

**CASE AND COMMENTARY: PEER-REVIEWED ARTICLE**

**How Should Long-Term Psychotherapy Address Ethical Questions During the Palliative Care of a Patient With Serious and Persistent Mental Illness?**

Constance E. George, MD, MA

**Abstract**

This commentary on a case considers the course of a palliative approach to care of a patient with a serious and persistent mental illness. Supposing a psychiatrist and patient mutually agree that the patient's chronic refractory illness should be palliatively managed with long-term psychotherapy, the next step is to forecast possible ethical questions that can arise during the course of such care and to share decision making about how to respond to those questions.

**Case**

AA is a 55-year-old combat veteran of the Iraq War with chronic posttraumatic stress disorder (PTSD) exemplified at this time by profound feelings of isolation, intrusive memories of combat, anxiety, depression, and frequent nightmares. AA is divorced, lives alone, and is alienated from children. AA is unable to sustain intimate relationships and avoids the public, as it triggers violent memories; AA is homebound much of the time. AA rarely sees a primary care physician and avoids health care settings, which also trigger painful memories and anxiety.

Over years of treatment, trauma-focused interventions—such as cognitive behavioral therapy and eye movement desensitization and reprocessing—have not proved beneficial. Medications are intermittently helpful with symptoms but have not resulted in remission. AA has a long-term relationship with a psychiatrist, Dr P, and they meet weekly. Dr P no longer focuses on medications or codified therapy for PTSD but does implement medications to relieve problematic symptoms when indicated. AA often reflects on how painful experiences in the present trigger memories of combat trauma, which in turn increase anxiety and depression. AA and Dr P agree that AA's treatment is palliative.

**Commentary**

Palliative care is a treatment course developed for patients with life-threatening illness that focuses on **quality of life** rather than remission or cure of disease. The World Health Organization defines palliative care as “an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated

with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual.”<sup>1</sup> It is often described as a team approach, enlisting professionals, caregivers, and patients.

Although psychiatrists are often members of palliative care teams in the general medical setting, primary psychiatric illnesses are not traditionally in the purview of palliative care.<sup>2</sup> This division of labor may be attributable to several issues, but one of the most relevant is a general disregard for the association between general medical illness and psychiatric illness and the hesitation on the part of the medical community to acknowledge that psychiatric illness may be terminal over the long run in a subgroup of psychiatric patients.<sup>3,4</sup> Indeed, those suffering from mental health disorders, particularly severe and persistent mental illness (SPMI), die younger than members of the general population.<sup>5</sup> There are measurable differences in years of life lost between people with and without mental disorders for both natural and unnatural causes.<sup>5,6</sup>

Defining psychiatric illness as life-threatening is also hindered by the lack of biological markers to aid diagnosis, as psychiatric illness is clinically defined by a cluster of symptoms rather than quantifiable biomarkers.<sup>7</sup> Of note, reliance on symptomatology is not unique to psychiatry; for many life-threatening illnesses that have long existed in neurology, such as Alzheimer’s disease, only recently have reliable biomarkers been identified, and they remain dependent on a constellation of symptoms for accurate diagnosis. Acknowledging psychiatric illness as the primary life-threatening illness in the implementation of a palliative care plan elevates it to its appropriate level of severity. In so doing, clinicians have impetus to explore effective palliative psychiatric care through multiple options that relieve suffering.

### **A Case for Palliative Psychiatry**

Presently, the goals of psychopharmacology and psychotherapy are recovery and remission.<sup>8</sup> Indeed, psychiatric patients do improve, recover, and live hopeful, satisfying, and productive lives per their own and their clinicians’ assessments.<sup>9</sup> However, there exist subgroups of people with SPMI who do not recover from their illness or experience symptom remission. Such subgroups include those with therapy-refractory mood disorders, **severe chronic schizophrenia**, therapy-refractive anorexia nervosa, or treatment-refractory PTSD.<sup>4,10</sup> These are life-threatening illnesses that negatively impact quality of life. Individuals with these illnesses may experience social distress in the form of homelessness, loss of employment, food insecurity, isolation, poor self-care, poor access to medical care, or physical deterioration. They may also experience symptoms of psychological distress: loneliness, despair, nightmares, flashbacks, unrelenting suicidal ideation, and compromised ability to concentrate or read. Moreover, hopelessness accompanies multiple failed medical and psychotherapeutic interventions employed to achieve remission.<sup>11,12</sup>

