Research Open

Psychology Journal: Research Open
Volume 6 Issue 4

Research Article

Existential Communication – Old Wine in New Skins?

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Received: November 15, 2024; **Accepted:** November 22, 2024; **Published:** November 28, 2024

Abstract

Background: The term *existential communication* did not emerge but recently in medical terminology. It refers to doctor-patient-communication comprising issues of mortality, fragility of human being, and associated rational and emotional coping.

Objective and methods: A literature search the term *existential communication* was carried out in PubMed. Moreover, from the results and the author`s long background of facilitating "breaking-bad-news" workshops for oncologists, features of an existential communication are demonstrated.

Results: A PubMed search resulted in only 8 papers from the last decade explicitly using the term *existential communication*. Hundreds of papers used *existential* in various other attributions - from *existential aspects* to *existential yearnings*. The term existential was rooted in various directions of predominantly German existential philosophy, which after National-Socialism resonated in the USA and catalyzed pioneering strategies of psycho-oncological support. Some training programs for existential communication have been established and share the principles of breaking-bad-news communication.

Conclusion: Existential communication describes more precisely than end-of-life (EOL) discussion a long-standing and teachable medical task which must not be neglected without compromising high quality patient care, in particular in oncology and palliative medicine. Existential communication is prerequisite to avoid burdening patients with very advanced cancers with futile tumor-specific treatments and detrimental adverse-effects. Existential communication is important for patients but may foster a deeper professional satisfaction of health care professionals (HCP).

Keywords: *Medical communication, Cancer, Psycho-oncology palliative care, Spirituality end-of-life discussion*

Im existentiellen Bereich sind Wahrheit und Kommunikation dasselbe.

In the existential realm truth and communication are identical (translation HK) Hannah Arendt, 1957 [1]

Introduction

Originally the term *existential communication* has been a central concept of the existential philosophy of Karl Jaspers (1883-1969) [2], a renowned German philosopher and psychiatrist. Nearly a century ago, he coined *existential communication* for a uniquely dyadic and non-hierarchical communication which enables both interlocutors to evolve their distinctive personhood, their existence. The term opposed the *Daseins*-communication (communication of *being*) of daily life inclusive clinical practice. Thus, Jaspers` philosophical construct of *existential communication* was not established for clinical practice and consequently did not enter medical terminology. Hence, in 1969 Swiss-American psychiatrist Elisabeth Kübler-Ross could finish her landmark book *On death And Dying* [3] without using the term existential, even if her end-of-life conversations with patients doubtlessly meet today´s understanding of existential communication. Neither can be found the term *existential* in Cicely Saunders paramount book of palliative medicine of 1978 [4]. However, this book outlined her concept of *total pain*, which soon should shape the understanding of palliative care of the World Health Organization (WHO) [5] and of international and national palliative care societies [6]. Since then, state-of-the-art care of patients with life-threatening disease embraces a spiritual dimension. Almost simultaneously with the term *spiritual* the term *existential* emerged in the Anglo-American medical literature, though. Unlike *existential communication* the single term *existential* had entered psychiatric literature of German language already in the first half of the 20th century. The German philosopher Martin Heidegger (1889-1976) had influenced the psychiatric and respective psychotherapeutic *Daseins-Analysis* of Ludwig Binswanger [7] and Medard Boss [8], both Swiss psychiatrists and psycho-analysts. Moreover, Viktor Frankl, an Austrian psychiatrist of Vienna, who had established his scientific reputation with innovative concepts of care for suicidal individuals and patients with depression, i.e. patients facing an existential crisis, had outlined his *Existence-analysis* and *Logotherapy* since the mid-thirties [9]. But during the Nazi-Era humanistic psychiatric patient care influenced by psychoanalysis and existential philosophy was eradicated in Nazi-dominated Europe and many of the most eminent representatives of German oncology and psychiatry - for being Jews - were forced to emigrate or into murderous concentration camps. In regard to their Nazi-collaboration German medical organizations put under taboo and discouraged any deeper reflection of existential-philosophical issues like responsibility, guilt, and shame after the defeat of the Nazi-regime for more than one generation. However, US-American psychiatrists explicitly referring to the above mentioned

