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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Return to Life

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The inpatient nursing home unit on which I work has 2 designations: long-term care and end-of-life care. Each of 20 patients qualifies for one, but it is rare that a patient's designation changes from one to the other.

Each patient has substantial medical reasons to be continuously hospitalized, and many have additional social and family considerations that make it unlikely that they could be managed at home. In addition, the incidence of mental health problems that complicate medical management is high.

Some nursing home residents have been staying at our facility for quite a while, while others may reside here only for a short time at the end of their life. For example, Mr A had been a nursing home inpatient for more than a year when a psychiatric referral was made.

CASE PRESENTATION AND PALLIATIVE CARE (Dr Senseney)

Mr A presented to us as an 80-year-old man, separated from his wife for many years after 25 years of marriage. They had 2 sons and a daughter. Mr A had served in Army intelligence for 30 years. His medical history featured a heart attack and bypass surgery, along with a recent diagnosis of prostate cancer. A lifetime of cigarette smoking had left him with chronic obstructive pulmonary disease (COPD).

Mr A spoke of being depressed "for the past 10 years," largely due to multiple eye surgeries that had left him blind in 1 eye. He had endured the death of a brother who was beaten and killed. He had recently fallen several times in his home, largely related to a loss of balance. Prior to coming to our hospital, he had suffered a stroke. On admission, he was noted to be dehydrated, confused, and delirious.

I first met Mr A about 18 months ago when I was asked to do a consultation for palliative care. His focus in recent years had been his chronic medical conditions and the personal losses he had suffered in his life. He was admitted to our Community Living Center for long-term care.

Initially withdrawn, Mr A stayed in his room, emerging only for meals. His delirium (later determined to have been medication induced) cleared rapidly. For a time, his cognitive status also improved dramatically, and he joined card games, group exercises, and church services. He befriended a resident, and they became inseparable. After her death, he retreated to his room once again. He became irritable and easily angered. He refused medications, and his appetite decreased drastically. He developed confusion and dyspnea, as well as lower extremity edema. In hindsight, I wondered if his symptoms were an angina equivalent since, in the elderly, only 50% have chest pain when they have angina.

The staff became concerned that Mr A's decline was directly associated with grief following his friend's death, and this concern was conveyed to the psychiatrist on our treatment team. As part of his palliative care treatment, Mr A's children were encouraged to speak often with their father: asking for and granting forgiveness, expressing gratitude and love for each other.

Almost as suddenly as his symptoms appeared, they began to resolve. He spent increased time out of his room. His nutritional status improved.

Although he was admitted initially because of concerns about progressive dementia and inability to perform activities of daily living, he also had multiple medical problems. These were managed appropriately. A palliative care approach accepted that his illnesses were life-limiting. In addition, his long-standing depression and complicated grief related to major personal losses were addressed. Our staff has become his extended family, along with his fellow inpatient residents. By focusing on his quality of life, we hope to allow him to live as fully as possible, for as long as possible.

MEDICAL COURSE (Dr Bride)

I met Mr A 6 months ago, shortly after my arrival on the nursing home unit, and successfully treated a mild scalp dermatitis caused by chronic wear of his cap. One month later, a key question concerned his complaint of weakness and fatigue. Its etiology raised the question of a viral syndrome versus depression. This issue was the focus of my work with him over the succeeding month, when a complaint of neck pain arose due to severe cervical arthritis. A lidocaine patch brought some relief.

Subsequently, a painful foot was seen to be a manifestation of gout and led to a prednisone burst for 5 days. Finally, 3 months after we met, I was asked to evaluate Mr A because of shortness of breath and confusion after he refused a diuretic because of his annoyance with nocturia. I found him to be in subacute congestive heart failure. A chest x-ray showed lung congestion. I treated him with intravenous furosemide.

After what seemed like a full recovery from his cardiac insult, weakness and anhedonia persisted. A palliative care consultation led to a transfer from long-term to end-of-life care at the patient's request. One month later, I was asked to evaluate his ankle edema and low serum albumin level. He was noted to actually be clinically improved! I thought inadequate nutrition might have been responsible for his problem, and after a few days of diuretic treatment, the problem resolved, and his albumin level normalized.

After another month, he seemed remarkably improved. I happily accepted him back to the long-term care unit and believe that his medical conditions played only a small part of his journey to end-of-life care and back. Parallel medical evaluation and treatment had helped him to ultimately survive this trip.

PSYCHOTHERAPY (Dr Schuyler)

Since joining the palliative care (inpatient hospice) team in March 2010, I am often asked to be involved in the care of some of the geriatric inpatients and also to treat outpatients in geriatric or oncology clinics.

