**Brief Psychotherapy**

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 DEFINATION

Psychotherapy can help patients countertheir demoralization, which is the despair, helplessness, andsense of isolation that many patients experience when affectedby illness and its treatments. Demoralization can be usefullyregarded as the compilation of different existential posturesthat position a patient to withdraw from the challenges of illness.A fruitful interviewing strategy is to discern which existentialthemes are of most concern, then to tailor questions and interventionsto address those specific themes. Illustrative cases show howsuch focused interviewing can help patients cope assertivelyby mobilizing existential postures of resilience, such as hope,agency, and communion with others.

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|  |   **INTRODUCTION**  |

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The real trouble is taking my phosphate binders. I carry themaround with me, but this thing of opening a bag, taking pills,that’s hard to do. Every time I have to take a pill inorder to eat at McDonald’s, it feels like I’m beingpunished.

—Dialysis patient, noncompliant with renaldietary restrictions

Demoralization is one of the most common reasons why psychiatristsare consulted for medically ill patients, with a request typicallyposed as, "Please evaluate and treat depression." Demoralizationrefers to the "various degrees of helplessness, hopelessness,confusion, and subjective incompetence" that people feel whensensing that they are failing their own or others’ expectationsfor coping with life’s adversities.[1,p.14](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R031000491) Rather thancoping, they struggle to survive.

Demoralization occurs so commonly that it can be regarded asa universal human experience. Analogous to bereavement, demoralizationcan result from a myriad of life’s insults other thanmedical illnesses. Slavney has argued that demoralization isproperly regarded not as a psychiatric disorder but as a normalhuman response to overwhelming circumstances.[2](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R031000492) Yet frequentlyother physicians ask psychiatrists to intervene.

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|  | **DEMORALIZATION VS A DEPRESSIVE DISORDER**  |

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Demoralization is commonly confused with depression, with whichit shares disturbances in sleep, appetite, and energy and evensuicidal thinking. It differs from major depressive episode,however, because reactivity of mood is usually preserved,in that cessation of adversity rapidly restores a capacity tofeel enjoyment and to hope. This is the case whether the reliefis physical, as with improved control of pain, nausea, or insomnia;or emotional, as with the happy appearance of a friend or unexpectedgood news about the medical prognosis. De Figueiredo proposedthat subjective incompetence due to uncertainty over what courseof action to take distinguishes demoralization from depression,in which apathy predominates even when a needed action is clear.[3](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R031000493)Demoralization also differs from depression in that it generallyfails to show robust improvement when antidepressant medicationsare prescribed. This is an important distinction in an era whenboth primary care physicians and psychiatrists often respondfirst to a patient’s distress by prescribing a pill. Rather,demoralization is best countered by either 1) ameliorating physicalor emotional stressors or 2) strengthening a patient’sresilience to stress.

Acknowledging suffering and restoring dignity are potent instrengthening a patient’s resilience to stress. Slavneyhas proposed conversing in a manner that normalizes a demoralizedpatient’s distress.[4](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R031000494) He has suggested that a clinicianask first about mood ("How are your spirits today?") and thepatient’s concerns ("What is the most difficult thingfor you now?") and then validate the patient’s distressas that of a normal person responding to abnormal, hard circumstances.[2](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R031000492)Viederman has shown how an empathic dialogue can help a patientto express and understand difficult emotions and grasp theirsignificance in terms of the patient’s life narrative.[5](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R031000495),[6](http://psy.psychiatryonline.org/cgi/content/full/46/2/109%22%20%5Cl%20%22R031000496) Weingarten has described compassionate witnessing as a socialand cultural process vital for maintenance of hope.

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|  |   **BREAKING DOWN DEMORALIZATION**  |

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The term "demoralization" is often used as if describing somesingular state of being. However, demoralization can be moreusefully regarded as a compilation of multiple existential posturesevoked by the medical crisis in which a patient is immersed.Viewing demoralization in terms of distinct existential componentsis pragmatically useful because it can help a clinician to askmore specific questions for mobilizing an assertive responseto illness.

Existentialist philosophers of the 19th century and early 20thcentury discussed such experiences as suffering, despair, meaninglessness,and a sense of isolation as the boundaries of human existence,in that every person is obligated to encounter and to respondto each of them.[9](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R031000499),[10](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R0310004910) Subsequent existentialist psychiatristsand psychologists elaborated psychotherapies based on associationsnoted between anxiety, depression, and patients’ dreadof these existential crises.[11](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R0310004911),[12](http://psy.psychiatryonline.org/cgi/content/full/46/2/109%22%20%5Cl%20%22R0310004912) Recent decades of psychosomaticresearch further extended this understanding by demonstratinghow existential crises involve not only the mind and spiritbut also the body.

