Revisiting the Role of a Palliative Care Psychiatrist

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.

Dr Schuyler is employed as a psychiatrist in the program of Geriatrics and Extended Care at the Ralph H. Johnson Veterans Administration Medical Center in Charleston, South Carolina.

Prim Care Companion CNS Disord 2013;15(2):doi:10.4088/PCC.13f01503

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

Funding/support: *None reported.*

Disclaimer: *The views expressed are those of the author and do not necessarily reflect the views of the Veterans Administration.*

I was hired 3 years ago to join a palliative care medical team at a Veterans Administration (VA) hospital. At the time, I speculated about what the work involved was likely to be. I wrote an article that appeared in the *Companion* titled "Roles and Goals of a Palliative Care Psychiatrist."[1] Now, after 3 years of actually doing the work, revisiting the description of the job seems reasonable.

My work encompasses 12 hours of the week. One morning is spent on a VA nursing home inpatient unit. One morning is spent in an oncology clinic. One morning is spent in a geriatric clinic. In each place, I am tasked to represent palliative care. In addition, I join the medical team on inpatient rounds on the VA hospital medical wards twice weekly. My dual role there involves aiding the treatment of inpatients and augmenting the teaching of medical residents.

Palliative care replaces curative intent with comfort care as the goal of treatment for these patients. Comfort care focuses on pain relief, sleep and appetite promotion, the reduction of fatigue, the elimination of diarrhea and constipation, and the minimization of anxiety and depression.

I learned quickly that the adjustment to admission to a nursing home unit could be represented psychologically as "starting a new life stage." The same was true of the impact on most outpatients of a diagnosis of cancer. I observed a similar phenomenon whenever a patient was diagnosed with a serious (often life-threatening) illness. For many, a signal that the "end of life" was approaching had a similar effect.

Some patients told me that now little in life was engaging. Others saw life passing them by. People with differing personalities often had different needs and engaged in different activities. For many, painfully little of their previous life stage seemed applicable to this new one. A significant number of people seemed overwhelmed by their new circumstance and seemed to have given up. On the nursing home unit, this was often indicated by the phrase, "I am here to die." With the passage of a brief amount of time, and with the benefit of regular meals and routine, the design of a plan to adapt to their new circumstance seemed to be a good prospect for many patients.

PSYCHOTHERAPY

Brief psychotherapy typically began with engagement,[2] the forming of a connection between patient and doctor. Encouragement to take initiative and to take responsibility for oneself followed. Complaints of loss of familiarity and loss of control were common. Separating the controllable from the uncontrollable was, therefore, often on the therapy agenda. This approach countered one aspect of dichotomous (black and white) thinking.

For some, a portion of the psychotherapy took up issues related to dying: writing a will, distributing possessions, considering the impact of death upon significant others. Decisions related to an advanced directive, power of attorney, and a life review often were relevant to a patient at the end of life. Many patients, however, had already made plans for their death. Since the period of this stage was variable in length for many, psychotherapy focused for them on living, not dying.[3]

There were issues of identity ("Who am I now?"), self-control, the reconciling of significant relationships, and, prominently, adjusting to the restrictions related to an illness. Often, there was anxiety, occasionally depression, and sometimes denial. For some, there was an inaccurate understanding of physiology or illness management or the potentially beneficial effects of hospice. Explaining these factors could form a part of the psychotherapy.

Some patients had a need to grieve earlier losses. For many, a problem-solving approach was an asset to help them deal with current situations. Sometimes, the therapist served as a "sounding board" and sometimes actively suggested alternative approaches to problems. Always, the patient was encouraged to be a "self-observer." Meanings were identified to guide the transaction. With some patients, the therapist served also to alert the internist (or the nurse or the recreational therapist) to a medical need of the patient!

Sometimes, the psychotherapy dealt with demoralization (loss of effectiveness). Sometimes, the therapist served as a "guide."[4] Sometimes, the therapist supported motivation to change. At times, the therapist "befriended" the patient.[5] At times, the therapist represented an element of reality. Always, the focus was on the patient's mindset.

If these transactions represented "cognitive therapy," how would that be identified? The dialogue was present oriented, problem solving, and focused on meanings. Cognitive errors were often pointed out: polarization (black and white thinking), personalization, and overgeneralization. Techniques varied from identifying meanings, to seeking alternatives, to shift of set ("What if this happened to a friend, what would your advice be?"). Common questions posed included "Is this a good strategy for you?" and "What are the components of your identity pie now?" The same model worked equally well when applied to preparing for the end of life, to dealing with the diagnosis of cancer or another serious illness, or to dealing with adjustment in general.

Applying the cognitive model to these patients framed a brief psychotherapy that could be utilized effectively by a palliative care therapist. Three years into this part-time role, it would seem to represent well one road to the future for a psychiatrist, psychologist, or social worker. I believe that providing the psychological viewpoint to trainees in medicine is critical to their development. I try to contribute to that process.

What are the results for patients? In many cases, some inpatients, and some outpatients with cancer (or other life-threatening illnesses), have been encouraged to adjust to this new life stage in a healthy way. For some, a lengthened life span may have resulted. I would like to think that the patient's quality of life, regardless of his or her situation, has been the largest beneficiary.

REFERENCES

1. Schuyler D. Roles and goals of a palliative care psychiatrist. *Prim Care Companion J Clin Psychiatry*. 2010;12(5):e1–e2.
2. Schuyler D. Engagement. *Primary Care Companion CNS Disord.* 2013;15(1):e1–e2.
3. Muniz da Costa Vargens O, Bertero C. The phantom of death improving quality of life: you live until you die. *Amer J Hospice Palliative Med.* 2012;29(7):555–562.
4. Schuyler D. Keeping hope alive. *Prim Care Companion CNS Disord.* 2011;13(1):e1–e2.
5. Schuyler D. Befriending. *Prim Care Companion CNS Disord*. 2011;13(4):e1–e2.