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"Why Are We Doing This?": Clinician Helplessness in the Face of Suffering

Anthony L. Back, MD,[1] Cynda H. Rushton, PhD,[2] Alfred W. Kaszniak, PhD,[3] and Joan S. Halifax, PhD[4]

Abstract

Background: When the brutality of illness outstrips the powers of medical technology, part of the fallout lands squarely on front-line clinicians. In our experience, this kind of helplessness has cognitive, emotional, and somatic components.
Objectives: Could we approach our own experiences of helplessness differently? Here we draw on social psychology and neuroscience to define a new approach.
Methods: First, we show how clinicians can reframe helplessness as a self-barometer indicating their level of engagement with a patient. Second, we discuss how to shift deliberately from hyper- or hypo-engagement toward a constructive zone of clinical work, using an approach summarized as ''RENEW'': recognizing, embracing, nourishing, embodying, and weaving—to enable clinicians from all professional disciplines to sustain their service to patients and families.

Case

Ms. R is a 40-year-old female with metastatic melanoma with brain metastases that have caused new blindness. The melanoma has progressed despite first- and second-line targeted therapy, and she is despondent. When the inpatient attending physician discussed with her that she was unlikely to regain her sight, and that her melanoma was very unlikely to respond to further anticancer therapy, she began to weep so intensely that further conversation was impossible. The physician and nurse looked at each other; the physician gave a tiny shrug that no one but the nurse would catch, and the nurse looked up as if to say, ''This is a fine mess.'' The patient's husband, appearing stricken, looked at the team and said, ''We have to do something—could she have some Ativan?''

Introduction

When the brutality of illness outstrips the powers of medical technology, part of the fallout lands squarely on front-line clinicians. Being a nurse or physician for a patient like Ms. R is a difficult assignment—she's despondent, her husband is desperate, and there isn't anything in the clinical toolkit that seems remotely up to the task. In our experience, this kind of helplessness has cognitive, emotional, and somatic components. The nurse and physician in the case might be thinking: ''Nothing will fix this, there's no way out of this, maybe I should give up.'' They might be feeling hopeless, angry, resigned, or even ashamed. They might notice sensations of bodily heaviness, lethargy, or a sinking feeling. Helplessness is known to be an occupational hazard,[1,2] and probably contributes to burnout. But ''low personal accomplishment,'' a component of burnout, seems inadequate to describe a moment of hopelessness like the one above.

Is it time to rewrite our story of helplessness? Although our first reaction to helplessness is often to remain silent, to push it away, to keep it at a distance—we think that another path is possible. Instead of seeing helplessness as something to avoid, and if that's not possible, as a pathology that must be extirpated, could we first reframe it as an indicator about our internal state, and second, reexperience it as a moment characterized by a particular state of relationality with our patient?

We are hoping to stimulate more dialog, and more research about helplessness by drawing on developments in contemplative practice, neuroscience, and psychological research on attention and affect.

Helplessness as a Self-barometer

The first part of our rewrite, reframing, involves our unintentional reaction to helplessness. Could we reframe our unintentional reaction to helplessness as a self-barometer that

[1]Department of Medicine, University of Washington, Fred Hutchinson Cancer Research Center, Seattle, Washington.
[2]Berman Institute of Bioethics; School of Nursing & Medicine, Johns Hopkins University, Baltimore, Maryland.
[3]Department of Psychology, University of Arizona, Tucson, Arizona.
[4]Upaya Institute, Santa Fe, New Mexico.
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gives us a reading on the quality of our engagement with a particular patient? The value of reframing our unintentional reaction as a self-barometer is that it enables us to see how challenges push us off balance constantly as a normal feature of clinical work. We don't expect the barometer readings to be unchanging, stable, and static—we expect them to fluctuate with our circumstances, and to vary with our capacities for ambiguity, uncertainty, empathy, and compassion on any given day. With some patients, we find ourselves behaving in a hyperactive mode. With other patients—even in the same day or hour—we find ourselves in a hypoactive mode.

