CASE STUDY

The following case study demonstrates the importance of psychological care for palliative patients.

Ella is a 63 year old woman recently diagnosed with metastatic small cell lung cancer. She was admitted to hospital after presenting to ED with chest pain, shortness of breath and a persistent cough. Following transfer to the oncology unit and further investigation of her disease, it was found that Ella’s prognosis was poor and her condition terminal. Clinical management plans were chemotherapy with thoracic radiation therapy and referral to community palliative care.

Ella’s oncologist had noticed that Ella seemed overwhelmed when she was given the news of her prognosis and seemed to disengage and withdraw from further discussions. The oncologist also noted reports in Ella’s medical file indicating she was experiencing panic attacks and had required mild sedatives and anti-anxiety medication. Although Ella’s oncologist knew she was symptomatically stable, she had concerns for Ella’s mental health. After obtaining Ella’s consent, her oncologist consulted with the psychologist from the community palliative care team and requested urgent contact with Ella upon discharge home.

A joint medical and allied health admission to community palliative care was undertaken with Ella on the same day she was discharged from hospital. A nurse and psychologist visited Ella at home to inform her about community palliative care services. Medical and allied health assessments were completed and plans for ongoing care were arranged. Through collaborative discussion with Ella, it was agreed that Ella would initially receive fortnightly nursing visits and weekly psychology sessions.

Psychological assessment

Given concerns about Ella’s mental health, the psychologist assessed Ella’s mood, psychological vulnerabilities, and presence of psychological risk factors such as history of mental health problems, risk of harm from self or others, and substance abuse. Ella appeared anxious and uncomfortable when discussing these issues. She seemed reluctant to engage but provided adequate information to suggest there were no risk factors requiring immediate action. Clinical assessment of Ella’s mood suggested an adjustment disorder with mixed anxiety and depressed mood as well as panic attacks. [1]

In the first psychology session, Ella appeared a little more comfortable to talk about her personal life and engage with the psychologist. She shared that she had lived alone since her husband died four years ago. She had one son who lived interstate and a few close friends who lived nearby. Ella relayed that it had been quite a shock to receive the news about her illness and she was finding it hard to accept. She said the news had raised some of her biggest fears: ‘Will I be able to live independently?’, ‘Who will care for me when I get sick?’, and ‘Will I die alone?’ Ella also mentioned that she was finding it difficult to cope with symptoms of anxiety and depression such as rumination, worrying thoughts, and panic attacks.
Psychological interventions

Over the course of six psychology sessions, Ella’s psychological, existential, and practical concerns were gradually addressed.

1. Psychological distress was treated using a combination of supportive therapy, psychoeducation and cognitive behavioural therapy, including acceptance and commitment therapy. Cognitive defusion techniques were used to assist Ella in reducing worrying thoughts and rumination. She was taught slow, deep breathing to manage her panic symptoms and breathlessness. Ella was also encouraged to practise various forms of relaxation to manage ongoing stress levels, including mindfulness, relaxation therapy, and social activities.

2. While Ella responded well to psychological therapies, it was recommended that she speak to her general practitioner about antidepressant medication to avoid overuse of benzodiazepine medication.

3. Ella was encouraged to speak openly about her existential concerns. A second joint session with the palliative care nurse allowed a number of her questions about symptom relief, end-of-life care, and advance care planning to be addressed. In line with Ella’s wishes, the nurse arranged for plans to be made for Ella to receive end-of-life care in a hospice. The psychologist referred Ella to relevant services that would assist with completing powers of attorney, funeral plans, and making a will. A referral was also made to the pastoral counsellor to address needs of spiritual support.

4. To assist Ella in continuing to live at home independently, a number of community support services were put in place such as home help, meals on wheels and hygiene support. Ella was informed about the availability of financial supports to help her manage financial burden due to medical expenses.

As a result of the various supports that were put in place, Ella was able to stay at home and live independently until the very end of her life. This was important to Ella as she was able to continue making choices about her wishes, the medical care she received, and advanced care plans.

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References

Resources


Centre for Palliative Care. Centre for Palliative Care [Internet]. 2015 [cited 2015 Sep 10].

CareSearch Resources

There are resources on the website that would assist allied health professionals to support Ella in her end-of-life planning.

- In the Clinical Evidence section, there are pages on Anxiety and Depression.
- In the Allied Health Hub there is a page on Psycho-social Assessment.
- In the Patients, Carers and Families section there is information on Living with Illness and At the End. There are Printable Resources on topics such as advance care planning, feelings and emotions, and dying.