European philosophers and clinicians soon should introduce the term *existential* into a now Anglo-American medical literature. Viktor Frankl, who had survived four concentration camps, took an important role for this transatlantic loop of the term *existential*. He refined his meaning-centered Logotherapy and Existence-analysis reflecting his years of existential threat and the murdering of his family in concentration camps. Initially his concept did not resonate much in the scientific community of post war Austria and Germany, but he gained recognition as a visiting professor at Harvard and other US-universities and with the English translation [10] of his post war book, which has been sold in millions of copies. In a 1991 survey *Man's Search for Meaning* was rated one of the ten most influential books in the US. Independently, Stanford psychiatrist Irvin Yalom developed his very influential *Existential Psychotherapy* [11] leaning on Viennese psycho-analytic concepts and European pre-war existential philosophy. Yalom´s resources-centered therapeutic approach has been modified for psycho-oncological support for patients with cancer: at Stanford psychiatrist David Spiegel established his *Supportive-Expressive Psychotherapy* [12,13], while William Breitbart – a child of Holocaust survivors, and explicitly referring to Viktor Frankl – developed his *Meaning-Centered Psychotherapy* [14] at New York´s Sloan-Kettering Cancer Center. *Spiritual, existential* and finally *existential communication* had entered literature of oncology and palliative medicine, even if the conceptual understanding of different authors diverge [15].

Methods and Materials

A literature search was conducted in Pubmed (accessed June 21,2024) using the search term *existential communication* which resulted in 834 references. These comprised both papers using the combined term or just the single term *existential* or *communication*. Thus, many references dealt with the vast fund of medical communication which was considered helpful for outlining principles of existential communication. Moreover, the author returned to his extensive experience from facilitating workshops for clinicians on "breaking-bad-news" [16] where modules of communication on death and dying and associated emotions regularly were appreciated most by the participants

Results

The term *existential communication* emerged in medical literature only a decade ago and of the 834 references only 6 papers had *existential communication* in their titles, with 5 of them affiliated with the Denish University of Odense [17-22]. In addition, 2 papers used the term (or modified as *existential conversation* [23]) in their abstracts or texts [24]. Hundreds of papers employed *existential* attributively to describe illness experiences, suffering, crisis, loss, shock, aspects of relationships and core values, feelings of guilt, isolation, and yearning (Table 1).

The term existential is embedded into two concurrent concepts. The European Association of Palliative Care (EAPC) und papers adopting its definition use spiritual as a meta-concept which includes *existential* [6]. Irvin Yalom`s *Existential Psychotherapy* considers *existential* as overarching concept, though, which comprises spiritual and religious issues [11]. In the same manner Scandinavian study groups understand existential as a meta-concept, which includes spiritual issues [20]. They are backed by a sample survey of the Denish population, which showed that "the existential" serves well as an overarching construct potentially including secular, spiritual and religious domains of meaning [25]. Moreover, general practitioners of the secular Denish society felt more at ease with the term *existential* in comparison to *spiritual*. However, the structural differences of both meta-concepts do not interfere much in actual communication with severely ill patients, and both meta-concepts sometimes may be found in parallel use by the same authors, or existential, spiritual and religious aspects are pragmatically put side by side on a same level [20,26].

Elise Tarbi`s study group at Boston`s Dana-Farber Cancer Institute defines *existential communication* "as any discussion concerned with confronting mortality and the fragility of existence; in particular, relating to major themes of (1) time as a pressing boundary; (2) maintaining a coherent self; and (3) connecting with others" [24]. This definition is compatible with the one used by the Denish study group at Odense University: "a metaconcept that includes communication about broad existential aspects and potentially, but not mandatorily, communication about spiritual and religious aspects [20].