> *After the family meeting, the physician was talking to a colleague, and said, ''I'm not even sure why we're doing this—it's such a sad situation, it just seems futile. This sounds terrible, but should we even bother with rehab?'' Meanwhile, the inpatient nurse was telling her colleague, ''She is suffering terribly. Why are we doing this—all these tests and treatments? I'm not sure that more tests are going to relieve her suffering. I feel frantic: I called the psychologist; I called the social worker; I talked to the occupational therapist—what else should we do?''*

The physician's thoughts suggest a kind of engagement that we would call *hypo-engagement*, because it feels resigned, passive, and apathetic. In contrast, the nurse's thoughts above suggest a kind of engagement that we would call *hyper-engagement*—because it feels anxious, pressured, vigilant, even desperate. The physician's and nurse's reactions both represent a common way of dealing with the feeling of helplessness, and a common assumption: Don't talk about it, and don't allow yourself to experience it, because that will make the helplessness more real—and worse than it is already.

Hypo- or Hyper-Engagement Can Exacerbate Suffering

There are physiological reasons why clinicians might react to a patient's helplessness in this way: We unintentionally mirror the emotions of other people.[3,4] But these mirrored emotions are then filtered through our own perspectives and prior experiences. So if we step back and reexamine these initial reactions to helplessness, we can see how they can be read as a barometer of our engagement. In this case, the physician's engagement with the clinical situation is decreasing, whereas the nurse's engagement is increasing. Both of their initial reactions to their own experiences of helplessness, however, draw them away from the person who is suffering. The physician is backing away from a situation where medical expertise has little to offer, and the nurse is intensifying her efforts to draw others into the problem-solving process. Neither clinician enters the patient's world more deeply, in a way that enables them to connect with the person who is suffering.

The danger of being unaware that one feels helpless or being unwilling to experience that one is feeling helpless, like other conscious and nonconscious affective states, is that the feeling of helplessness may bias attention. Recent studies document (in nonclinical settings) how affective states place filters on what we perceive. For example, if one's visual filters are ''pre-tuned'' by anxiety to see more angry faces in a crowd, one might be more likely to experience feelings of negative affect in a stressful situation.[5] Conversely, those who have higher levels of depression-related symptoms show attentional biases away from positive events.[6,7] Interestingly, attentional biases appear to be modifiable over time, with specific training.[8] Extrapolating from this research, we think it is likely that a clinician in the grip of helplessness is likely to proceed with a constricted view of a clinical situation, meaning that important facts will be missed, conclusions drawn prematurely, and that the patient's views, values, and stories will be insufficiently seen[2,9,10]—distorting even palliative care into a series of medical treatments and procedures.

As illustrated, these initial reactions of hypo-engagement and hyper-engagement span professional roles. In the example above, we have illustrated hyper-engagement with a nurse, and hypo-engagement with a physician. However, their responses could easily be reversed. A physician who feels helpless might react with a hyper-engaged series of diagnostic tests (''If we know as much as possible, we'll find a treatment.''). A nurse who feels helpless might react in a hypo-engaged way by spending less time at the patient's beside, avoiding conversation (''I'm so busy today.''), and requesting a different assignment.

Both hypo- and hyper-engagement overlap with other issues in the clinical literature. For example, chronic, sustained hypo-engagement may be related to empathic distress, vicarious traumatization, or burnout.[11,12] Alternatively, hyper-engagement may be related to moral distress that is characterized by ''empathic over-arousal''[13,14] in which the nervous system is stuck on high alert.

Reexperiencing Helplessness as a Moment of Relationality

The second part of our rewrite involves using the reading taken by the self-barometer, and reexploring our experience of helplessness. Could we change the experience of helplessness from one of being ''at the end of the road'' to being ''in a moment of relationality with a patient''? Reexperiencing helplessness as a moment in a clinician-patient relationship can enable the clinician to shift to a middle place between hypo- and hyper engagement. Between hypo- and hyper-engagement, we hypothesize that there is a middle place, that we call the zone of constructive engagement. By *constructive engagement*, we mean a moment in which a clinician is willing to take on a challenge, to bring her whole self to the bedside, and to relate to the situation as it is—what one colleague calls ''being in the muck.'' In more formal terms, constructive engagement is the willingness to put in effort in the form of cognitive, emotional, and spiritual work that goes beyond guidelines about professional competence—we are talking about clinical work performed in the service of an intention to alleviate suffering that invokes deep personal commitments and embodies a way of being that is open, flexible, and compassionate.

