CASE STORY – Psychology

The following case story demonstrates the importance and benefits of Psychology for palliative patients.

Susan was a 42 year old female diagnosed with metastatic lung cancer in 2015. With increasing symptoms and a multitude of medical appointments, Susan was forced to retire from her career in corporate administration. Susan had exhausted all treatment options prior to being referred to the Community Palliative Care Service for symptom management and supportive care. Susan lived with her husband Eric and 16-year-old twin daughters. Eric had resigned from full time employment to become Susan’s full time carer. Over the course of the year, the frequency and intensity of Susan’s symptoms increased as her level of functioning decreased, to a point where Eric felt he could no longer manage his wife’s care needs alone in the family home.

The Community Palliative Care Team organised for an inpatient admission for Susan to enhance symptom control and to alleviate carer distress. As an inpatient, the multidisciplinary team were able to assess key elements of Susan’s level of functioning and found that both her and her husband were scoring High on the Palliative Care Problem Severity Score (PCPSS) for Psychological & Spiritual Distress and Carer Stress subscales. [1]

Psychological Assessment

Susan agreed to speak with the team’s clinical psychologist about her level of distress and her adjustment to end of life issues. Although Susan did not meet diagnostic criteria for a mood or anxiety disorder, she did report anxiety symptoms such as a fear of suffocating and increased heart and breathing rate around periods of dyspnoea. [2] She also reported having an intense fear of burdening her family as well anticipatory grief for the losses associated with her progressive terminal illness.

In the second session, Susan additionally discussed her sense of unfinished business and reported that she had experienced a sexual trauma in her final year of university before meeting her husband. Whilst she had never told anyone about this, she felt she wanted to unburden herself from this secret with a professional as opposed to her family, before she died. Susan was assessed not to meet diagnostic criteria for a current episode of Post-Traumatic Stress Disorder, despite her recent rumination on the traumatic event 20 years ago. [2]

Her expected length of admission was deemed likely to be 10 days before discharge home with increased nursing services in the home to assist with Susan’s decline in functioning and Eric’s carer burnout.
Psychological Intervention

In consultation with the clinical psychologist, Susan prioritised her treatment targets to be 1) management of her dyspnoea distress, 2) sense of unfinished business associated with a past traumatic event, and 3) emotional adjustment to end of life, specifically fear of burdening her family and anticipatory grief regarding expected losses.

In consultation with the physiotherapist, occupational therapist and medical team, a shortness of breath plan was designed specifically for Susan. Cognitive reframing strategies were practiced along with basic grounding techniques to manage the dyspnoea-related distress.

Susan was introduced to a number of distress reduction strategies, finding grounding techniques, guided imagery, and mindfulness practice to be more beneficial for her than progressive muscle relaxation and other basic breathing exercises. Susan and Eric were encouraged to make time to engage together in these distress reduction strategies to assist them both to share in these health-promoting behaviours and to be more accepting and present in their time together in the remaining days of Susan’s life.

The social work team were able to engage regularly on the ward with Eric to offer education and support regarding carer fatigue with appropriate resources also offered to their teenage children. In consultation with the clinical psychologist, it was recommended that both Eric and the children be referred to a community based, private clinical psychologist to assist them with the adjustment to their wife and mothers’ declining health and grief and loss.

A family meeting was held with the multidisciplinary team to discuss the treatment plan and the discharge planning process. The family reported this experience to be highly beneficial. In addition to the family meeting, the ward social worker and clinical psychologist separately engaged the family in a joint family therapy session, with the focus on normalising and validating emotions in a supportive environment. Susan felt confident to share her own feelings around how the children would cope without their mother present in their lives after she died. This allowed the children to reassure Susan that although it would be difficult at times, in honour of their mother they would cope and live out their lives after she had passed, giving Susan permission to let go of her guilt for leaving them.

Given the limited time Susan spent on the inpatient unit, she agreed to be referred to the Community Palliative Care Outpatient Clinic to continue to address her two remaining treatment targets relating to the past unresolved trauma and her own emotional adjustment. Over the course of 6 outpatient sessions, Susan’s experience of trauma was explored using a combination of acceptance and commitment therapy and cognitive therapy. Susan reported that she was able to ‘let go’ of her self-blaming beliefs associated with the traumatic experience and reported feeling a sense of relief over having shared her story. Susan responded particularly well to values work and self-compassion exercises throughout treatment. With the input from the allied health assistant, Susan created a Legacy Document in the form of a recipe book for her daughters, which included a brief biography of her life and cherished photos of her family. Susan reported feeling a sense of accomplishment and found meaning in the life review process and in leaving a tangible legacy for her family after her death.
An integral part of specialist palliative care is the understanding that a person lives a whole life that is multifaceted before their diagnosis that deserves to be acknowledged. Focusing solely on a patient’s adjustment to the end of their life only serves to address part of a whole picture. With this in mind, the power in delivering true multidisciplinary care within a palliative care setting cannot be underestimated.

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References


CareSearch Resources

There are resources within CareSearch that could help allied health professionals in the care and support of their patients. Some of them have been highlighted here:

In the Clinical Evidence section information is available on symptoms including Anxiety and Dyspnoea. There is also information relevant to Carer Support

There is a page in the Allied Health Hub on Working with Families, a page in the Nurses Hub on Family Meetings and a page in the RAC hub on Case Conferencing (these terms are often used interchangeably)

There is also a page in the Allied Health Hub on Psycho-social Assessment that may be of interest

There are Systematic Review Collections on Anxiety, Carers, Dyspnoea, Psychological Issues and on Existential Distress. There are also relevant PubMed topic searches on Psychologists and on Multidisciplinary Teams as well as searches on the above issues.