Advances in medical science have resulted in our living longer and healthier lives. With this increase in life expectancy, conditions once thought episodic or terminal can now be viewed in a chronic disease model.

In adapting to the rigors of chronic disease, such as the gradual loss of function, patients often will ask questions related to quality of life and existential concerns. Psychiatrists are uniquely suited to engage in these conversations and to help patients determine what is of meaning and value in their lives. Yet, few training programs teach their residents how to explicitly discuss end-of-life issues.

Psychiatrists are not alone in their lack of training in the discussion of end-of-life issues. The tendency toward specialization in the medical system has split the topic of death into roughly four camps:

- **Physical**: Realm of general medicine; usually goal is to prevent death.
- **Psychiatric**: Realm of psychiatrist, psychologist; goal is to prevent suicide and self-harm.
- **Palliative**: All aspects related to amelioration of suffering, but erroneously started at near end of life.
- **Spiritual**: Realm of spiritual providers, chaplain, and priest; goals are existential, focused on helping the patient find peace and meaning in life.

This division can result in a patient’s own personal meaning and values not being incorporated into care. Psychiatrists have the ability, and hopefully the training, to help patients integrate these various areas and treat the “whole” patient in a life-affirming manner, regardless of the stage of illness.

In this issue, we explore the palliative stage of treatment, including ways to discuss death openly with patients; gain an understanding of the various pharmacological treatments available; and learn the common threads linking various therapies used in traditional palliative care settings.

James L. Griffith, MD, and colleagues give the clinician a systematic method of exploring and discussing pleas to be allowed to die from patients (see page 127).

Sanaz Kumar, MD, and colleagues give readers an overview of psychotherapies developed to address palliative care (see page 133). The authors describe dignity therapy, meaning-centered group psychotherapy, and short-term life review. These therapies give the clinician an evidence-based approach to help patients maintain dignity and build resilience in the palliative phase of care.

Robert Meisner, MD, and colleagues (see page 138) present a case where a cancer survivor is now faced with finding the true purpose of his life. The authors skillfully examine the potential role of the therapeutic relationship to help patients address existential concerns. The case also highlights the inherent limitations of utilizing a strictly cognitive-behavioral approach to treat patients in existential distress.

Lynsey P. Tamborello, MD, and colleagues discuss pharmacological...
guest editorial

Strategies for common symptoms in the palliative phase of care (see page 142). Symptoms such as fatigue, pain, and anxiety can be very distressing for patients. There is substantial literature on the use of medications such as antidepressants and stimulants for conditions other than primary mood disorders. Unfortunately, a number of psychiatrists are unfamiliar with the principles behind the use of such medications in the palliative phase of care. Proper treatment of these conditions can allow patients to continue living according to their own values and principles, and without suffering.

Julia Dorfman, MD, PhD, and colleagues explore integrative approaches to patient care at the end of life (see page 150). This is a new area in medicine that potentially could offer alternative treatment strategies in situations where standard medication management or psychotherapy is not feasible.

I wish to particularly thank my assistant editor, Louis Joseph, MD, and our senior program associate, Julie Noblick, both of whom were invaluable to making this issue a reality.

doi: 10.3928/00485713-20120323-03

about the guest editor

Lorenzo Norris, MD, graduated from Case Western Reserve University School of Medicine; completed his residency in General Psychiatry at Mount Sinai in New York; and did his fellowship in Psychosomatic Medicine at Yale University. Dr. Norris is The George Washington University Hospital’s Director of the Neuropsychiatry Program; Associate Residency Director, Psychiatry Department; and is Medical Director of Psychiatric Behavioral Services for The George Washington University Hospital.