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Young clinicians dealing with death: Problems and opportunities

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ABSTRACT

Objective: The formation of a strong bond between patients and therapists can lead to successful treatment outcomes. Yet, little is known about the mechanisms that function to control this relationship. The objective of this case report was to examine the ruptures and repairs in the working alliance between a young therapist and an elderly caregiver, and to suggest ways in which to deal with age-related challenges to such an alliance.

Method: In order to examine the ruptures and repairs in a working alliance, this case report reflects on the interdependent relationship among therapist variables, patient variables, and the therapeutic alliance. The clinical experience presented describes a newly educated psychologist's struggles to overcome the challenges in forming a strong working alliance with an elderly dying cancer patient's spouse. The spouse was enrolled in the DOMUS study (Clinicaltrials.gov: NTC01885637), an ongoing randomized controlled trial of a patient-and-caregiver intervention for facilitating the transition from an oncology ward to palliative at-home care, and then bereavement. As part of the DOMUS study, the patient and spouse received a psychological intervention based on existential-phenomenological therapy.

Results: A therapist's therapeutic approach to breaking down age-related barriers to communication matters greatly. The existential-phenomenological method of *epoché* offers a way to effectively address ruptures and repairs in a working alliance, as it enhances the therapist's openness to learning. In addition, the insights of senior supervisors can promote a therapist's openness to learning.

Significance of results: In conclusion, the method of epoché benefits the working alliance in several ways, as it enhances personal insight and provides methods for repairing an alliance. The reflections in this paper may be applied to clinical settings in oncology, gerontology, and palliative care, which are likely to be of great interest to young clinicians experiencing age-related challenges in their daily work.

KEYWORDS: Therapeutic alliance, Advanced cancer, Caregiver, Distress, Psychological intervention

INTRODUCTION

Age Disparities as a Challenge to Cancer Care

The number of elderly cancer patients is increasing rapidly worldwide (Rowland & Bellizzi, 2014; Parry et al., 2011). This will inevitably result in a growth in the number of older cancer patients who receive care from clinicians much younger than themselves. Previous research has shown that a therapist's younger age or inexperience can negatively influence the formation of a strong working alliance, which ultimately influences the outcome of therapy (Martin et al., 2000). In line with this, recent investigations also confirm the oncologist–patient working alliance to be of importance in the provision of efficient cancer care (Trevino et al., 2013). A growing number of studies have investigated the effect of communication training programs offered to oncologists and the

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influence of such a program on the alliance and relationship between oncologists and patients (Meystre et al., 2013; Hoerger et al., 2013). However, little is known about how to address ruptures in the alliance caused by age disparities. In order to improve intergenerational relationships and care of the rising number of elderly cancer patients, this study sought to explore methods and techniques addressing an early rupture in the alliance between young inexperienced therapists or clinicians and elderly dying patients.

The aim of this case report was to explore the formation of an alliance between a younger psychologist interacting with an elderly patient's caregiver and to discuss approaches to handling age-related challenges to a therapeutic working alliance.

The Working Alliance: Toward Understanding the Nature of Professional Relationships

The concept of the working alliance is central to an understanding of the relationship between patient and therapist. This study do not employ measurement tools to assess the quality of the working alliance in the present study, but instead investigate a working alliance from the therapist's points of view. The concept of a "working alliance" originally stemmed from a psychodynamic context, but in recent years it has been applied across a variety of therapeutic schools, and the concept has recently been implemented in the context of cancer research. Edward S. Bordin (1979) took the first steps toward synthesizing a definition of the working alliance, which according to him entails three elements: (1) a joint therapeutic goal; (2) a joint understanding of the problem at issue, which needs to be solved to reach the therapeutic goal; and (3) a strong emotional bond between therapist and client, which entails joint feelings of trust and security (Bordin, 1979). There has been increasing interest in understanding the factors that control the formation of a strong working alliance. The psychologist John L. Holland (1997) proposed that the degree to which two people are congruent with one another should influence the degree to which they experience a positive interpersonal outcome. This proposal was further investigated in a cross-sectional study of the association between client–therapist personality congruence and working alliances (Taber et al., 2011), which showed that personality similarity is associated with a strong emotional bond between client and therapist. Thus, when two people meet, the empathy for each other deepens when they find similarities, and vice versa. Therefore, manifest characteristics—such as age, ethnicity, and gender—may create barriers to a strong working alliance. The central hypothesis of this study is that the therapeutic alliance will be influenced by such characteristics as age-related disparities.

