EDITOR'S NOTE

Through this column, we hope that practitioners in general medical settings will gain 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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Potential conflicts of interest: None reported.

Funding/support: None reported.

Disclaimer: The views herein are those of the authors and do not necessarily reflect the views of the Veterans Administration.

Prim Care Companion CNS Disord 2011;13(4):doi:10.4088/PCC.11f01235

Published online: August 18, 2011 (doi:10.4088/PCC.11f01235).

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Befriending

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In 1953 in Great Britain, the Reverend Chad Varah founded Samaritans, an organization whose major offering to the suicidal and the despairing was called *befriending*. It stands to reason that, for some patients receiving palliative care at the end of their life, befriending may be an important component.

I have applied the cognitive therapy model to the end stage of life to provide one approach to the correction of the distortions of thinking that may mark this period.[1] But, what if the patient with end-stage disease presents none of these distortions of thinking? What if he has considered the event of his death and proclaimed himself "prepared" for this? What if he has performed a life review and pronounced it satisfactory? What if his significant others support him and accept the outcome, or what if there are no significant others?

Sometimes, he may just need a friend to talk to. The psychiatrist providing palliative care can be that friend (as can the nurse or anyone else who provides care to the patient). That was the case for Mr A.

CASE PRESENTATION

Mr A is a 70-year-old man who is married for the second time and who suffers from metastatic cancer. His disease began in the liver, but it has spread widely. He has never had an alcohol habit, nor has he been a cigarette smoker. He has 3 daughters from his first marriage, but he is close to none of them, and they each live far away. His present wife, with whom he has been loving and close, now has end-stage liver disease and is often disoriented and rarely in contact. His parents are deceased, and his 3 brothers and 3 sisters live in California. He has little contact with his family.

His disease has led to the frequent accumulation of ascites, which results in daily paracentesis to remove abdominal fluid. His admission to the Veterans Administration nursing home was expected to form the context for the final stage of his life. In addition, it was a response to the problem of no provision for his care at home.

On the inpatient unit, Mr A spends some time visiting with other residents. He does crossword puzzles daily, and he always seems to have a book to read. But, he has few visitors, and he has no formed plan for this stage of his life. He is oriented to time and place, and he keeps a calendar in a prominent place in his room. He follows, and keeps abreast of, world events. He has never before consulted a psychiatrist, nor has he been hospitalized in a psychiatric facility. He tends to be a loner, and he has few friends. He maintains that he has little anxiety, and he has never been clinically depressed. His *DSM-IV* psychiatric diagnosis is adjustment disorder, not otherwise specified.

PSYCHOTHERAPY

I have so far seen Mr A 7 times. Our visits have tended to be brief (15–30 minutes). Often, there is no agenda. When his views seem unrealistic, I try to represent reality to him. When he has questions about his medical condition, I try to answer them or refer him to someone who can.

I suggested to our recreational therapist that she might get Mr A some materials with which he could work, as he has worked much of his life with

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his hands. Mr A inventoried for me the activities that formerly gave him pleasure (fishing, hunting, construction), but these activities were better suited to an earlier life stage and were not options for now.

We discussed what we each were reading. We exchanged views on some current events. Mr A told me stories about his children and about his first marriage. He constantly praised his current (but largely unavailable) wife.

"I can't any longer be out doing what I want to do, or what I used to do," Mr A said, "but here I see some people who are in worse shape than I am." He talked about his ability to make something with his hands that allowed him to "give gifts to people who have treated me well." Over time, Mr A became focused more on this life stage, rather than on reminiscences about the past.

After each visit, Mr A told me how valuable it was to have these opportunities to meet and talk together. Although my orientation initially was to seek out problems to solve, I quickly switched to letting our conversations go in whatever direction that Mr A led them. There was, in truth, little problem-solving accomplished. Our talks in the setting of a nursing home unit could have taken place in a coffee shop.

What became clear was that our sessions were meeting a need but were not oriented to a "usual clinical purpose." Although the cognitive therapy model seems to inform whatever I do, these sessions were more like 2 people who enjoyed talking together doing just that, and little else. I believe that befriending could play a part in every clinical interaction, and, at times, it may form the central organizing point of therapy.

REFERENCE

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