



# Reflective practice in palliative care

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This article follows on from our feature in April *InPsych* which addressed the common misconceptions surrounding the end of life. Palliative care is holistic care that helps people nearing the end of their life to live as well as possible for as long as possible. Palliative care supports the person, their family and carers and can include bereavement support following death. The aim is to allow people to experience each moment at the end of life more fully through effective management of pain and other symptoms, and assessment and management of their psychological, social, emotional and spiritual needs. It is key for psychologists working in this field to understand the importance and implications of communication, self-care and reflective practice.

## **Communication in palliative care**

Good communication underpins the quality of palliative care (Murray, McDonald & Atkin, 2015) and is associated with better quality of life for adults receiving palliative care (Walczak, Butow, Bu & Clayton, 2016). The importance of good communication is recognised in the National Palliative Care Strategy 2018 ([bit.ly/2uVIETW](https://bit.ly/2uVIETW)) and is also included in well-recognised standards for end-of-life care (NICE, 2011).

Dying is a normal part of life. Acknowledging the reality of dying and death can help people to prepare for the end of life in a meaningful way. Yet conversations about death and dying are difficult. These conversations may be distressing as the person may be very ill or rapidly deteriorating, scared, or asking questions that are difficult to answer.

Anxiety is normal for people, their families and clinicians during these discussions. Creating a safe space for people to express themselves and feel heard can provide significant comfort, reduce anxiety and result in a sense of peacefulness. This can then lead to less-invasive care and better adjustment to bereavement (Bernacki & Block, 2014).

While communication is a fundamental skill in all psychological practice, there are specific challenges when working with people approaching the end of their life. Psychologists in palliative care need to be able to communicate in such a way that hope is fostered realistically. Key to providing the highest standard of care is building trust and showing empathy through verbal and non-verbal communication skills. Emerging evidence has revealed the positive neurophysiological effects of touch and face-to-face interaction with trusted others. Trust and empathy have a significant effect on the body's creation and secretion of beneficial chemicals that can help reduce depression and regulate anxiety (Kerr, Wiechula, Feo, Schultz, & Kitson, 2019).

Evidence indicates that people and their families place a high value on good communication that enables them to prepare for the end of life. Respectful and compassionate care acknowledges their values and allows them to be considered as a whole person (not as a sufferer of a certain disease), and to maintain their dignity (Rawlings, Devery & Poole, 2019). It also allows people at the end of their life to stay as well as possible and engage in their own care (Masso & Grootemaat, 2016).

Active listening skills are paramount in palliative care to fully appreciate what troubles the person. Giving the person full attention and listening empathetically can provide an avenue for expression and reassurance. Giving time for silence can allow the person the space and time to connect with their thoughts and feelings. Families may require time to fully understand the issues and the best way forward and to find the courage to continue to discuss these issues. It is not always possible to have the answers to a person's questions. Not knowing the answers to all questions is acceptable particularly if, as an addition to empathetic listening, there is a willingness to guide the person to ways of finding helpful information and resources.

Developing confidence in having difficult conversations takes practice and regular communication skills training is recommended. A good place to start is by exploring personal beliefs, attitudes and perhaps hesitations about death and dying, and the factors that have shaped these. This can provide the opportunity to recognise and understand uncomfortable thoughts and feelings that may be triggered by encounters with people at the end of their life. Developing this self-awareness can help understand emotional reactions to difficult situations and recognise early signs of stress.

### Supportive psychotherapy

It is essential that supportive psychotherapy underpins all interactions and training in end-of-life interventions. These are mainly existential approaches (Spira, 2000) and include meaning and purpose therapy (Lethborg, 2010), dignity therapy (Chochinov et al., 2005) and the managing cancer and living meaningfully approach (CALM; Rodin, 2017). Skill development in family-focused grief therapy (Kissane & Bloch, 2002) and bereavement counselling is also critical. Learning to sit with silence and discomfort in the face of suffering is important, as is recognising that humanity is the most valuable skill psychologists possess.

