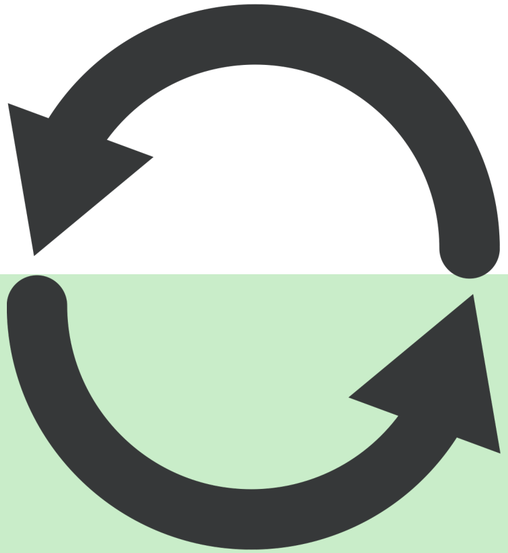
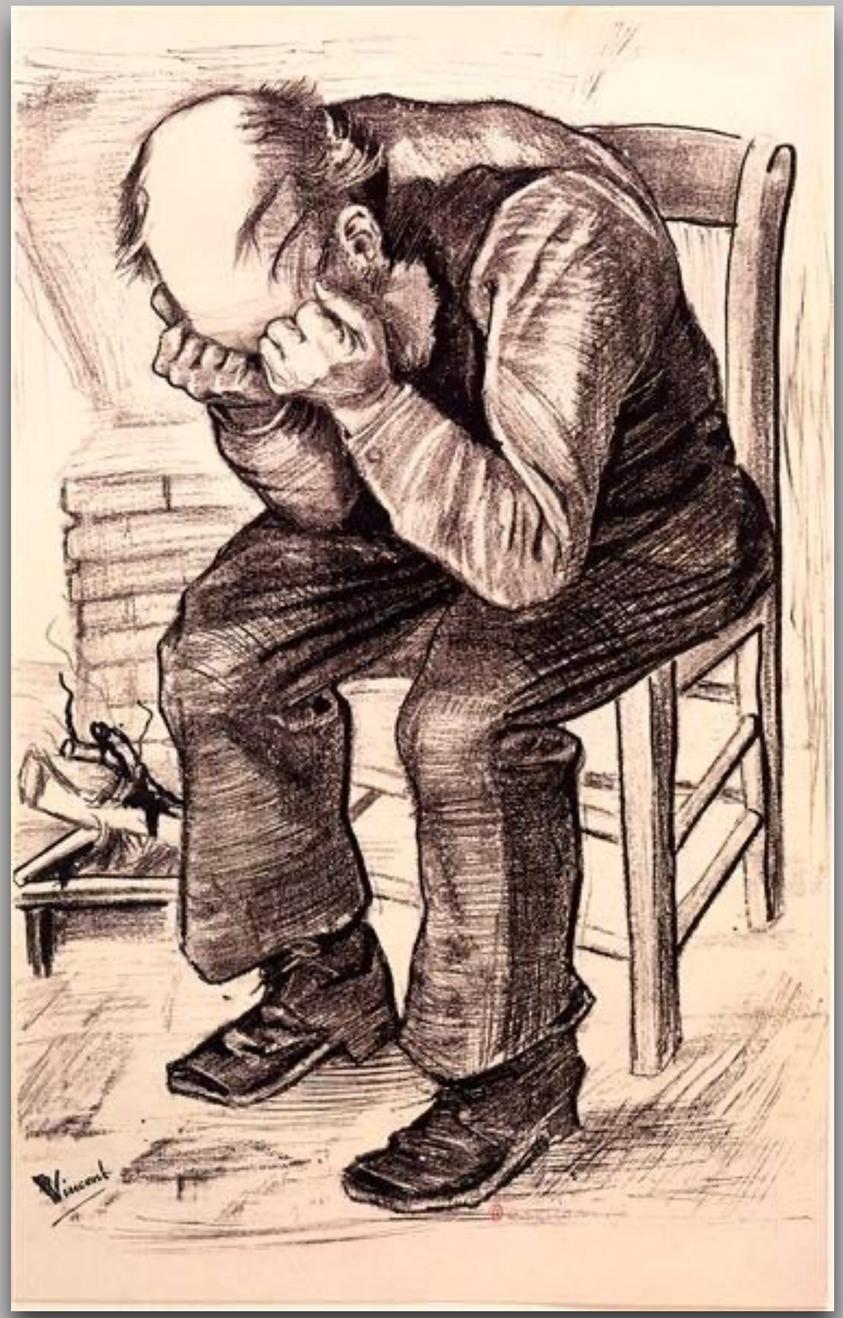
Our professional work with seriously ill, dying, and bereaved patients is **extremely personal** in nature, that we **are profoundly influenced by our patients** and their families as much as they are impacted and influenced by us, and that **our emotional responses do impact the clinical moment**—whether we want them to or not, whether we are aware or not, **whether we can admit it or not**.

Katz.

