Palliative Care Rounds

Contradictions and Dialectics in the Palliative Dialogue: Enhancing the Palliative Dialogue by Dialectical Principles

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Abstract
The application of required communication skills in the palliative dialogue necessitates a significant transition from the paternalistic medical approach to the holistic psychosocial approach that focuses on the patient and views the individual as a whole entity. Understanding the evolution of a therapeutic relationship in terms of entrance into the relationship, development, maintenance, and leave taking as well as the adoption of dialectical ideas gives palliative caregivers flexibility in the dialogue with patients and families. Accepting the principles of dialectics, in which the existence of contradictions is seen as an inherent part of a reality that is undergoing constant change, gives the caregiver the flexibility to interpret dichotomic thoughts and emotions as a dialectic failure and, in accordance, to move toward a synthesis of the ideas of living and dying. This approach provides caregivers the means to promote the palliative dialogue, implement varied communication skills to clarify the patient’s goals, and implement a therapeutic plan to realize them. J Pain Symptom Manage 2014;48:992–997. © 2014 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.

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Professional quality of life, palliative dialogue, therapeutic relationship evolution, dialectical approaches, coping strategies

Introduction
Quality communication is an essential element in the optimal care of dying patients and their families. Patients’ attitudes and partnership in the decision-making process are key elements in treatment planning, alongside attention to their physical, emotional, and social needs. Providing bad news, truth telling, planning treatment, and advance directives are among the central issues cited in the literature as barriers to quality communication.2,3 Oncologists who incorporated both medical and psychosocial aspects into communication with patients perceived themselves as having a positive influence on the flexibility of patients and families in coping with the process leading
up to the acceptance of death and derived greater satisfaction from their work. Supportive behavior on the part of the physician, as well as active participation of the patient and family in the dialogue, was associated with greater patient and family satisfaction.

Poor communication skills and lack of time to communicate with patients were associated with high levels of stress, burnout, compassion fatigue, and lack of work satisfaction. Additional issues reported by physicians included a low level of confidence in their ability to apply complex communication skills, such as providing bad news, encouraging communication within the family, helping in situations that entail uncertainty and coping with denial, avoiding providing patients a honest prognosis even when they express readiness to accept it, and handling moral dilemmas related to concern and anxiety when patients have dashed hopes.

When patients and families present extreme emotions such as denial, anger, aggression, and despair during the dying process, the caregiving team has no choice but to respect this attitude and adjust the goals of therapy and intervention modalities. Understanding the evolution of a therapeutic relationship as an ongoing process in terms of entrance into the relationship, development, maintenance, and leave taking as well as adopting the dialectical approach might expand our ability to deal with these thoughts, behavior, and extreme emotions and recommend effective techniques to avoid the described barriers.

This article describes an intervention used with a terminal patient in a home-based hospice. For better understanding of the implementation of these strategies, we choose to present the development of the relationship according to the phases described by Baxter. At each stage, we emphasize the inherent significance in the text and the main dilemmas that the caregivers confronted because of that message, with recommendations for how application of the dialectical approach could influence the interventions and allow better management of the palliative dialogue.

**Case Description**

Ronen, a 62-year-old man, is married and the father of three children. He was diagnosed with leukemia three and a half years ago. After a prolonged period of treatment, his condition slowly deteriorated. At the last follow-up appointment in the hospital, his oncologist raised the issue of referral to a community hospice as an option for support in between courses of chemotherapy. Ronen gave his consent, and the hospice team scheduled their first home visit. On the referral application, the oncologist recommended a nutritional consultation before beginning total parenteral nutrition (TPN) in the hospital. Because TPN is a life-sustaining intervention, the hospice team decides to reconsider the issue after clarifying Ronen’s treatment goals. After the first visit, Ronen’s preferences were still ambiguous.

**Comment**

**Dialectical Strategies for Balancing the Tension of the Palliative Dialogue**

One of the barriers to quality communication is the constant tension between the role of the hospice caregivers as leaders in their field and the need to allow the patient to take the lead. The members of the palliative care team are knowledgeable experts in the processes of death and dying and the prevention of associated suffering. In contrast, patients and their families are perceived as experts in alleviating their own physical and emotional suffering in a way that is appropriate for them and is supported by the palliative caregivers.