Why Existential Communication?

In oncological and palliative care e*xistential communication* means communication in and about an existential crisis. Coping with a crisis situation depends on communication. Thus, existential communication features both a diagnostic and a therapeutical dimension [27]. The concept of total pain [4] already underscores the

Table 1: Attributive use of existential in medical literature.

existential anxiety	e. conflicts	e. guilt	e. outcome	e. struggle
e. aspects	e. constructs	e. impact	e. pain	e. suffering
e. beliefs	e. crisis	e. uncertainty	e. perspective	e. support
e. burden	e. decision making	e. insight e. intervention	e. problems	e. survivorship e. terror
e. care	e. determinator	e. isolation	e. quality	e. thoughts
e. challenges	e. dimension	e. issues	e. questions	e. threat
e. circumstances	e. distress	e. loneliness	e. reactions	e. values
e. communication	e. encounter	e. loss	e. relation	e. vulnerability
e. concern	e. experience	e. meaning	e. rupture	e. well-being
e. condition	e. fear	e. needs	e. shock	e. yearnings

importance of giving attention to existential suffering for adequate symptom control [24,28] and quality of life. Otherwise patients might run the risk of being labeled as "difficult" by medical care providers. Breitbart pointed out that he teaches his trainees that "whenever they encounter an angry patient with advanced cancer think existential guilt […]Anger and anxiety have the same etymological roots, and in fact angry typically comes from fear. The fear of loss; loss of love, hope, life. [..]. Clinically I see Existential Guilt manifest as either depression, shame, anger, or intense death anxiety" [29].

Patients with advanced cancer usually want to talk about existential issues with their doctors. But doctors often fail to recognize these wishes or feel time pressured or incompetent for a sensitive wording or consider these issues too private to address. Moreover, physicians with their training in the biomedical approach often focus on obtaining objective measures and fixing a problem. Confronted with problems that cannot be measured objectively and with no direct solutions at hand this approach is bound to reach deadlock [26]. On the other hand, HCPs who engage in communication about existential issues report higher professional meaning and satisfaction and personal depth. Early communication on death and dying with patients with advanced oncological diseases entails less futile and costly oncological treatments and detrimental adverse effects in the weeks before death. These patients have a better quality of life, spend fewer days in a hospital, are less frequently admitted to intensive care units and have a higher chance to die outside a hospital [30]. As the percentage of patients receiving futile oncological treatment in the last weeks of their life did not diminish in the last decade eminent US-American cancer centers pleaded for a better training of oncologists to communicate with patients on existential issues [31].

Principles and Practice of Existential Communication

Existential issues like finitude, mortality and meaning of life cannot be solved but require an individual positioning, acceptance and maybe a possible reevaluation. Patients with life-threatening illness may have a lot of physical and psychosocial problems, but in contrast, they share their existential condition with their HCPs – even if the latter sense less urgency for grappling with their existential issues. Thus, doctors and nurses, wo feel confident in providing medical expertise or advice, generally feel far more challenged when a patient addresses existential suffering. It is beneficial for HCP-teams to reflect personal values and existential beliefs. As a matter of fact, doctors who have been confronted with existential threats in their biography tend to be more attentive to their patients` existential concerns [2]. Spiegel`s concept of "detoxifying dying" in group therapy constructively confronts one´s own mortality when faced with death or imminent loss and can be helpful for HCP-teams [12]. Communication is not an end in itself. Medical communication should be beneficial in coping with severe illness: patients should experience: (1) a sense of resonance – having been seen, heard and understood; (2) a "solidarity of mortals" – an empathetic relationship respecting the remaining autonomy and dignity; (3) hope – an expectation that in severe illness and even with facing death positive experiences may be possible [27]. For Suchman "the feeling of being understood by another person is intrinsically therapeutic: it bridges the isolation of illness and restores the sense of connectedness that patients need to feel whole." [32] Quite often physicians neglect the crucial elements of establishing a therapeutic relationship: respectful greeting, eye contact, attention and showing interest and empathy. Connection will fail, if doctors just have eye contact with the display of their digital tools for timesaving and simultaneous documentation of patient information. Empathy is not identical with professional friendliness.