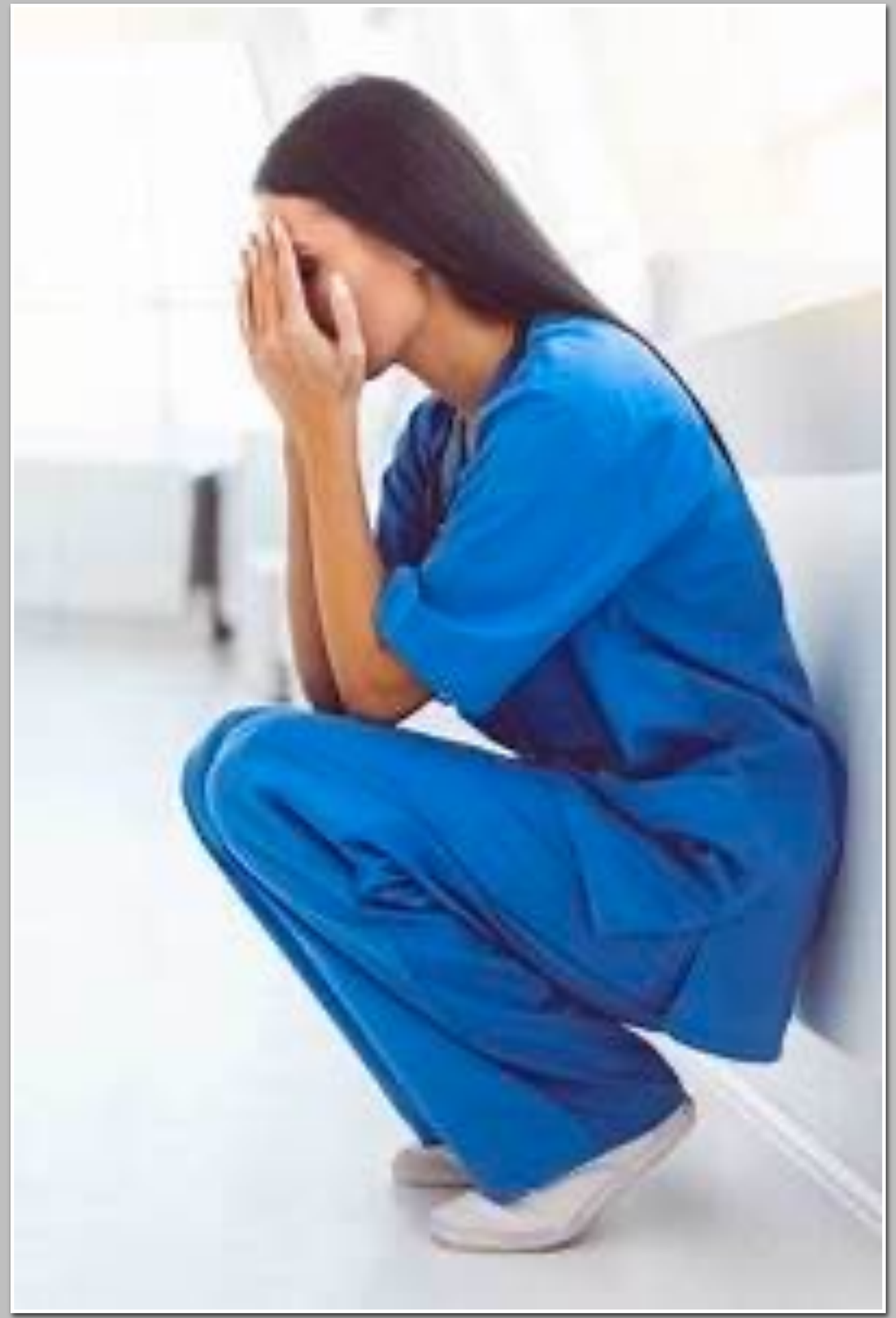
Becoming Aware of our Emotional Reactions to Improve Clinical Practice



CAP-C Masterclass 2022
Vickie Leff, LCSW, APHSW-C



Worn Out (1882) | Vincent van Gogh



Worn Out (2021) | Us


Our work is like a river...
Predictably unpredictable
Flowing forward, full of meaning...
Can we please get some of these rocks out of the way?