Epoché: A Technique to Improve the Working Alliance

> "I know that I know nothing."
> — Plato (2009)

One key aspect of psychotherapy is to develop methods to strengthen the emotional bond (the working alliance) between therapist and patient. According to psychodynamic therapy, one main obstacle to formation of a strong bond is when the therapist's feelings become negatively involved in the therapeutic work (Gabbard, 1994). Sigmund Freud stated that these feelings that occur within the therapist is a result of patient *countertransference* (Gabbard, 1994). According to Freud, what is happening in the countertransference is outside the therapist's consciousness until the therapist reflects about the feelings that the patient awakens in him or herself, and begins to work through the emotions that get in the way of a strong alliance. Existential-phenomenological theory followed in the wake of psychodynamic theory, and it led to a movement away from the concept of the subconscious mind toward a focus on such existential givens as death, freedom, and meaninglessness (Yalom, 1980). Existential-phenomenological theory has played a pivotal role in the development of psychological intervention in palliative care (Yalom & Greaves, 1977; LeMay & Wilson, 2008; Fegg et al., 2013; Kogler et al., 2015). Though the existential-phenomenological approach diverges from psychodynamic therapy, the theory entails concepts related to countertransference, for instance, *epoché*. According to existential-phenomenological philosophy, the true art of helping—or, more up to date, formation of a strong working alliance—requires that the clinician master the act of phenomenological listening. Phenomenological listening (Spinelli, 2005) emphasizes that the clinician must be able to focus on immediate descriptions of the patient's life. In brief, being present is the core element of phenomenological listening. It entails the technique of epoché, which means *bracketing* the clinician's own understanding, prejudices, and attitudes. Plato's famous "I know that I know nothing" captures the essence of epoché in several ways. First of all, epoché involves a humble attitude from clinicians. Embedded in the method of epoché is a recognition of our ignorance. However, it implies a conscious act, so it should not be confused with the act of suppression of knowledge. Second, it encourages us to be filled with curiosity. If they direct attention to their own assumptions

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(e.g., "I think I'm way too young to be able to help this patient"), the clinicians should recognize that such an assumption should be subject to curiosity and examination, perhaps asking the patient "Do you think our age difference could influence the treatment?" In this way, the clinician does not omit his own prejudices and recognizes that "I know that I know nothing."

A CASE ILLUSTRATION OF AN EXISTENTIAL-PHENOMENOLOGICAL APPROACH TO THE REPAIR OF RUPTURES IN THE WORKING ALLIANCE

History of Present Illness

Mr. Gergen was a 65-year-old man married to Mrs. Brix, a 69-year-old woman with stage IV esophageal cancer. When I first encountered the couple, Mrs. Brix had recently been diagnosed with metastases in her lungs. She was initially treated with adjuvant concomitant radiotherapy and chemotherapy. A year later, scans showed recurrence of the lung metastases. As second-line treatment, she was given a mixture of carboplatin, Taxotere, and Xeloda until progression after seven months. Then, Irinotecan was begun as third-line treatment, which was discontinued almost six weeks later due to Mrs. Brix's declining health. She was admitted to a hospice two months later, where she passed away within three weeks.

