

Clinical Psychologists in specialist palliative care: what do we actually do?

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Introduction

Psychological distress contributes to the difficulty of managing physical symptoms such as pain, breathlessness, nausea etc. Yet significant psychological distress is an area of practice that many specialist palliative care clinicians feel ill-equipped to address. Clinical psychologists – whose training emphasises individual formulation drawing on a range of theoretical models, and adapting evidence-based interventions to meet specific patients' needs – have much to contribute.

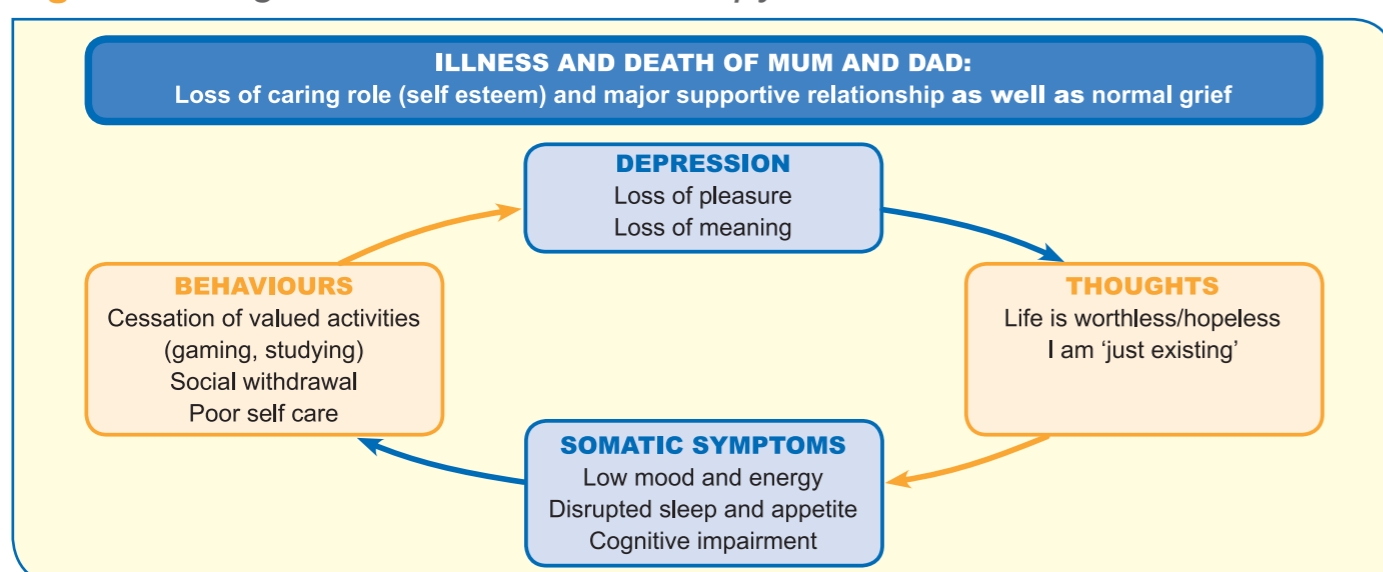
Reports suggest lack of clarity about the role of clinical psychologists may present a barrier to optimum working. Despite this, little has been published describing their activities in concrete terms. We attempt to address this gap by presenting examples illustrating the work of a clinical psychologist in an Edinburgh hospice.

Case One

'traditional' psychological therapy

- Andy, 30, a socially isolated man with Asperger's traits had lost both parents in quick succession. The Bereavement Support Service were concerned that he was significantly depressed.
- The psychologist formulated Andy's problems within a Cognitive Behavioural Therapy (CBT) framework. (Figure 1)
- Planned intervention: 8-10 sessions of CBT to explore and challenge his catastrophic beliefs and promote re-engagement with enjoyed activities, sources of self-esteem and social support.

Figure 1: Cognitive Behavioural Therapy framework.