States of being associated with existential crises are markersfor the junctures where the physiological and psychosocial worldsmost definitively meet. They are both distinctive experientialstates and indicators for physiological dysregulation. Thereare research literatures linking such states as despair, helplessness,and a sense of isolation with vulnerability to a range of physicaldiseases, including cardiovascular disease and cancer.[13](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R0310004913)–[16](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R0310004916)These same states are reliable triggers for the onset or relapseof axis I psychiatric disorders, whether psychoses, mood disorders,anxiety disorders, or dissociative disorders.

Dimensionally, existential states can be regarded as posturesturned relative degrees toward, or away from, assertive copingwith illness. Those in the left-hand column of [Table 1](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#T1) representstates of breakdown in goal-directed coping.[17](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R0310004917) They set thestage for withdrawal from active engagement with living. Confusion,despair, helplessness, and related states each help constitutea readiness to quit responding to challenges, whether mentalor physical. The existential postures in the right-hand columnrepresent an effort to meet challenges and to embrace life withall its circumstances. Mindfulness for these polarities canguide bedside interviewing toward helping patients sustain theseexistential postures of resilience as much of the time as ispossible.[1](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R031000491)

Helping patients to sustain existential postures of resilienceis done by whatever means creativity can devise: convincingthe attending physician to sit down at the bedside for a discussionwith the patient about the medical diagnosis and its prognosis;cajoling the medical team into providing more aggressive painmanagement; responding to the patient as a normal person dealingwith abnormal circumstances; helping to mobilize contact withfriends or family who have lost track of the hospitalized patient.We focus here on methods of bedside interviewing that can helpmobilize existential postures of resilience.

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|  |   **COHERENCE VERSUS CONFUSION**  |

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Confusion, an inability to make sense of one’s situation,disables all forms of assertive coping. Confusion commonly occursamong patients in general hospitals as the salient symptom ofdelirium, in which metabolic brain abnormalities disturb perception,concentration, memory, and higher cortical functions. However,confusion also arises for cognitively intact patients when adefinitive medical diagnosis cannot be established, a medicaldisorder does not respond in expected ways to treatment, ordifferent medical team members give conflicting communicationsto the patient.[8](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R031000498),[17(pp.292–297)](http://psy.psychiatryonline.org/cgi/content/full/46/2/109%22%20%5Cl%20%22R0310004917) Questions that can helpa patient to regain a sense of coherence include the following:

* How do you make sense of what you are going through?
* Whenyou are uncertain how to make sense of it, how do you dealwithfeeling confused?
* To whom do you turn for help when you feelconfused?
* [For a religious patient] When you feel confused,do you havea sense that God has a way of making sense of it?Do you sensethat God sees meaning in your suffering?

The most useful questions are often those in which the clinicianin essence lends to the confused patient the clinician’sexecutive functions for organizing, planning, and judging byembedding them within questions:

Ms. A was a 32-year-old woman with recurrent lymphoma for whoma bone marrow transplant had failed. She complained that heroncologist was not adequately addressing her pain. She was alsoangry that he disagreed with her wish to stop chemotherapy.She felt alone and uncared for and added spontaneously, "Whycan’t everyone leave me alone so I can die?" She was visiblyconfused and overwhelmed.

After listening for a few moments, the psychiatric consultantsaid, "I’ve heard you mention four main areas of concern—arranginga consultation at another cancer center for a second opinion,your feelings of depression, the physical pain, and whetheror not to continue with cancer treatment. Are there other thingsthat should be on the list?" When she said, "No," the consultantasked her to put these four items in order of their concernto her. Ms. A gave highest priority to controlling pain andthen listed arranging the consultation for a second opinionand then dealing with depression. Whether to continue chemotherapywas actually a distant fourth.

The consultant wrote down the list and handed it to her. Shesuggested that Ms. A hold it during her meeting with her oncologistthat afternoon so she could stay focused on what she wantedto accomplish. As the conversation progressed, Ms. A stoppedholding her head, rocking, and shifting her position as if inpain. The consultant asked if she felt less anxious. Ms. A respondedmore assertively, "I can think more clearly. Now I have a plan."She later reported that, although her oncologist "still didn’tget it," she felt that she could continue chemotherapy.

