THE DEATH AVOIDANCE PARADOX IN PSYCHIATRIC END-OF-LIFE CARE: A MULTIDIMENSIONAL CONCEPTUAL FRAMEWORK OF CLINICIAN AVOIDANCE

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Abstract:

Background

Patients with severe mental illness (SMI) experience high physical morbidity and reduced life expectancy yet remain underrepresented in palliative and end-of-life care. Clinicians working in psychiatric settings face complex clinical, ethical, and organizational challenges, contributing to disparities in care.

Aim

This paper develops a conceptual framework to explain how avoidance behaviors emerge and persist among healthcare professionals in psychiatric end-of-life care.

Conceptual approach

The framework is based on a conceptual synthesis of literature from palliative care, psychiatry, Terror Management Theory, experiential avoidance research, and organizational behavior. It integrates psychological and systemic perspectives to develop a multidimensional explanatory model.

Proposed framework

The Death Avoidance Paradox is introduced as a five-dimensional model comprising existential, emotional, cognitive, organizational, and cultural avoidance. These interrelated domains interact recursively, transforming mortality-related anxiety and clinical uncertainty into sustained patterns of professional and institutional avoidance, ultimately shaping communication and care delivery.

Conclusions

The framework provides a comprehensive explanation for persistent disparities in psychiatric palliative care by conceptualizing avoidance as a multilevel and dynamic process. It offers a theoretical foundation for future empirical research, clinical training, and organizational interventions aimed at improving end-of-life care for patients with SMI.

Keywords: *Severe mental illness; Palliative care; clinician avoidance; conceptual framework; TMT.*

Introduction

Patients with severe mental illness (SMI) experience significantly reduced life expectancy and high rates of physical comorbidity, including cardiovascular disease, diabetes, respiratory illness, and cancer, compared with the general population (Loeb et al., 2016). Despite increasing recognition of their complex needs, individuals with SMI remain systematically underrepresented in palliative and end-of-life (EOL) care, resulting in persistent disparities in access and quality of care (Ayalon et al., 2016; Shuftan et al., 2025).

Providing EOL care in psychiatric populations presents unique challenges. Clinicians must simultaneously address terminal physical illness, severe psychiatric symptoms, impaired decision-making capacity, communication barriers, ethical uncertainty, and complex family dynamics. This dual burden creates heightened clinical complexity and emotional strain that extends beyond traditional palliative care settings.

Existing literature attributes disparities in psychiatric palliative care to stigma, diagnostic overshadowing, inadequate training, fragmented services, and limited integration between psychiatric and palliative care systems (Clement et al., 2013; Noblett et al., 2017; Davis et al., 2023). While these factors are well documented, they are typically treated as independent variables, limiting understanding of how they interact to shape clinician behavior.

The Death Avoidance Paradox offers a unifying conceptual lens suggesting that healthcare professionals may unconsciously distance themselves from dying patients as a psychological response to mortality-related anxiety. Although previously explored in somatic palliative care, its application to psychiatric settings remains underdeveloped, despite the added complexity of severe mental illness, stigma, and diagnostic ambiguity (Davis et al., 2023).

This paper proposes that psychiatric EOL care represents a distinct clinical context in which avoidance is amplified through the interaction of existential, emotional, cognitive, organizational, and cultural processes. Building on Terror Management Theory and experiential avoidance research, the study develops a multidimensional framework explaining how these interacting mechanisms shape clinician engagement with terminally ill psychiatric patients.

By integrating psychological and organizational perspectives, the framework aims to explain persistent disparities in care and provide a theoretical foundation for future empirical research, clinical education, and system-level interventions.

From Existential Anxiety to the Five-Dimensional Framework

Existing explanations of disparities in psychiatric end-of-life (EOL) care have largely focused on individual factors, including inadequate training, emotional burden, stigma, diagnostic uncertainty, and organizational barriers (Clement et al., 2013; Davis et al., 2023; Hofmann-Broussard et al., 2017; Lifshits et al., 2025). Although these determinants are well established, they are typically examined in isolation, providing only a partial explanation for clinicians' disengagement from EOL care. The present framework proposes that avoidance emerges through the interaction of multiple psychological and organizational processes, drawing on behavioral and organizational perspectives commonly used to understand health-related professional behaviors (Scherrens et al., 2023).

