Our Patients, Our Families, Ourselves

The Impact of the Professional's Emotional Responses on End-of-Life Care

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As professionals working in end-of-life care, awareness of our emotional responses to the people with whom we work is critical for good diagnosis, treatment, and service delivery. Understanding the personal and professional connections between our own losses, life experiences, and intimacy needs is essential in this work. If we fail to recognize our personal feelings about mortality, suffering, and powerlessness that are evoked in the clinical situation, and if we allow ourselves to be "hooked" by situations and dynamics that push our buttons, we may find our patient care compromised. Five common issues arising for the professional working in end-of-life care are delineated and illuminated by case examples in this article: unresolved grief work, threats to professional omnipotence and to professional omniscience, overidentification, and intimacy needs. The authors present a framework that professionals can use to begin to discern the potential convergence of personal and professional issues and their impact on end-of-life care.

Caring for patients near the end of life can be one of the most stressful yet one of the most rewarding experiences in clinical care. As helpers in this privileged work, we are forced to confront our humanity in the face of powerlessness and hopelessness, vulnerability, and loss.

Despite professional training and education that emphasizes objectivity and intellectual understanding, we are often deeply and profoundly affected by this work (Katz & Genevay, 1987; Tansey & Burke, 1985). Multiple losses, especially if they are sudden or traumatic, can shake us to the core—challenging our beliefs, ideologies, and assumptions about the world (Wilson & Lindy, 1994).

Our relationships with parents, siblings, partners, and grandparents shape our attitudes and coping styles (Weiner, 1989) and our self-concepts and biases (Genevay & Katz, 1990). We inevitably bring these relationship histories, perceptions, defenses, and personality styles into our personal and professional relationships (Wilson & Lindy, 1994). When our own vulnerabilities and family

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experiences resonate with those of the patient and his or her family, an emotional trigger point may be activated. The results are often intense feelings and behaviors that can affect truly objective judgment and professional intervention. The personal histories and issues that we bring to the table—although we may be totally unaware of it—can subtly and insidiously affect our decisions and actions on behalf of patients near the end of life (Katz & Genevay, 1987; Meier, Back, & Morrison, 2001).

FACING THE ISSUES

The mental health professions have long acknowledged the importance of clinicians' feelings about patients (countertransference) in clinical work (Freud, 1910; Gabbard, 1999; Kernberg, 1965). The literature in these professions clearly delineates the therapeutic necessity of naming and confronting these emotions—whether they are conscious or unconscious, prompted by the client, or brought forth by events in the clinician's own life (Beitman, 1983; Genevay & Katz, 1990; Langs, 1983). In fact, personal feelings of the professional helper have been regarded as appropriate, natural responses that can be of positive value in therapeutic intervention (Kernberg, 1965; Racker, 1968; Wilson & Lindy, 1994).

Only recently, however, have mental health and health care professionals acknowledged the usefulness, indeed the necessity of examining one's own emotional responses in end-of-life care (Katz & Genevay, 1987; Meier et al., 2001; Varghese & Kelly, 1999). It is extremely rare, however, that professional training (across disciplines) teaches us to look critically at our internal lives. Rarely are we encouraged to consider the impact and unintended consequences that our own losses, vulnerabilities, relationships, and personal life experiences may have on our emotions and ultimately on our professional work. Yet it is precisely through our personal observations of our families, ourselves, and our feelings that we can become more effective helpers. Although a complete examination of these "hooks" is beyond the scope of this article, five common emotional responses will illustrate why examination and management of our internal responses to patients are critical to quality end-of-life care. Because of the need for confidentiality, the case examples are disguised or are composites of work with several different patients or health care workers with similar issues.

UNRESOLVED GRIEF WORK

It is critical for professional helpers to keep up with the grieving of their own personal losses. Only when we are comfortable grieving our own losses and confronting our closeness and distance from potential loss can we adequately help

our clients give voice to the overwhelming grief in their own lives. For psychological healing and/or peaceful dying to occur, our patients' losses must be explored and acknowledged so that there is emotional space to do the healing work that may be necessary to put their houses in order. The following case illustrates the professional's need to be intentional about confronting loss and grief.