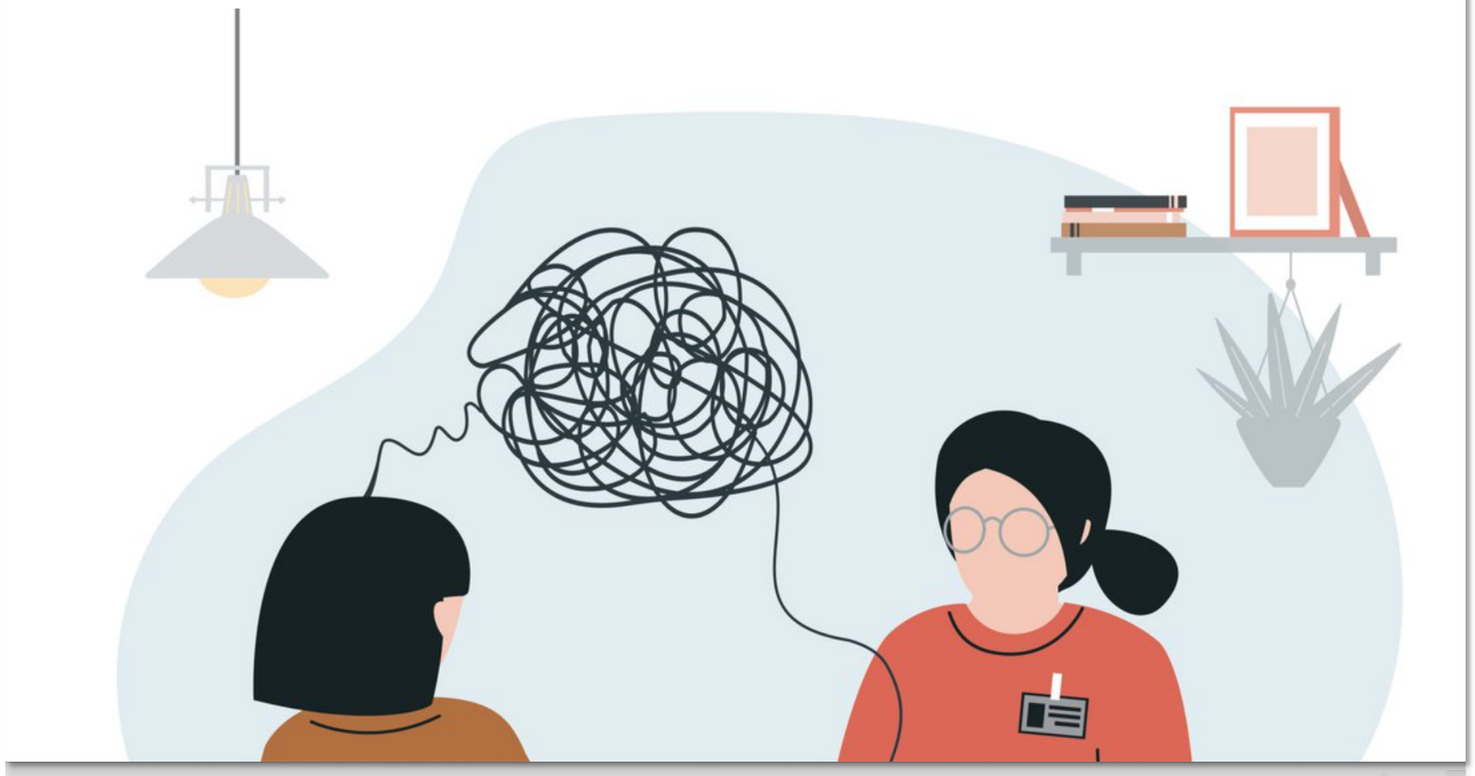
It Matters

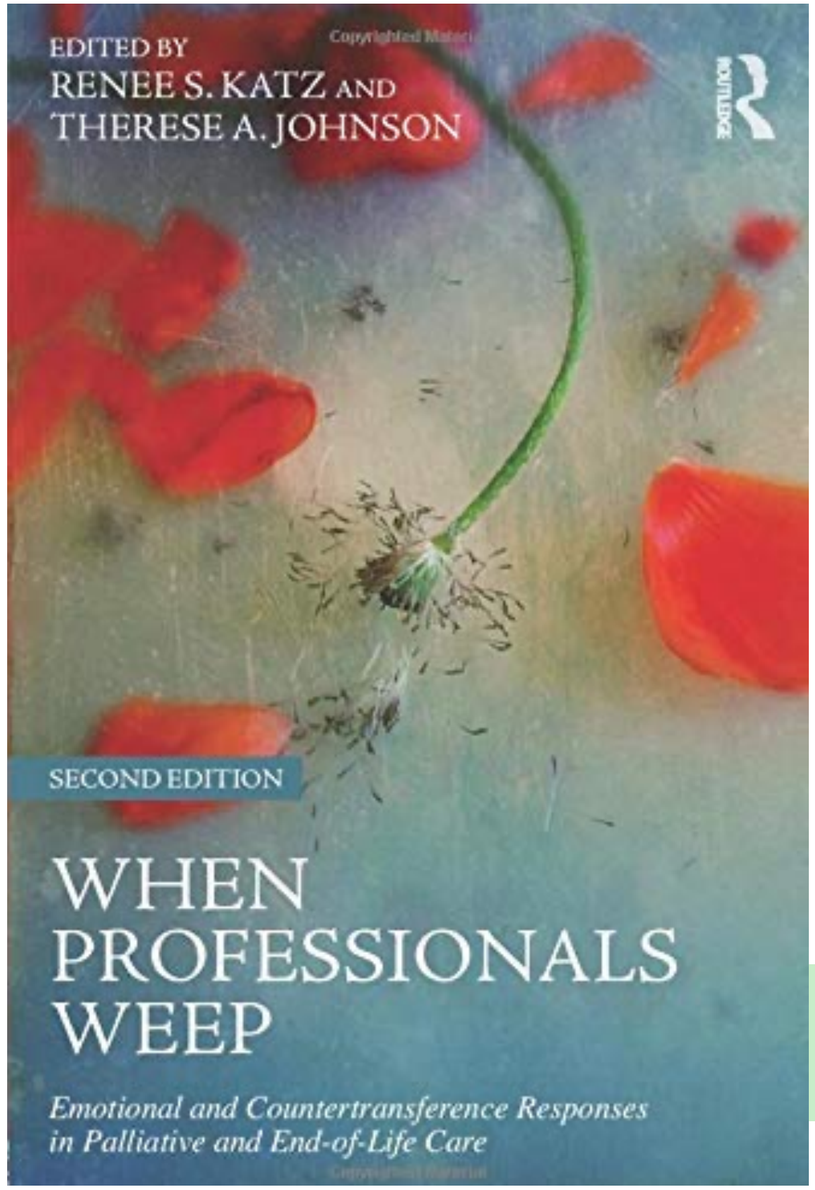
"Doing our own work to show up for ourselves will reflect in the provision of optimal care for our patients".

Countertransference in Palliative Care Practice: What's a Clinician to Do?

January 17, 2022 | By Jill Farabelli

Understanding the psychology behind an unconscious response in patient encounters, and how clinicians can make meaning of these experiences.





"Only by genuinely exploring, processing, and integrating **the conscious and unconscious** components of their **own responses** and transcending them can professionals **be fully prepared to help** patients and experiencing serious illness or at end of life."

Pg. 206 Katz

The practice of self reflection is key for any good clinical practice

We can not be totally subjective in this work.

this is real life

Acting on our own anxiety, without understanding why, can harm the pt & the relationship

We will always have our own emotional reactions - it's normal

Try a different lens…

These are not one sided interactions:
They are always inter-relational

We are not conditioned to engage in self-reflection.

- We may understand difficult clinical conversations as “patients **who make us feel** like we are ineffective”.
- Or, “**may make us feel inadequate”.**
- if every time we encounter a patient who **makes us feel** a certain way we change our behavior to accommodate those feelings, we may find ourselves going beyond the care we feel able to routinely provide for almost all our patients! And that is unsustainable.

We already know…

the process of self reflection is critical

“ To accurately understand what belongs to the patient, the helping professional must **first examine the contributions of his or her own psychological vulnerabilities.** This requires us to relinquish our omnipotent, perfectionistic, “professional” images and, instead, accept our humanity.”

Beitman, B.D. 1983. Categories of counter-transference. Journal of Operational Psychiatry, 14(2) 82-90.

Houston, we have a problem…”

Our Own Resistance

Perhaps our own resistance as professionals gets in the way?

<u>Only</u> 60% of mental health professionals would be willing to seek help if they needed it. (Mathieu, 2015)

Our responsibility

"We must be **both participant and observer**, willing ourselves to be drawn into the patients experience, while simultaneously remaining sufficiently separate so we can monitor and more objectively understand what is happening."

When Professionals Weep. Katz. 2016

Even HBR is talking about this!

Harvard Business Review

Diversity Latest Magazine Ascend Topics Podcasts Video Store The Big Idea

Managing Yourself

Why You Should Make Time for Self-Reflection (Even If You Hate Doing It)

by Jennifer Porter

March 21, 2017

Foundational Concepts

Self- Reflection

As critical thinkers, we know how to do this.