Self-inquiry and reflective practice can assist effective care and enhance the ability to discuss issues related to death and dying in an open and professional manner. It is therefore essential that psychologists considering a career in palliative care develop insight into their own death anxiety through training and ongoing intensive personal development and supervision. This process of self-reflection, supervision and consultation with experienced colleagues can help psychologists to determine their skills to work with terminally ill people.

### Resources for working in palliative care

- Specialist training is available from the Australian Centre for Grief and Bereavement ([bit.ly/2OC74Be](http://bit.ly/2OC74Be)), Flinders University ([bit.ly/30qCuAT](http://bit.ly/30qCuAT)) and the Centre for Palliative Care ([bit.ly/2LH8BIT](http://bit.ly/2LH8BIT)).
- The CareSearch website hosts a collection of evidence-based and peer-reviewed palliative care e-learning resources for independent learning ([bit.ly/2WSrjid](http://bit.ly/2WSrjid)).
- End-of-Life Essentials offer modules and supporting resources to help doctors, nurses and allied health professionals develop their skills and confidence in end-of-life care ([bit.ly/2W3WWYD](http://bit.ly/2W3WWYD)).
- The Quality of Care Collaborative Australia (QuoCCA) Communication Learning Module *Communicating with families about children who have life-limiting conditions* is a learning opportunity for any health professional with an interest in understanding more about communicating with families or those who currently support children with a life-limiting condition and their families ([bit.ly/2YuVGLJ](http://bit.ly/2YuVGLJ)).
- Useful resources for working with diverse cultural beliefs about death and dying are available on Palliative Care Victoria's website ([bit.ly/2HsjJEs](http://bit.ly/2HsjJEs)).

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## Appropriate language and culturally responsive care

The therapeutic value of touch as part of communication must also be considered in palliative care. Emerging research indicates the importance of touch and gaze. The neurophysiological response to touch includes the release of specific chemicals and neurotransmitters that lead to neuroendocrine effects, vagal stimulation, and the reduction of stress, pain and depression (Kerr et al, 2019). It may therefore be necessary for psychologists to reinterpret ethical guidelines regarding practitioner-client boundaries, particularly around the use of touch. The *APS Ethical guidelines for managing professional boundaries* indicates ‘from some perspectives a reassuring touch may be considered an appropriate response with certain clients in some situations’ (6.9.1). The use of touch must be managed with sensitivity respecting the wishes of the person’s preferences and cultural beliefs and norms.

Language is also a critical component of culturally responsive healthcare, as is the ability to recognise and understand the influence of our own background and positioning. Age, education and gender will impact in significant ways on a psychologist’s beliefs and approach to care, unconscious or otherwise.

Appropriate language is an important part of effective communication, and person-centred and culturally responsive care. Euphemisms for death and dying are part of our everyday language to describe things that we would rather avoid saying. When euphemisms are used, there may be misunderstandings, or the meaning may be lost (Rawlings, Tieman, Sanderson, Parker, & Miller-Lewis, 2017).

Conversations about death should be conducted with sensitivity for the person to determine their openness to discuss and explore death and dying. It is common for people to avoid saying words such as ‘death’, ‘dying’, ‘dead’ yet they may be open to hearing and speaking these words in an empathetic supported discussion. They may be accepting of open and honest discussions.

Certain words may be appropriate for some ages or cultural groups whilst other words may never be uttered. In some cultures and age groups, direct statements about death and dying may not be acceptable or comfortable either in the first instance or at all. It may be that a family member participates in discussions on behalf of the person with a life-limiting illness. Therefore, conversations about death should be conducted both strategically and with sensitivity.

It is worth being mindful that in palliative care communication can be disjointed, as serious illness or marked deterioration may limit interactions and symptom management may create interruptions. A lack of privacy may also impede open, considered communication.

