

Essay/Personal Reflection

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“A science of positive subjective experience, positive individual traits, and positive institutions promises to improve quality of life and prevent the pathologies that arise when life is barren and meaningless” (Seligman and Csikszentmihalyi 2000). This is how Seligman and Csikszentmihalyi introduced positive psychology over 20 years ago. Who could not agree with these noble goals?

Based on findings showing in particular that gratitude lessens death anxiety (Althaus et al. 2018; Lau and Cheng 2011, 2013), positive psychology interventions (PPIs) have been widely welcomed in palliative care as a promising lead to enhance patients’ quality of life (Althaus et al. 2018). But it’s not all positive, and debate surrounds PPI, which is fought with arguments of all sorts (Coyne and Tennen 2010; Coyne et al. 2010; Macaskill 2016; McDonald and O’Callaghan 2008; Otto et al. 2016; Ryff 2022; Sewaybricker and Massola 2023). Among the critiques and criticisms on positive psychology gathered in a very recent systematic review, van Zyl et al. (2003) figured, for instance, the lack of proper theorizing and conceptual thinking, the use of a rhetoric of promise despite doubts regarding evidence or the commercialization of positive experiences, and the related view of positive psychology as a capitalistic tool. The clinical argument is largely absent from the debate, even though positive psychology and PPI raise concerns in the medical setting. It, therefore, seems all the more important to make room to address clinical aspects regarding the application of PPI in the palliative care setting.

This commentary is based on our experiences as liaison psychiatrists working as clinicians and supervisors in palliative care (F.S. and L.M.) and as a social scientist, who has centered her research on physicians’ lived experience and clinical interactions (C.B.).

Aims of PPI in palliative care

Traditional psychological and psychotherapeutic interventions in palliative care have specific aims such as to treat psychopathology and associated suffering, facilitate mourning, re-establish dysfunctional relationships with significant others and staff, or increase insight and autonomy (Stiefel and Bernard 2008). In contrast, PPIs address positive subjective states, feelings, or experiences such as optimism, hope, post-traumatic growth, or gratitude, and their purpose is to improve patients’ quality of life (Althaus et al. 2018; Lau and Cheng 2011, 2013; Macaskill 2016). The question arises: why subjective states, feelings, and experiences should be targeted by interventions and hereby enhanced? Whose request is it? In certain medical settings such as palliative care, not only the patients’ but also the clinicians’ emotional burden is significant and feelings of impotence, sadness, or guilt are prevalent. Consequently, clinicians may encounter difficulties in distinguishing between their own needs and the needs of their patients (De Vries et al. 2018; Stiefel et al. 2017). The prosocial motivation and sensitivity of clinicians may, moreover, have their dark sides in the form of over-engagement, called “*furor sanandi*” by Freud (1982) and “*apostolic function*” of physicians by Balint (2005). Health care professionals, whose career choice has been motivated by experiences of suffering during development, might especially be at risk (Elliott and Guy 1993). It was shown that “*furor sanandi*” might, for example, occur as a therapeutic obstinacy in cancer or intensive care (Bonvin et al. 2022; Casella et al. 2018). Why shouldn’t palliative care clinicians succumb to palliative obstinacy? By turning toward action, impotence can in fact be transformed into feelings of potency and passivity into activity, at the cost of replacing reflection by action.

The development and application of PPI are unquestionably not solely related to clinicians’ needs, but they may be a driving source, which should also be carefully considered. Clinicians’ needs cannot be met by actions oriented toward patients, they require interventions such as supervision by psycho-oncologists or reflexivity training, which are known to be beneficial (Stiefel et al. 2018).

Vague indications for PPI in palliative care

Indications are of utmost importance, especially when it comes to psychological interventions, since a risk of psychologization – the reduction of individuals to their psychological dimensions – exists (De Vos 2014). While indications for traditional psychological interventions are oriented by psychopathology and psychological distress, those for PPI remain ill-defined. Targets such as gratitude, optimism, or hope are directed toward the human existence. Palliative care patients may thus feel less grateful, optimistic, and hopeful compared to the time when they were in good health, which may correspond to an adequate perception of reality. Moreover, the threshold below which an enhancement of gratitude, optimism, or hope would be justified remains obscure.

In conclusion, from our point of view, the existential fact does not fall within the realm of psychology. What psychology can contribute is to help patients face their existential issues and questions (e.g., death, vulnerability, and feelings of solitude) and, in the case of distress, to investigate why a given individual responds to an existential situation with distress (e.g., because of separation anxiety) (Stiefel 2023).

The (lack of) theoretical grounding of PPI and its clinical consequences

The theoretical grounding of traditional psychological interventions is psychodynamic, systemic, or cognitive-behavioral metapsychology. PPIs are anchored in the evidence that enhancement of positive subjective states, feelings, and experiences is possible (Seligman and Csikszentmihalyi 2000; van Zyl et al. 2003). Subjectivity, on the other hand, can only be grasped by means of a phenomenological approach, which takes into account the first-person perspective. First-person perspectives are by definition unique and singular, which implies that they cannot be reflected by a meta-psychological, theoretical framework. What are the consequences of this lack of theoretical grounding of PPI?

