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Top Ten Tips Palliative Care Clinicians Should Know About the Psychological Aspects of Palliative Care Encounters

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Abstract

Palliative care clinicians enhance the illness experiences of patients and their families through building therapeutic relationships. Many psychological concepts underlie a clinician's approach to a specific patient. Through high-yield tips, this article highlights ten selected psychological elements that palliative care clinicians often use to support patients. As we all (both clinicians and patients) bring our own histories and unique biographies to the work of palliative care, a more explicit focus on the psychological aspects of this work can enhance our own experience and efficacy as providers. With a thoughtful focus on the psychological aspects of how we engage with patients, palliative care clinicians can offer a more meaningful therapeutic encounter.

Keywords: communication aspects; countertransference; palliative care; psychological aspects; therapeutic alliance; transference

Introduction

Palliative care clinicians improve perceived quality of life for patients managing serious illness.[1] We do this through multiple means, including expert-level symptom management to verbal exploration of personal values. Our work is deeply interpersonal. We know that human connection is essential to our success,[2] but sometimes it can seem nebulous to describe. This article offers ten high-yield tips on the psychological elements of caring for patients with serious illness. Drawing from psychological concepts, we will explore the often-subtle components of our therapeutic connection. Embedded in each tip, the psychological term for the concept being addressed will be highlighted in *italics.*

Tip 1: We Help Patients Through the *Therapeutic Alliance* Created by Our Presence

Our very presence with patients and their families can mitigate distress. *Therapeutic alliance* is the psychological term for this aspect of care. Research suggests that these alliances help patients in a variety of ways and improve outcomes in a wide range of medical care settings.[3–5]

Palliative care clinicians create *therapeutic alliances* by offering patients a supportive, inviting, and attentive presence, allowing space to include the *who* to medicine's *what.* We are consistent and they can count on us to be there, in ways that many of our patients could not with other important caregivers in their lives. We do this through clinical skills like

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creating a sense of presence, maintaining attunement[6] to their needs, and accompanying the patient in all circumstances. We listen actively and curiously to understand the patient within the context of their unique life. We also support patients amidst the challenges and decisions common in the serious illness experience.

Tip 2: We Are Clear About What Patients and Families Can Expect from Us, Setting the *Frame*

Patients with serious illness interact with a dizzying variety of different clinicians, specialists, services, and often settings of care (e.g., home, hospital, clinic). Each clinical environment and encounter require patients to adjust their expectations for different aspects of care, called the *frame* in psychology. This includes elements such as the focus, frequency, setting, and visit duration.[7] Sometimes patients understand these differences explicitly; for instance, an oncologist may say ''I'd like to see you every month while you're on active treatment.''

However, sometimes the expectations are unspoken or assumed. When clinicians do not discuss the frame openly, patients can struggle with the lack of clarity. They can ask the wrong clinician a question (e.g., asking a cardio-oncology consultant about chemotherapy costs), become surprised by discontinuity in care during transitions in setting (e.g., being seen by an inpatient clinician during admission, rather than their usual outpatient clinician), or not utilize available resources (e.g., not calling the after-hours emergency line for symptom crises).

We can help our patients by clearly describing what each clinician is there to do, how to access each clinician (including after hours), how things change across settings, and similar issues.[8] We can help reduce their anxiety by setting expectations and allowing patients and caregivers to optimally utilize each member of their care team. For some patients, a clear frame gives them stability, a sense of control and predictability in a situation that may otherwise feel uncontrollable.

Tip 3: We Can Communicate Better by Asking "Why" to Create and Hone Our *Formulation* of the Patient

When a patient responds to us in a surprising way, there is generally a psychological reason at play. As clinicians, we can reflect on the ''why'' beneath a patient's emotions and behaviors, and ideally offer a more therapeutic connection through understanding them better. As we get to know our patients, we develop a kind of hypothesis about the psychology underpinning the outward reactions that we observe. This is called a *formulation* in psychology. Our *formulation* becomes the compass that guides us in communicating with each patient.[9] Two patients displaying similar behaviors may require markedly different clinician responses based on the underlying *formulation*. Unlike a diagnosis, a *formulation* can change over time as we learn new information about a patient.

