Psychology’s Contribution to Practice

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General Considerations for Practice in Palliative Care

- Existing skills and knowledge adapted, applied in new ways, new settings
- Competencies in basic palliative care vs. specialty/advanced practice
- Emphasis on interprofessional practice, care coordination; systems perspective (family, health care)
- Considerable constraints
  - Outcomes measurement; value added
  - Billing, reimbursement
Key Domains of Practice in Palliative Care

- Psychological, Sociocultural, Spiritual, & Interpersonal Factors in Chronic, Serious Life-Limiting, Terminal Illness
- Normal, Abnormal Grief, Bereavement
- Goals of Care/Advance Care Planning
- Assessment of Physical Mental Health Conditions
- Psychotherapy for Individuals with Chronic, Serious or Terminal Illness
- Assessment and Treatment of Families
- Interdisciplinary Teams, Consultation, Professional Self-Care
Intersection between Geriatrics & Palliative Care

Geriatrics
- Diagnosis, treatment, prevention of disease;
- Problems common to older adults (frailty, disability, incontinence, cognitive impairment, sensory impairment);
- Maximize independence, ADLs

Palliative Care
- Advanced illness & end of life across lifespan;
- Symptom management;
- Attention to care transitions;
- Bereavement

QOL; function; team-based; complex patients; consideration of social system; advance care planning;
Palliative Care Practice: Representative Examples

- Assessment
- Intervention
- Goals of Care/Advance Care Planning
- Interprofessional Practice
Assessment

• Psychologists have a unique skill in assessment which is needed and applicable to palliative and end-of-life care

• Skills such as:
  • Mood assessment
  • Brief cognitive assessment
  • Bio-psychosocial-spiritual integrated evaluation
  • Capacity evaluation
Assessment

- Psychologists have also been involved with pain and sleep assessment, and these well established methods can be altered to address care needs across the continuum of the palliative population

- Assessment skills can also be applied in a similar manner to other physiological symptoms as well
Common Symptoms Assessed

- Pain
- Energy
- Appetite
- Dry mouth
- Weight
- Drowsiness
- Constipation
- Sleep difficulties
- Difficulty concentrating
- Dyspnea
- Nausea
- Worry
- Sadness
Assessment

• Assessment can occur across settings within primary care, specialty clinics, acute care, palliative outpatient clinic, and in-home

• Assessment usually incorporates not only the patient, but also family, friends, and associated caregivers as palliative care provides services and support to all involved

• Evaluate grief and bereavement needs for patients and families
Intervention

• Limited evidence base in palliative care
  • Reasonable extrapolations with assumption of similar theory of human behavior, mechanisms of change
  • Application of psychological principles vs. manualized approach

• Flexibility
  • Rapid, unpredictable pace, need to “seize the moment”
  • Therapy goals may be focused, time limited, each session to stand on own (accommodate prognosis of hours, days, weeks, months)
  • Modifications to accommodate medical status, complicated medical management
Intervention

- Focus on normative and pathological reactions; reducing distress, promoting adaptation amongst system (individual, family, health care team), managing psychological and physical symptoms
- Requires high degree of cognitive flexibility, distress tolerance, tolerance for ambiguity
- Possible greater pull for self-disclosure, although guidelines in service of patient still apply
- Potential for stronger emotional, countertransference responses
- Relative emphasis on self-awareness, self-reflection, self-care
- Power of bearing witness
Intervention: Existential distress

• Identify aspects of identity that transcend illness/functional decline; understand disease context and see the person they have been, rather than disease with which they live
• Explore and intervene upon religious/spiritual beliefs, evaluations of self-worth, sources of meaning/purpose, ways to continue to contribute that accommodate the illness, values and legacy; sources of suffering and distress
• Sit with suffering, raise possibility that life can have meaning in the midst of suffering. Bear witness, validate, affirm the individual’s humanity-complete with flaws, regrets, failings, goodness, resiliencies, and fundamental worth to others
• Avoid trying to “fix” or lessen the feeling
Intervention: Existential distress

• Utilize the team and take advantage of interdependence of skills/knowledge

• Engage in goals of care conversations early and often

• Consider the following therapeutic approaches
  • Life Review
  • Acceptance & Commitment therapy
  • Meaning-Centered Group Psychotherapy
  • Dignity Therapy
  • Legacy Interventions (e.g. Legacy Project)
Goals of Care Conversations

• Conducting discussions with patients and families about their values, goals and preferences for care is vital to providing patient–centered and patient-focused care.

• Defines Quality of Life for the individual and develops a vision and map to assist with navigating care.

• Often incorporates or leads to advance care planning.
Goals of Care Conversations

• Goals of Care conversations require:
  • Excellent communication skills
  • Understanding of cultural influence
  • Understanding of decision-making processes
  • Knowledge of coping styles as they may apply to diagnosis, prognosis and decision-making
  • A dynamic process

• Consider evidence base approaches
  • E. g. FAmily CEntered (FACE) pediatric Advance Care Planning
Interprofessional Practice

• Significantly overlapping roles and shared focus on bio-psycho-social-spiritual

  • Navigate shared and unique skills, advocate for own discipline while respecting perspective/role of others

  • Shared ownership, transdisciplinary vs. interdisciplinary care
Conclusion

• Palliative Care is a practice area that has many unique aspects and often is practiced in non-traditional psychological practice settings

• Psychologists have numerous clinical competencies in assessment, intervention and communication that can elevate interdisciplinary Palliative care practice

• Many psychologists are currently contributing to aspects of this work across settings and with flexibility, support and a willingness to move outside of the box, can refine their practice

• Psychologists’ unique and valuable contribution is much needed to impact the lives of numerous patients, families and caregivers during one of the most vulnerable and challenging times in their lives
Resources

• On-line curriculum (e.g. ELNEC, EPEC) & Fast Facts
• Training opportunities (VA Interprofessional Fellowship program, internship training sites with Hospice/PC rotations)
• Listserves (VA palliative psychology group)

• Books, journal articles
• National Organizations (NHPCO, CAPC, AAHPM) newsletters, training activities, organizational memberships
Thank you!!!!!

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