

MEDICAL EDUCATION

Four Communication Skills from Psychiatry Useful in Palliative Care and How to Teach Them

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Abstract

Palliative care and psychiatry share a number of the same priorities, including careful attention to communication skill development. In this article, we identify 4 communication skills helpful in both fields: (1) attending to countertransference, (2) practicing active listening and active reflection, (3) remaining silent and neutral, and (4) naming the emotion. We then describe strategies for teaching these skills.

Parallels between Palliative Care and Psychiatry

Two primary skill sets in palliative care are complex symptom management and communication on difficult topics. Expert communication in palliative care is not only vital for patients and families but also can be a challenge for clinicians of all levels.^{1,2} In considering the communication skills needed in palliative care, we have noticed parallels with psychiatric training. Palliative care has always been interdisciplinary in perspective and practice, as reflected not only in its team approach to care but also in its recruitment of physicians from diverse specialties, including psychiatry. We propose that these similarities exist due to the intimacy of the clinical relationship in palliative care and psychiatry, the affectively charged clinical situation in which care occurs, and the primary role of patient-clinician relationships in decision making and treatment. In this article, we identify communication skills for difficult conversations common to palliative care and psychiatry, describe the theoretical underpinnings for these skills as taught in psychiatry, and discuss pedagogic practices that operationalize these skills in palliative medicine. Our goal is to help palliative care clinicians of all disciplines deepen their knowledge of and skills in communication by recognizing these contributions from psychiatry.

Important Skills for Conversations in Palliative Care

Attending to countertransference. Goals-of-care conversations are central to the work of palliative care clinicians. Clinicians might struggle with discussions about goals of care for many reasons, including prognostic uncertainty, fear of negatively affecting patients, and feelings of inadequacy or hopelessness.³ These limitations often lie within the clinician, which leads to the first communication skill that palliative care shares with psychiatry: recognition of countertransference.

Briefly, *transference* involves feelings that the patient has about the clinician, including those “transferred” from other significant relationships in his or her life.⁴

Countertransference encompasses the feelings and fantasies that the clinician has about the patient. Like transference, *countertransference* includes feelings that resonate with the clinician’s past as well as feelings evoked by the patient.⁵ In psychiatry, these phenomena are among the greatest sources of diagnostic information.⁶

How might countertransference be manifested in palliative care? Consider the clinician of a patient facing a diagnosis of metastatic lung cancer who confesses to a colleague, “I don’t want to bring up palliative care because I worry it will rob the patient of hope.” The clinician has little way of actually knowing what effect bringing up palliative care will have. However, she might have feelings that could be expressed as, *I am afraid*, and maybe, *I will lose hope*, perhaps followed by, *I won’t know what to do after that*. She fantasizes that the patient will feel the same, possibly due to her identification with the patient and perhaps to avoid the discomfort of her own fear and hopelessness.

These concerns are part of the countertransference that the clinician brings to the encounter. The patient, of course, might share these fears; perhaps the clinician feels them strongly because the patient is contributing them to the countertransference. Teasing out transference reactions that emanate from the clinician and from the patient is one way that palliative care clinicians navigate transference and countertransference. The goal is to draw out the patient’s underlying concerns and preferences—without the clinician imposing his or her own. This process is necessary for understanding patients’ and families’ goals and necessitates another skill: practicing active listening and reflection.

Practicing active listening and active reflection. In psychiatry, active reflection means developing awareness not only of our feelings of countertransference but also of our decisions and behaviors during clinical encounters in order to understand the influence that the clinician–patient relationship has on us and on our clinical decision making. Reflection does not free us from this influence but rather allows us to analyze and discuss it with the patient or change our behavior when indicated.

Similarly, in palliative care, active reflection enables us to observe ourselves in an encounter and ask, “Why am I having this reaction at this time with this patient?” such that we can separate our needs from those of the patient. While this skill of reflection is not specific to palliative care, it is highly important in the context of palliative care where decisions about preferences and goals of care are highly complex and often rapidly changing. For example, suppose a palliative physician is consulted for pain management of a woman with high-risk myelodysplastic syndrome. She had delivered a baby 2 days previously and her husband is at her bedside holding the infant. Upon meeting them, the physician becomes caught up in memories of his own child and has the impulse to say, “I

remember when my youngest was born in this very hospital." Active reflection might lead him to wonder, *Why do I feel the need to say that right now? Does it demonstrate empathy because I am away from my own children? Or that I feel guilty for being away? What is the benefit, if any, of my disclosing this to the patient and family?*

Active reflection is essential for active listening. True active listening, which builds and conveys empathy, requires not only the outward behaviors of attending and responding to the speaker but also the cognitive and affective process of wondering, *Why is the speaker saying that in that way at this moment?* By going through this internal process, verbally reflecting its results back to the patient (eg, "I'm hearing you say..."), and giving the patient the opportunity to correct or add data to our analysis of his or her experience, we begin to develop and convey empathy and we clarify patients' preferences and goals.⁷