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|  |   **COMMUNION VERSUS ISOLATION**  |

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Communion is the felt presence of a trustworthy person. It isevidenced by the nuanced language we possess for describingits different expressions: making contact, acknowledgment, feelingheard, witnessing, intimacy, community. Theologian Henri Nouwenobserved about men who had survived long jail terms that "aman can keep his sanity and stay alive as long as there is atleast one person who is waiting for him.... And no man can stayalive when nobody is waiting for him."[18(p.66)](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R0310004918)

Medical illness is profoundly isolating for many people. Anillness cannot be fully experienced by other people, even whenthey are sympathetic. Illness removes a person from both familiarroutines and the special pleasures of living with other people.It sometimes isolates harshly through stigma from disfigurementor fears of contagion. Isolation is a distinctive accompanimentof physical pain, when that which feels most real in one’sbody is invisible to others. Questions that can initiate stepstoward communion with others include the following:

* Who really understands your situation?
* When you have difficultdays, with whom do you talk?
* In whose presence do you feela bodily sense of peace?
* [For religious patients] Do you feelthe presence of God? How?What does God know about your experiencethat other people maynot understand?

Mr. B was a 51-year-old man who was hospitalized for AIDS andpneumocystis pneumonia. Psychiatric consultation had been requestedto treat his depression and to assess his risk for suicide.After summarizing the psychiatry resident’s initial assessment,the consultant commented, "This is a hard illness to go through.How well are you keeping your spirits up?"

"Not very well," Mr. E. responded. "Sometimes I really wouldlike to leave this world."

"At those times, what helps you find a will to live?" the consultantasked.

"My mother and brother came to visit me yesterday," he said.

"Your relationships with your mother and brother help you finda will to live?" the consultant reflected back.

"Yes. And my AA group," he added.

"I wondered about that. I knew you were in AA but wondered whetheryou just dropped into different groups, or whether you had asponsor and close relationships."

"They visit me every day," he responded.

"So they are a real community for you. You choose to live foryour relationship with them, and they with you?" the consultantasked.

"Yes."

Mr. B told how he had many troubles and disappointments in hislife—acknowledging that he was gay, going through divorce,dealing with alienated children, living with HIV and AIDS, feelingused and exploited by different friends and partners. "But whenI began going to AA, I learned that people in AA would not hurtme."

The consultant asked whether there were other sources from whichhe drew hope and purpose for his life.

"Well, I’ve tried relying on religious beliefs, but thathasn’t worked very well." He said that he had grown upas a Catholic but had never been able to believe in God.

"I’m supposing that in AA, your relationship to a HigherPower is important. Is that different from the God of the CatholicChurch?" the consultant asked.

"AA is my Higher Power," he responded.

"This community—these relationships with those in yourAA group—they are your Higher Power?" the consultant askedfor clarification.

"Yes," he said. He then told how someone had come unexpectedlythe day before to see him, which was a good surprise.

While medications were recommended to address Mr. B’ssleep and anxiety symptoms, the primary recommendation fromthe psychiatric consultation was that his supportive networkof AA community and his family members be integrated more fullyinto his care.

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|  |   **HOPE VERSUS DESPAIR**  |

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Despair, or hopelessness, has predicted coping failure in researchstudies.[14](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R0310004914) Hope is essential both for discerning present desiresand for making future plans. Questions that help mobilize asense of hope include the following:

* From what sources do you draw hope?
* On difficult days, whatkeeps you from giving up?
* Who have you known in your lifewho would not be surprised tosee you stay hopeful amid adversity?What did this person knowabout you that other people may nothave known?[19](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R0310004919)

Mr. C was a 48-year-old man who had been admitted to the hospital72 hours earlier because of weakness in his arm and leg thathad progressed over several days. He entered the hospital fearingthat he had had a stroke. After a chest X-ray and magnetic resonanceimaging scan of his brain, however, he reported being told,"You have stage-four cancer and it has metastasized to yourbrain." He responded by feeling that "it’s the end ofthe race," and he told a nurse that he was going home to shoothimself with his gun. The on-call psychiatry resident, askedto evaluate Mr. C’s risk for suicide, determined thathe was in shock over the news and angry over its mode of deliverybut not at imminent risk of self-harm.

Mr. C was a mathematician who always focused on statisticalodds. Knowing the low likelihood of cure for his cancer deepenedhis despair. He had no past history of a mood disorder, however,and his score of 10 on the Hamilton Depression Rating Scalewas not significantly elevated.