As soon as a patient gets informed about a life-threatening disease existential issues intermingle with questions about therapeutic options and treatment schedules: "How much time will I have left? "Why me?" "I am trapped in a black pit", "I can´t be a burden for my family", or "oh gosh, that´s the end!" During the last three decades very useful protocols for "breaking bad news" communication have been evaluated, even if lack of adherence to them still is a problem in clinical reality [33,34]. Existential topics are rarely expressed explicitly in palliative care conversations [21]. They often sprinkle patient-caregiver contacts for physical or psycho-social symptom assessment, medical or nursing procedures, or are woven within practical conversations during medical rounds. Statements like "It´s enough!", "please give me something to die" deal with death, others with issues of justice and guilt: "Why do I have to suffer like this?" Issues of existential loss – loss of self-esteem and identity - emerge in sighs like "I am just a burden", "This isn´t me anymore!" Again, as in "breaking-bad-news" communications, it is of paramount importance for HCPs not only to grasp the literal content of those statements but also to identify and to primarily address their implicit and dominant emotional contents: uncertainty, fear, despair, anger, shame, feelings of worthlessness. That is how emotional resonance is achieved [16,32,35]. A clinical snippet may demonstrate this approach:

Patient: "*This is no life any more.*"

Physician responding to the literal message:

"*Oh no, we do everything to help you, you can rely on our palliative care expertise.*" *Physician responding to the emotional message:*

"You are really despaired." Pause, and when the patient confirms non-verbally (nod, eye contact):

"*Please tell me what is haunting you most?*"

The response to the literal message implicitly devaluates the present illness experience while dodging the emotional issue as a "empathetic terminator" [32]. To minimize a risk of rebuff patients weave existential cues within conversations during medical care or nursing procedures. They sound the openness of HPCs for existential communications [22]. This may be underlined by another clinical snippet:

A 67-year-old woman presenting with ascites was diagnosed with advanced ovarian cancer. She is scheduled for a diagnostic laparotomy. When the experienced anesthesiologist sees her the day before surgery to explain his procedure he is puzzled by the welcome statement of that friendly lady: "I wonder about my future?" The senior doctor hesitates, then answers: "In my opinion, people don´t reflect enough about death." The patient is startled. She just answers to the technical questions relevant for adequate anesthesia. She is too upset to sleep during the night before surgery.

The patient´s statement "I wonder about my future" doubtlessly is a distinct existential cue. The doctor perceives the emotional message of fear of death. He could address this emotion by labeling it: "Are you afraid to die soon?" However, the doctor flinched from dealing with the emotional issue und took refuge to a rational comment, schoolmasterly dodging the patient´s existential distress. Every existential crisis is charged with unpleasant emotions. Therefore, physicians may be tempted to side-step these emotions by moving quickly to the field of professional action competence with comments, giving advice, or hurriedly suggesting solutions. But it is crucial to take up the patients´ emotional cues first in order to advance to an existential communication. Moreover, HCPs should keep in mind that strong emotions hamper cognitive information processing. Nevertheless, before engaging in an existential communication HCPs should clarify, whether there are any interfering uncontrolled physical symptoms such as pain, thirst, or an urge to urinate. The above snippet demonstrates: Existential clues often hit the HCPs by surprise. They have to decide whether momentarily engaging in an existential communication is a feasible or wise option. Anyway the HCP should signify having registered the cue, maybe – concerning the above snippet by commenting: "*That´s an important issue for you, but it makes sense to wait for the results of tomorrow`s operation.*" *Or t*he consultant may request the patient´s consent to inform his responsible physician about a desire for a deeper communication, or may ask permission to pass a more specific religious topic to a chaplain.