We put the *formulation* together through considering several aspects of a patient. We gather data from our own psychosocial-spiritual assessment, insights from the interdisciplinary team (e.g., social work, chaplaincy), our past experiences with other similar patients, and insight derived from our clinical relationship dynamics (see *transference* and *countertransference* below). All these factors guide us to a cohesive *formulation* that informs how a given patient may respond to difficult conversations and lead us to more therapeutic approaches to their care.

Tip 4: Patients May Respond to Us Based on Their Past Experiences, with *Transference* Fueling Either Positive or Negative Emotions

There is a give and take to every patient–clinician interaction. Patients bring their life experiences and emotional reactions to the visit, and so do we as clinicians. In the psychological tradition, the term *transference* refers to the patient's response to us.[10] *Transference* can be positive or negative, respectively, drawing patients toward or away from us. One patient may feel comfortable with us and say, ''you remind me of my daughter.'' Another patient may be standoffish; perhaps we remind him of a disapproving parent. In this way, *transference* may contribute to a patient applying attitudes from past provider experiences onto us.

When we encounter a patient who appears guarded, we should take a moment to ask ourselves why this might be. We can remain engaged and open while learning more about a patient's background and past experiences. These *transference* reactions can also change over the course of a clinical relationship—many of us have known a patient and family that ''warmed up'' over time. We can also find acceptance when patients do not want our involvement; we can offer support to their primary team and remain open for questions or other help.

Our interdisciplinary model is also a source of strength in approaching patient *transference*. While patients may not always feel connected with one clinician on the team, they may find more connection with another person. For example, we may knowingly choose a nurse practitioner to make a bereavement call to a specific patient as opposed to another team member, based on what we perceived and remember from our previous care of the patient.

Tip 5: We May Respond to Patients Based on Our Past Experiences, with *Countertransference* a Powerful Force for Clinicians to Understand to Provide Optimal Patient-Centered Care

The counterpart of *transference* (see Tip 4) is *countertransference*, or our experience of the patient. We come to this work with our own full lives. We feel different ways about given patients and families. One patient may remind us of our loving grandmother, while another patient may evoke helplessness and hopelessness. These reactions might seem universal (i.e., all team members respond positively to a particular patient) or be deeply personal and individual (i.e., a patient with similar challenging mannerisms as a clinician's family member).

Countertransference is not something that should or can be avoided; it is everywhere. We approach our work carrying our own histories with loss, our attitudes about coping, our spiritual beliefs, and our own significant relationships, past and present. We may choose to become curious about these moments where something feels ''different.'' When we avoid a specific patient's room or alternatively overly attach and cannot easily leave, we can recognize that something is afoot—this is *countertransference*. We can learn from these encounters, allowing these reactions to attune us to a patient's situation, inform our *formulation* (see Tip 3), and offer them a supportive *therapeutic alliance* (see Tip 1).

Tip 6: We Can Create an Emotionally Safe Place for Patients and Families, a *Holding Space* Where Patients and Families Can Explore and Process Their Situation

Palliative care encounters contain multitudes. There are moments of anxiety, fear, hope, levity, and tedium. From the moment a patient is diagnosed with a serious illness, they need clinicians to offer an emotionally stable and secure place to process their feelings. The British pediatrician and psychoanalyst Donald Winnicott developed the term *holding space* to describe a clinical encounter where therapy and emotional healing could happen. In palliative care, we try to offer our patients and families the time and opportunity to process what is happening in their lives.[11] We don't try to fix or remove their feelings but rather offer curiosity, acceptance, and encouragement as they explore, process, and integrate their emotional experiences.

We create emotionally safe environments through offering our attention, consistency, and positive regard. We use nonverbal communication extensively, including thinking about how we sit in the room, how we speak and to whom, and our overall tone and energy level. We meet our patients where they are and dial up or down our interpersonal qualities in response to the needs of a patient. Even within a single visit, we promote their emotional safety through a dynamic approach to our own communication style.

