

Reflecting on working with palliative cancer patients through a CAT 'lens' with a focus on reciprocal roles

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Introduction

'Self-awareness is a supreme gift, a treasure as precious as life. This is what makes us human. But it comes at a costly price: the wound of mortality.' (Yalom, 2008, p. 1).

When cancer patients receive a palliative diagnosis, this means that their disease is not considered curable. In some cases, patients at this stage may still receive treatment which may treat the cancer but will not cure it. In other cases, they may receive palliative care, which is medical care to relieve symptoms such as pain, to improve quality of life as much as possible. Although patients with a palliative diagnosis have a life-limiting illness, this does not always mean they are at the end of their life. When patients receive this diagnosis, they become acutely aware of their impending death and they are forced out of the functional denial of their own mortality.

The strong emotions and pulls I have felt when working with patients who are palliative, have piqued my interest in this topic. Therefore, the focus of this article is on reciprocal roles that patients may find themselves in when at this stage of their illness, as well as reciprocal roles that therapists and palliative care nursing staff may get pulled into. Ways of working with these issues in the form of Exits into more helpful reciprocal roles will be explored.

Due to a paucity of CAT research on this topic, I will be using both

personal reflections from learning that has occurred through my clinical work, my own supervision, and supervision with nursing professionals. I shall also use findings from other clinicians and researchers in this field, with a focus on developing an understanding from a CAT perspective as the literature is mostly not CAT specific. When real clinical examples are utilised, pseudonyms will be used and any identifiable information omitted or changed.

Patient reciprocal roles

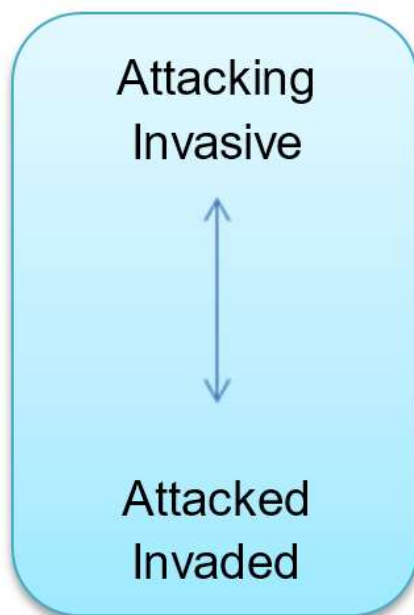
'No news, however awful it may be, will ever give me the dreadful fright I got when I was told I had cancer. Something in the depths of my heart has turned into stone.' (Brennan, 2004, p.51) Susie Black talked about cancer being powerful, attacking, unpredictable and frightening leaving patients feeling out of control, attacked, powerless and frightened (Physical CAT workshop, November 2017).

Despite huge advances in cancer research and treatments for cancer, cancer remains an unpredictable disease and when a cancer patient's diagnosis is palliative, this powerful and unpredictable cancer can leave people feeling powerless. Early relationship patterns can be reactivated by physical illness, especially when this is life-threatening, which may bring feelings of powerlessness, being out of control and bullied back to the fore. In terms of reciprocal roles this can be thought of as unpredictable to out of control and powerful to powerless.



The very nature of the illness of cancer means that the person's body 'has been 'invaded' and 'attacked' by a disease that threatens its integrity and survival' (Brennan, 2004, p. 73) and the body

is often then further 'invaded' with treatments. The societal rhetoric that exists around cancer may reinforce these roles of attacking and invasive to attacked and invaded, as in the media, people with cancer are often described as fighting a battle with their illness, and having lost this battle if they die with cancer (Breast cancer care, 2016). The words battle, fight, survivor and victim are all used when describing people with a cancer diagnosis, words which allude more to war rather than illness.