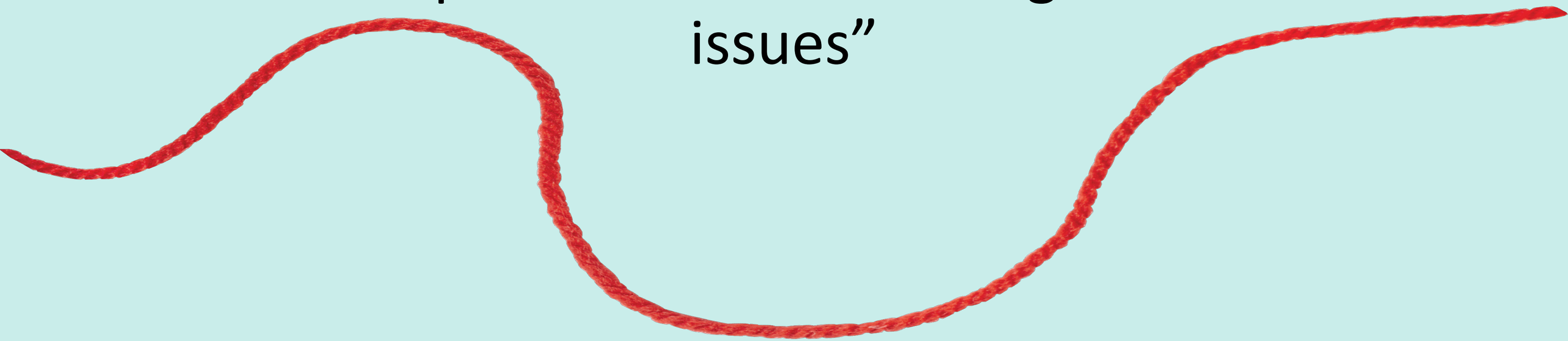
Development of the Professional Self

Self reflection builds competence in the development of the Professional Self.

Countertransference

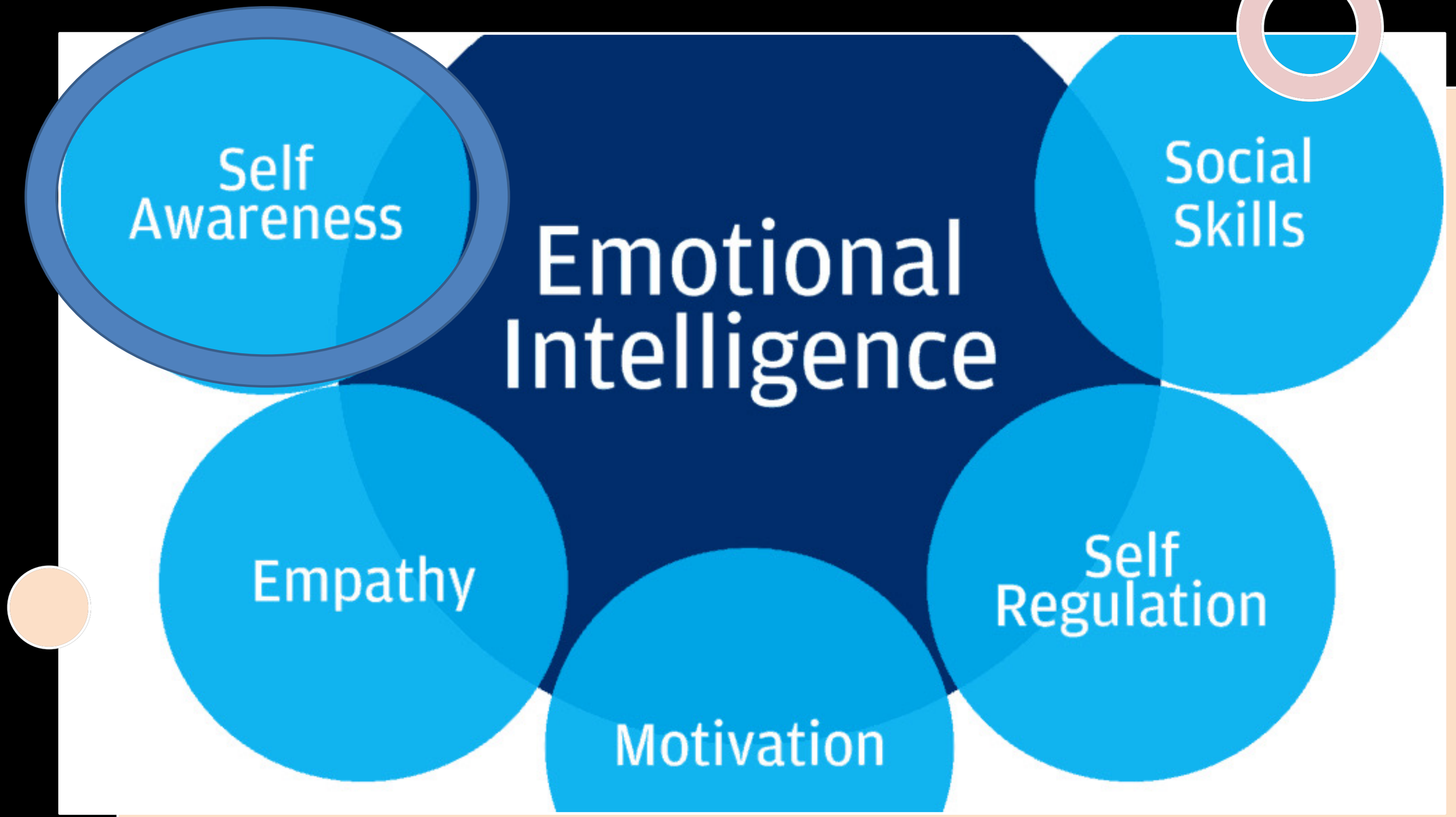
A psychoanalytic concept used in Palliative Social Work that provides a useful lens and understanding to learn from.