We consider that conceptual and theoretical frameworks not only function as explanatory models for the effects of psychological interventions but also provide clinicians with orientation and prudence when intervening with psychologically vulnerable individuals. One might argue that PPIs do not address psychopathology and that such frameworks are thus irrelevant. However, according to our clinical experience, palliative care patients are vulnerable, and any psychological intervention in this setting has both effects and side effects (see section Side effects of psychological interventions in palliative care) and therefore needs to be anchored in a framework that orients clinicians in their work. This has also been observed by Macaskill, who concludes in a review of positive psychology applications in medical populations that interventions aimed at making patients more grateful, optimistic, or happier “seem somewhat insensitive” (Macaskill 2016).

PPI and the clinician–patient encounter in palliative care

There are many therapeutic ingredients of psychological interventions. Among the most powerful, also in the medically ill, is the patient’s experience of feeling understood, which decreases the feeling of solitude. Other ingredients are the recognition of links between emotions and thoughts, or past and present, and an understanding of how developmentally acquired ways to perceive the world impact the illness experience; such links situate patients and allow them to regain a sense of control (Viederman 1983). But most

of all, and across all psychological approaches, the relationship is the most powerful therapeutic ingredient (Stiefel and Bernard 2008). However, in a therapeutic relationship, it is up to the therapist to meet the patients “where they are,” and not vice versa. Any directivity, as is the case for PPIs with their beforehand defined aims (e.g., to enhance well-being), may hamper the encounter and even alienate patients (Stiefel and Bourquin 2018).

Patients’ resources are recognized in psychological interventions since the time humanistic psychology has shed light on the tendency of psychology to neglect them (Froh 2004). However, patients’ resources and vulnerabilities often coexist, and a one-sided focus on resources, as advocated in PPI, may impede the cathartic experience of witnessing the “dark side” of human existence – such as finitude, vulnerability, and solitude – which emerges when we are hit by the fate of falling ill. Ryff, who researched over 30 years on psychological well-being, referred in her commentary on PPI to what Rilke called the beauty and terror of life (Ryff 2022).

Finally, from our perspective, PPIs adopt a utilitarian approach and instrumentalize fundamental human experiences: if one is invited to show altruism to enhance one’s own quality of life, is it still altruism? From a psychological perspective, such an injunction may be perceived as replacing an authentic experience with a goal-directed, and thus false, experience.

The role of (negative) emotions in palliative care

PPIs concentrate on positive emotions and tend to evacuate the so-called negative ones. This loss of negative emotions may deprive patients of important information: anxiety, for example, points to inner or outer threats, which can be identified, faced, addressed, and worked through; avoidance, on the other hand, might be dangerous, since threats tend to persist and sooner or later affect the individual. A therapist ought to support the patient to identify, face, and express the emotions and thereby contribute that patients cease to constantly run away from themselves (Derry et al. 2019).

Moreover, positive and negative emotions can coexist (e.g., feeling relieved and sad after the death of a loved one); negative emotions may be positive (e.g., being angry about injustice), and positive emotions may be negative (e.g., being optimistic in the face of danger). Social emotions in particular (e.g., shame) have a double valence, positive and negative (e.g., they regulate social conduct but might also prevent individuals from fulfilling their desires). All these observations, and the fact that emotions are situated on a spectrum, suggest that the binary positive/negative classification of emotions is not valid. Lastly, suppressed (or otherwise avoided) emotions may find other ways of expression, which might be harmful; for example, unacknowledged separation anxiety in both physicians and patients might lead to overtreatment (Stiefel et al. 2017). On the other hand, to be able to realize that multiple and coexisting, joyful and painful emotions exist and that they don’t need to be avoided, but to be embraced by a true self, negotiated with the world in an authentic way, may be an enriching experience (McGovern 2023).

Side effects of psychological interventions in palliative care

In traditional psychological interventions, patients may feel overwhelmed, wish to terminate prematurely, or consider treatment as useless, and ruptures occur (McQuaid et al. 2021). In PPI, side effects do certainly also exist, but they are not addressed in the

specialized literature. We know, from past experiences with prescriptive psychological approaches (e.g., to love oneself more when affected by cancer [Siegel 1998]), that patients who are unable to live up to these expectations might feel inadequate, which adds to their already existing physical and psychological ordeal (Stiefel and Bourquin 2018). This observation led Wood et al. to call for an assessment of potential negative effects of gratitude interventions (Wood et al. 2010).

The porosity of medicine and palliative care

Medicine is embedded in and shaped by society: the fear of death in society and within medicine is a good example of this, as is the desire of palliative care clinicians of a “good death of their patients” (Zimmermann 2012; Zimmermann and Rodin 2004). Patients have expectations toward medicine, but also society as a whole, and clinicians, for their part, have expectations toward patients. Indeed, isn't the ideal patient optimistic, hopeful, grateful, and capable to grow psychologically and to die peacefully?

When concepts such as gratitude, which are considered to be central in traditional religious worldviews (Lavelock et al. 2016), are introduced into medicine, the borders between psychology and society become even more porous. The danger exists, as stressed by Kleinman, that the moral category “suffering” is turned into a medical one, and that tragedy becomes a professionally managed disorder (Kleinman 1997); however, human suffering is unavoidable, and all suffering cannot be treated like an uncomfortable symptom. The danger also exist that PPI is in the serves not the patient, but an institution (medicine and palliative care), and a society, which have become intolerant toward suffering; a society which delegates to medicine the task to silence the restless and noisy voices of the dying.

The question of cui bono, for whom are the benefits, must thus be considered when introducing PPI in the clinics of palliative care.

Competing interests. The authors declare none.

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