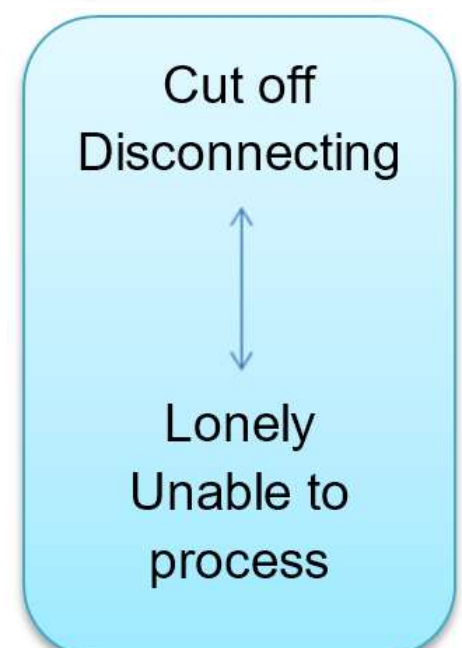
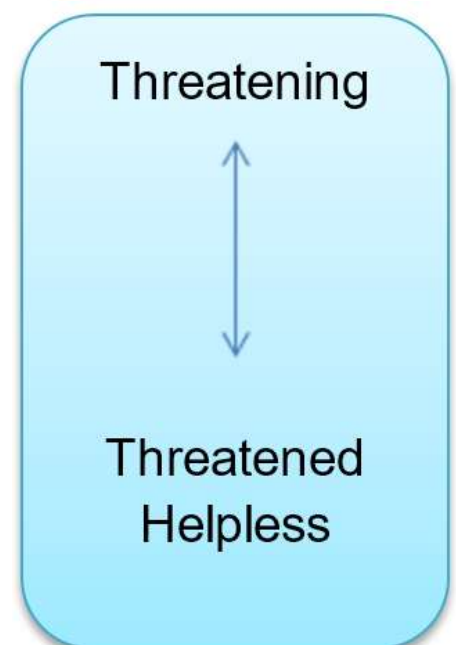
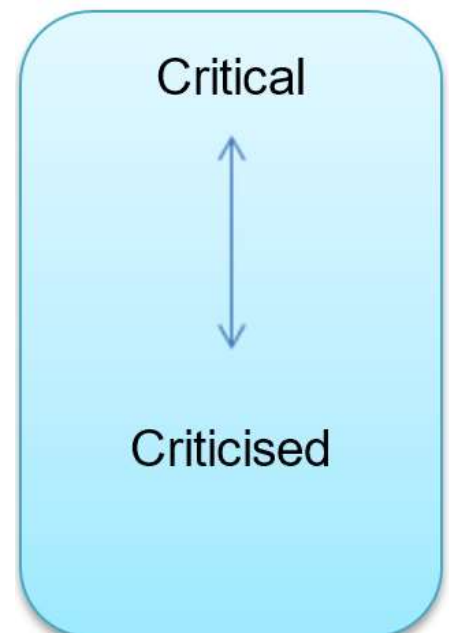
As the cancer may reignite early experiences of abuse or trauma, this may come with intense emotions of feeling not good enough or criticised. This may lead to feelings in the person that they are not coping as they should as if critical to criticised. Indeed, the cancer diagnosis may be such a shock that it may interrupt previously established patterns of coping that have helped the person manage so far in their lives (Black, 2017). Patients with difficult early relationships may feel fearful and threatened but lack the confidence to achieve support and care from loved ones and professionals (Pitceathly et al., 2011). Their early attachment styles can influence their ability to form collaborative therapeutic relationships (Tan et al. 2005). This may lead to withdrawal and avoidance and perhaps a cutting

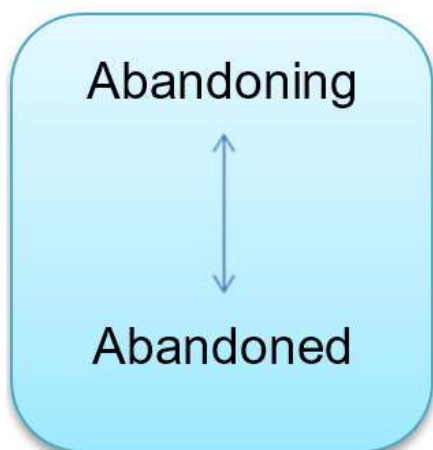
off from emotion leaving them less able to process their situation.

I worked with a lady, who I will call Fay, who had been diagnosed with palliative bowel cancer and had two teenage children. I will use Fay as an example, although I have noticed similar themes with other palliative patients. When we first started working together, she had not told her children about her prognosis, however, as our work unfolded, she would give them small chunks of information which alluded to the fact that her cancer could not be cured. In the beginning, she was seemingly able to cope incredibly well with her illness and prognosis and she wondered whether sessions were actually necessary. As we continued, it became apparent through our work that this was avoidance as she was fearful that if she really faced her mortality, this would bring about an unmanageable grief. She talked about spending less and less time with her children so that they could form better bonds with their father. At these times, it seemed she was disconnecting not only from her own feelings but also from her family, leaving her feeling incredibly lonely.