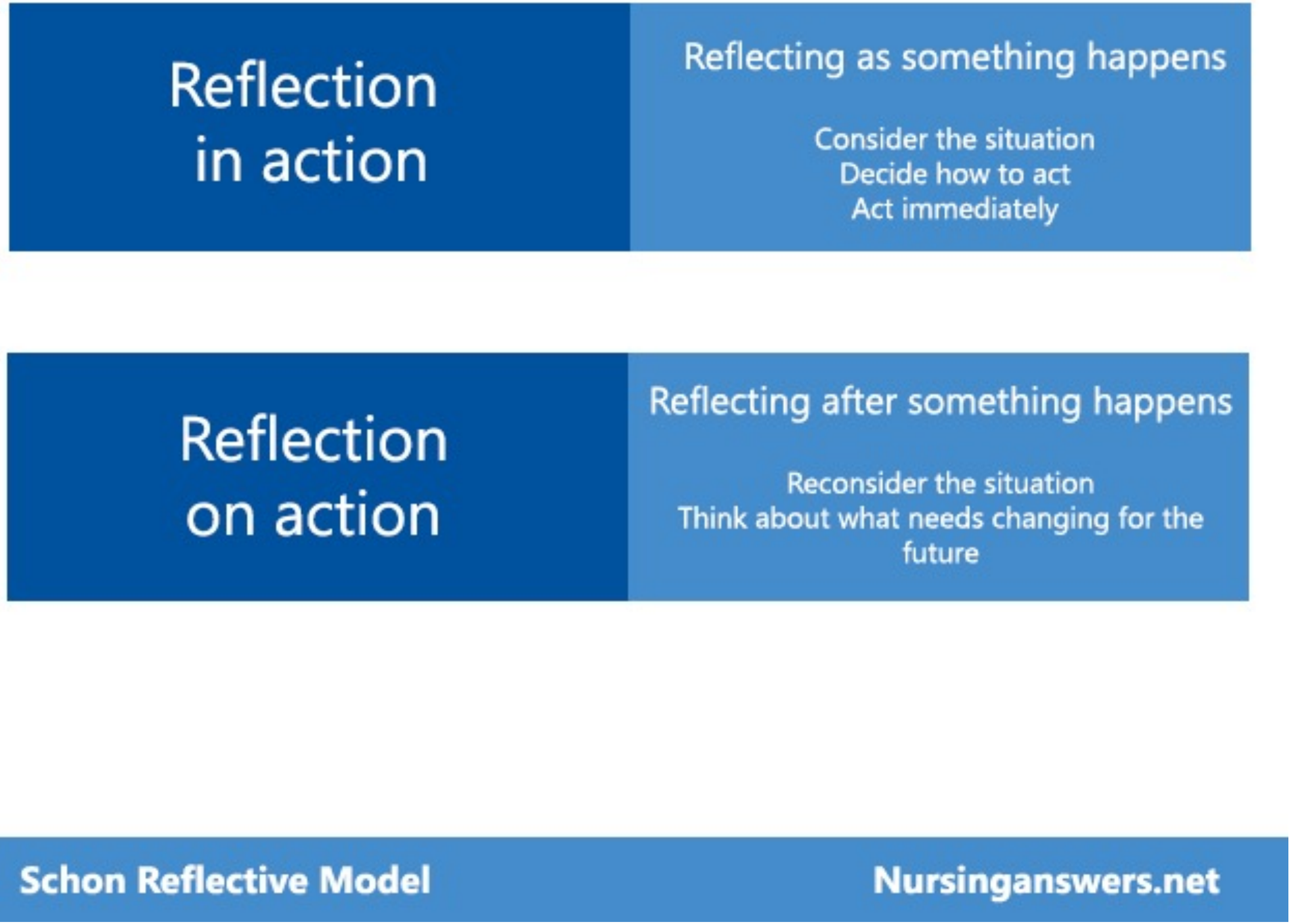
The object is not to eliminate countertransference, but to follow and understand it…so that we can more deeply know our patients without acting out our own issues”



Katz, R. When Professionals Weep. P.279


NYPD
You're like my son
Transference
You're like my dad
Countertransference


Self Awareness
Emotional Intelligence
Social Skills
Empathy
Self Regulation
Motivation



Schon Reflective Model 1991

Is Palliative care work different ?

We know this work is emotionally provocative; we witness pain, suffering, longing, sadness, grief, on a daily basis.

“Caring for seriously ill demands empathy, sympathy and compassion. Empathy involves self-awareness. Also called emotional regulation.”

JPM Rushton 2013

The Reality

I had strong C-T with this young woman with CF.

Complicated: Triggering of an issue

A situation or relationship you are struggling with may be triggered by a patient or family member.

Unconscious

You may not know right away why you're angry with them.

Needs intentional & deliberate attention

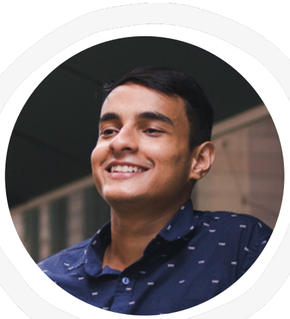
Use this skill throughout your clinical career.

Gives us pause

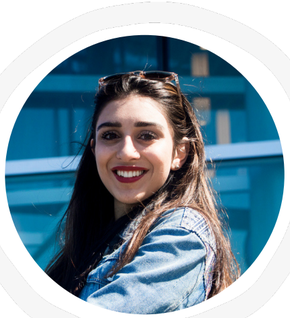
Can change the way we interact, respond…

I’ll never do that!
I have great emotional intelligence!

Yes, you will.



Yes, you will.



Of course, you will.

The Challenge

"It can be extremely challenging to stay aware of these countertransference responses while attempting to meet the needs of patients and families and all the while acknowledging and demonstrating respect for the institutional goals, an outcome that impacts the survival of consult services…"

Katz, pg. 133

The Pay off

Self-reflectiveness is a basic cornerstone for the development of the professional self.

Reflection gives the brain an opportunity to pause amidst the chaos, untangle and sort through observations and experiences, consider multiple possible interpretations, create meaning.

HBS 2017

“If our hearts hurt, or our minds feel stuck, we may use our feelings, our discomfort, or our empathic responses **as clues** to discover which confluence of factor – individual, team, or system; conscious or unconscious; internal or external – may arise. Then we bring them to light to **be observed, processed, and utilized to enrich our work**.
“

P. 128 Prism of the Heart in When Professionals Weep. 2016.

Definitions

Transference

Redirection of a patient's feelings, attitudes and desires onto the clinician (may represent unconscious agenda for the pt).

i.e. the patient over identifies with young clinician, reminds them of a sibling start interacting, unconsciously as a sibling – familiar, collegial.

Unconscious, confusing, subtle

Countertransference

- Objective
- Subjective
- Diagnostic

Redirection of a clinicians direct response to the transference exhibited by the patient.

i.e. Clinician may respond by interacting with patient that reflects their own relationship with their sibling.