This failure of treatment focused on recovery or remission for people with SPMI, along with the significant negative impact of the condition on their quality of life, indicates the appropriateness of palliative care for such patients as a primary intervention and the easing of their suffering as a primary goal. Manuel Trachsel at the University of Zurich and colleagues have written extensively on palliative psychiatry in the last decade and provide the following definition:

Palliative psychiatry (PP) is an approach that improves the quality of life of patients and their families in facing the problems associated with life-threatening severe persistent mental illness (SPMI) through the prevention and relief of suffering by means of a timely assessment and treatment of associated physical, mental, social, and spiritual needs. PP focuses on harm reduction and on avoidance of burdensome psychiatric interventions with questionable impact.<sup>4</sup>

Applicable palliative care interventions in psychiatry range from psychopharmacological, psychotherapeutic, and medical and social interventions involving caretakers, practitioners—and, when available—family members. One such intervention argued for here is long-term psychotherapy.

### **Long-Term Psychotherapy as Palliative Care**

Long-term psychotherapy has proven effective in the treatment of chronic mental illness.<sup>13</sup> The long-term relationship between the patient and psychiatrist is a locus of predictability and trust for the patient.<sup>14</sup> The relationship itself serves as a safe harbor for the patient to discuss concerns regarding the present and future. Patients themselves have noted the value of a psychiatrist who remains a steadfast presence even when treatments don't achieve the desired positive effect.<sup>14</sup> In this way, the demoralization a patient might otherwise experience from multiple failed treatments is ameliorated and hope is sustained.<sup>14,15,16</sup> It is within this therapeutic alliance that the patient may find access to resources both practical and existential, provision of support, and collaboration in exploring ideas and meaning.<sup>14,17</sup>

Patient and psychiatrist can discuss the prognosis and address the patient's feelings of loss and despair as well as what to hope for. In the context of palliation of psychiatric symptoms, hope can expand in definition from hope for a full recovery, with all its inherent benefits, to hope for a day without the burden of suicidal thoughts or hope for a week without a flashback. Psychiatrist and patient can also collaborate on advance care planning, both psychiatric and medical.<sup>4</sup> The psychiatrist can document the patient's capacity to make thoughtful, informed decisions with an eye not only to advance care planning but also to attestation of the patient's stable capacity over time. This documentation can help other medical professionals or surrogate decision makers in the future should the need arise.

In addition, the psychiatrist is uniquely positioned to administer medications when necessary as well as psychotherapeutic interventions to address symptoms that affect the patient's life on a week-to-week basis, thereby palliating distress and pain. The psychiatrist may also serve as a liaison between the patient and the general medical community, again helping the patient gain access to care needed to relieve physical concerns outside the purview of psychiatry.<sup>4</sup> All these interventions—providing medications, acting as a liaison, remaining a safe harbor even when treatments fail—work together to improve a patient's quality of life.<sup>14</sup> The relationship itself is one of the most effective means of improving quality of life for patients undergoing long-term therapy.<sup>18</sup> Patients in long-term relationships with psychiatrists often remark on the benefit of the relationship to their quality of life based on the compassion, involvement, and expertise of said physicians.<sup>19</sup>

### **Ethics and Long-Term Therapy as Palliative Care**

Although palliative psychiatric care is focused on buttressing patient autonomy and the delivery of beneficent care by a treating psychiatrist, ethical issues can arise. Patients can and will, for example, discuss their desire to die. In such cases, psychiatrists must balance their desire to offer the patient a safe place to discuss suicidal thoughts and