When the diagnosis is palliative, the threat to one's own mortality may be experienced as abandoning to abandoned. No further offers of treatment may be experienced as being abandoned and looming death may feel like they are abandoning loved ones. Patients in this situation often describe sorrow at not being there for their children growing up or leaving their partner to cope on their own with the loss.

Therapist reciprocal roles:
In this field of work, one of the biggest challenges I have found personally is working with patients who are palliative. I noticed the powerful pulls I feel when working with people who know they are going to die with cancer





and my responses to those pulls. One of the pulls I have noticed in response to feeling powerless in the face of a disease that is not curable, is to strive to be perfectly caring out of a need to rescue the person I'm working with from the terrible situation they have found themselves in. At times, I have noticed this inevitably leading to feeling powerless and sharing the patient's feelings of grief and helplessness, as this cannot be achieved. When this gets too much or if the patient themselves cuts off from emotions for fear of them being too intense, I have found there is a pull to go along with this and detach

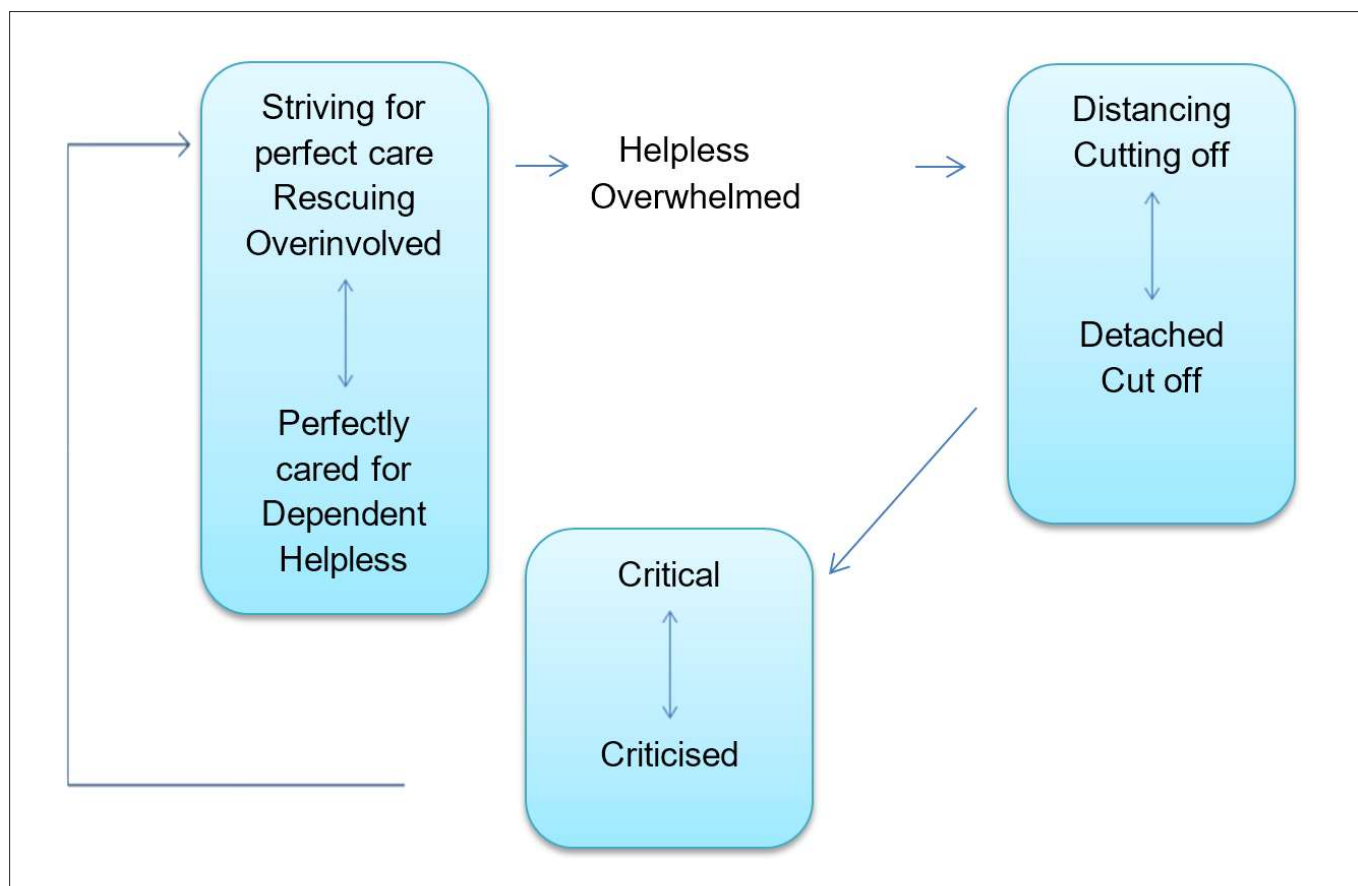
from the difficult feelings, perhaps due to sharing a similar fear with the patient.