Shifting Toward Constructive Engagement

Our approach to helplessness involves reading one's unintentional reaction to helplessness as a barometer of one's own engagement, then deliberately shifting from hyper- or hypo-engagement toward the constructive zone, and finally working directly with the patient's suffering. When a clinician is working in his constructive zone, he can evaluate the situation for what it is, empathize without getting overwhelmed, draw on his wisdom and expertise, all the while

experiencing moments of effectiveness and moments of disappointment. The zone of constructive engagement is not a static state, but a range of possible experiences that reflects the dynamic nature of clinical work. Reframing helplessness enables us to reframe vulnerability from being ''a soft underbelly'' that must be hidden and protected to an essential connection with the tragedy and fragility of being human.[15,16]

RENEW: A Practical Approach to Clinician Helplessness

The nurse caring for Ms. R noticed that her stomach was churning and her hands were moist. She thought: ''I need to take a moment here.'' She went to the break room to sit for a minute, and realized, ''I know this feeling—it's helplessness.'' She thought: ''I've been through this before, and I have a way of dealing with it.'' She sat for another minute, while allowing her breathing to relax and deepen. She remembered a mentor who had said, ''Accept all your feelings—don't push them away.'' So after finding a more relaxed pattern of breathing, she thought back to Ms. R, and remembered how she had a picture of her daughter by her bed. The nurse thought, I'll go sit with her for a few minutes and ask her about her daughter.

The physician caring for Ms. R noticed he was holding his chest tightly, breathing shallowly, and realized he was clenching his jaw. He thought, ''I'm all wound up about this. I'm worried I'm going to fail her.'' So he walked to his next patient by taking a detour past a window on to the hospital garden. He stopped for a moment to look out at the trees, and a thought came to him: ''Worrying about failure is a habit of mine—I can shift it.'' He started walking again, and did a kind of walking meditation by consciously feeling the weight of his body through his feet into the floor. After a moment of conscious walking, his mind cleared a bit, and he realized, ''I need to talk to her and her husband about what is possible now—not just the limited time they have.'' I'll loop back to do that before I leave.

The nurse and physician are both following an approach, detailed below, that can be summarized as ''RENEW.''

1. Recognize helplessness. The nurse recognized her stomach was churning; the physician recognized his chest was tight and jaw clenched. In both cases, the clinicians noticed somatic cues that represented familiar manifestations of helplessness. Table 1 lists common responses that accompany hyper- or hypo-engagement. Although these are not mutually exclusive categories, there may be somatic responses that are similar but produce different results. The clinicians used the somatic cue to step back from their initial reactions to Ms. R's suffering at the family conference.

Table 1. Cues That Can Signal Helplessness

Hypo-engagement	*Hyper-engagement*
Somatic	Somatic
• Lifeless limbs	• Tense muscles, e.g., neck, shoulders
• Numbness in the chest	• Increased heart rate
• Heaviness in the stomach	• Churning stomach
Emotional	Emotional
• Apathy	• Irritability
• Disconnected	• Anxiety
• Hopeless	• Hyper-vigilance
Cognitive	Cognitive
• ''Nothing ever changes.''	• ''We have to DO something to fix this!''
• ''Why bother?''	• ''Why are we doing this?''

2. Embrace your first reaction. Neither the nurse nor the physician ignored the somatic and affective cues—in fact they both took time for them. The nurse took a moment to sit down, a useful counter to hyper-engagement; the physician took a walk, a useful counter to hypo-engagement. They both consciously investigated their reactions—and the nurse realized she felt helpless; the physician realized that his worry about failure was a flavor of helplessness. Recognizing one's unique somatic and affective responses to suffering provides clinicians with a useful tool to assess where they are on the engagement continuum.

3. Nourish yourself. Both nurse and physician had an intentional strategy to step back and deliberately invoke something to help with a tough moment—the nurse reached back to a mentor, the physician reached back to a skill for dealing with an old habit. As illustrated here, the nourishment can be in the form of an inspiration, or a practice—and could also be a friend, a pet, a memory. We think of nourishment as different than simply soothing (''It will get better.'') or discounting (''It is what it is.'')—nourishment taps into a deeper level of commitment and meaning.