The psychiatric consultant asked how he wished that the medicalteam would have spoken when reporting such bad news. "I wouldhave picked a time when I wasn’t in so much physical pain,getting stuck with needles and IVs. It made a lot of differencewhen they started doing what they said they would do. For 2days, they stood around talking about radiation therapy, andnow they are finally doing it."

Recalling that Mr. C stayed aware of the betting odds, the consultantasked how he managed to stay in an emotion of hope even thoughhe knew the odds were long against him. "I’m able to lookat the whole spectrum, then to decide what position to take."

"Many people can’t do that," the consultant noted. "Whenthe odds are long, they feel too overwhelmed. How have you learnedto do this?"

"There are people who go to Las Vegas with ten dollars and win$300,000," Mr. C responded. "I know of one woman who was givena terminal diagnosis of cancer, but she is still alive."

"So you do know some examples, stories, and analogies that youcan draw from to sustain a realistic sense of hope. When inyour life did you learn to do this, or who did you learn itfrom?"

"Different people are good at different things," he said, explainingthat his years of work in industry had centered on making decisionsabout which new products to invest in and for how long and whento give up on one and turn to another that showed more promise.

"It sounds like this is something that makes you good at yourwork, and now you are bringing your skill to confront this illness,"the consultant commented.

Through the remainder of his hospitalization, Mr. C maintaineda sense of humor and focus on the future.

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|  |   **PURPOSE VERSUS MEANINGLESSNESS**  |

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Suffering without meaning is unbearable. Yet many who sufferenough to desire death instead choose to live because they havestrong purposes for living. Physical illness is a challengebecause it can make a purposeful life not only difficult toconduct but even difficult to imagine. This is particularlyso when medical disabilities end productive work or pleasurableactivities that had been vital for life’s meanings. Reconstructionof a robust purpose for living is often a key step in rehabilitation.Questions for starting a generative inquiry about purpose includethe following:

* What keeps you going on difficult days?
* For whom, or for what,does it matter that you continue to live?
* [For terminallyill patients] What do you hope to contributein the time youhave remaining?
* [For religious patients] What does God hopeyou will do withyour life in days to come?

Mr. D was a 45-year-old man with severe degenerative spinaldisk disease. A complex regimen of an antidepressant, a psychostimulant,and multiple analgesics only partially relieved his chronicpain. In addition, he recently had been placed on disabilityand was financially stressed. Psychiatric consultation had beenrequested to assess his risk for suicide.

Mr. D said he wondered now whether life was still worth living.He denied having a plan for suicide but acknowledged spendinga recent evening on the Internet looking at suicide web sites.

"What holds you back?" the psychiatric consultant asked.

"The efforts that my doctors and a few other people have madeto get me as far as they’ve been able," he responded."I don’t want to let them down." He named four peoplewho had most helped him rally after he had become despondent.

Then he added, "I’ve always spent my time helping otherpeople." The consultant asked what he meant.

"All my work has been for other people—nonprofit organizations,public service. I’ve always worked in the government."He told how he not only had worked long hours in his governmentjob but also had volunteered time for community service projectsand nonprofit advocacy groups.

"It sounds like a strong sense of purpose from your work lifehas been important," the consultant said. "It has mattered alot to know that what you do makes a difference in people’slives."

Mr. D agreed, adding that it had been a mistake to stop working.Then he described his current dilemma. His last remaining volunteerrole was as secretary in a nonprofit organization. He was underpressure to resign because he had not kept good track of itsrecords during his illness. While he agreed that his performancein that position had been erratic, he worried about what itwould be like to feel that he had nothing useful to offer. Thishad in part precipitated his current crisis.

The consultant included among his recommendations a subsequentmeeting with Mr. D and supportive friends that would includeaddressing ways in which he could continue using his knowledgeand skills to make a contribution to the lives of others.