As Barnard (1995) comments, moments of intimacy, between professional and patient in palliative care, are often accompanied by fear of entering fully into another person's agony and being overwhelmed by suffering. Perhaps this is due in part to it being a reminder of our own mortality. Thoughts such as 'If I help the patient get in touch with their own feelings of grief will we get stuck there?' tend to surface. This might lead to being critical of ourselves as therapists, leading to a need to try harder, and ending back up in the striving position (see figure below). Peter Blackburn (2014) described Reciprocal Role Procedures that staff may experience when working in palliative care, which include some of these ideas, (PhysCAT, 2014).

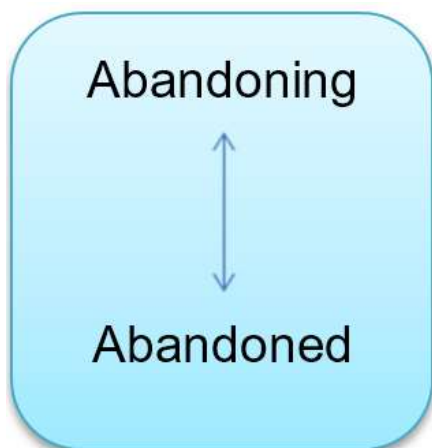
When working with the aforementioned patient, Fay, I found myself getting pulled into these RRP. When her health deteriorated, she was admitted onto the palliative care ward for

symptom management around Christmas time. She did not want her children to visit her much when she was in there as it was important to her that they kept 'normality' going as much as possible. I remember feeling helpless, that nothing I could do was going to make this any easier and at the same time striving, which led me to contact the ward relatively frequently (probably more than usual) checking whether she was well enough to see me, as she often cancelled our contact towards the end of her life when she was too unwell to see me.

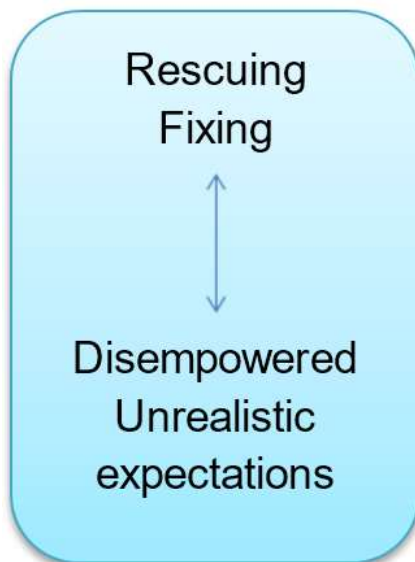
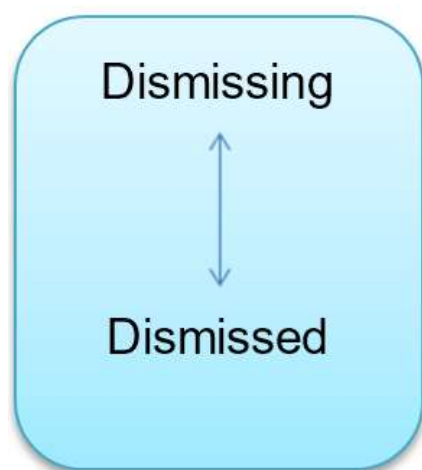
In terms of the abandoning to abandoned reciprocal role that was mentioned in the context of what a patient might be going through, professionals may find themselves at either side of this, too. For example, when the patient's health suddenly deteriorates, as happened with Fay and there has been perhaps little preparation for this in therapy, the end can bring up feelings in the therapist of being 'abandoned' or 'abandoning' when goodbyes have not been possible



or when there had been limited collaborative reflection on the therapy including whether they found the therapy helpful at this time in their lives.



Nursing team reciprocal roles
Providing supervision to specialist cancer and palliative care nurses and oncology day unit nurses, has meant that I have gained some insight into what these groups find most challenging in their work and often it is patients who are young, have a palliative diagnosis and have children. As Brennan (2004) mentions, the 'contagion' of distress from patient to professional is probably intrinsic to the work and cancer care may touch on the professional's fears and relationships with their loved ones. He also talks about the fact that the emotional distress of dying might be 'shuttered off' by staff who may then employ 'blocking' practices like distancing or maintaining a 'stoical brightness'. This may look like the distancing to cut off roles explored



earlier, or even dismissing to dismissed, as patients may feel that their distress is ignored or not listened to.