> Jane was a postmastectomy patient who successfully battled recurring cancer for 20 years. While undergoing chemotherapy and radiation, she was also caring for her husband, Jim, who suffered from multiple long-term, complex medical problems. Jim had always been "difficult" and demanding, but the two had been married 52 years and were very committed to each other. Jane's only goal in life was to care for Jim until he died; she believed that given his personality, no one would be able to give him the care that she could. At one point in her chemotherapy/radiation regimen, Jane was so exhausted and so debilitated by side effects that she wearily asked to stop treatment so she could stop the pain. Her nurse, Ian, immediately launched into a pep talk: "You're not giving your medications a chance! The cancer will respond, but you have to do your part: You've got to commit to another round of this regimen." Jane felt blamed for her poor health and reluctantly conceded. Two weeks later, she "no-showed" for her appointment and never returned. Ian was shocked. He had worked with Jane for so many years, and he thought he had been perfectly clear about the medical necessity of continuing treatment.
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> Ian consulted with his clinical supervisor and found himself in tears. He realized that he was deeply attached to Jane and could not bear the thought of her dying. Ian had just lost his own mother to metastatic breast cancer. He had stuffed his feelings of grief and loss and immediately returned to work—telling himself that he had done so much anticipatory grieving that he was "just fine." Ian realized that indeed, he was not fine. His loss was significant and so was his grief. When Jane raised the issue of discontinuing treatment, Ian realized that he had cut off further conversation to avoid having to hear her deep feelings of loss and fear—feelings that so resonated with his own. Rather than face Jane's overwhelming losses and emotional pain, Ian pushed medical treatment—much as he had pushed down his own grief to avoid his own emotional pain. By "blaming" Jane for her deterioration, Ian avoided not only his pain and anger but also his own sense of guilt about the difficulty of her regimen.

Had Ian taken time to ask a few questions, to look at the context of Jane's request, and to listen to the underlying meaning of her words, there might have been another outcome: Jane might have felt free to unload the enormity of her losses (loss of finances, loss of freedom, loss of her husband as she knew him, loss of her physical self-concept, and loss of hope). She might have had an opening to admit, "I am overwhelmed. I am terrified that my cancer will take me first and no one will be able to take care of my Jim." Ian would have had an opportunity to support Jane in her grief and to provide information and resources to help alleviate some of her concrete psychosocial concerns. Rather than responding to Jane's literal words, he could have dealt directly with Jane's underlying real pain.

THREATS TO PROFESSIONAL OMNIPOTENCE

Medical professionals trained to cure often find themselves at odds with the type of care that is needed when patients are no longer curable. They may underhelp and withdraw when things look hopeless—as did a psychiatrist who was called in to see a patient dying of head and neck cancer. The psychiatrist went in to see the patient and came out 5 minutes later. He wrote a chart note and terminated his involvement in the case. His chart note read, "Patient depressed due to terminal condition. Anti-depressants prescribed. Social Worker to see patient for grief counseling." In this brief encounter, the psychiatrist avoided having to face his personal and professional helplessness in the face of death. By transferring the case, he could intercept any difficult feelings that might be stirred up by this dying patient.

Conversely, medical professionals may find themselves overhelping as a means of fending off uncomfortable feelings of guilt and failure. In the following case, Dr. B illustrates what can happen when feelings evoked in our professional lives resonate with unresolved experiences in our personal lives.

> Ed was a physician hospitalized for severe kidney disease at the end of his life. He had just seen his wife of 40 years die a very difficult death from lung cancer, and he did not want to linger in pain as she had. Ed had prepared no advanced directives, but he had told his two sons he wanted treatment stopped if there was no hope of a quality life for him. They knew his definition of *quality.*
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> When Ed was hospitalized in the same hospital where he had been on staff, his personal physician, Dr. B, a former colleague, pushed for additional kidney dialysis in spite of the fact that Ed's kidneys were obviously failing. Ed did not want to live this way. He repeatedly asked Dr. B to stop treatment, but his colleague cajoled him into staying on the dialysis machine a few more weeks. Ed asked again. This time Dr. B exploded. "Look Ed, you were a great doc, but now I'm in charge. Please let me do my job; I want the best for you." Ed felt totally dismissed and pleaded with his sons for help.