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|  |   **AGENCY VERSUS HELPLESSNESS**  |

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Agency is the sense that one can make meaningful choices andthat one’s actions matter. Agency does not imply thata person is in control, which is usually an unrealistic expectationwhen a person is medically ill. It does imply that a person’schoices and actions have influence and make meaningful differences.Agency is often expressed in terms of empowerment or "havinga voice." Antonovsky’s research on coping in medical illnessfound a sense of agency to be an important predictor for goodhealth.[20](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R0310004920) Questions for inquiring about a patient’s senseof agency include the following:

* What is your prioritized list of concerns? What concerns youmost? What next most?
* What most helps you to stand strongagainst the challenges ofthis illness?
* What should I knowabout you as a person that lies beyond yourillness?[21](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R0310004921)
* Howhave you kept this illness from taking charge of your entirelife?[21](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R0310004921)

An important way to help a patient to regain a sense of personalagency is to assist in rediscovering his or her identity asa competent and effective person. Cassem has emphasized thevalue of asking seriously ill elderly men, "When were you atthe top of your game?" and then fleshing out a rich descriptionof this era of the man’s life.[22](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R0310004922) The following vignetteillustrates how this can be similarly accomplished by helpinga person recollect an identity of competence, such as she hadbeen known by her mother:

Ms. E, a 60-year-old woman, had had neurosurgery for a brainglioma 3 days earlier. Psychiatric consultation was requestedfor her depressed mood. Her initial symptoms had begun a weekearlier with incoordination and weakness in her left arm.

"I only have half a brain now," she told the psychiatric consultant,bursting into tears. The consultant asked what was the hardestthing to bear with this illness. She said she could think thatshe was moving her left hand, but it in fact would not move."This has knocked me for a loop," she said, again weeping.

"Yes, this has thrown you for a loop. It would be that way formost anyone," the consultant reflected.

Ms. E spoke about guilt she felt while remembering how she hadbecome frustrated with her chronically ill, elderly mother."Now I know what it was like for her." The consultant wonderedwhat she now better understood. "I respect her more now," Ms.E said. "Now I realize how hard it had been for her."

"If your mother could speak to you about your illness, whatdo you suppose she would say?" the consultant asked.

"She would say, ‘Get on with it!’" Ms. E responded.She then remembered the story of two frogs who fell into a farmer’spail of milk. One frog, seeing their predicament, gave up anddrowned. The other kept paddling. Soon butter formed and floatedto the top. The frog kicked against the butter and hopped out."I want to be the frog who keeps kicking," she said.

"Your neurological team wanted us to see you because they wereconcerned you may be depressed," the consultant said to her."We don’t think you are depressed. We do think you areas discouraged as anyone would be dealing with something thishard. We won’t recommend treatment for depression butdo recommend that you get started with physical therapy andrehabilitation. We will come by to see how you are doing." Duringthe ensuing days, she engaged successfully with her physicaltherapy, and her mood brightened.

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|  |   **COURAGE VERSUS COWARDICE**  |

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Courage is a refusal to be subjugated by fear, even when fearis intensely felt. Witnessing oneself performing even smallacts of courage can anchor a sense of self-respect that motivatesfurther courageous acts; likewise, witnessing oneself retreatingbecause of fear can encourage future capitulations. Questionsthat help patients witness their acts of courage include thefollowing:

* Have there been moments when you felt tempted to give up butdidn’t? How did you make a decision to persevere?[23](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R0310004923)
* Ifyou were to see someone else taking such a step even thoughfeeling afraid, would you consider that an act of courage? [Ifso] Can you imagine viewing yourself as a courageous person?Is that a description of yourself that you would desire?
* Canyou imagine that others who witness how you cope with thisillnessmight describe you as a courageous person?[23](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R0310004923)

Ms. F was a 35-year-old non-English-speaking Asian woman withrecurrent metastatic breast cancer who had a poor prognosisfor long-term survival. With her husband interpreting, she toldabout her fears: that she could not bear more bad news, thatshe could not bear the pain, and that she could not face goinghome from the hospital. After she spoke for a time, her husbandturned to the psychiatric consultant and said, "I think sheis a very courageous woman. She has already been through thistwice, and now she may be facing it again. Most people couldn’tdo what she has done." The consultant turned to Ms. F and said,"Your husband says you are courageous. Is that how you mightdescribe yourself?" Her demeanor changed as she relaxed andsmiled, nodding, "Yes." The consultant then asked what had helpedher to be so courageous during this time. She said that thepresence and support of her family members helped her to bestrong even when afraid.

Picking up this theme during subsequent inpatient and outpatientmeetings, the consultant periodically asked Ms. F either torecollect how she had acted with courage or to notice otheroccasions when the presence of her family members enabled herto be courageous.