The other side of this is when staff describe going 'the extra mile' for patients but this never feeling enough, or when the patient has passed away, a feeling that they could have done more for them. When discussing this with staff, they often acknowledge they go into a rescuing role e.g. perhaps co-ordinating aspects of their care that the patient or carer would normally do for themselves, even when they would still be able to do this. Staff sometimes acknowledge however, that this may leave patients feeling disempowered but also setting unrealistic expectations for future care, which inevitably cannot be met.

Exits

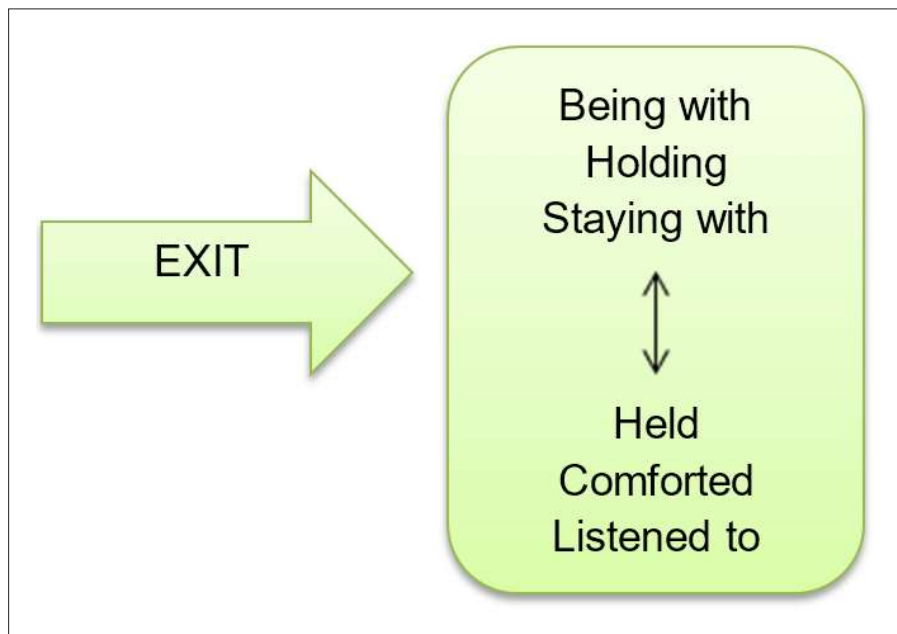
By recognising the reciprocal roles the patients occupy and the ones that as therapists we get pulled into, as well as helping nursing staff gain insight into what they might be invited into, we can then help patients and staff alike to develop exits in the form of more helpful reciprocal roles.

Smith-Pickard (2009) talks about if the person can share their reality with another human being and talk about the unspeakable reality of their condition, this might not make the last

moments of their lives any easier but perhaps a little less lonely. As cancer patients often express their sense of isolation, 'being with' them can provide an exit from these feelings of loneliness. Barnard (1995) notes that hopelessness of suffering can be endured where the pain can still be articulated, highlighting the importance of giving patients space and a voice to express what they are going through. Yalom (2002) also reinforces this idea by suggesting therapists or helpers may want to encourage patients to share their thoughts 'about their tears' and thus explore their pain in a gentle way that allows them to experience compassion for themselves and what they are dealing with. This can help us as therapists feel less helpless and through our own supervision, reflect on the importance of helping the person articulate their pain, be with them in compassion and perhaps help us in turn process that pain and be compassionate with ourselves.

Often as professionals when we feel helpless as to what we can do or experience a pull to rescue, it is important to remember that 'being with' is of value and at times perhaps all we can offer. Yalom (2008) talks about the power of presence and holding the suffering one, no matter how much fear the person has. If the therapist can remain calm this may help alleviate the person's terror and thus provide exits for both therapist and patient.

