Caring for an Ill Spouse

Dean Schuyler, MD

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.

Dr Schuyler is a psychiatrist and a member of the palliative care team at the Ralph H. Johnson Veterans Administration Medical Center, Charleston, South Carolina.

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Corresponding author: Dean Schuyler, MD, Geriatrics/Extended Care, Ralph H. Johnson Veterans Administration Medical Center, Charleston, SC 29401 (deans915@comcast.net).

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I have worked at the Ralph H. Johnson Veterans Administration Medical Center in Charleston, South Carolina, for nearly 7 years. During that time, I have spoken with many male veterans and a few female veterans. I also have met with many interesting third-year medical residents at the cusp of deciding what field they will spend their professional lives in.

In the past year, I have spent 30 minutes 3 times a week speaking with medical trainees about the articles I have written concerning the psychological elements in palliative care. Many of these trainees have assured me that no one else has spoken with them about these issues.

We talk about their relationship with their patients. We talk about responsibility, demoralization, and their patients' thoughts. In the process, I call their attention to the patients' caregivers. I emphasize the devotion and time given to managing the life of an ailing spouse. Often, I have spent time speaking with the caregiver of an ailing spouse. I see this not only as time well spent, but also as an integral part of providing palliative care. Palliative care, like hospice care, is typically provided to the family and the patient.

As a result of advertising (informally) my interest in caregiving, the internist I work with most closely (John Franklin, MD) has periodically referred caregivers to me for counseling. That is the way I met Mrs A.

CASE PRESENTATION

Mr A is a 60-year-old male veteran, married for 20 years, with 6 children, 3 of whom live locally. He has a family history of heart disease but has suffered an increasingly severe neurologic illness that has rendered him speechless, paralyzed, and generally unable to care for many of his needs. He is an end-of-life patient under the care of Dr Franklin.

Dr Franklin had become concerned that Mr A's wife was not doing well as his primary caretaker. She had continued her office job but refused to allow the nurses who attended her husband to do much for him. She saw caring for his needs as her sole responsibility, and this extended to their children, whom she prohibited from helping to care for their father. Dr Franklin recommended that I speak with her. Mrs A said she could not meet with me as her office job necessitated her presence each day and she couldn't possibly take the time to visit the hospital so that we could meet.

One month later, as her husband's condition deteriorated, she agreed to travel to the hospital to see me. The focus for my meeting with this 55-year-old woman was the need for her to care for herself. In addition, she needed to realize that there was a benefit to her children being allowed to care for their father. If they were allowed to help with his care, it would most likely be easier for them to deal with his passing when that occurred, and Mrs A taking on the role as his exclusive caregiver deprived them of this opportunity.

My first task was to establish a relationship with Mrs A. I took her personal history and asked about her husband's medical course.

I established early my concern for her well-being. I spoke about her children, particularly those who lived locally. I asked about her job.

Mrs A spoke about a shopping trip with a friend and acknowledged the guilt she felt about "abandoning" her husband. I noted how important it was for her to live her life as well as take care of her husband. I asked if I might call her weekly for a while, emphasizing my concern for her well-being and her caregiving responsibilities. She said that she was glad that we had met and that she would look forward to my calls.

One week later, I called her as I had promised. We spoke about her caretaking role as well as the need to take care of herself. We spoke about the value of allowing her children to care for their father.

I called again 1 week later. Mrs A had allowed her daughter to stay with Mr A while she went shopping with a friend. She was putting into practice the notion of encouraging her children to stay with their father. She was beginning to consider some of her own needs as well as those of her husband. She spoke about her concerns about "living life without him." She emphasized how good it was to have someone to talk with about her personal needs as well as her caretaking needs. Her boss at work had granted her unlimited leave when she needed to be home.

I called again 1 week later. I spoke with Mrs A at her office. She assured me that she was doing much better and planned to be busy over the holiday break. Her children were coming to town to visit with their father, and she would cater to their needs and to her own. The house would be filled with guests. Could I possibly call again after the holiday was over? I told her that I was looking forward to speaking with her again and would call in 10 days.

Palliative care involves action to relieve an end-of-life patient of undue suffering. But, it also involves addressing the needs of the patient's family. Being involved with the spouse caring for an ill husband satisfies that important aspect of end-of-life care.