Remaining silent and neutral. Constant reflection can be daunting and exhausting. Luckily, silence—another skill necessary for difficult conversations in palliative care and psychiatry—allows the time and mental space for the clinician to reflect while also producing clinically useful information. The therapeutic use of silence has its origins in Sigmund Freud's psychoanalytic technique. After attempts at hypnosis, Freud found that free association could produce the same preconscious and unconscious material.⁸ In palliative care, the surfacing of insights from a patient following a pause can lead to further elucidation of the patient's preferences and values. Although goals in difficult conversations in the palliative care setting are different than those in psychoanalysis, in both situations, [deliberate silence](#) can often allow the patient (or family) to reveal herself in ways that more immediate verbal reactions might impede.

These uninterrupted glimpses into our patients' inner lives that silence can afford are vital in conversations about dying and end-of-life care, because, as in psychoanalysis, it is our intention to remain neutral and facilitative. The psychoanalyst Roy Schafer wrote in *The Analytic Attitude*, "The analyst does not crusade for or against ... is not judgmental ... remains neutral ... attempting to allow all the conflictual material to be fully represented ... to avoid ... the imposition of his or her own personal values."⁹ Analogously, a clinician's goal in discussing end-of-life wishes is not to impose her own values, such as personal ideas of a "good death" or the "right" decision about a certain treatment, but to elucidate the patient's values and wishes.

For example, suppose a physician is seeing a woman with heart failure and progressive dependency who is considering moving in with her daughter and entering hospice. The physician, patient, and daughter are all meeting together. "Can we talk about my daughter?" the patient asks. "Sure," the physician responds. "We go to the grocery store, and I want to push my own cart, and she insists on pushing the cart, and we go back and forth. 'I can push my own cart!' 'No, Mom. I'll push the cart.'" The physician remains silent. The patient continues, "You know what's happened? She's become the mom, and

I'm the child. And the truth is that I might not have much time left, so there are things I need to do to make sure my daughters are taken care of." The daughter starts crying.

In this example, the use of silence (and not offering a specific question or answer) allowed the patient to express the pain of losing her autonomy and to mourn the losses associated with her illness while also recognizing her daughter's motivations. In his silence, the physician remained neutral to the interpersonal conflict, which facilitated the patient's revealing her underlying fear for her daughter's future well-being, and, hopefully, would allow her daughter to connect with her. Moreover, now that the physician better understands the patient's changing relationship with her daughter in the setting of her illness, he could make a recommendation for involving social work to help support them emotionally and interpersonally through the transition of moving in together. He could also affirm the recommendation of hospice in order both to assist the patient in her goal of completing practical matters and to relieve some of the strain of the patient's and daughter's growing interdependency.

Palliative care clinicians often describe a part of their role as getting to know the patient and family in order to make recommendations consistent with their values. Asking both general and specific questions of patients and their families helps us get to know them, and these questions are traditional tools of medical interviewing. But so is silence. Intentional silence allows patients to elaborate on thoughts and feelings that communicate important values that guide treatments.

Naming the emotion. A companion to silence is naming the emotion. Before she can translate values into a recommendation, the clinician must first demonstrate an understanding of the emotional motivation(s) behind the values. Naming the emotion is one way of conveying understanding. Importantly, it will often follow silence; when it precedes silence, it could lead to premature closure of an interaction.

For example, suppose a patient with metastatic colon cancer has been waiting for a palliative care clinician who is running late. When the clinician walks into the room, the patient's wife says, "You're all incompetent! We got here last night and had to wait all day to see palliative care. Aren't you supposed to be helping? He laid here in pain all day. We might as well have been home." The palliative care clinician pauses a moment before saying, "I can see you're angry. It must have been scary to see him in so much pain." In this case, **demonstrating understanding** of the family member by naming the emotion underlying her attack rather than reacting defensively assures her that she is being heard and may begin to restore trust, such that she will be more receptive to the clinician's recommendations. Furthermore, naming helps to contain (ie, make sense of) the overwhelming affect she might be feeling.^{10,11}

Pedagogical Practices for Teaching the 4 Communication Skills in Palliative Care

How do we teach these skills—attending to countertransference, practicing active listening and reflection, remaining silent, and naming the emotion—to palliative specialists of all levels? Since all clinicians in palliative care will encounter scenarios such as we have described, these skills are necessary for predoctoral (eg, medical, nursing) students and for residents, fellows, attending physicians, practicing nurses, and so on. In what follows, we describe basic approaches to teaching these skills to learners of multiple levels of experience. The complexity of the cases and the material can be varied depending on level of experience, but the overall approach is appropriate for all levels and disciplines.

