Retirement

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The aging of the American population has been written about and discussed in public forums. This phenomenon is particularly evident in cities like Charleston, South Carolina, a popular location for retirees to move and settle. A mild climate, access to water, plentiful golf courses, and a variety of communities from which to choose all draw older people to the area.

I have found it useful to think about a person's life as a series of stages. For adults, life may be defined by working at an office, raising a family, managing a home. As the person ages, the children typically leave home to pursue their own lives, the worker reaches retirement age, and home management may acquire a new definition. This ushers in a new "life stage," one for which some adults seem to have little preparation. Particularly for those men and women whose self-image (and worth) is defined by their adult "job," the transition to this life stage is often accompanied by anxiety and depression.

CASE PRESENTATION

Jack is a 65-year-old man, married for 40 years to Beth, with 2 sons and 4 grandchildren. He is a college graduate who went on to obtain an M.B.A. degree. He held a series of responsible administrative positions throughout his work life at several universities, a medical center, and several community organizations, all in the Midwest. His father died at age 60 of heart disease. His mother died at age 72 after a stroke. He is an only child. He has no prior history of depression, nor of an anxiety disorder. There is no history of substance abuse.

Jack retired from his last job in January 2001. With Beth suffering from asthma, a move south was suggested, and the couple moved to Charleston on April 1, 2001. He first consulted me in September of that year. Since January, he has had a "negative outlook." There is little pleasure. His life is "disorganized." He feels like a "fish out of water."

He has multiple awakenings from sleep at night, but does not see insomnia as a problem. His appetite is unchanged, and his weight is stable. He feels more generally nervous now than he did during stressful periods at work. He doesn't believe his thinking is sharp. His energy level is unchanged, and fatigue is not a particular problem. He can concentrate, but in truth, there is "little need for concentration." He has noted no memory changes; in fact, he seems to recall all too well the days he worked, the problems he faced, and the goals he set.

He feels no sense of belonging in Charleston. He has met several people, all of whom are retired, whose lives are focused on "golf, fishing, and grandchildren." He has little interest in golf, does not fish, and seeing his grandchildren twice a year is quite sufficient for him (although his wife might disagree). He feels he has little in common with the people he has met, but acknowledges that Charleston "is a beautiful place."

He consulted a primary care physician, who diagnosed depression and prescribed sertraline, up to 150 mg per day. He felt somewhat less anxious, but in truth, little better. There were 2 other drugs offered, but he cannot recall their names. Feeling no better, he went to the library and read about cognitive therapy. He then asked his doctor for a referral.

PSYCHOTHERAPY

My diagnostic impression was of an adjustment disorder with anxious and depressed mood, but no major depression, no dysthymia, and no formal anxiety disorder. I suggested no drug prescription and agreed to a course of brief cognitive therapy. Jack reported for our initial therapy session with his wife and asked if she could join us. I agreed. Their marriage was a close one, and they enjoyed each other's company, but each maintained a need for some privacy. His goal for treatment was "to be able to relax more and to accept retirement."

As he had some knowledge of the cognitive therapy model, I led into a brief discussion of how we would work by describing my understanding of it "so we would be on the same page." He described spending an inordinate amount of time ruminating about the past each morning. He was concerned with what he "ought" to be doing. We reviewed his interests: bicycling, swimming, bridge,

pottery, and "university life." I suggested that he keep a log of those occasions when he felt particularly sad or anxious and try to capture and write down his thoughts. We would use this log to guide our work in subsequent sessions. We agreed to meet every 2 weeks.

Jack and his wife came for session 3. His log had 11 separate situations. His thoughts ranged from "It is hard to find affordable housing to meet our needs," to regret over a purchase he had made ("I should have thought through the process better"), to waking up anxious and thinking "I wish we had a more pleasant place to live," to reading the newspaper and becoming agitated ("the constant conflict and futility of life"), to "not feeling attached to anything," and that "so much of what I do is 'busy work' with no real relevance." We patiently went over each situation, stressing the relationship of the thought to the feeling. I asked him to judge the thoughts in terms of their reasonableness and their strategic value to him. If they failed either criterion, we sought alternative possibilities. His wife was encouraged to contribute options. I emphasized that no alternative belief was "right," rather that one might suit him better than another.

In session 4, he once again brought in his log of situations, feelings, and thoughts. I encouraged him to add a fourth column for "options or alternatives." Now, we referred to the alternatives as "choices" and considered likely consequences as we discussed each one. He reported that he was actually using the model between sessions, and his wife added that he seemed "enthusiastic" about it. He reported sleeping better and that his mood was "more even" than previously.

In session 5, we discussed life stages and defined retirement as the end of one stage and the beginning of another. I stressed that the stage ending was often better defined than the one beginning. I reminded him that the Chinese character for crisis combines a symbol for danger with one for opportunity. He had focused on the first, while ignoring the second. He noted that he "needed permission to experience pleasure."

He was more familiar with life as obligation. We discussed a reordering of priorities. In session 6, he and his wife agreed that he was now "making real progress toward the goal of a more tolerable retirement." We focused on self-standards and setting priorities for himself. He and his wife now walked for 1 hour each morning. He had met with the pastor of the church they had joined and discussed a role for him involving education. He had made a friend of a man in his community, with whom he now was speaking daily about some common interests. He and his wife were actively house-hunting, and they had defined the area in which they wished to live.

He described the cognitive approach as a "life skill" and wondered if he would be qualified to "put a group together, teach the cognitive model, and be of help to a group of retirees." We discussed his gains over the period of 3 months and how they had occurred. Periods of anxious or depressed mood were now "rare" and "manageable" for him. We agreed that we would end this active phase of therapy that day. The next session would be at his initiative.

Jack called me 6 months later to say that he had been functioning and feeling well.

Editor's note: Dr. Schuyler is Clinical Associate Professor of Psychiatry at the Medical University of South Carolina.

For further reading: *A Practical Guide to Cognitive Therapy*. 1st ed. by Dean Schuyler, New York, NY: WW Norton & Co; 1991. ISBN: 0393701050