## Effective communication

**Engage in active listening** – this requires concentration so that you understand and remember what was said so that you can respond appropriately. Ensure congruence between verbal and non-verbal skills – what you say and what you look like when you say it must align otherwise you will be sending mixed messages.

**Understand personal attitudes and beliefs about dying and death** – you must become comfortable with discussing these difficult issues.

**Learn to sit with silence and personal discomfort** – listening intently without interruption takes discipline.

**Respect cultural beliefs** – the best way to do this is to ask the person about their beliefs.

**Use touch appropriately** – a light touch on the forearm is sufficient but ask permission if you are unsure.

**Provide open and honest information** – never use euphemisms or give false hope.

**Give your full attention** – ensure that you are not time-pressured and maintain eye contact.

**Involve the person’s support network** – palliative care is inclusive of people, their family, carers and sometimes friends and neighbours.

**Listen empathetically** – your concern for a person’s suffering is the best tool you have.

**Acknowledge if you don’t have the answers** – there is nothing wrong with saying you don’t know.

**Check the person’s understanding of what you have said** – summarise frequently, ask the person to repeat what you have said.

**Encourage questions and further discussion** – use open-ended questions.

**Use person-centred and flexible approaches** – psychologists must be competent in a broad range of interventions and match these to the needs of the person.

**Seek training in specialised end-of-life interventions** – these are generally not part of standard psychological training so must become part of professional development.

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# “To effectively support people in their care and be fulfilled in their personal life, psychologists are advised to practise self-care and engage in reflective practice”

## Practising self-care

Supporting clients to live well at the end of life can provide psychologists with a high level of meaning and satisfaction. However, it can also present a challenge to maintaining personal emotional health and wellbeing. Working in palliative care confronts our mortality and this can be accompanied by stress and grief with the loss of multiple clients, dealing with strong emotions, and addressing multiple complex client and carer needs.

Good palliative care often sees the creation of strong bonds between the people who provide care, receive care, and their extended network. Therefore, grief over the death of a person is not unusual and may contribute to stress, burnout or compassion fatigue. Fatigue, poor sleep, headaches, negativity, cynicism, lack of enjoyment and absenteeism are all signs that a practitioner is not coping. Stress, burnout or compassion fatigue will affect emotional capacity and physical availability to communicate effectively with people in care, and their potentially extensive support network.

Compassion fatigue and burnout can occur if little attention is paid to the effects of the death of clients and of working in an emotionally charged environment. To effectively support people in their care and be fulfilled in their personal life, psychologists are advised to practise self-care and engage in reflective practice. Developing self-awareness through these practices is important as it can help the psychologist to understand emotional reactions to difficult situations and recognise early signs of stress (Mills, Wand, & Frase, 2017). These are fundamental practices in an environment known for its high rates of burnout and compassion fatigue (Girgis & Hansen, 2007).

As highlighted in the *APS Ethical guidelines for managing professional boundaries* (6.8.2), providing psychological services can often be stressful ([bit.ly/2RUjDJ7](https://bit.ly/2RUjDJ7)). The importance of self-care and self-compassion is widely recognised

in the literature and is included in the National Palliative Care Standards ([bit.ly/2Eb4oac](https://bit.ly/2Eb4oac)). Psychologists are therefore encouraged to monitor their levels of stress, and regularly attend to self-care and reflective practice to avoid lapses in professional judgment. While these undertakings need to be tailored to suit individual needs, they will be most beneficial if they are not only a response to a crisis but practised routinely, and are enjoyable and satisfying (Mathieu, 2007).

