Psychotherapy at the End of Life

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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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As a nurse working at the community living center of the local Veterans Administration hospital and a doctor working in geriatrics and extended care at the same facility, we are both concerned with helping veterans adjust at life's end. The veterans admitted to our unit are designated to receive either palliative care or end-of-life care.

Chronic medical illnesses are prominently featured in these patients, and their medication lists tend to be extensive. There are 20 beds, occupied largely by men. These veterans typically served the military in World War II, but a few who are younger saw combat in Korea or Vietnam. The medical team consists of an internist-director, a nursing staff, a physical therapist, a recreational therapist, a dietician, a pharmacist, and several social workers.

The burden of psychotherapy rests largely in the hands of interested nurses and 1 psychiatrist. For each patient admitted, there is the task of adjusting to this new stage of life.[1] For many patients, this is their final stage, and their death paves the way for a new admission to occupy the bed. Some residents, however, are dramatically affected by the receipt of 3 square meals, good medical care, and considerable activity and attention, leading to a lengthy stay, recovery, and discharge.[2]

Some veterans attract the psychological involvement of both a nurse and a psychiatrist, each often working independently. The length of psychotherapeutic treatment tends to be unpredictable. Mr A merited attention from us both, and the treatment was lengthier than either of us could have anticipated.

CASE PRESENTATION

Mr A was admitted to our geriatric unit about 1 year ago. He had experienced several falls at home, and his invalid wife could no longer care for him. His 70 years of life included a bout with hepatitis that is thought to have resulted in cirrhosis of the liver. It is this condition over a lifetime (with little medical care) that was expected to end his life. Diabetes, hypertension, and gout were each surprisingly well controlled.

As a child, Mr A was part of a large family, having 6 sisters and 4 brothers. He graduated from high school in Kansas, married young, and joined the navy, in which he served for nearly 20 years. Upon discharge, he worked for several years at the naval shipyard in Charleston, South Carolina. He lived with his second wife of 40 years and, while each enjoyed relatively good health, had a busy and complete life. Mr A's life revolved around his home and his wife. He cooked many of the meals and kept busy at hobbies and activities during the day. He enjoyed working on flowers and a garden, restoring old cars, and repairing a piece of equipment or furniture. Mr A enjoyed jumping in his truck and taking his wife fishing. As time went on, and his wife became disabled, he assumed the role of primary caretaker.

Throughout his life, Mr A had been a loner, with few close friends. He was typically not demanding, preferring to do things independently and to not involve others. He "blew up" when he got upset, then quickly calmed down. He had never been clinically depressed or anxious. He seemed aware that his time left was short, but also that this could not be determined with accuracy. He kept a calendar in his room that helped him remain oriented to the month, the date, and the day of the week.

Since Mr A's admission, changes within his home life greatly affected his outlook and mood. His wife, who had moved in with a son because she could no longer care for herself, had to move again to Massachusetts to live with another child, her eldest daughter. The weekend visits, which Mr A looked forward to, ended abruptly. His wife (his love) now was only a voice on the telephone. He now received telephone calls from her daughter and was told that his wife's condition was failing, that she had been in and out of the hospital, and that she had made numerous trips to the emergency room. Mr A, who once had hope (whether realistic or not) that he would get stronger and be able to return home, now had little reason to hope. He experienced sadness, helplessness, anger, and regrets and even used the word *torture* to describe his feeling of being unable to be at his wife's side.

Following admission to our nursing home unit, Mr A's condition improved. His gait became stronger, he mastered exercises prescribed for him, the responsibilities of caretaking were lifted from him, and he began to wonder why he needed to be on the unit. As we saw it, his major task involved making an acceptable adjustment to his new residence, to the other occupants, to the staff, and to this new stage of life.

PSYCHOTHERAPY (Ms Sharpton)

Mr A talked when he was given a chance and someone was there to listen. He reflected on his long life, often pulling out pictures of himself as a little boy. He enjoyed telling stories about childhood fun. He spoke of being a young man and missing out on an opportunity to date a "really sweet girl" because he was too shy to ask her out. He spoke of his mother with tears in his eyes. He told of being one of many brothers and that he had decided he was the one who was not very smart, but he enjoyed reading and eventually made something of himself. He talked of joining the military and missing an opportunity to be a pilot but overall being proud of gaining an education and being able to visit many countries. Mr A had many regrets about his role as a father, which he did not openly discuss. The biggest smile crossed his face, however, when he talked about his wife, the love of his life.

It was also during discussions about his wife that Mr A showed the most sadness. He looked around his room and said, "I never thought that this is how it would end up. I am here spending my last days, while my love is many miles away. I should be beside her, and now, I will probably never see her again." The statements were profound, and as a hospice nurse who strives to be empathic, I found my own heart aching when he spoke.