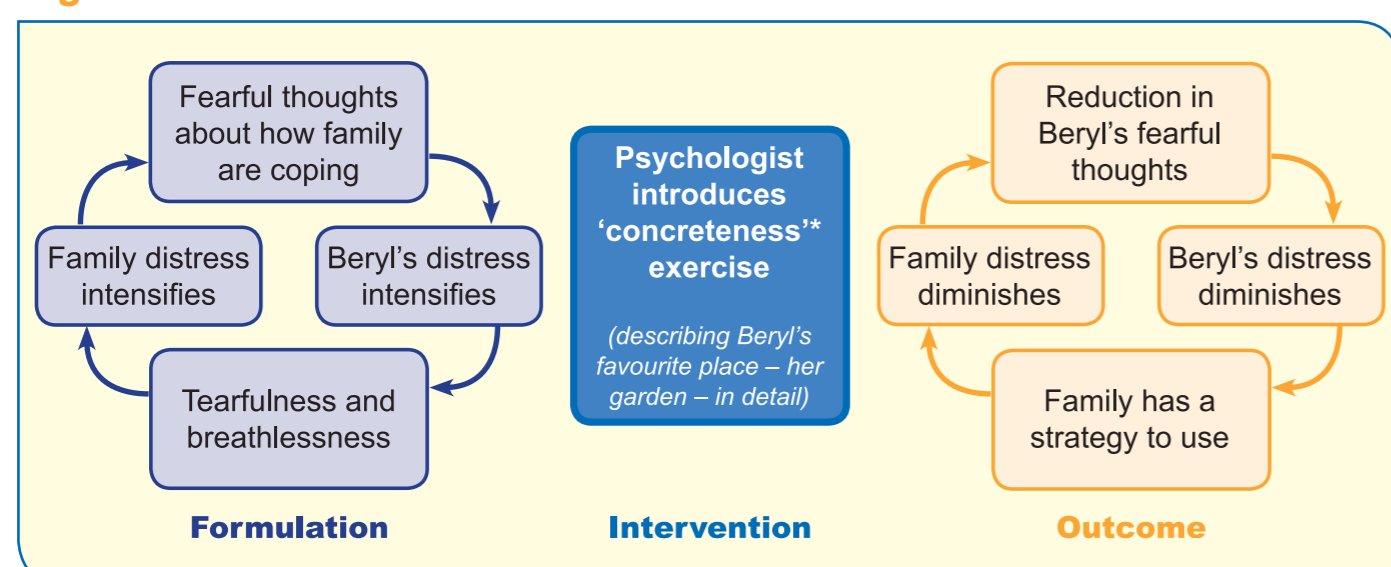


Case Two

Single session bedside intervention

- Beryl, 80, who had breast cancer, was receiving end-of-life care. Ward staff had observed periods of intense anxiety.
- 'Concreteness' – research indicates distress in final days is associated with dwelling on 'unanswerable' or abstract questions about the future, and that practicing focussing on concrete past or present experiences alleviates it.¹ (Figure 2)

Figure 2: Intervention.



Case Three

Re-framing a 'problem' using psychological theory

- Charlie, 60, had lung cancer with a short prognosis, but spoke of the future with unrealistic positivity ('I'll be going fishing in July'). This perceived 'denial' caused his wife significant distress and presented a barrier to treatment planning for staff.
- The psychologist met with Charlie and concluded that his positivity was not true denial (dysfunctional and unconscious rejection of information due to lack of coping strategies) but rather disavowal (functional and conscious temporary downplaying of information as a coping strategy).²
- Using pleasant fantasy to improve the moment was an important emotional regulation strategy, but it would become harder to maintain as Charlie's disease progressed. Rather than challenging Charlie's 'denial', the psychologist suggested people work with him to develop alternative strategies.

Case Four

Supportive person-centred care

- Denise, 60, who had throat cancer, had been recently widowed, and was caring for her father who also has cancer, and mother who has dementia. Her community nurse was concerned about her complex circumstances and potential support needs.
- The psychologist assessed Denise and concluded that she was not currently clinically depressed or anxious, (in fact she had good coping skills) but was vulnerable. They arranged that she could 'book herself in' for an outpatient session on an as-needed basis. Denise scheduled sessions on average monthly over eight months. Denise's recent challenges were discussed, along with insights and strategies from various psychological models which might improve her experience.

In addition to direct patient contact, the psychologist has; Given a series of psycho-education talks to day service users; contributed to the regular community nursing meeting; offered informal support to staff with work-related concerns; offered consultation and formulation in challenging cases; led reflective practice sessions around challenging cases and planned a programme of training for frontline staff.

Conclusion

Clinical Psychologists in palliative care may be called upon to work with diverse people and 'problems'. A capacity to draw on multiple theoretical models and a willingness to offer interventions flexibly is necessary but not sufficient. Clinical psychologists must integrate themselves with the various teams and be open and informative about what they do to promote optimal uptake of what they have to offer.



References: 1. Galfin, J., Watkins, E. & Harlow, T. (2012) A brief guided self-help intervention for psychological distress in palliative care patients: A randomised controlled trial. *Palliative Medicine*, 26, 197-205. 2. Salander, D. & Windahl, G. (1999) Does 'denial' really cover our everyday experiences in clinical oncology? A critical view from a psychoanalytic perspective on the use of 'denial'. *British Journal of Medical Psychology*, 72, 267-79.