Grieving the Loss of a Friend

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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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We belong to what have been called the "helping professions." I serve on a health care team that delivers palliative care. Palliative care aims to bring comfort and pain relief to a dying person. My work at a Veterans Affairs (VA) hospital has focused on doing psychotherapy with a variety of veterans who are at the end of their lives.

The focus of what I do is typically directed to the veteran patient and his or her family. Only rarely do I consider the effect of caring for patients at the end of life on me and other team members. It is commonly observed that interactions with some patients leave a deeper impression than do others. Located at life's end, the work often ceases when the patient dies.

Families grieve the loss of a loved one, but hospital staff members are less often acknowledged in their grief. When I came to the Community Living Center (VA nursing home unit), the director asked me to develop a meeting to respond to the needs of staff who had lost patients. I scheduled a meeting each month for several months; however, few staff members attended. "Self-care" sounded like an important concept, but our health care team seemed to have little time in their days for it. The meetings were discontinued.

I forgot about the meetings and continued my work, as staff members and veteran residents came and went. One day, an oncologist asked me to meet with a hospitalized inpatient. Mr A and I met on 8 different occasions over a 4-month period, each time during one of his admissions to the hospital. It would be melodramatic to state that my time with Mr A "changed my life" or changed his. As he negotiated his final life stage, however, he made as much of an impact on me as I may have made on him. When Mr A finally died, he left an empty space in my life, and I will dearly miss him.

What follows is the story of those 4 months, which, I am aware, forms a significant part of the process of my grief for his loss.

CASE PRESENTATION

Mr A was born in Raleigh, North Carolina. His father was an Army colonel and his mother was a school teacher. He had a brother who was 5 years older. Mr A attended high school but left early and later obtained a general education diploma. He joined the US Army and served for 3 years (including some time abroad).

By the time he was in his mid-20s, Mr A's mother had died, and he had embarked on a career of selling insurance. He met and married a younger woman when he was in his late 30s. Until the decade of his 40s, he was generally in good health, except for a diagnosis of diabetes.

Then, 4 months before we met, he noticed blood after a bowel movement. Mr A was admitted to the VA hospital, and a diagnosis of colon cancer was made. When the cancer was discovered, it had already widely metastasized to his liver and 1 lung. Shortly thereafter, his wife was diagnosed with a rare form of cancer that would prove to be quickly fatal.

PSYCHOTHERAPY

When I was asked to meet with Mr A, I learned the medical history noted above and the brief life story. His focus was on nutrition and a plan for chemotherapy. We spoke initially about the cognitive therapy model and stressed the process of attribution and people's need for explanations. Mr A proved to have a well-developed sense of humor, and we “clicked” immediately during that initial visit.

About 2 weeks later, he was rehospitalized, and I went to see him. He had disagreements with the staff about his care and had quickly gained the reputation of being controlling, narcissistic, and difficult. Mr A spoke with me about the importance to him of Tony Robbins’ motivational books and speeches. “They are very cognitive in nature and ought to be right up your alley,” he said. “Are you familiar with him? And, if not, you should be!”

Two days later, we met for the third time. We focused on Mr A’s relationship with his young wife and how important it was for each of them. We spoke about how difficult it was that she was dying, and at the same time, that he was dealing with what seemed to be a terminal illness as well.

About 1 month later, he was rehospitalized, and we met for the fourth time. I walked with him to the VA store and to the coffee shop, and then we spent 30 minutes talking in his room. We focused on his need to plan for this new life stage. He mentioned wanting to use Robbins’ ideas to try and help others. He spoke, too, of compiling and writing the personal stories he has told to others as a guide. His doctors apparently knew very little about how much time he had left. He expressed an interest in reading a book I had written about cognitive therapy, and I sent a copy to his home. I told him several stories about cancer patients who had “outlived their prognoses.” We worked together to separate facts from beliefs.

Our fifth meeting came 1 month later, once again during a hospital stay. Mr A was astonished, he said, to receive a copy of my book. He brought a copy of Robbins’ *Unlimited Power* for me to read. I promised to read it. He spent much of his time thinking about dying, he said, although he stressed that he had already completed making preparations for his death. I asked him whether the strategy of focusing on dying made sense for him. I reminded him of his many attributes and skills: thoughtful, a salesman, a storyteller. He agreed, finally, that he might rather focus elsewhere.

One week later, Mr A’s mind was on a proposed upcoming procedure to relieve pain. I encouraged him to formulate his questions before he agreed to the procedure and to ask his doctors the questions. I talked with him about the value I had found reading Robbins’ book. I expressed my appreciation and agreed with him that an important aspect of Robbins’ system was cognitive. I returned the book to him.

He asked that I call his father and gave me his cell phone number. I did so and then spoke with Mr A about my 30-minute conversation with his dad. After our meeting, I spoke briefly with the medical resident monitoring Mr A’s care.

Our seventh meeting occurred on the day that he was being discharged home. I emphasized that this new life stage required some thought and planning on his part. Mr A spoke about meaningful contact he had had with several Army buddies who served with him 20 years ago. He felt that it was important that he was treated as “one of them.” I stressed my availability to him as he negotiated this stage of his life.

Subsequently, he was admitted to the VA Community Living Center on an “end of life” contract. Circumstances were such that I was unable to see him and speak with him. I decided to go to the nursing home to see Mr A on the afternoon of a day that I normally did not go. I spoke with him at length and met his brother as well. He showed me photos taken earlier in his life, as a child and as a soldier. He spoke about some of his regrets. He was clearly weak and in a final phase of his life. Mr A drifted in and out of consciousness. I emphasized how meaningful it had been for me to meet and speak with him over the past 4 months. Our discussions had taught me a great deal, and he acknowledged that they had taught him as well. I knew that I would miss the opportunities that this friendship provided and acknowledged to him what our relationship had meant for me. He assured me that it had been important for him, as well as for his family.

Mr A died 3 days later.