Tip 7: We Can Consider Our Patients' *Attachment Styles* When Communicating with Them, and Tailor Our Approach Accordingly

Some patients do well with frequent calls, check-ins, and clinician contact. Others do not. These preferences for care are deeply informed by *attachment styles*.[12] *Attachment styles* are shaped by individuals' early-life experiences and inform the way they navigate relationships throughout their lifespan. Although there is individual variation, there are four common attachment styles. (1) Individuals with *secure attachment* can feel cared for across a range of relationships. (2) Individuals with *preoccupied attachment* thrive with closer relationships with frequent contact. (3) Individuals with *dismissive attachment* may prefer more space and independence. Finally, (4) individuals with *fearful-disorganized attachment* may have had traumatic experiences with caregivers early in life and may struggle significantly when ill.

Attachment styles are not mental illness, however, they shape and influence patients' experiences.[13] Palliative care clinicians must understand these styles as patients' life-long patterns and preferences may become more pronounced in the context of serious illness.[14] We can learn about attachment styles during our psychosocial assessments (i.e., often reading between the lines of unstable past relationships) and we can directly ask patients what sort of support is most helpful to them as we tailor care to meet patients' needs.

Tip 8: Every Behavior Is a Form of *Coping*; Some Are More Adaptive Than Others

Everything patients do can be considered an attempt at *coping* or maintaining a sense of psychological balance while confronting their illness, limitations, and mortality. Everyone copes differently and sometimes the stressors of illness lead people to not be as resourceful or adaptive as they have previously been.

Palliative care clinicians can consider whether a patient's *coping* is adaptive (reducing stress and allowing time for adjustment) or less adaptive (preventing necessary adjustments). We can ask ourselves: is this behavior meeting their emotional needs? While a *coping* mechanism such as denial may not help a given patient making end-of-life care decisions in the intensive care unit, the same mechanism may have enabled that patient to go on a much-desired vacation earlier in the serious illness experience. We must consider whether coping is more or less adaptive with the perspective of whether it is helping them meet their goals or not, rather than labeling it as good or bad.

Tip 9: We Must Be Mindful of the Ways *Boundary Crossings* Impact Care

Palliative care clinicians must consider multiples of boundaries in the care of our patients. While *boundary violations* are unethical (e.g., financial or sexual exploitation), a *boundary crossing* is a more subtle departure from the *frame* (see Tip 2) of customary clinical practice. Skillful boundary crossings can draw us closer to a patient and support the therapeutic alliance. As palliative care clinicians, we are likely to encounter professional *boundary crossings* because of the intimate nature of caring for people with serious illness.[15] Examples of a *boundary crossing* may include giving personal contact information, accepting a hug or a small gift, extending oneself after hours, or self-disclosure.

Boundary crossings may be quite beneficial for a specific case but must be offered thoughtfully as they may be a hindrance in other cases and can also put clinicians at risk for burnout.[16] When we are doing something different from usual practice, we must ask ourselves ''why?'' and consider whether *countertransference* is driving the departure. These points of self-reflection can highlight possible *boundary crossings* and help us be mindful about using them appropriately.[17]

Tip 10: We Are Well-Equipped and Situated to Offer Support to Referring Clinicians, in Addition to Patients and Families, as These *Psychologically Minded Interactions* Can Be Therapeutic for Our Colleagues

The tips and concepts highlighted in this article can be applied to support clinical colleagues throughout the health care system—including unit staff, primary teams, and consultants—as they care for patients with serious illness. For example, at the nurses' station, in the team room, or in the clinic, we can offer our colleagues a *holding space* for the inevitable challenges and frustrating dynamics inherent to serious illness care. It is due to the therapeutic presence we offer to the larger health care system that we may hear a nurse say, ''thank goodness palliative care is finally here'' when we enter the unit to open a case. Palliative care can mitigate distress by offering clinicians opportunities for authentic processing of the interpersonal dynamics of a case as well as our own reactions.[18]

Conclusion

As psychologically informed palliative care clinicians, we can model curiosity-based and emotionally connected approaches to complex clinical situations. Palliative care is interdisciplinary by design. Since every patient and family we encounter is unique in their psychological needs, we cannot ease the crises of our patients using any sole provider. Rather, we demonstrate the wisdom and necessity of the interdisciplinary viewpoint to our nonpalliative care colleagues through offering the contributions of palliative care nurses, social workers, clinicians, and chaplains in challenging patient care situations. When we consider the psychological aspects of our patients, we must be nuanced in our approach. Embracing this nuance can add therapeutic value and will undoubtedly contribute to our own professional satisfaction and sustainability.

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