## Elements of self-care

- Include a balanced healthy diet, regular exercise, a routine schedule of restful sleep, a balance of work and leisure, and recognition of emotional needs
- Explore activities to find those that are pleasurable e.g., exercise, meditation, massage, singing, visual or manual arts
- Make time for leisure activities and personal hobbies outside of work
- Take short breaks throughout the day to focus on breathing and send yourself some compassion
- Connect with friends who are not associated with your workplace or profession
- Connect with a network of supportive peers
- Cultivate self-awareness and connect with personal thoughts and feelings through journaling or other artistic pursuits
- Make a list of coping skills to use in times of stress
- Learn to say “no” to help you manage your emotional needs
- Use workplace strategies such as support groups, open discussions, employee assistance programs and mental health days
- Seek personal therapy and/or professional supervision

## Questions to encourage self-reflection

- What were my thoughts, assumptions and expectations about the interaction at that time? What are they now?
- What was I feeling? How do I understand my feelings then and now?
- On considering my actions during this session what did I want to happen?
- What theories do I use to understand what is going on?
- What past professional or personal experiences affect my understanding?
- How else might I interpret this event or interaction?
- How might I test out alternatives? Where to from here?
- How will the client's responses inform what I do next?
- What resources could I draw upon in my workplace to build self-awareness and expression, or develop an individual self-care plan?
- What steps could I take to maintain balance in my compassion for others and compassion for myself?

## Engaging in reflective practice

Reflective practice is a critical tool to process and learn from daily interactions. A key rationale for this is that experience alone does not necessarily lead to learning and therefore deliberate reflection on experience is essential (Senediak, 2013). It involves paying attention to the practical values and theories that inform everyday actions by examining practice. It can increase self-awareness so that practitioners can achieve a deeper understanding of thought and action.

Reflective practice is not only about looking back on past actions and events, but also taking a conscious look at emotions, experiences, actions, and responses. The end goal is improvements in service delivery for people, their families and carers, and enhanced job satisfaction for psychologists.

Identifying personal and professional strengths are two of the key benefits of reflective practice but it also permits practitioners to identify their professional development needs. It can therefore lead to the acquisition of new knowledge and

skills, which then facilitate self-directed or formal learning. It is often a critical incident that prompts reflection but not always. It can be very useful to use positive experiences as the basis of reflection so that 'what worked' can be recognised and reproduced.

Some weaknesses in reflective practice should be acknowledged. For example, not all practitioners will understand the formal process of reflective practice as it may not have been part of their training. Therefore it is important that this knowledge is obtained through ongoing professional development. Another limitation is that it is not necessarily a comfortable experience as it challenges and evaluates personal practice. It can threaten sense of self and lead to self-doubt and defensiveness. Reflective practice may not always be enough to resolve a clinical problem. Unrecognised external factors may influence an outcome rather than a practitioner's skill-base and the therapeutic relationship.

Organisations have an important role in promoting staff resilience by offering supervision, reflective practice, opportunities for staff communication, mindfulness-based training and developing schedules that promote team engagement (Gillman et al., 2015). If these services are not available in a workplace then psychologists should advocate for their inclusion or, alternatively, seek external support.

## Rewards and outcomes

Being part of a team can provide the opportunity for support, supervision, reflection and debriefing. This may be particularly helpful in developing realistic expectations of the degree of support that can be provided to a dying person. Establishing regular supervision and joining a special interest group can provide connections to a larger community of support and learning. The Australian Allied Health in Palliative Care (AAHPC) ([aahpc.committee@gmail.com](mailto:aahpc.committee@gmail.com)) and Program of Experience in the Palliative Approach (PEPA) ([bit.ly/2E8lRjx](http://bit.ly/2E8lRjx)) may be of particular interest.

Palliative care can be a rewarding area of practice for psychologists. Supporting people to live well at the end of life can provide a high level of meaning and personal satisfaction. Self-care and reflective practice can enable practitioners to maintain focus, energy and wellbeing over the long-term. Effective communication can create a safe space and give time for silence to allow the person the space and time to connect with their thoughts and feelings as they explore loss, face their mortality and set realistic goals. Psychologists with appropriate training and support can deliver high-quality care that helps people to live well until the end of life and support bereaving families and carers.

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