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|  |   **GRATITUDE VERSUS RESENTMENT**  |

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Sustaining a capacity for experiencing gratitude rather thanresentment or bitterness can help shield against feelings ofanxiety or depression. This is particularly so when some goodderiving from otherwise tragic events can be acknowledged. Questionsthat can help locate a sense of gratitude include the following:

* For what are you most deeply grateful?
* Are there moments whenyou can still feel joy despite the sorrowyou have been through?
* If you could look back on this illness from some future time,what would you say that you took from the experience that addedto your life?[21](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R0310004921)

The following vignette shows how gratitude can emerge even inthe midst of profound suffering.[17](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R0310004917)

Mr. G was a 57-year-old man who earlier in the day had askeda friend to bring a gun to the hospital so he could kill himself.He had become distraught after being told that his right legneeded to be amputated because of impending gangrene. This precipitateda request for psychiatric consultation to assess his suiciderisk and to determine whether he had the decision-making capacityto refuse surgery.

The consultant explained why he had come: his doctors were worriedabout his safety, and they wondered as well whether his thinkingwas clouded by his medications. The consultant asked Mr. G toexplain what he understood his doctors to be saying about hiscondition and what needed to be done medically. Instead of answeringthe question, Mr. G started telling how hard it is for a manwho lives alone to take care of himself—taking care ofhis yard, getting things out of a cabinet in the kitchen—ifhe has no leg.

The consultant asked him what he understood to be the alternativeif he did not have the surgery. Mr. G said that he would developgangrene, which would spread and, within a few days, kill him.He would not permit this to happen, so he saw his only choicesto be surgery and suicide.

Then Mr. G spontaneously interjected that there was nothingto do but "to go along with what they said." The consultantrecalled that moments earlier he had been thinking that it wouldbe better not to live. The consultant asked what had been theturn in his thinking. "I had prayed like hell. I asked God totake it away. But he didn’t." The consultant asked whetherMr. G sensed what God would want him to do now.

"He wouldn’t want me to kill myself," Mr. G responded.

"What do you think God understands about your situation?" theconsultant asked.

"He knows I’ve done the best I could," Mr. G said, beginningto weep.

"Is it that you feel you know what God would want you to do,but it is hard to understand what he has in mind—and itis hard to feel trusting toward God, even if you are going todo what you know he wants you to do?" the consultant asked.

Mr. G nodded.

The consultant then asked who were other important people whowould be with him in his suffering and whom he could count onto support him. "My ex-wife has been calling me," he responded,weeping. She had told him that she loved him and wanted himto have the surgery. He also told about telephone calls fromhis children encouraging him to have the surgery. He expressedappreciation for his doctor, whom he felt had stood by him patiently.Mr. G then consented to the amputation and proceeded with rehabilitationuneventfully.

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|  |   **CONCLUSION**  |

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Demoralization in medically ill patients can be usefully regardedas the compilation of different existential postures that positiona patient to retreat from the challenges of illness. For mosthumans, illness touches on multiple existential themes, someof which are more pressing than others. For one person, helplessnessmay dominate, despair for another, and meaninglessness for yetanother. When different existential postures blend together,they give rise to a sense of subjective incompetence that hasbeen regarded as a distinguishing feature of demoralization.[1](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R031000491),[3](http://psy.psychiatryonline.org/cgi/content/full/46/2/109%22%20%5Cl%20%22R031000493),[24](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R0310004924)

In bedside interviews with patients, a fruitful strategy isfirst to discern which existential postures most dominate thepatient’s experience of illness, then to focus furtherquestions and interventions toward those themes. Interviewingmethods that aim to mobilize specific existential postures ofresilience are built on the witnessing, validating, and normalizingof a patient’s personal experience of illness.[2](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R031000492),[5](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R031000495)–[8](http://psy.psychiatryonline.org/cgi/content/full/46/2/109#R031000498)This must be underscored, since resilience-building questionsasked prematurely fall flat, regarded as naive efforts to solvetragic problems that are insolvable. The root meaning of "compassion"—"tosuffer with"—is key, in that a patient must first knowthat a clinician can understand and is willing to feel togetherthe suffering, before opening to the intimacy of such a questionas, "During the worst of times, from where do you draw hope?"

Bedside psychotherapy has long challenged consultation-liaisonpsychiatrists because of limitations on privacy, patients’preoccupations with biomedical concerns, and the fact that attendingphysicians and not patients usually request psychiatric consultations.Its role has been curtailed by managed mental health care, whichfurther shifted the focus of consultation-liaison psychiatrytoward diagnostic questions and medication-based managementof psychiatric emergencies. However, the need for effectiveinterventions that can restore morale in medically ill patientscalls for a renewed focus on bedside psychotherapy in the consultation-liaisontraining of psychiatrists.