What kinds of personal and professional issues were pushing Dr. B's buttons? Dr. B felt he never measured up to his authoritarian parents' expectations. No matter how successful he was, they always demanded that he try a little harder. Dr. B felt dismissed and rejected by them. He spent his life overcompensating for this parental lack of acceptance by overachieving and by choosing a profession in which he could be the authority—in power and in control. The deterioration of his esteemed colleague threatened Dr. B's sense of professional omnipotence and control. He felt personally responsible and compelled to try a little harder. Yet, he was totally unable to cure or save his beloved friend. Unknowingly, Dr. B's feelings of guilt and of failure got the best of him; they interfered with his ability to hear and honor his colleague's request for a peaceful death.

THREATS TO PROFESSIONAL OMNISCIENCE

Helping professionals working in end-of-life care must glean and assimilate a vast and diverse array of information to do their jobs well. From theory to practice, from legal and ethical dilemmas to psychosocial concerns, from community resources to spiritual issues—it seems as if the professional must know it all.

For professionals whose identities are bound up in knowing it all, this sense of omniscience is an enormous load to bear. What can happen when a professional sees himself or herself as the grand inquisitor? Consider the following case.

> Lolinda, a Latina patient on a hospital surgical oncology floor, was "supposed to have died" a week ago; she was unresponsive, and her body had shut down. Lolinda's nurse, Caitlin, gave a report at the change of shift, saying: "Technically, she should have died; the doctor expected her to go last week and so did I. But she's got this huge family that refuses to leave the hospital; they've set up an around-the-clock vigil and are praying and saying rosaries. I am sure they are doing the typical thing for their culture: They are holding on to her and she must be holding on for them—otherwise, why would she still be here?"
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> Over the course of the week, Caitlin became increasingly frustrated. She knew she had done all the right things: She had called in the hospital chaplain, she had Lolinda's family members say goodbye, and she had worked to make Lolinda comfortable, pain free, and "ready" to die. But Lolinda refused to die! As Caitlin continued to try to make sense of Lolinda's perplexing longevity, her irritation grew. During psychosocial rounds, her social work colleague, Ted, offered to meet with the family. Caitlin begrudgingly agreed. She knew that this was simply a religious and cultural issue, and she felt certain that Ted would come to the same conclusion.
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> Ted arrived in Lolinda's room and gathered her large family together. He spent time talking with them about Lolinda. He asked them to talk about their relationships with Lolinda and about any feelings they had about her impending death. The family cried and laughed as they reminisced together. They too were wondering why Lolinda was lingering; they had been ready for her to go—last week. Ted began to wonder about all of this: The family's report was in direct contrast to Caitlin's diagnosis of them.
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> Ted asked if everyone in the family had had a chance to say their goodbyes. Yes, they had, a son replied—except for one brother, Juan, who was incarcerated in a state penitentiary in an adjacent state. Ted wondered aloud about this missing family member. Together, they decided it would be a good idea to try to locate Juan.
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> Ted made numerous phone calls. He finally reached the warden of the state penitentiary, who agreed to allow Juan to have one last phone call to his mother. Ted put the phone receiver up to Lolinda's ear, and Juan was able to tell Lolinda he loved her and to say his goodbyes. Ted returned to his office, telling the family he'd check back with them shortly.
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> Twenty-five minutes later, Ted returned. Lolinda was dead. She had died peacefully just after receiving Juan's phone call.

Separate from the fact that Caitlin was imposing her own view of a proper death onto this family, how is it that she missed such important information? As head of her nursing unit, Caitlin saw herself as the wise and worldly expert in end-of-life care. When she could not find a rational reason for Lolinda's refusal to die, Caitlin became frustrated with herself. She was no longer the purveyor of exquisite clinical insight and knowledge. How could she truly be a leader of her unit if she did not know the answer to this riddle, she silently asked herself.