Guided by Terror Management Theory (Greenberg et al., 1986; Solomon et al., 2004), repeated exposure to dying patients activates mortality awareness, which may trigger unconscious defensive responses aimed at reducing existential distress. In psychiatric settings, these reactions are intensified by severe mental illness, diagnostic ambiguity, impaired decision-making capacity, stigma, and ethical uncertainty, creating a uniquely demanding clinical environment (Carrara et al., 2023; Davis et al., 2023).

The **Death Avoidance Paradox** suggests that clinicians may reduce engagement with terminally ill psychiatric patients not because of diminished professionalism or compassion, but as an adaptive response to cumulative psychological burden. Although these responses may temporarily reduce emotional burden, they can also weaken therapeutic relationships and delay patient-centered palliative care (Davis et al., 2023; Kraitenberger et al., 2021; Omoya et al., 2022).

Accordingly, the proposed framework conceptualizes avoidance as a dynamic process operating across five interconnected dimensions:

- **Existential avoidance**, driven by mortality awareness and fear of death.
- **Emotional avoidance**, reflecting efforts to regulate distress associated with repeated exposure to suffering.
- **Cognitive avoidance**, arising from diagnostic complexity, uncertainty, and reduced confidence in managing psychiatric palliative care.
- **Organizational avoidance**, reinforced by fragmented services, limited resources, insufficient training, and institutional norms.
- **Cultural avoidance**, shaped by cultural beliefs surrounding death, mental illness, communication, and family involvement.

Rather than functioning independently, these dimensions interact recursively. Existential anxiety increases emotional burden, emotional strain influences cognitive processing, and organizational and cultural contexts may reinforce avoidant behaviors. Through this dynamic interaction, individual defensive responses may become embedded within professional practice and healthcare systems, contributing to persistent disparities in psychiatric end-of-life care.

Existential Avoidance

Existential avoidance represents the initiating dimension of the proposed framework. Drawing on Terror Management Theory (Greenberg et al., 1986; Solomon et al., 2004), repeated exposure to dying patients increases mortality awareness, confronting clinicians with their own vulnerability and existential uncertainty. In psychiatric end-of-life care, these concerns are intensified by the coexistence of terminal illness and severe mental illness, where clinicians frequently encounter hopelessness, suicidality, prolonged psychological suffering, and ethical ambiguity. To regulate this distress, professionals may unconsciously limit emotionally demanding conversations, postpone advance care planning, or shift their focus toward technical aspects of care (Davis et al., 2023; Kraitenberger et al., 2021). Although these responses may temporarily reduce emotional burden, they can also weaken therapeutic relationships and delay patient-centered palliative care. Within the proposed framework, existential avoidance serves as the primary catalyst that activates the remaining dimensions of avoidance.

Emotional Avoidance

Emotional avoidance represents the behavioral expression of existential anxiety. Rather than confronting distress associated with death and suffering, clinicians may consciously or unconsciously regulate emotional discomfort by reducing engagement with terminally ill patients. In psychiatric end-of-life care, this process is amplified by the simultaneous management of progressive physical decline and persistent psychiatric illness, increasing emotional demands beyond those encountered in conventional palliative care (Davis et al., 2023; Moureau et al., 2023). Although avoidance initially functions as an adaptive coping strategy, persistent reliance on emotional distancing may reduce empathic communication, discourage end-of-life discussions, and contribute to fragmented care. Emotional avoidance therefore acts as the principal mechanism through which existential concerns become translated into observable clinical behaviors.

Cognitive Avoidance

Cognitive avoidance reflects clinicians' attempts to reduce uncertainty when managing complex psychiatric palliative care. Severe mental illness introduces diagnostic ambiguity, fluctuating decision-making capacity, communication difficulties, and ethical dilemmas regarding prognosis and treatment planning (Carrara et al., 2023; Davis et al., 2023). Under conditions of sustained emotional strain, clinicians may increasingly rely on heuristic decision-making, defer difficult conversations, or avoid complex clinical decisions. Rather than reflecting inadequate competence, these responses represent adaptive efforts to manage cognitive overload. However, persistent cognitive avoidance may reinforce delayed decision-making, inconsistent advanced care planning, and reduced confidence in providing integrated psychiatric palliative care.

Organizational Avoidance

Organizational avoidance describes the institutional reinforcement of individual avoidance behaviors. Repeated defensive responses may become embedded within healthcare systems through fragmented services, limited collaboration between psychiatric and palliative care, inadequate professional education, resource constraints, persistent mental-health stigma, and organizational cultures that discourage discussions about death (Davis et al., 2023; Lifshits et al., 2025; Moureau et al., 2023; Heim et al., 2020). These structural factors normalize avoidance, contributing to delayed referrals, fragmented communication, and inequitable access to palliative care for patients with severe mental illness. Within the proposed framework, organizational avoidance links individual psychological defenses to persistent system-level disparities in care.