Mr A told stories, shared pictures, and often spoke of sadness and heartbreak. He forgot to whom he had told what and often repeated himself, and that was okay with me. He mentioned some unrealistic plans of moving to Oregon, getting a semiprivate room in an assisted living facility, and sharing the rest of his life with his wife. He spoke occasionally about getting a part-time job in order to better provide for himself and his wife. He told of going fishing with his wife on days they both felt well. This was also okay with me. There were financial and medical obstacles that prevented his plans from becoming reality, and he knew this. I never reminded him of this fact. Instead, I encouraged him to talk about his dreams, because this was the end of his life, and it is reasonable to do so. I sat and listened, smiled, and, in general, offered him my presence. I believe that this is what he really wanted from me.

Hospice nursing requires medical expertise to assess and manage undesirable or uncomfortable symptoms, but it requires so much more. It requires empathy and an unwavering capacity to realize that the process of adaptation belongs to the patient, not to the provider. Nurses are trained to react and to try to fix the problem. There is typically a possible intervention. When a patient voices a concern, we often feel the need to say something therapeutic. Sometimes we need to sit still and say nothing, and this requires practice and patience.

PSYCHOTHERAPY (Dr Schuyler)

Over the year of his stay with us, I met with Mr A on 26 separate occasions. His initial focus was on finding a place for himself and his wife to stay after he left the nursing home. Often, his suggestions seemed unrealistic, but instead of disputing them, I encouraged him to problem-solve. Where his interests had previously centered on the outdoors (hunting, fishing, hiking), he accepted that he was no longer able to participate in these activities. He oriented himself instead to reading and watching movies on television.

During his initial month at the community living center, Mr A gradually accepted the changes in activity. He walked the halls and found other residents "in worse shape" than he was. He spoke often about his family, but his focus emphasized how they had disappointed him and the "need to accept that." Mr A began to speak about other residents and staff whom he had met. "There are more nice people here than I have known all my life," he said. A gifted artist, he spent time painting and then bestowing his finished products as gifts to other people.

Mr A discussed his alienation from family, often wistfully and without rancor. This wistfulness was paired with a wish to spend time with his wife. He missed seeing her and tried to find satisfaction from frequent phone calls supplemented by occasional visits. I noted his productivity with a paint brush and encouraged our recreational therapist to supply him with materials to aid painting. The therapist took Mr A to a hobby shop and helped him choose materials that she purchased.

Periodically, Mr A would reminisce about activities with his wife or with his navy buddies of years past. The death of a sister prompted a brief period of normal grieving. He kept busy by turning out paintings. "I don't enjoy being idle," he said, “so I have my fingers in a lot of pies.” He pictured what he wanted to create in his mind and then painted from this memory. Mr A became a frequent participant in recreational trips to go bowling, fishing, or shopping. “Seeing others whose capacity is less than mine,” he said, “reminds me to keep good perspective.”

As the months passed, Mr A started doing daily crossword puzzles and continued to read. He spoke with his wife about the possibility of taking a place for them near the nursing home. When she responded that they could not afford this, he changed his plan to a trailer. I asked him to reflect on how he was seen here by residents and staff. His response was accurate, I believe, and quite positive.

Mr A attended a reunion of his naval crew, after anticipating this for many months. His ideas about a future for himself and his wife continued to evolve but also continued to be mostly unrealistic. The element most frequently lacking was the provision of care for himself and for his wife. I gently reminded him of this each time he brought up a new proposal.

By 9 months into his nursing home stay, aspects of dementia became more prominent. He was less often accurately oriented and a proposed plan to return to work seemed very unrealistic. When a daughter came and took his wife (but not Mr A) to live in her town, he reacted with disappointment, and then surprising acceptance.

Subsequent months were filled with Mr A expressing how much he missed being with his wife. He hatched one plan after the other aimed at reuniting them. When that did not occur, he consistently maintained that he understood and accepted it. “I’ve adjusted all my life,” he said. “Rarely am I given anything.”

SUMMARY

Each psychotherapy intervention served a major relationship function for Mr A; each encouraged problem-solving and worked hard to not be disputatious. Each emphasized the many ways in which he had successfully adapted to his new environment and noted how a former loner had managed to make multiple new relationships and fulfilled his need to have a productive existence.

The act of being present is an important aspect of psychotherapy. Being silent may be uncomfortable for some, but sometimes its positive effect is like no other. Mr A is a good example of this. He does not always want us to explain things to him or to apprise him of facts related to realistic goals. He feels that he has had significant losses, and he is aware that he is living out the end of his life. He sometimes just wants to be heard. We must remember that what he may really want is for us to be quietly and unconditionally present.

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