Grasping for some intellectual understanding, Caitlin turned to multicultural possibilities. She had just attended a continuing education class on "Cultural Diversity and Competence." The class reinforced for her what she already knew: that each person's sociocultural, ethnic, and religious/philosophical backgrounds significantly influence the beliefs, values, and meanings that they attribute to living and to dying. And certainly, these issues were crucial to consider in working with this Latino family. However, in her eagerness to apply the information she learned in class (and thus regain her personal sense of all-knowing head nurse), Caitlin made a significant error: She imposed a preformulated template onto Lolinda's dying process and onto her family's response to it. Caitlin made incorrect assumptions about their cultural and religious backgrounds without exploring this particular family's own responses to their loved one's dying.

Although well intentioned, Caitlin has missed the boat. Had she been willing to drop her omniscient persona, she might have allowed herself to confess her confusion—privately with a supervisor or peer consultant or publicly at rounds. Either one of these options would have provided her the opportunity to stand back, take a more objective look, and disengage from the stereotypes she was imposing on Lolinda and her family. Caitlin felt too insecure about her self-assigned role to do this.

OVERIDENTIFICATION

We are all drawn to this work for different reasons—many of which have to do with our families of origin or our personal life experiences. For those of us who have faced death, loss, and bereavement in our own lives, our histories can create a sense of bonding—with both patient and family. This is the good news: If we use this bond to sow seeds of compassion, to really listen, to tolerate and encourage our patients' full range of grief and mourning, then we can provide that safe "holding environment" so necessary for therapeutic healing.

On the other hand, if we overidentify with the patient or family, we may find ourselves in precarious territory. One psychologist, Paul—who considered himself a specialist in traumatic grief—found himself in just such a position.

> Paul's beloved wife had recently died of ALS, and it was all he could do to put one foot in front of the other. At the first-year anniversary of her death, Paul declared himself healed. His colleagues noticed him becoming sarcastic and angry about

his work. Paul insisted he simply needed a vacation. His colleagues expressed their concern for him and encouraged Paul to seek support through individual psychotherapy. Paul refused; he steadfastly asserted that he simply needed a good vacation.

Several weeks passed, and then one of Paul's colleagues received a phone call from Melanie, a recent patient of Paul's. She was looking for another psychologist. Why wasn't Melanie returning to complete her work with Paul? Melanie explained that her fiancé of 3 weeks had been diagnosed with a late-stage malignant melanoma. She had not realized how traumatized by this diagnosis her fiancé had been. One evening when she had been out grocery shopping, he took his own life. Melanie was shocked and overwhelmed with grief. A friend had recommended Paul to her because he was an expert in this area. She reported that in each session, Paul shared his experiences of his own grief process with her, and in each session he declared Melanie "normal, right on target, right where you should be in your grief." In fact, Paul thought Melanie was so "normal" that he suggested they meet every other week. Melanie, distraught and confused, felt she needed more. And rightly so.

Thus, the arena in which we find we can most often reach out to patients—deeply and compassionately—can become the very source of our most egregious professional blind spots. As a longtime psychologist, Paul intellectually knew that he should be part of a regular peer consultation group. Yet when Paul's colleagues accurately noted his personal distress and his need to receive help, Paul could not hear it. His denial of his own unprocessed pain lingered. He overidentified with Melanie in such a way that he remained in denial of her grief and could not allow her to process her real, very raw pain in the aftermath of her fiancé's suicide.

INTIMACY NEEDS

The professional's and the patient's needs for intimacy and for emotional and physical closeness frequently affect the help we provide. Older patients, for instance, may have outlived their family members, friends, and intimate others. This often means that there is no one to provide personal support near the end of life except for the professional caregiver. These lonely clients often demand much time and attention, view the helper as a love object, or want to become a member of the helper's family.

Simultaneously, some professionals may choose not to attend to their own relationships at home and instead fill their intimacy voids with clients who need them, who idealize them, and whom they can schedule into their lives at their own convenience. If the professional helper is one of only a few intimate others in the patient's life, an ethical question often results: Where is the line drawn between the personal and professional relationship? Fred illustrates the case in point.