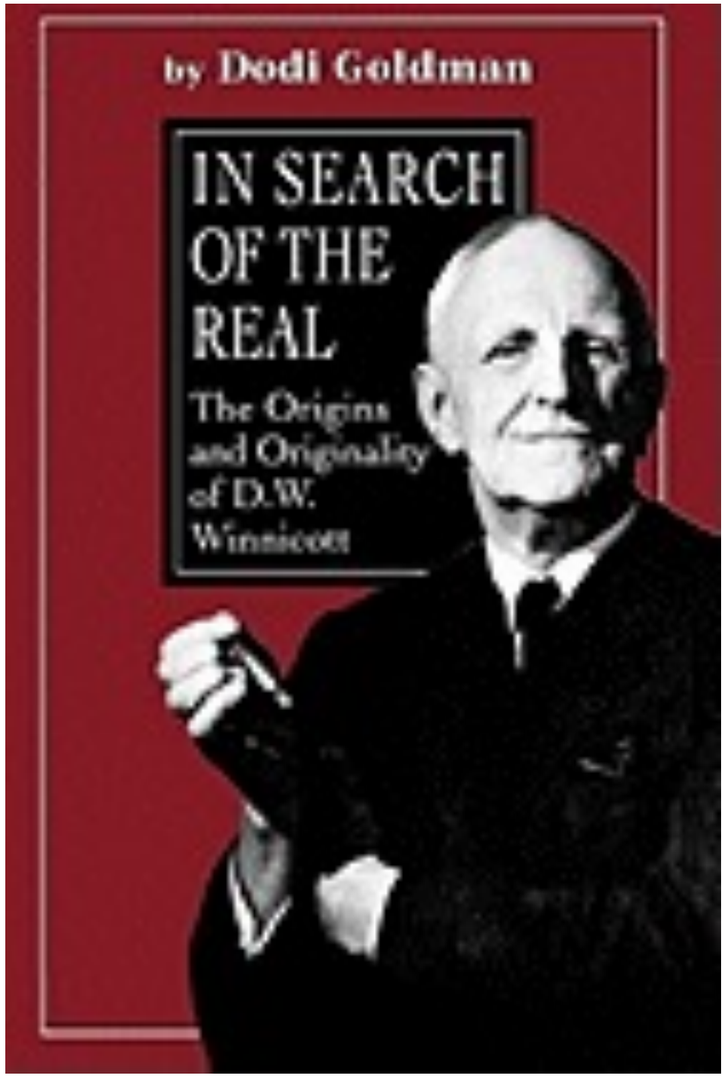
Crossing boundaries is often a consequence of countertransference.

Objective Countertransference

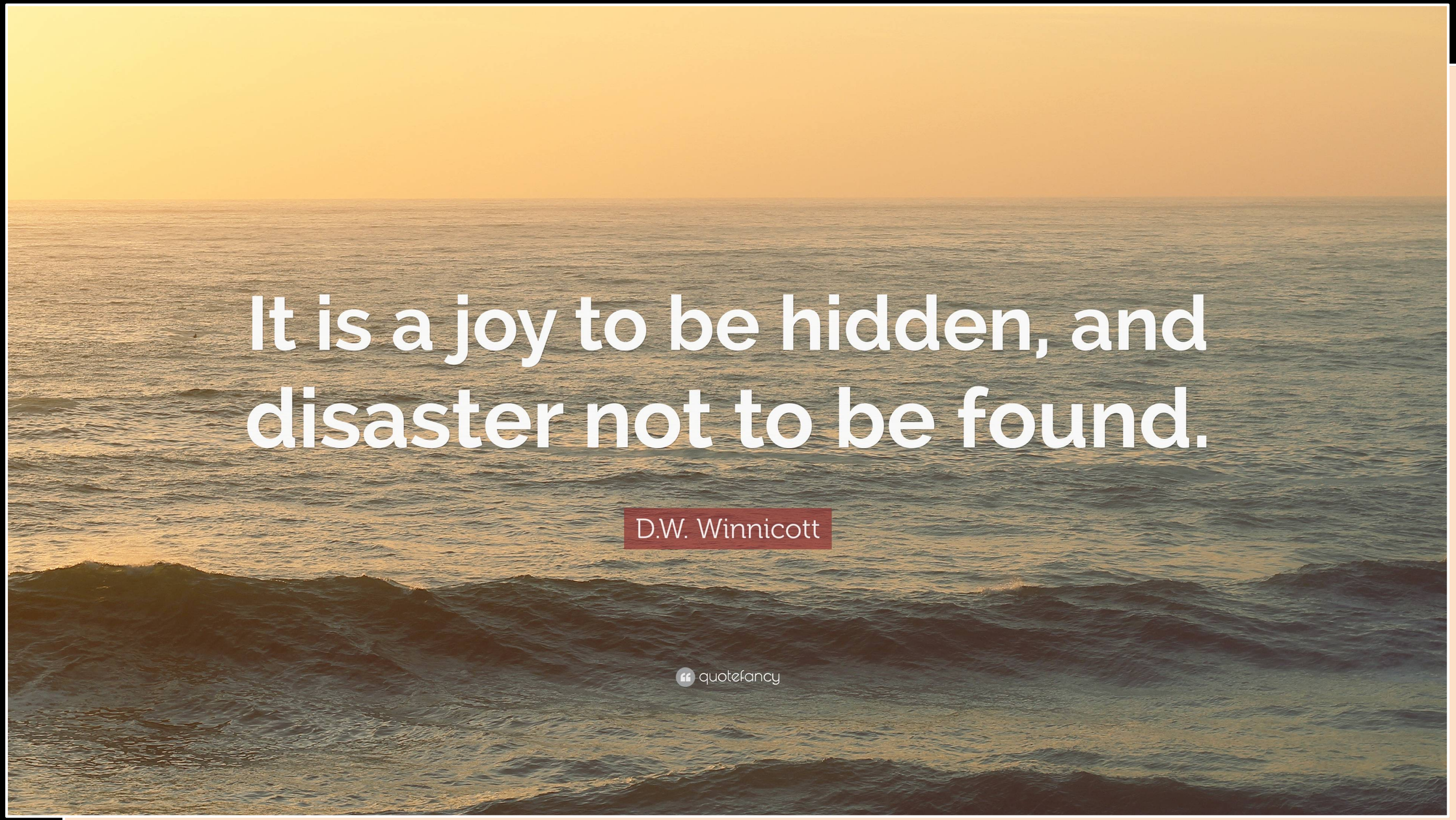
- Our <u>expected reactions</u> to a patients presentation, personality and behavior. Most often “triggered” by an emotion or situation belonging to the patient.

i.e. overidentifying with the patient, reminding you of a relationship, conflict, etc.

“Countertransference is a way to feel in one’s bones that which the client cannot convey through language alone.” Berzoff



D.W. Winnicott 1949


It is a joy to be hidden, and disaster not to be found.
D.W. Winnicott
quotefancy


HILL

Subjective countertransference

Comes out of **our own issues and histories**, rather than the client's.

- One possible source of subjective countertransference is our <u>past relationships;</u>
  - for example, when a client reminds us of our mother or daughter, a childhood friend or bully, and therefore elicits feelings from these relationships.
- Another source of subjective countertransference is <u>emotional difficulties</u>, traumas, or other vulnerabilities we've experienced.

Leading to our reactions that are an unconscious effort to assuage that anxiety, resolve that issue, etc.