As with many skills in palliative care, these communication skills are learned formally in the classroom and at the bedside. In the classroom, role play and [simulation](#) are approaches to teaching these skills. Role play allows clinicians to “try on” a role, drill down on a communication technique, and receive specific feedback.^{12,13} Role plays are most effective when they have focused communication objectives.¹⁴ And though role plays will sometimes have general objectives, such as practicing delivering a new diagnosis of breast cancer, the skills we described above can be objectives of role plays. Learners and teachers can focus on these skills in the development of a role play case, its enactment, and its debriefing. At the bedside, role modeling of these skills is a goal for experienced educators in palliative care.¹⁵ Role modeling itself is a skill that is more than just having trainees shadow a more experienced clinician. Physicians’ role modeling active reflection and listening with patients requires active listening and reflecting with *each other as colleagues*. As a teacher, it is not enough to “do” these skills in front of a learner and expect him or her to recognize them; we need to attend to situations in which these skills are applied, actively listening to patients, reflecting back what we hear them saying, and debriefing with learners on what they saw and how they would enact these skills. Role modeling parallels the clinical skill of naming the emotion; as we name the emotion with patients, so we can also name the emotion (and name the skill) with each other as clinicians. We identify points of tension and difficulty—as the clinician did in the above example by waiting for the wife’s emotion when accused of ignoring her—because these are areas of skill development that require more attention from us as teachers.

As we are describing them, these two educational approaches—the use of role play and careful attention to role modeling—are appropriate for teaching communication skills to clinicians of multiple levels of experience. Finally, we offer another idea from psychiatry that we believe palliative care can learn from: psychiatric supervision.¹⁶ In classic psychiatric supervision, trainees bring cases to a senior clinician and discuss not only clinical aspects of the case but also, more importantly, the trainee’s experience of the patient (eg, transference and countertransference). We have begun to experiment with this approach at Northwestern University Feinberg School of Medicine with our faculty

and palliative care fellows. In this type of regular sharing of difficult and meaningful cases between two clinicians, the communication issues we have described can be modeled in order to deepen subsequent patient interactions.

References

1. Granek L, Krzyzanowska MK, Tozer R, Mazzotta P. Oncologists' strategies and barriers to effective communication about the end of life. *J Oncol Pract*. 2013;9(4):e129-e135.
2. Quill TE. Perspectives on care at the close of life. Initiating end-of-life discussions with seriously ill patients: addressing the "elephant in the room." *JAMA*. 2000;284(19):2502-2507.
3. Hancock K, Clayton JM, Parker SM, et al. Truth-telling in discussing prognosis in advanced life-limiting illnesses: a systematic review. *Palliat Med*. 2007;21(6):507-517.
4. Freud S. The dynamics of transference. In: Strachey J, trans-ed. *The Case of Schreber, Papers on Technique and Other Works*. London, England: Vintage Classics; 2001:97-108. *The Standard Edition of the Complete Psychological Works of Sigmund Freud*; vol 12.
5. Sandler J. Countertransference and role-responsiveness. *Int Rev Psychoanal*. 1976;3:43-47.
6. Gabbard GO. Countertransference: the emerging common ground. *Int J Psychoanal*. 1995;76(pt 3):475-485.
7. Basch MF. Empathic understanding: a review of the concept and some theoretical considerations. *J Am Psychoanal Assoc*. 1983;31(1):101-126.
8. Schwartz C. A brief discourse on psychotherapy and psychoanalysis: historical perspective. *Psychoanal Rev*. 2003;90(2):153-177.
9. Schafer R. *The Analytic Attitude*. New York, NY: Basic Books; 1983.
10. Segal H. The Klein-Bion model. In: Rothstein A, ed. *Models of the Mind: Their Relationships to Clinical Work*. Madison, WI: International Universities Press; 1985:35-47.
11. Basch MF. *Understanding Psychotherapy: The Science behind the Art*. New York, NY: Basic Books; 1990.
12. Spear ML, Guillen U, Elliott DJ, Roettger L, Zukowsky K. The use of role play for interdisciplinary teaching of palliative care communication skills. *J Palliat Med*. 2013;16(8):825.
13. Jackson VA, Back AL. Teaching communication skills using role-play: an experience-based guide for educators. *J Palliat Med*. 2011;14(6):775-780.
14. Kissane DW, Bylund CL, Banerjee SC, et al. Communication skills training for oncology professionals. *J Clin Oncol*. 2012; 30(11):1242-1247.
15. Hurd CJ, Curtis JR. How to teach communication skills for palliative care conversations. In: Mookherjee S, Cosgrove EM, eds. *Handbook of Clinical Teaching*. Basel, Switzerland: Springer; 2016:195-204.

16. MacDonald J, Ellis PM. Supervision in psychiatry: terra incognita? *Curr Opin Psychiatry*. 2012;25(4):322-326.

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