Dialectical approaches focus on the inherent contradictions that exist in social life. One of the fundamental assumptions is the existence of contradictions that exist at all times and are mutually related. In addition, there are ongoing changes that relationships go through over time, alongside turning points.

In light of the dialectical approach, three coping methods have been identified to balance the tension between the patient and palliative caregiver points of view:

1) Selection and denial: A common method to achieve balance is by choosing one role, leader or follower, and behaving as if the alternative does not exist. For
example, when the patient finds it difficult to bring these issues up, the caregivers may follow the patient’s lead and ignore their role as leaders. An analysis of recordings of discussions of palliative caregivers with their patients showed that the physicians were dominant and took charge of the dialogue, 60% of the time.\(^5\) Results of studies show that physicians tend to focus on medical aspects, procedures, and therapy, whereas patients and families tend to relate to the dying process with a much broader perspective that includes spiritual and emotional aspects.\(^{13}\)

2) Segmentation and adaptation of strategy to content as it comes up: Another approach is to choose a specific strategy for a specific content. This may be manifested in the palliative dialogue if the caregivers take the lead on medical issues, for example, types of treatment, adverse effects, technical matters, and so on, but choose to follow the patients and families when emotional issues are raised. The degree of familiarity is very significant in this strategy.

3) Interactive use of strategies: Another strategy involves the use of varied communication skills to foster flexibility in switching between leading and following, in a variety of subjects and content areas.

First Home Visit. The Stage of Entry Into the Relationship: Difficulty in Balancing Sincerity With Sustaining of Hope

Ronen: ... I need to be told the truth. I’m always being promised there is much more that can be done. The oncologist told me that it looks like we will have to put chemotherapy on hold until my condition improves and I gain weight. In the meantime she recommended TPN and that you treat me in the community ...

The Inherent Significance: Focus on curing intervention to sustain hope simultaneously with the desire for sincerity.

A central conflict in the palliative care dialogue is the desire for sincerity in contradiction to the desire to sustain hope. Patients expect their physicians to be sincere and honest, but at the same time, 91% of them expected their physicians to be optimistic. This conflict develops between the belief in the patients’ right to know the truth and the difficulty in finding out what the patient actually wants to know in a specific situation and to respond accordingly.\(^{8,14}\) That conflict can lead to the use of a selection and denial strategy.

The palliative caregiver in a “following” role:

It sounds like you have faith in the physician who is treating you. If so, we would be happy if you would update us tomorrow. You will have to tell us what our role should be in monitoring your anticipated weight increase.

Using the integrative strategy to manage the dialectic allows the palliative caregiver to maintain the principles of the palliative care approach while building trust with Ronen:

The symptoms that you describe can be alleviated and we would be happy to expand on the methods that we have at our disposal to reduce both the pain and the vomiting significantly. This will require cooperation on your part since we will need to change the medication for vomiting (leading), while at the same time leaving the matter of the TPN to you and your oncologist’s decision (following).

The Stage of Enhancing the Relationship: The Tension Between Hope for Recovery and the Provision of Advance Directives

As the relationship develops, it becomes easier to move toward the leader role. One type of tension is between hope for recovery and the provision of advance directives.\(^{3,15}\) The “mechanism of hope” describes the double role of treatment—on the one hand, to increase the chance for cure and, on the other, to enable the patient and caregiver to escape the anxiety associated with the reality of the situation.\(^{16}\) The central mission of clarifying advance directives is played out within this context.
Ronen: I’m not getting better. The pain and vomiting have gone down, but everything is becoming more difficult ... sometimes I even have to think about my breathing ... (Silence). I didn’t plan it this way ... (He cries) ... I am not ready to give up yet ... I have things to live for. Can this be it?

The Inherent Meaning: A desire for truth telling and planning for the future.

The palliative caregiver as a leader in the direction of focusing on treatment:

... Everything has a time and a place. When things become relevant we will deal with them ...

The Inherent Significance: Focus on treatment as a strategy to reduce the anxiety that builds up around the desire to know the truth and get advance directives. That strategy allows the caregiver to ignore the emotional aspect and to present advance directives (the possibility of joining Ronen as a leader).