At 82, Fred was alienated from his adult children as a result of many years of family blame and misunderstanding. He "fell in love" with his social work intern, who

was seeing him for "depression." The social work intern, Ellen, found Fred attractive, warm, and caring. She found reasons to visit him and to stay late at his home. This seemed to work well for them both: Fred had no contact with his family and was lonely; Ellen's husband worked long hours, so she had plenty of free time on her hands. Ellen spent longer and longer periods of time with Fred. She held his hand while he described his painful struggles with his children. She massaged his shoulders to help alleviate the tension that built there after he talked about his family. She hugged him closely when he cried and when he described the depth of his loneliness. She kissed him goodbye so that he would feel as if he had an "adopted" family member.

Soon, Ellen found herself making excuses to visit Fred on the weekends. She found herself dressing up and wearing slightly revealing, short dresses that showed off her legs. She loved the attention. As Ellen spent increasing amounts of time with Fred, she found herself thinking about him when she was on other home visits and even when she was out with her husband. She began to feel extremely uncomfortable. Ellen loved her husband but had "fallen" for Fred. She was in a horrible bind. Ellen decided she had better pull back. She decreased the length and frequency of her visits and held Fred at a business-like distance. Fred, dumbfounded, tried to ask Ellen what was going on. She avoided his questions and cut short her visits. Fred became severely depressed; he thought that Ellen no longer cared about him and he now had nothing and no one to live for. When the other health care professionals on Ellen's team came to care for him, Fred became angry, hostile, and verbally abusive. He withdrew further into himself, refusing phone calls and refusing home visits. Finally, he terminated the services of Ellen's agency—services he desperately needed to function.

Ellen, realizing that something had gone wrong, brought her discomfort to her supervisor. In the course of supervision, Ellen realized that she had come to depend on the emotional gratification and compliments she received from Fred. It was as if his attention compensated for the emotional distance experienced with her own father—a wealthy, narcissistic man who traveled constantly and disapproved of Ellen and of her choice to become a social worker. In her rush to "replace" her father's attention, Ellen had forgotten to tend to her own healthy relationships at home: She allowed her professional work to encroach on her time and energy with her husband and with other members of her family and support system. Unknowingly, Ellen had used Fred to fulfill her needs for intimacy and closeness.

Clearly, we all need emotional closeness—through talking, writing, touching, holding, sharing the past, confiding our innermost feelings, listening to how others feel, and grieving together over the losses of our lives. This work near the end of life is exceedingly intimate business. As professional helpers, we need to make these areas high priorities.

IMPLICATIONS FOR PRACTICE

Memories, feelings, and issues related to aging, intimacy, grief, and loss in our personal lives inevitably—and often unconsciously—affect the work we do near the end of life. The threat of our own mortality as well as the confrontation with suffering, powerlessness, and the often futile nature of medical inter-

TABLE 1: Early Behavioral Indicators

Forgetting or arriving late to appointments
Losing patience
Feeling sleepy or bored during patient contact
Frequently changing the subject, distracting the patient, or "filling in" the silences
Intervening beyond the call of duty (overhelping)
Intervening much less than is usual (underhelping) or withdrawing completely
Attempting to persuade/bulldoze through your point of view (soap boxing)
Arguing for no good reason
Avoiding a particular client or family
Having the impulse to fake sympathy
Falsely reassuring a patient/family about their concerns
Comparing tragedies with the client
Attempting to go for a quick fix (and avoid important process issues)
Looking for ways to transfer out a patient
Wishing a patient or family would disappear or seek services elsewhere
Tuning out or doing mental errands while with the patient or family
Making snide or condescending remarks about the patient/family to other professionals
Feeling pushed to cure or fix a patient—especially when he or she is incurable
Bringing home intense feelings or frequent thoughts about the patient/family
Having great difficulty setting or collecting fees
Labeling clients inappropriately (e.g., "difficult," "aversive," or "borderline personality")
Making unnecessary home visits or hospital visits
Promising more than you can deliver
Minimizing the patient's/family's concerns
Suggesting concrete, pragmatic "solutions" to fix emotional problems

ventions aimed at cure all affect the help we provide. When our personal feelings triggered by professional encounters go unacknowledged or unmanaged, we risk compromising care: We may find ourselves avoiding patients and families who activate these feelings in us, or we may find ourselves helping patients live longer than they might wish or in a manner that they do not choose.