One of the patients I have worked with, Tanya, has metastatic breast cancer, which is therefore incurable. At times of stress, Tanya's fear of death surfaces and she worries about her two children who are young adults. At these times, she accesses therapy and has stated she finds it helpful to be able to talk openly about her worries and fears in an environment where she is not worried about burdening others. Once she has done this she feels she is able to continue focusing on 'living'. These ideas



can be summarised in the following exit for both patient and professional:

If people are encouraged to tell their stories and express their feelings, they may be helped to find meaning in their condition (Neimeyer, 2001). As patients who die with cancer usually have some warning, this affords them the opportunity to prepare themselves and their family for their death. As Mannix (2017) highlights: 'Sometimes, the role of a psychotherapist is to help someone to re-evaluate their worth and their meaning, and to discover their true colours, shining through the humdrum of everyday life, and already appreciated by everyone except themselves. That in itself is a therapeutic win, and can transform a person's life' (p. 224).

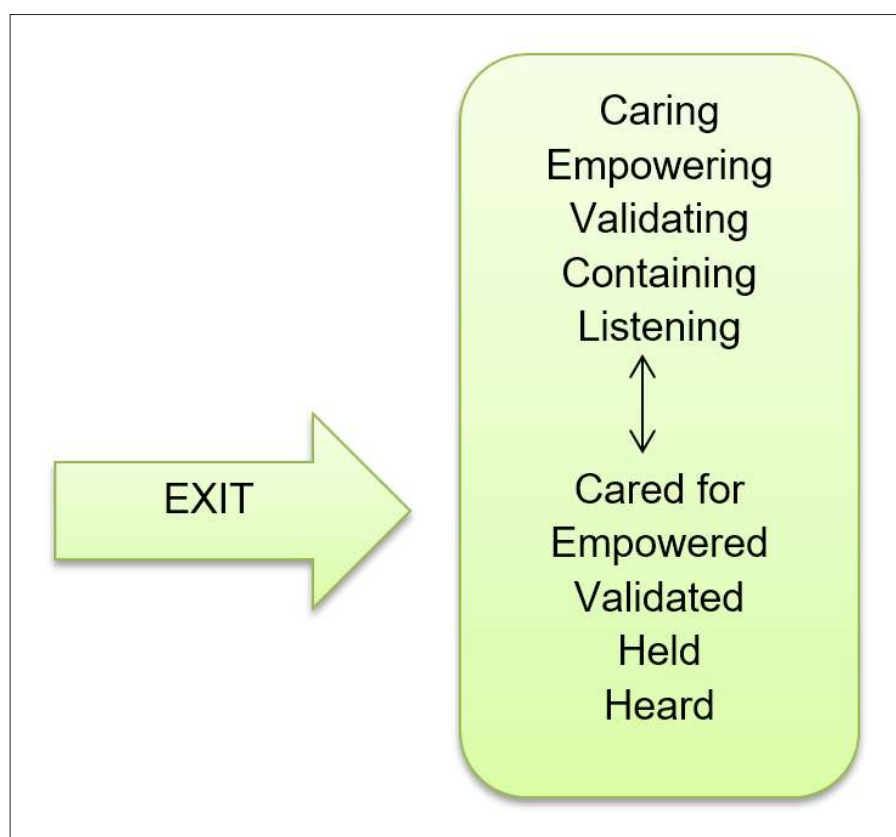
The idea of emotional boundaries is an adapted version of the boundary see-saw model (Hamilton, 2010) as adapted by Ian Lorentz, 2015. More helpful and bounded professional roles would include being able to be caring and validating through listening and containing the patient's distress, but at the same time empowering the patient so that they feel able to cope, use their own resources and access the support they need from others, as they are able to as this ability can deteriorate.

This can be modelled in supervision by not jumping in to try to rescue staff from feeling distressed when working with these patients but being able to hold the space, listen to and be with their distress which hopefully in turn helps them feel validated, held and empowered to continue providing care for these patients. This process may also foster more kindness towards the self and an acceptance

that not everything can be fixed, that medicine and life has its limits. So, a more healthy set of reciprocal roles may look like the exit below:

Conclusion

Reciprocal roles that patients may get pulled into including self to self, self to other as well as cancer to self were reflected on. It was important to think about the roles that we as therapists may feel a pull towards when working with the challenges that this patient group are experiencing, as this awareness may mean we are less likely to get drawn in to unhelpful reciprocal roles or procedures. It was also of interest to reflect on what might happen between the nursing professionals, who build up a therapeutic relationship with patients over the course of their treatment, and their patients. This awareness can be used to explore these roles further within therapy. It creates opportunities to discuss with patients and to explore with them what is coming up for them or what they are struggling with and in turn perhaps think about exits.



Being able to develop exits in the form of more helpful reciprocal roles is crucial for staff as well in order to avoid burn out. I hope there will be more CAT thinking in future around working in cancer and palliative care as I see this as an invaluable approach to reflect on this area of work.

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