Palliative Psychotherapy

After hearing my doubts about whether I had done anything to help a middle-aged, talented, but characterologically difficult patient lead even a marginally better life, a trusted colleague said, "I think you made his existence a little less lonely and painful." I supposed I could agree with that—but it somehow felt like setting my therapeutic expectations much too low. After years of therapy, shouldn't I have catalyzed greater change in a patient's behavior and lifestyle?

Perhaps—but then I realized that my treatment could be thought of as palliative psychotherapy. After all, I had provided comfort, if not cure. I had avoided inflicting harm. I had provided some humor and perspective for a life chronically lacking in both. I had helped a habitually poor problem solver to solve many basic problems. I had even met with several of his family members. What if fundamentally altering his many decades' worth of maladaptive coping was beyond my skills, and perhaps anyone's? Despite my hopes and efforts, my patient had not put away childish things and moved beyond erratic work and stormy relationships; but can we expect patients with cystic fibrosis to run marathons—or, for that matter, jog—even with proper coaching?

Palliation aims to reduce suffering, minimize pain, and increase comfort. Treatment is focused explicitly on improving quality of life rather than altering the natural course of illness. How does this apply to psychotherapy? It may mean that although the patient will not stop being self-involved, impatient, petulant, self-sabotaging, and so forth, the doctor can nevertheless continue to help the patient locate and use remaining strengths. Doing so generally improves self-regard and gives both a needed sense of accomplishment. Loneliness reduction is another goal. Palliative psychotherapy can use elements of psychodynamics, cognitive-behavioral therapy, psychopharmacology, pastoral counseling, coaching, and common sense. The criterion for application of a specific technique is not ideology but pragmatism: whatever helps the patient feel better and improves his or her life. Palliative psychotherapy is for those patients whose unyielding constellation of character problems feels terminally unmodifiable, yet who continue to seek some form of relief.

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The palliative psychotherapy perspective can help trainees see their ongoing work with "impossible" patients as something other than futile drudgery. After I've interviewed such a patient at a case conference, and have tried to bring out the patient's well-hidden and often modest strengths, a resident will typically—and with polite skepticism—ask, "But what kind of treatment actually works with this kind of person?" An excellent question, in my opinion, and one for which the answer "palliative psychotherapy" seems to crystallize meaningful expectations and goals.

A reasonable objection to this perspective might be that it represents a fancy way of defining expectations downward and rationalizing failure. I do not think this is the case. Just as research is now showing that palliative medicine may improve survival (as well as quality of life) over more active treatment in certain situations (1), so palliative psychotherapy, by stressing acceptance and adaptation rather than behavioral change, might offer patients more help in seemingly hopeless situations. When we reconsider expectations and recognize that therapy, like politics, is the art of the possible, taking a palliative approach may lead to more satisfying outcomes—for therapist as well as patient.

Reference

1. Temel JS, Greer JA, Muzikansky A, Gallagher ER, Admane S, Jackson VA, Dahlin CM, Blinderman CD, Jacobsen J, Pirl WF, Billings JA, Lynch TJ: Early palliative care for patients with metastatic non-small-cell lung cancer. N Engl J Med 2010; 363:733–742

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