When I was asked to meet with him, Mr A had been a resident on the unit for 16 months. There was a real initial question of engagement. His daughter had brought him a crossword puzzle book, about which I expressed substantial enthusiasm. He, in turn, made it clear that crossword puzzles didn't interest him. We discussed his eye infection that was proving difficult to treat. He emphasized the various impediments he had to activity. I countered with a comment about his orientation to "doing nothing," which I thought was a poor strategy for dealing with this new life stage. "You've given me some things to think about," he said. One month after we met, his interest in football and chess seemed to vanish. He was noted to be more withdrawn. "I don't see much future," he said. In response to his fatigue and withdrawal, I decided to taper and discontinue both of his antidepressant medications, as well as a sedative he was taking at bedtime. Once this was accomplished, I planned to start a trial of fluoxetine, 20 mg/d.

At our next visit, he related being "totally exhausted" during his club visit to the monthly neighborhood meeting in Lexington, South Carolina. Meanwhile, a resident to whom he had become close had suddenly died. We discussed their relationship in detail. He spoke about disrupted sleep and noted that another sedative that had been recently started was of no help. He suggested an older drug that had once helped him sleep at home. I ordered it for him.

His bereavement reaction to the loss of a coresident led us to review together his earlier reactions to personal losses. He related never taking time to grieve, despite multiple significant family deaths. Despite being defined by his attendance at the monthly meetings at his Lexington neighborhood clubhouse, he decided to forego this month's meeting. In the process of our sessions, he sometimes spoke about medical complaints that I relayed to the internists caring for him. He noted once that telling me about things was effective for him, as his doctors responded more quickly to my requests than when he told them himself.

At our tenth session, and in light of no clear response to 20 mg of fluoxetine after 6 weeks, I doubled his dose. He next complained of neck pain. I spoke to his internist, who prescribed a lidocaine patch. Within a week, he told me that he felt better for the first time. He was eating more and his outlook was better. His interest in football had returned. His eye was finally feeling better as well. He said that analgesic medication had helped his neck pain. Now, his left foot was painful, red, and tender, but his mood seemed unaffected by it.

I attributed the mood change to the increased dose of antidepressant medication. The next task of recovery, I believed, would involve psychotherapy, not chemotherapy. However, 2 weeks later, he was once again withdrawn and inactive. In the interim, he had been diagnosed with congestive heart failure. He had also been made aware of his ex-wife's serious

illness. He spoke now about dying and seemed to have little hope for the future. It was at this point that his designation was switched from long-term care to end-of-life care (palliative care). A staff member who knew him well suggested to me that Mr A had "given up."

Over the ensuing 2 weeks, he fell twice. Once his congestive heart failure was successfully treated, however, he suddenly began to show some concern about his appearance. This was accompanied by the return of some "spunk" as well. In our session, he reported having suffered periods of depression "like this" in the past, prior to being hospitalized. He agreed to take a trip with members of the unit, after declining to do so for months previously.

Once again, a resident to whom Mr A had become close died suddenly. However, instead of grief and withdrawal, Mr A was a participant in the memorial service and remained active, now getting out of bed early and eating better. He began working diligently with the physical therapist on increasing his capacity to walk. His prior interests were back, and he seemed decidedly upbeat. During our 17th meeting, we discussed possible etiologies for an episode of nocturnal breathing difficulty. We agreed that it could be related to COPD and his insistence on periodic cigarette smoking.

By session 19 (4 months after we met), he described himself as "consistently better"—more motivated, less often depressed, more active, and less withdrawn. His children had commented to him on the change. "I'm a completely different person than I was 2 months ago," he said. He began to discuss with me (for the first time) the logistics involved in his going home! It was at this point that his designation was returned to long-term care.

For the next 2 weeks, Mr A was preoccupied with his ex-wife's terminal illness. He shared many personal family details with me, once insisting that his internist call me at home to tell me what he had learned about her condition. His personal symptoms of depression were now gone. He spoke of returning to neighborhood club meetings. When his former wife succumbed to her illness, he attended her memorial service in the town in which she had lived and discussed it in detail with me when he returned.

COMMENTARY (Dr Schuyler)

I have had a total of 30 sessions with Mr A. Our 6-month relationship, I believe, has been a central area within which he was encouraged to problem solve. I am not convinced that medication played any role in his recovery from depression. We may have seen merely the course of his depressive illness, waxing and waning, complicated by cardiac disease, COPD, chronic pain, and bereavement. The relationship provided him with a stable setting in which to consider alternatives and to make choices.

It is always hard to know what the "outcome" will be. However, there is little doubt that Mr A is in a different (and better) place today than he has been for the past 18 months. And, he is grateful for it!