The Story of a Spouse Caregiver

Mr. Gergen was adversely affected both psychologically and physically by his wife's illness. He had a prior history of atrial fibrillation and presented with depressive symptoms—including fatigue, insomnia, and lack of initiative—which regularly prevented him from participating in social life. He described the past eight years as horrifying. First, his wife had a cerebral thrombosis, which caused temporary numbness and aphasia. Her adult daughter then died dramatically in an accident, and then the cancer was diagnosed. Mr. Gergen and Mrs. Brix had been married for almost 30 years. They both had been married once before, and each had one child from their previous marriages. The couple described their relationship with their stepchildren and stepgrandchildren as loving and close.

COURSE OF TREATMENT

A few months after I graduated with a degree in clinical psychology, I met with Mr. Gergen and Mrs. Brix, who were scheduled for psychotherapy as a part of the DOMUS study (Clinicaltrials.gov, NTC01885637), which is an ongoing randomized controlled trial of a patient-and-caregiver intervention for facilitating the transition from an oncology ward to palliative at-home care and then bereavement (Nordly, 2014). I realized that my age was a barrier between Mr. Gergen and myself during the first session. It was an obstacle to a strong working alliance, which I knew could potentially affect the treatment outcome (Trevino et al., 2013; 2015). What actually took place was the following.

Immediately after my short introduction during the first session, Mr. Gergen expressed his disappointment with me. He asked me my age, to which I replied "29 years." He told me that the first time he had spoken to me on the telephone to plan the home meeting, he sensed that I was young and that he had wanted the psychologist to be a person of his age or older. He said that my voice did not sound mature, that it sounded young. He would have preferred a psychologist with more experience. I recalled the life story of the couple—the loss of a daughter, his wife's cerebral thrombosis, and her recent severe cancer diagnosis—and suddenly I felt concerned about my ability to form a therapeutic bond with this man.

I knew from many valuable talks with my supervisor that my age was my Achilles heel. I felt a strong impulse to assert myself and establish my own competence. Instead, I took a journey into my memory. I found myself in the office of my supervisor, who was using the French word "epoché," which means "bracketing," and is one of the principal elements of existential-phenomenological therapy (Spinelli, 2005). I understood that I had to bracket my own assumption that I was too young. So I decided to keep my feelings of inadequacy and inexperience to myself and remain focused on the issue raised by Mr. Gergen. I asked him how he thought the age difference would influence the therapy. He explained that he had had a bad experience with a psychologist. Some years before, following the loss of their daughter, the couple underwent psychotherapy, which they did not consider helpful. So the couple had turned to a chaplain, with whom they experienced a comforting, trusting relationship. Filled with curiosity, I started to investigate Mr. Gergen's assumption of a helpful relationship in order to identify in which way age mattered to him. I discovered that his psychotherapist had also been younger than him, whereas the chaplain was of similar age. Still, I was curious to learn more about what it was about age that mattered to him. Mr. Gergen explained that a healthcare provider could be trusted only if he or she was an expert in the field. While he was talking, he noticed my curiosity and became eager to talk about himself. He looked at me thoughtfully and noted that, as I was employed by the Copenhagen University Hospital, he supposed that I was highly qualified. Moreover,

he explained that he preferred authenticity and confrontation in situations established to provide help. By this he meant, for instance, that therapists should not hesitate to express their personal opinions. At the end of the session, Mr. Gergen said that he did not think that my age would actually affect the therapy after all, that what mattered most was being professional and authentic rather than a certain age.

The Closing Session

I visited Mr. Gergen for a final session about four weeks after the loss of his wife. In that session, he returned to the theme of age. Even though he had initially been skeptical about me because of my comparative youth, he told me that it did not really have a negative effect. In his numerous visits to the oncology ward, he had noticed that most of the doctors and nurses appeared young to him, whereas he had wished that the treating oncologist be about his age or older and radiate experience. Some weeks after the first session, he had realized that he was himself in his mid-60s and that the "young" oncologists reminded him that he himself was no longer so young, which was difficult to accept.