It has been shown that the hope for recovery can coexist with provision of advance directives. In effect, the process of providing advance directives does not disrupt the feeling of hope, and the existence of hope does not disrupt the process of providing advance directives or future planning. Awareness of this finding can lead to the implementation of integrative strategies that enable switching of the leader role and having a more flexible attitude.

Caregiver: I see that these issues really bother you. You have a great influence on what is expected to happen. I would really like to speak to you about your preferences (leading the dialogue). As I mentioned we have the ability to reduce suffering significantly. You will have to direct us (transferring the leadership role to Ronen). With your permission I’d like to ask you a few questions ...

The Inherent Significance: Focus on the desire to know the truth and plan for the future.

The Maintenance Stage: Support for the Living by Relief From Immediate Suffering While Coping With Spiritual Issues

During the maintenance stage, the relationship between the patient and the palliative care team has a unique significance. The team’s availability and its ability to find creative solutions, adapted to the patient and family, for new difficulties as they arise, alongside sensitivity to emotional needs, give the patient and family the confidence that they will be able to deal with any expected developments. The main tasks are support for the living by relieving the suffering, support for the family members, and coping with the spiritual and emotional issues associated with the process of death and dying.

The next encounter took place after Ronen was discharged from the hospital and considers his options:

Ronen: I feel better, I have no pain and my breathing is better with the oxygen and the medications. I feel weak, but that’s not the problem. The problem is the thoughts that I can’t solve. I think all the time that things are happening not at the right time.

I can’t die now. Life with me wasn’t easy. I did a lot of mistakes, and those were difficult years for my wife. She never complained no matter how I acted towards her, and she didn’t leave. She has already gone through so much and now this ...

The Inherent Meaning: Acceptance that involves coping with spiritual issues, regrets, and taking leave.

The caregiver as a leader (denying the possibility of joining in the dialogue with Ronen as the leader):

Caregiver: This kind of thought doesn’t help you get better or stronger. Why don’t you focus on progressing with your breathing and nutrition? I’m really pleased. Let’s make use of this meeting to improve your functioning even more (leading the dialogue into specific symptom control while avoiding emotions related to the situation). This will improve your wife’s spirits. You know how important it is to her that you gain weight (giving false hope as a strategy to reduce tension).

The Inherent Meaning of the Health Care Provider’s Response: Focusing on treatment as a strategy to reduce increasing anxiety.

The maintenance stage is characterized by relative symptom stability and intervals of relief.
from immediate suffering. In these circumstances, the use of an integrative strategy can enable focusing on significant reduction of spiritual suffering by processing the patient’s life history, asking for forgiveness, expressing gratitude, and preparing for leave taking, as demonstrated here:

Caregiver: ... Your suffering is more spiritual than physical, with a lot more regrets about the past and thoughts about the future (following Ronen’s lead by validating his thoughts). It is very moving to know how much thought you are devoting to your wife. Does she know how important she is to you?

Ronen: I tried to tell her, but I can’t talk to her about it, she immediately gets scared and starts crying.

Caregiver: From your experience, what is the right way for her to deal with a crisis like this at age 60? (taking the lead in the dialogue with Ronen)

Ronen: I would like to know that she will get through it. I know that it will be hard for her to carry on. She is a good and loving woman. Let her carry on.

Caregiver: That sounds like you are very loving and sensitive to her needs. Would you like us to think together how to talk with her about your thoughts? (gives the lead back to Ronen).

The Inherent Meaning: Acceptance that is linked to coping with spiritual issues, closure, and leave taking.

Conclusion

Understanding the evolution of a therapeutic relationship in terms of entrance into the relationship, development, maintenance, and leave taking, in addition to the adoption of dialectical ideas gives palliative caregivers the flexibility to interpret the dichotomous thoughts and emotions of the patient as a dialectic failure, instead as the patient’s will. At each stage, the professional caregiver makes unconscious decisions about how to participate, and which strategy to use—selection and denial, segmentation and adaptation, or interactive use of strategies. In our experience, the dialectic strategies must be used respective to the development of the relationship, when the integrative strategy enables the caregiver to move toward a synthesis of the idea of living and dying.

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