Double-Edged Swords: Understanding Transference and Countertransference in Non-analytic Therapy
by Judith A. Schaeffer, Ph.D.

Subjective CT

When subjective CT is triggered, clinicians may respond in ways that **gratify their needs** to recue and be needed or in ways that soothe their own suffering or emotional pain.

Katz, When Professionals Weep, 2016

Diagnostic Countertransference: The spillover

Theory behind transference/countertransference

> “Where there is no countertransference, we would think, there is no real engagement or treatment. “
>
> Berzoff, 2010

Why it happens:

- We have a primary need for relationships.
- They are influenced by previous experience (from childhood).
- In new situations we have expectations that are partly determined by our realistic perceptions and partly by our associated experiences.

Objective Countertransference

Example

- She reminds me of my grandmother

Everybody will have a reaction to a patient and family member – **NORMAL** & doesn't interfere with relationship.

Examples

Hang On!

I can save you!!

‘The need to feel helpful, to be able to restore function, and to be effective is sorely challenged by the dying patient.”

Case Example

88yo reminds you of your grandmother. You didn’t get to say goodbye. Without prompting, you encourage the family to come and say goodbye.

Case Example

44yo w/ hx of substance use, finding it difficult to feel motivated to change in order to improve health. You have a sibling who struggles with substance use.
You start to feel resentful & angry with patient because they aren’t taking responsibility. You start to avoid pt.

Before we know it, it brings us back…

Look at what we choose to share:

What do you share?

- Why the details?
- What is necessary?
- What are the circumstances? (i.e. need to join quickly; crisis intervention; push a clinical issue to the front).

In whose interest?

- Assuaging anxiety
- Providing modeling
- Joining statement

Glossary

Projection

- It’s natural to see what we expect to see. Put our own interpretation onto the pt.

Ego Defenses

- How is the pt coping?
- What behavior are they using to help them?
- How are you reacting to that behavior?

Dual-Awareness:

- are your feelings/reactions interfering with your interaction?

Reflection on Action: Questions

Ask yourself

Am I behaving in some way that indicates that a personal-professional TRIGGER point has been activated??

- Losing patience
- Arriving late
- Changing the subject (silencing)
- Over/under helping
- Avoiding a pt
- Providing false assurances
- Tuning out

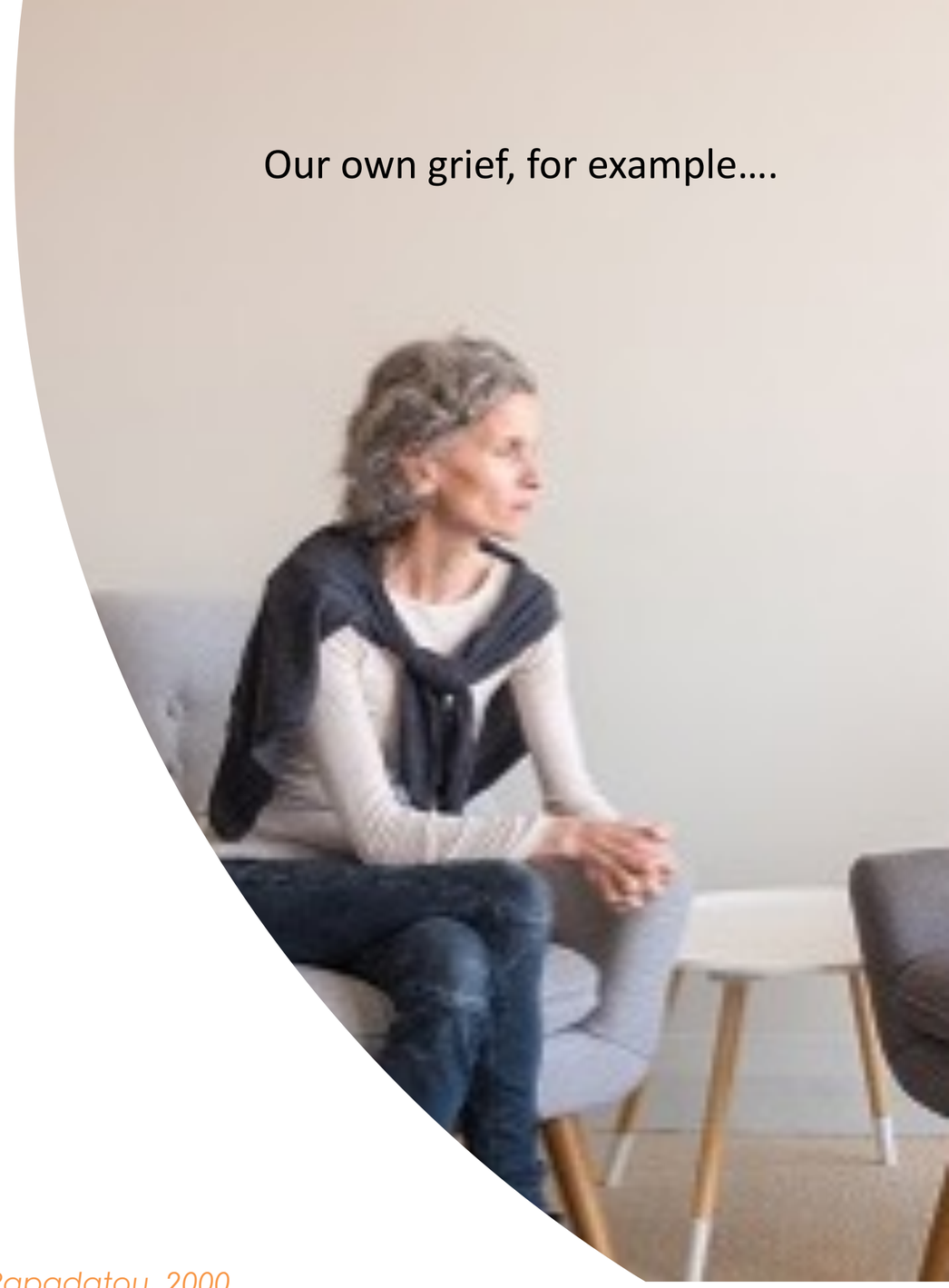
Ask yourself

- What is it about THIS person that is hooking me? Behavior, feature?
- When I’m with this client, what am I doing? (look for behaviors, thoughts)
- Am I having similar feelings to those expressed and happening to client?
- At which developmental stage do I feel like when I’m with this client?
- Am I more over involved or disengaged when I’m with them?