DISCUSSION

In this case, the question of age became a turning point in the establishment of the working alliance. Although this result is consistent with previous studies (Martin et al., 2000), there are also findings that point to a positive influence of the clinician's younger age on treatment outcomes. In a recent systematic review of evidence gathered from 27 studies on the association between clinicians' characteristics and treatment outcomes for adult cancer patients, de Vries and colleagues (2014) concluded that there was no significant effect of clinician's age on quality of communication, prescription of chemotherapy, or capacity to detect distress. Contrary to the common belief that young age negatively affects treatment outcomes, these authors noted that younger clinicians more often responded empathically to patients.

Communication and assessment of distress do not, however, account for all aspects of comprehensive treatment. In a qualitative study of feedback from 28 experienced psychosocial oncology clinicians using an empirical model of therapeutic effectiveness, the physician's personal insight and personal growth were found to contribute significantly to efficient treatment (Chochinov et al., 2013). Thus, in terms of personal growth, senior clinicians might be more effective than recently educated clinicians because of their greater experience. However, Chochinov and colleagues concluded that the capacity for self-reflection and openness to learning is critical to acquisition of personal growth because it allows clinicians to learn from personal and professional experience.

The young psychologist of this case study employed two strategies in her challenge to form the alliance. First, she employed her personal insights about her Achilles heel, which she had learned from supervision. Existential-phenomenological philosophers have long been aware of the ability to suspend one's own assumptions and prejudices, thus focusing solely on the patient and practicing the true art of helping (Kierkegaard, 2009). In the present case, the age mismatch affected the process of identification between clinician and patient, and vice versa, thus making it difficult for the therapist to fully master the art of helping. As mentioned, previous studies have shown that personal growth and openness to learning are associated with better treatment outcomes (Chochinov et al., 2013; Oddli & Halvorsen, 2014). In the present case, supervision was instrumental in promoting personal insight and thereby enhancing the alliance. This is in line with previous studies showing that supervision significantly influences treatment (Callahan et al., 2009; Freitas, 2003; Watkins, 2011).

The second strategy employed in formation of the alliance involved the rules of epoché, which represent the psychologist's inner work in suspending her own assumptions about lack of competence. To intervene in this way, authority was established deriving from empathetically listening and avoidance of an authoritative stance. Previous studies have shown that communication training focusing on positive communication and empathy is associated with a strong alliance, whereas negative talk and biomedical information are associated with a weaker alliance (Meystre et al., 2013).

The existential method of epoché guides the intervention toward strengthening the alliance. Previous studies have employed existential therapy in the field of death and dying (see Lo et al., 2014). Cognitive behavioral therapy (CBT) is an alternative approach that might have been taken into consideration as a method to establish an alliance between young psychologists and elderly patients. CBT studies have demonstrated that the amount of the psychologist's experience or their age is unrelated to successful treatment outcomes (Norton et al., 2014; Huppert et al., 2001). In contrast to existential therapy, CBT is characterized by a highly structured approach, and its structure might diminish the effect of experience or age on alliance formation. However, the present study questions if CBT targets the specific difficulties of end-of-life patients and caregivers' experience, and whether this therapeutic approach is

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suitable in an end-of-life context given the realistic threats imposed by a life-threatening illness.

This study encourages policy makers in end-of-life settings to offer high-quality supervision and to plan for highly structured interventions in order to ensure good treatment outcomes for young therapists and elderly patients. This study have focused on age and/or experience as a barrier to establishment of the working alliance. A variety of factors might have been taken into consideration (e.g., the context of the study, which represents a transition from oncology to palliation). I consider it a limitation of this study that I have not taken into consideration the effect of this transition on the therapeutic alliance. I might hypothesize that the transition is a crucial point in the illness trajectory, at which hopes are scattered and frustrations are high.

To protect the anonymity of the patient and the caregiver, I have disguised identifying information in terms of the names of the patient and caregiver. In accordance with the therapist's ethical obligation of confidentiality, the caregiver's written authorization was obtained to publish content from the therapeutic sessions. The caregiver was informed about the probable risk and benefits for the caregiver and of his right to refuse to participate or withdraw consent.

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