state law pertaining to psychiatrists' obligations regarding suicidal patients. Psychiatrists may find themselves in a situation wherein they are legally obligated to inform the state of an impending suicide.<sup>20</sup> For this reason, at the time the patient is reflecting on decisions regarding sharing in therapy, the psychiatrist is under an ethical obligation to inform the patient of their obligation to the state. This disclosure might make the patient less inclined to discuss their inner conflicts regarding life and death, which are likely crucial issues for the patient. However, the therapeutic alliance can ameliorate this ethical dilemma. Given a strong level of trust developed over time, the psychiatrist can help the patient make realistic choices regarding life and death in the absence of an imminent plan. For example, the psychiatrist and patient might have open and frank discussions pertaining to the patient's distress in contemplating suicide or the realities of certain types of suicide vs romanticized notions of ending one's life. They can collaborate on specific palliations of such distressing thoughts, including the use of medications. New medications, such as psilocybin, have proved helpful in palliation of hopelessness, depression, and demoralization in patients with life-threatening illness and will soon be available in the psychiatric arsenal.<sup>21</sup> By incorporating medication, long-term psychotherapy can palliate psychic pain when suicidal thoughts are present.

The emergence of psychosis is another concern in which the psychiatrist's ethical obligations to others and to the state intersect. A patient may wish to stop all psychotropics; however, if the patient presents a danger to others due to symptoms such as paranoia, the psychiatrist has an obligation to protect the public and thereby to continue a medication that reduces paranoid symptoms regardless of patient choice.<sup>20</sup> A long-term relationship can weather temporary paternalism and loss of autonomy as the patient leans on years of a beneficent relationship and trust in the psychiatrist's judgment during episodes of decompensation.<sup>22</sup>

There is also an ethical conflict in naming long-term therapy as *palliative*. Does this designation imply giving up? It is true that when caregivers give up on patients, patients give up on themselves.<sup>15,23</sup> However, palliative care never branded itself as hospice care, as it is not focused on care before dying; rather, it is focused on improving quality of life when curative treatments remain elusive in life-threatening illness. Futility in psychotropic management focused on cure or remission is not equated with futility of *treatment*—to ameliorate pain and suffering in the absence of a cure remains an act of beneficence.<sup>15,24</sup> It is incumbent on the psychiatrist to educate the patient on the difference between treatment aimed at cure or symptom remission and treatment aimed at relief of suffering and to collaborate on the choice. Equally pertinent is the fluidity of palliative care. Palliative care can change course in both psychiatric and medical illness.<sup>25</sup> When a new treatment arises, a psychiatrist is uniquely positioned to implement that treatment should the patient be both interested and willing. Such treatments include emerging treatments focused on remission and cure, resulting in a possible exit from the palliative care paradigm. Again, it is incumbent on the psychiatrist to educate the patient on the fluidity of choice over time based on medical advances.

### **Conclusions**

If the mental health community resolves to implement palliative care and long-term psychotherapy as a part of that treatment, practical issues present a formidable structural barrier.

Finding a treating psychiatrist in general and finding one who accepts insurance can be difficult in and of itself, let alone for long-term treatment.<sup>26,27,28</sup> And for those under care

at present, an insurance change can translate into a loss of coverage and loss of clinician.

Psychiatric care is also not well subsidized publicly. Community mental health care is unlikely to be equipped to provide palliative psychiatric care to those who need it. Multidisciplinary teams to implement palliative care in psychiatry do not exist, with the result that willing clinicians are overburdened—stretching boundaries to help patients where other help does not exist—and knowing that the loss of any single clinician can prove emotionally catastrophic to the patient.

Implementation of adequate palliative care in psychiatry is necessary for compassionate care of both patient and practitioner. In this way, those with SMPI are not left behind and demoralized. Long-term psychotherapy is an essential tool of palliative care for such patients, as a trusting, dependable relationship with a practitioner is integral to improving quality of life. In the future, should long-term psychotherapy and proper medication management—along with social work care, medical care, and, if available, family participation—be combined to provide **full-spectrum palliative care**, the improvement in quality of life for patients with SPMI will prove immeasurable.

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**Constance E. George, MD, MA** is a general adult psychiatrist who practices at a small-group clinic in Austin, Texas. She is active in the Texas Society of Psychiatric Physicians Ethics Committee and is an affiliate faculty member at the University of Texas at Austin Dell Medical School.

**Editor's Note**

The case to which this commentary is a response was developed by the editorial staff.

**Citation**

*AMA J Ethics.* 2023;25(9):E661-667.

**DOI**

10.1001/amajethics.2023.661.

**Conflict of Interest Disclosure**

Author disclosed no conflicts of interest.

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