Acknowledging professional fallibility and accepting our personal vulnerabilities and limitations is critical. Identifying situations that hook us and recognizing feelings we have been trained not to have is a difficult task but one that makes us more human. Thus, Socrates's early injunction to "know thyself" is the basis from which we can begin to detect the subtle ways in which our personal issues may be affecting our therapeutic interventions.

First, we must accept that it is normal, in fact universal, to have strong feelings and reactions in this work. Second, we must take time to reflect and to ask ourselves some difficult questions:

1. Am I behaving in some way that indicates that a personal-professional trigger point has been activated within me? (See Table 1.)
2. If I am honest with myself, what feelings are being evoked in me? Which of these feelings are most intense? Most disturbing? (See Table 2.)

TABLE 2: Feeling Self-Reflection Survey

Feeling Evoked in Me	*By Patient*	*By Family*
Angry	1 2 3 4 5	1 2 3 4 5
Defensive	1 2 3 4 5	1 2 3 4 5
Impotent	1 2 3 4 5	1 2 3 4 5
Manipulated	1 2 3 4 5	1 2 3 4 5
Taken advantage of	1 2 3 4 5	1 2 3 4 5
Inadequate	1 2 3 4 5	1 2 3 4 5
Exhausted	1 2 3 4 5	1 2 3 4 5
Afraid	1 2 3 4 5	1 2 3 4 5
Sad	1 2 3 4 5	1 2 3 4 5
Tense	1 2 3 4 5	1 2 3 4 5
Helpless	1 2 3 4 5	1 2 3 4 5
Numb	1 2 3 4 5	1 2 3 4 5
Like a failure	1 2 3 4 5	1 2 3 4 5
Like a hero	1 2 3 4 5	1 2 3 4 5
Irritated/frustrated	1 2 3 4 5	1 2 3 4 5
Disgusted	1 2 3 4 5	1 2 3 4 5
Useless	1 2 3 4 5	1 2 3 4 5
Resentful	1 2 3 4 5	1 2 3 4 5
Out of control	1 2 3 4 5	1 2 3 4 5
Disillusioned	1 2 3 4 5	1 2 3 4 5
Inept	1 2 3 4 5	1 2 3 4 5
Like giving up	1 2 3 4 5	1 2 3 4 5
Dread	1 2 3 4 5	1 2 3 4 5
Burdened	1 2 3 4 5	1 2 3 4 5
Confused	1 2 3 4 5	1 2 3 4 5
Intimidated	1 2 3 4 5	1 2 3 4 5
Ineffective	1 2 3 4 5	1 2 3 4 5
Guilty	1 2 3 4 5	1 2 3 4 5
Bereft	1 2 3 4 5	1 2 3 4 5
Overwhelmed	1 2 3 4 5	1 2 3 4 5
Responsible	1 2 3 4 5	1 2 3 4 5
Concerned	1 2 3 4 5	1 2 3 4 5
Deep empathy	1 2 3 4 5	1 2 3 4 5
Affection/love	1 2 3 4 5	1 2 3 4 5
Warmth	1 2 3 4 5	1 2 3 4 5
Hopeful/optimistic	1 2 3 4 5	1 2 3 4 5
Infallible	1 2 3 4 5	1 2 3 4 5
Sexually attracted	1 2 3 4 5	1 2 3 4 5
Privileged	1 2 3 4 5	1 2 3 4 5
Grateful	1 2 3 4 5	1 2 3 4 5

NOTE: Rate each feeling by intensity (1 = *mild*, 5 = *intense*), then examine these in light of the questions in Table 3.

3. What dynamics are pushing my buttons? What particular meaning does this patient or this family have for me? (See Table 3.)