4. Embody constructive engagement. Notice that both the physician and nurse got themselves ready to reengage—the nurse by finding a relaxed pattern of breathing, the physician by walking consciously. They are consciously directing their bodies to prepare for constructive engagement. With the foundation of somatic awareness and readiness the mind-set of the clinician can shift and begin a process of inquiry into the meaning of his or her response.

5. Weave a new response. Once the body is stabilized, emotional and cognitive preparation is also needed. Recognizing the emotional valence and meaning associated with such challenging situations can allow clinicians to gain insight into their own responses and vulnerabilities. The process also enabled both nurse and physician to refocus on aspects of the family conference they had previously overlooked, and to take new actions—the nurse to ask about Ms. R's daughter, the doctor to raise new considerations about what would be possible. Both of these helped to redirect them to focus on Ms. R, her suffering, and the resources she has to deal with her suffering. Similarly, it could also alert clinicians to their own responses to suffering and internal and external resources for dealing with them.

What Do We Mean by "Training"?

The approach we suggest owes much to a tradition of contemplative practice that emphasizes cultivation of the ability to experience emotion fully without avoidance, sometimes described as a ''nonjudgmental'' stance, and then seeking to understand it, sometimes described as ''discernment.'' A variety of secular methods of employing these contemplative practices, the best known of which is ''mindfulness-based stress reduction,'' are available. A growing body of evidence supports the relevance of such contemplative practices for

emotion regulation.[17] In conjunction with contemplative training, the use of reframing and perspective taking are well known to palliative care clinicians; however, some clinicians may be less familiar with the use of somatic cues described in the case and the RENEW approach above. A detailed rationale for using somatic cues is beyond the scope of this paper, but we can say the following: We draw on somatic cues in reading our own emotional states. Recent research indicates that emotions are felt in the body, and that interoception, or awareness of internal bodily states, and emotional experience share information-processing resources in the brain.[18] In addition, some research supports a link between interoceptive ability, empathy, and decision making.[19,20]

Is Helplessness Different for Nurses and Physicians?

Although helplessness is clearly shared across all the professional disciplines involved in primary and specialty palliative care, we observe that there are predisposing conditions for helplessness that are specific to each profession. Nurses may feel that they are caught ''in the middle'' carrying out decisions that physicians, patients, and families have made. This can lead nurses to feel that the structure of their profession sometimes places them in a situation of ''responsibility without authority.'' They feel responsible to try to address suffering that has been caused, for example, by a physician decision that they have no authority to challenge. Physicians can feel burdened by their responsibility to ''fix the problem'' and are often saddled with a sense of failure if the technical fix was unsuccessful. They feel responsible for the patient's outcome—that ''the buck stops here''—and that if they show their vulnerability they will be labeled as incompetent or loose their ability to be ''objective'' and effective.

The physician ran into the nurse at the end of the day. The nurse said, ''I was feeling a little crazy after that conference this morning, but I did settle down and went back to talk to Ms. R. We had a nice talk about her daughter, who I think she can ask to come out to spend some time with her.'' The doctor smiled—''you are always helping me to see things differently—thank you. For my part I went back to talk about what might be possible—and we talked about some ways to make care at home more manageable. Plus she'll have her dog.'' The nurse said, ''That is so great that you went back. I bet it meant a lot to them. And I really appreciate this conversation—it makes me realize how we can work together to make a bad situation better.''

Although we have not tried to outline specific ways for clinicians to address each others' helplessness, we have emphasized the approach one takes with oneself because we must first take responsibility for ourselves. When it comes to helplessness, it is not helpful to tell others what to do if you are not doing it yourself.

Conclusion

The feeling of helplessness in the face of suffering is an unavoidable experience for clinicians who work with serious illness. Yet ''human beings are not only passive perceivers in the context of social interactions but also active creators of shared emotional experiences.''[21] How we respond to our own helplessness likely shapes the suffering of our patients. The approach we recommend here can be summarized as RENEW; it involves recognizing, embracing, nourishing, embodying, and weaving as a way to work with one's own helplessness, in a way that enables clinicians to sustain their service to patients and families.

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Address correspondence to:
Anthony L. Back, MD
Seattle Cancer Care Alliance
825 Eastlake Avenue E
Seattle, WA 98102

E-mail: tonyback@uw.edu