Cultural Avoidance

Cultural avoidance reflects the influence of cultural beliefs surrounding death, mental illness, family involvement, and communication on clinicians' engagement with end-of-life care. Uncertainty regarding culturally appropriate communication, combined with limited training in transcultural palliative care, may discourage professionals from initiating discussions about prognosis, goals of care, or dying (Cáceres-Titos et al., 2025). These challenges are further reinforced by organizational limitations and societal stigma surrounding both mental illness and death. Consequently, cultural avoidance interacts with the other dimensions of the framework, contributing to communication barriers and disparities in patient-centered end-of-life care.

Discussion

Principal Contribution

The Death Avoidance Paradox provides a conceptual framework for understanding clinician avoidance in psychiatric end-of-life care as a multidimensional phenomenon. Rather than attributing disparities solely to stigma, burnout, inadequate training, or fragmented healthcare systems, the framework proposes that avoidance emerges through the interaction of existential, emotional, cognitive, organizational, and cultural processes. By integrating these domains into a single explanatory model, the framework offers a broader understanding of why patients with severe mental illness continue to experience inequitable access to palliative care despite growing recognition of their complex needs (Carrara et al., 2023; Davis et al., 2023; Lifshits et al., 2025).

Relationship to Existing Literature

Previous studies have identified important barriers to psychiatric palliative care, including diagnostic overshadowing, stigma, communication challenges, fragmented services, and clinician burnout (Clement et al., 2013; Moureau et al., 2023; Pattison et al., 2020; Treister-Goltzman et al.,2024). However, these factors have generally been examined independently. The proposed framework extends this literature by suggesting that they are interconnected manifestations of a broader avoidance process initiated by mortality awareness and reinforced through emotional regulation, cognitive uncertainty, organizational structures, and cultural influences. In doing so, the model expands the application of Terror Management Theory to psychiatric end-of-life care while integrating insights from experiential avoidance and organizational behavior into a unified conceptual framework (Greenberg et al., 1986; Solomon et al., 2004).

Clinical and Organizational Implications

Viewing avoidance as a normal psychological response to repeated exposure to death and suffering, rather than as professional failure, may encourage reflective practice and reduce stigma surrounding clinicians' emotional experiences. The framework suggests that improving psychiatric end-of-life care requires interventions beyond knowledge acquisition alone. Communication training, structured reflective supervision, interdisciplinary collaboration, and closer integration between psychiatric and palliative care services may help clinicians manage existential and emotional challenges while strengthening patient-centered care (Davis et al., 2023; Lifshits et al., 2025; Moureau et al., 2023). Organizational strategies should likewise address institutional barriers by promoting integrated care pathways, clearer

professional roles, and education in both palliative psychiatry and culturally sensitive communication.

Future Research

As a conceptual model, the Death Avoidance Paradox requires empirical validation. Future qualitative studies should explore clinicians' experiences of psychiatric end-of-life care across diverse healthcare settings, while quantitative research should develop and validate measures of the five avoidance dimensions and examine their relationships with communication quality, referral practices, and patient outcomes. Longitudinal studies may further clarify how avoidance develops over time and whether targeted educational and organizational interventions reduce avoidant behaviors and improve the quality of psychiatric palliative care.

Limitations

This framework is based on conceptual synthesis rather than empirical testing, and the proposed relationships between the five dimensions remain theoretical. The relative importance of each dimension may vary across healthcare systems, professional groups, and cultural contexts. Nevertheless, the model offers a structured theoretical foundation that integrates evidence from multiple disciplines and provides a basis for future empirical investigation.

Conclusion

Patients with severe mental illness continue to experience significant inequities in end-of-life care despite increasing recognition of their complex physical and psychiatric needs. The Death Avoidance Paradox proposes that these disparities arise from the interaction of existential, emotional, cognitive, organizational, and cultural avoidance processes rather than from isolated barriers alone. By conceptualizing avoidance as a dynamic, multilevel phenomenon, the framework offers a novel theoretical perspective on clinician behavior in psychiatric palliative care. Future empirical research should evaluate the proposed model and examine whether interventions targeting these interconnected dimensions can improve communication, reduce disparities, and strengthen person-centered end-of-life care for individuals living with severe mental illness.

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