How do we react??
Implicit and Explicit Rules:
Examples…

- Health professionals are expected to invest in and develop close relationships with their patients and families.
- The expression of grief must be tempered and controlled.
- Grief must never be so intense as to impair clinical judgement or result in an emotional breakdown.
- The grief of professionals must never exceed that of families.
- Other patients and families should never know you are grieving or experience your mourning.
- Support of your colleagues is expected but must only occur in specific gathering places.

Our own grief, for example….



Papadatou, 2000

RESULT…

- We may become jaded or closed off to being able to hear our patient's story about grief;
- This can impact how we respond, what we say, word choice;
- Can impact treatment decisions (wanting a quick death, less suffering, all based on our own needs);
- Cannot be as present to our patients/families;
- Impact our own grief reactions when we are faced personally with death and/or loss.

Facilitating Understanding

- Case reports
- Clinical supervision
- Develop empathic window
- Debriefs
- Understanding the impact
- Strive to improve practice

What is the setting?

What is the frequency?

Requires

Show up & be genuine

Let go of perfectionism, omnipotence

Be willing to be vulnerable

Be empathic; tolerate strong affect.

- Intention & deliberation
- Humility
- Honest reflection

Your Roadmap

Step 1

Sharpen your ability to pay attention to your reactions. (i.e. to your subconscious)

Step 2

Resist the urge to fix.

Step 3

Tolerate the discomfort, ask yourself questions.

Step 4

Remind yourself, this will help you be a better clinician.


Some things cannot be fixed.
They can only be carried.
Megan Devine - Refuge in Grief
REFUGE IN GRIEF
#ItsOKYoureNotOK
refugeingrief.com/book

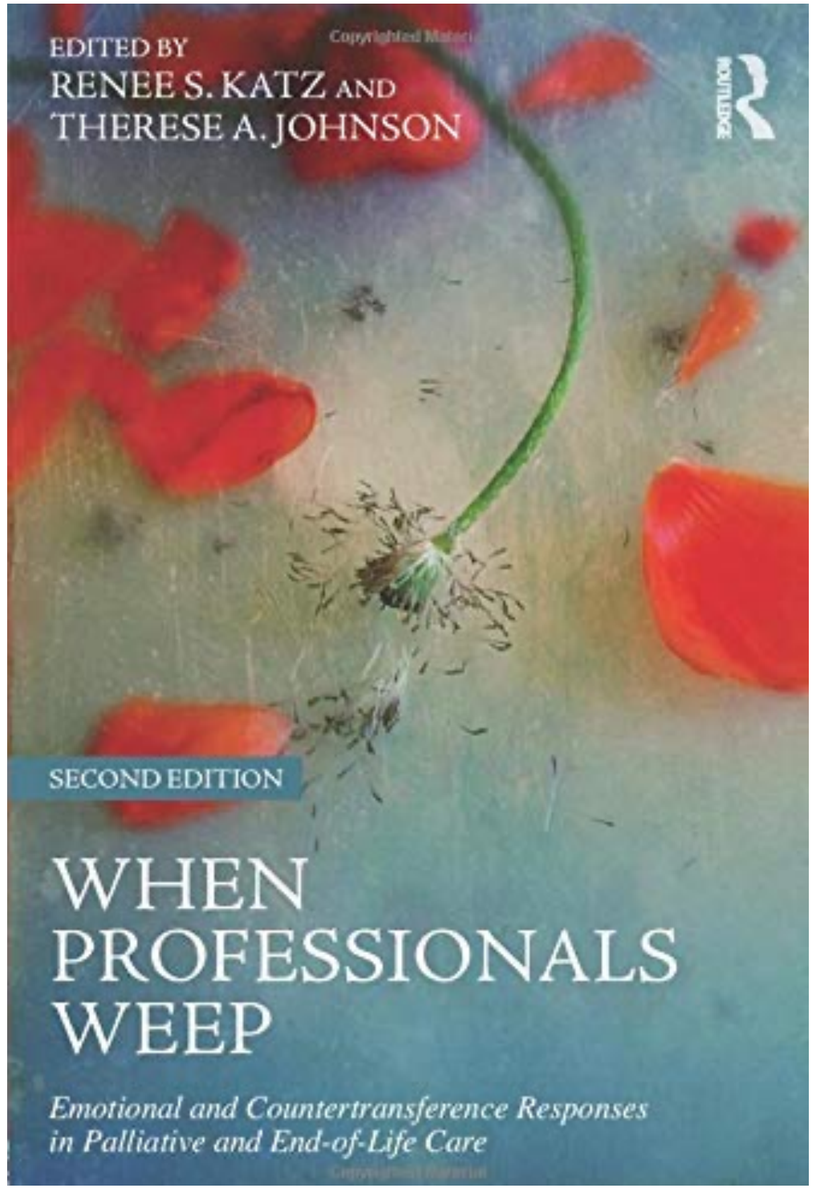
Take-Aways

<u>Should become part of medical training.</u>

Only by genuinely exploring, processing, and integrating the conscious and unconscious components of their own responses and transcending them can professional be fully prepared to help patients and experiencing serious illness or at end of life.

Pg. 206 Katz

Cultivating of observing oneself in the midst of the complexity needs to be conscious and intentional



tend

www.tendacademy.ca

resources

Contact me

Vickie.leff@gmail.com

Vickie@aphsw-c.org

Exercises to raise awareness

Your Loss History

Why this work?

Why this patient?

Exercise: In the face of pain

- Mary, a 69yo post mastectomy patient, had successfully battled recurrent breast cancer for 20 years. When she discovered another lump in her breast that was found to be malignant, she returned to her local cancer center for additional chemotherapy and radiation. With the onslaught of the new regimen, Mary became increasingly weak and debilitated. She would arrive at the center hunched over and would slowly and painstakingly drag herself to her “station.
- One afternoon, Mary wearily confided in Sarah, her nurse of many years: “It’s too much”, she whispered. “The nausea, the pain…it’s excruciating.” Then, turning away, she wept silently. “I’m just so tired. This is no way to live. I’m done, I’m not coming back”
- As her nurse and as someone who has developed a deep affection for Mary through all the years you’ve worked together, what might your initial impulse be?

What might your initial impulse be?

1. Convince her that this pain is temporary, “Just give it a chance”.
2. Tear up and cry.
3. Analyze aloud the possible reasons for her distress.
4. “Discuss”/push the medical necessity o the chemo/radiation regimen (aka guilt trip her into continuing treatment).
5. Shut down emotionally. Become quiet.
6. Other?

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