TABLE 3: Self-Awareness Exploration Questions

When I think of this patient/family, how do I feel? (Think especially of any uncomfortable feelings or reactions that are unusual for you; see Table 2.)
In what other situations or with which people in my life do I feel the same way?
What were my initial reactions to this patient/family?
What is it about this patient/family that is hooking me/pushing my buttons? Is it a specific feature? Behavior? Word(s)?
When I am with this patient/family, what do I find myself doing? (Note any behaviors, activities, and thoughts that are uncomfortable/unusual for you; see Table 1.)
In what areas do I feel stuck (need support, need to ventilate, feel I'm not progressing)? In which of these areas do I need clarification?
What personal experiences with aging, grief, loss, and dying (past and present) may be dovetailing with my work at this time?
What is going on inside this patient/family? Are these same feelings being induced in me?
Are there any parallel issues occurring in my life or in my family's lives now, or are there any issues that I have experienced in the past that are reminiscent of this patient/family?
Who does this patient remind me of? Someone in my present life? Someone from my past?
At what developmental stage of my life do I feel when I am with this patient/family?
In what way(s) is this client's family tree/constellation similar to my own?
What role am I playing in this particular relationship?
Where on the continuum of overinvolvement versus disengagement am I?
Am I giving too much of myself to my job? If yes, are my obligations real or self-imposed?

Confronting personal and professional fears of failure, analyzing our needs for control and for intimacy in the face of loss, facilitating our own grief work, and clarifying beliefs about professional competency as they relate to feelings of personal responsibility and guilt are crucial facets of our self-examination. Consultation, training and continuing education, professional support groups, and individual therapy are our quality assurance monitors. They are the vehicles with which to process and make connections between our emotional responses and our professional actions. We can then utilize these emotional responses as sources of clinical insight—integrating them into our work and helping our patients and their families face dying with dignity and with integrity (Katz & Genevay, 1987).

DIRECTIONS FOR RESEARCH

Clearly, our emotional reactions to the patients and families with whom we work (i.e., countertransference) need investigation—both clinically and empirically. We have seen how challenging such investigation can be in clinical practice. Equally difficult is designing and implementing research protocols that can measure the impact of professional blind spots in end-of-life care. As Dalenberg (2000) so aptly stated,

> The specific research arena of countertransference is . . . complicated by the fact that theory would suggest that the person telling the tale . . . might be the individual least competent to do so. That is, because countertransference is by definition often unconscious, it is difficult to justify the assumption that the dynamics will be well explained by the clinician who generated the experience. (pp. 18-19)

Nevertheless, empirical research is called for to systematically study the relevance and impact of the clinician's emotional responses when working with patients and families near the end of life. It is important to investigate and more clearly delineate high-risk factors for professionals working in this arena. For example, which emotional responses most frequently hook which professionals? In which situations are these responses most often elicited? With which patients? With which families? When evidence-based information has been gathered in these domains, it would then be useful to examine the efficacy of various approaches to identifying and managing emotional responses that might otherwise impede delivery of the highest quality end-of-life care (e.g., individual or group supervision, training, academic coursework, peer consultation groups, individual self-examination, or personal psychotherapy). Further research could help us understand how, when, and in which circumstances these approaches would be most beneficial.

CONCLUSION

Professionals working in end-of-life care are regularly confronted with the fragility of life and the inevitability of death. We may unknowingly react to patient and family issues in ways that reflect our own biases, emotions, and life experiences—past and present. When we do so, our professional objectivity is diminished; we risk compromising our abilities to provide accurate diagnosis, appropriate treatment, and compassionate care.

If we can squarely face our feelings and accept responsibility for the ways in which they may contribute to the patient-professional interaction, we not only help our patients, but we also benefit: We grow in awareness and in our capacities to become more effective helpers. We can use the information we have gathered as an empathic bridge to compassionate and therapeutic connection. It is through this personal-professional connection that we can understand the richness of the patient's experience. If we have erred, we can make corrections. If we are picking up the patient's and family's unprocessed dynamics and emotions, then we have been given an exquisite opportunity to truly communicate our humanness, our capacity for attachment and relatedness in this complex and deeply personal journey.

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