Tarbi found that conversations with more discussion of prognosis also contained more discussion of existential topics [24]. But without showing a lack of courteous manners doctors often focused on strictly medical facts, failing to notice or ignoring the patient´s existential illness experience and strife for meaning and validation. "Courteous but not curious" is Agledahl`s [36] summary of analysis of doctor-patient encounters in a Norwegian teaching hospital. Whether patients open up to share their existential thoughts heavily depends on non-verbal and sensory elements of an encounter: whether a HCP is perceived both physically and relationally present. "The bodily sensation of presence and sensing seems to precede the verbal dimension of spiritual care and communication […] The patients use a sort of decoding in which they try to sense and decipher whether they will be accommodated, if they initiate a conversation about spiritual matters" [37]. Reciprocally HCPs have to decode the patients` non-verbal cues and keep in mind the most important principles of medical communication: (1) active listening – learning the illness experience; (2) asking questions – showing interest, and encouraging a narrative and its clarification; (3) perception – what and how does the patient communicate verbally and non-verbally. It is important to recognize that a patient is the single expert of his illness experience which he might share by answering to questions like:

"What burdens you most?"

"If you ponder on your illness, how much time do you think you have got to live?"

"When thoughts of death and dying come to your mind, do they cause fear or anxiety?"

"When you think about the rest of your life, what matters most for you?"

"Do you have a specific event or goal you would like to live?"

"When you think back, what did help you most in coping with your disease?"

"When you reflect on your life, what makes you really proud?"

I encourage this kind of "empathetic curiosity" which had been lacking in Agledahl`s study of patient-doctor encounters [36]. Addressing tabooed or anxiety-ridden issues reduces anxiety. Moreover, a simultaneous validation of coping efforts will diminish a patient´s sense of helplessness, hopelessness, and isolation and restore a sense of agency in spite of an advanced disease. Meanwhile, useful concepts of existential communication have been established [18,20,22]. In addition, established guidelines for "breaking bad news" in medicine and reviewed programs of communication skills training in oncology [34] comprise the principles of existential communication.

Conclusion

The recent term existential communication with its secular roots and associations excellently describes a long standing medical task which is crucial for state-of-the art patient care, especially in oncology and palliative medicine. In contrast to the common term *end-of-life* discussion *existential communication* semantically does not focus on the end of life but also on the life before. Existential communication also deals with maybe lifelong individual values and resources which impact treatment decisions. But on disease progression of advanced cancer oncologists often "skip over discussions of prognosis and jump to offering a new line of therapy" [31]. They struggle with "taking away hope" [38]. feel uncomfortable with existential issues, and biasedly believe that additional treatment will benefit the patient. That is why existential communications are to be actively scheduled in patient care and are particularly crucial when disease-modifying treatment is stopped. Existential issues of remaining life time and anxiety or confusion surrounding dying regularly emerge at this phase of an illness trajectory. At the same time therapeutic responsibility often changes which may structurally augment the patient´s suffering of having to leave behind loved ones. A patient`s complicit encouragement of his oncologist to offer additional treatment sometimes is motivated by the patient´s fear that otherwise his medical life-line will be cut. Therefore, an early integration of palliative care specialists into the oncological care team is important. Moreover, patients may feel very relieved when oncologists empathetically explain, that with stopping a futile treatment survival will not be shorter but quality of life will be better because adverse effects will cease.

Acknowledgment

The author thanks Matthias Demandt, MD,. for constructive comments on early versions of the manuscript

Competing Interest

The author declares that he has no competing interests.

Funding Information

The author did not receive external funding.

The author did not receive external assistance with data collection, analysis, and manuscript preparation

Ethical Declaration

This study did not involve human participants or animal subjects.

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Citation:

Kappauf HW (2024) Existential Communication – Old Wine in New Skins? *Psychol J Res Open* Volume 6(4): 1-5.