Engagement

By Dean Schuyler

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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I have had the opportunity to think about, and to speak with trainees about, the importance of connecting with a patient that you treat. Some health care professionals become consumed with disease processes. They allow these data to dominate their fund of knowledge. In the process, they forget that a human being forms the host for the disease process in question. When clinicians limit their interaction with the patient to the disease and its treatment, they may obtain misleading information or valuable information may be omitted. Engagement, therefore, is the first necessary stage of a medical interaction.

When reminded about the importance of "establishing a connection," many trainees complain of a heavy workload that takes up much of their time. My typical counter to this complaint is that engaging the patient rarely demands much expenditure of time. I work one morning per week in a Veterans Affairs oncology clinic. Members of the staff sometimes direct their inquiry to the disease process rather than to the patient. When asked to evaluate a patient, I have been told, "We know so much more about him when you see him than when we see him ourselves."

My understanding of the patient typically encompasses taking a history, asking about family, education, work experience, and his/her health record. Only then do I get to inquire about the patient's cancer-specific symptoms. By that point, our relationship is typically established, and the patient and I could be said to be "engaged."

This experience is not lost on me during the once-weekly morning when I work on a nursing home unit at the same VA hospital. When approaching a new patient on a medical ward, my initial task is to explain why a psychiatrist has come to speak with him or her. Then, my job is to establish the connection that may allow brief psychotherapy to be useful. As most workers in health care know, some people are easier to form a relationship with than others. A history of good relationships suggests that the patient may form a connection with the health care professional as well.

Mr A appeared to offer a challenge with regard to engagement. He had maintained few good relationships. His focus was primarily on the chronic pain he suffered after experiencing combat and sustaining multiple accidents over the course of his life. In addition, my anticipated unavailability for several weeks was likely to play a role in making engagement more difficult.

CASE PRESENTATION

Mr A is a 70-year-old man, widowed and divorced, each several times. He has 2 adult sons and 1 adult daughter but has no relationship with any of his children. His parents are deceased. He has no contact with any of his 3 older brothers and sisters.

Mr A graduated high school in Denver, Colorado, and then joined the US Air Force, in which he served for nearly 10 years. He was involved in a plane crash and was wounded in combat several times. As a consequence, Mr A had evidence of traumatic brain injury.

Once discharged from service, Mr A flew planes for commercial airlines and endured a second crash. This traumatic event left him with chronic back and neck pain as well as severe atrophy of both arms. Over time, Mr A's vision had deteriorated and his mobility dramatically decreased. Finally, he was admitted to the nursing home unit on an "end of life" contract.

PSYCHOTHERAPY

The intake session when I met Mr A lasted for nearly an hour. I aimed to demonstrate interest in the many events that Mr A related to me about his life. I offered no judgments. The result was a detailed history, some of which I mentioned above. Before we were finished with this session, I asked Mr A about his goals for

his nursing home stay. His response was not very different from most patients in a similar situation with whom I have spoken: "I will be here until I die," he said. My reply emphasized that neither I, nor he, nor his medical team knew when that might be. I then told him that I had met many men and women at the nursing home who were quite alive after several years! A few of them were actually discharged. I encouraged him to formulate a plan for his stay. This admission would begin a new life stage, the duration of which could not be determined in advance. He replied that he had seen a good deal of combat and trauma in his life and that he would like the opportunity to speak with some younger veterans about it. He could "build up their self-assurance" and encourage a "fighting attitude." I told him that I might be able to help him do this. I promised to see him regularly.

And then, because of a federal holiday and a week's vacation, 3 weeks passed before I worked on the nursing home unit again. I dreaded the apology I would have to make for not seeing Mr A after promising to do so. I told myself that 3 weeks for someone at the "end of life" would be like an eternity.

So, I was surprised when Mr A seemed glad to see me; he was far calmer than he had appeared earlier, was no longer focused on pain, and was eager to begin our work together. I reminded Mr A about his statement of purpose related to dying, and he replied that he had thought a lot about this since we had spoken. He had identified some differences in the service of World War II veterans and those younger soldiers who had served in Iraq and Afghanistan. He saw his immobility as the major stumbling block to what he hoped to achieve. "I need the return of my electric wheelchair so that I can get around," he said. I told Mr A about the National Crime Victims Research and Treatment Center at the Medical University of South Carolina, Charleston, which focuses on treating posttraumatic stress disorder, a problem he had suffered from. He replied that he might like to work with the center and that this might be added to the list of things he hoped to do.

It was gratifying to see that Mr A had forgiven my absence after my promise to see him regularly. It was encouraging that he had given a great deal of thought to how he might help other veterans. It was surprising that Mr A maintained this focus for 45 minutes without any comments about pain. I believe that this session cemented in my mind the success we had achieved in the engagement phase that had dominated our initial visit. It predicted that this interaction was very likely to continue and would be useful for Mr A.

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