun taking the first realistic steps to determine how he would spend his time. Alcohol, he told me, was no longer a major issue for him.

I called Mr A's internist to thank him for the referral and to provide an update on his patient's progress toward making a good adjustment to this phase of his life. Mr A seemed to have gained the tools he needed to fashion a retirement worthy of his earlier life's successes.