Addressing the Psychological and Psychiatric Domain of Palliative Care

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Over the past decade, populations with advanced illness have received increasing attention from the medical community and the public. Because healthcare systems are focused on disease-modifying treatments and acute medical management, there has been inadequate focus on addressing the needs of patients for whom curative treatments are no longer an option and who are approaching death. Not surprisingly, research has shown a high prevalence of poorly controlled physical symptoms, psychological distress, depression and anxiety, caregiver burden, and socio-economic stress.

The term “palliative care” has come to describe a worldwide movement in health care, evolving from a United Kingdom model of domiciliary care for the dying.1 Palliative medicine is now officially designated as a certified subspecialty by the American Board of Medical Specialties2 in internal medicine, family medicine, neurology and psychiatry, anesthesiology, pediatrics, surgery, emergency medicine, physical medicine and rehabilitation, obstetrics and gynecology, and radiology. In the United States, the field has grown significantly over the past several years with the development of a consensus document3 aimed at identifying a best practices model of care in the various domains of palliative care (including psychiatric and psychosocial domains of care). In 2006, NQF National Framework and Preferred Practices for Palliative and Hospice Care4 adopted the following definition of palliative care:

Palliative care means patient and family-centered that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs to facilitate patient autonomy, access to information and choice.4

The therapeutic model of palliative care is interdisciplin ary and addresses all types of chronic, progressive illnesses, including cancer; AIDS dementias; and end-stage renal, cardiac, and lung diseases. Because the primary focus of palliative care is relief of physical and emotional symptoms that negatively affect quality of life for patients with serious and life-limiting illness and their caregivers, palliative care is relevant throughout the course of the disease—from the moment of diagnosis, through the curative phases, through transitions of care, and during end of life. This implies that palliative care must be available throughout the course of the illness. Palliative care identifies patient and family as the unit of care. Therefore, according to this philosophy, attention to caregiver distress and bereavement is as important as addressing physical symptoms in the patient. Palliative care recognizes that suffering, whether physical, psychological, or spiritual, is experienced by the patient and the family.

The goal of palliative medicine is to allow the patient to maintain a quality of life and prevent and manage physical, psychological, existential, and spiritual suffering of patient
and family by reducing the burden of illness and promoting adaptation and coping. Palliative care begins with a multidimensional assessment and development of a patient-centered and family-focused palliative plan of care. Focus is placed on maintaining and facilitating ongoing communication between the treatment team and the patient-family unit of care to support shared decision making and advance care planning, with due regard for culture, religion, and other sources of individual variation and preference. In this way, not only is patient comfort possible through symptom control, but management of psychiatric symptoms, psychosocial and spiritual distress, complex problems associated with advanced illness and active dying, family distress, and grief and bereavement is also achievable. In *The Nature of Suffering and the Goals of Medicine*, Cassel recommends that three goals be met by physicians in order to reduce suffering:

The first aim is that all diagnostic or therapeutic plans be made in terms of the sick person, not the disease. The second is to maximize the patient’s function, not length of life. The third goal is to minimize the suffering of the patient and the family.\(^5\)

In this context, palliative medicine and hospice care relieve suffering by allowing patients and caregivers to maintain their personal integrity, even in the face of advanced illness and impending death.

William Breitbart, MD, and E. Alessandra Strada, PhD, are delighted to undertake guest editing this special issue on psychiatry and hospice/palliative care. The articles in this issue provide the psychiatric and mental health clinician with a broad overview of the most essential and core issues relevant to the psychiatric care of patients with advanced illness receiving palliative care. The articles range from overviews of psychotropic medication use and psychotherapeutic interventions in palliative care, to examination of two very specific and common issues in palliative care: delirium and bereavement. Carla Garcia, MD, FRCPS, and colleagues review the use of psychotropic medications in the palliative care setting, focusing on the unique roles these drugs can play in the control of both psychiatric and non-psychiatric symptoms. E. Alessandra Strada, PhD, and Barbara M. Sourkes, PhD, review clinical principles of psychotherapy with palliative patients focusing on the unique challenges of the palliative care setting. Yesne Alici, MD, and William Breitbart, MD, provide a concise update on the assessment, diagnosis, and management of delirium in the terminally ill. E. Alessandra Strada, PhD, reviews clinical presentation, diagnosis, and management of grief, bereavement, and demoralization in palliative care patients and caregivers.

**REFERENCES**