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To cite this article: David B. Feldman (2017) Stepwise Psychosocial Palliative Care: A New Approach to the Treatment of Posttraumatic Stress Disorder at the End of Life, *Journal of Social Work in End-of-Life & Palliative Care*, 13:2-3, 113-133, DOI: [10.1080/15524256.2017.1346543](https://doi.org/10.1080/15524256.2017.1346543)

To link to this article: <http://dx.doi.org/10.1080/15524256.2017.1346543>



Published online: 28 Jul 2017.



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Stepwise Psychosocial Palliative Care: A New Approach to the Treatment of Posttraumatic Stress Disorder at the End of Life

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ABSTRACT

Although evidence-based therapies for Posttraumatic Stress Disorder (PTSD) exist for physically healthy populations, these often do not adequately address PTSD in dying patients. Particularly because these interventions require 8–16 weekly sessions, and the median stay in U.S. hospices is 17.5 days (National Hospice and Palliative Care Organization [NHPCO], 2015), there is a potentially serious timing mismatch. Moreover, these treatments may temporarily increase trauma symptoms (Nishith, Resick, & Griffin, 2002), resulting in some patients dying in greater distress than had they not received care. The Stepwise Psychosocial Palliative Care (SPPC) model presented in this article compensates for these difficulties by embracing a palliative care approach to PTSD. Although it utilizes techniques drawn from existing PTSD interventions, these are re-ordered and utilized in a time-responsive, patient-centered manner that takes into account prognosis, fatigue, and logistical concerns. The SPPC approach is further considered with respect to existing social work palliative care competencies (Gwyther et al., 2005) and a case study is used to demonstrate its application.

KEYWORDS

Cognitive-behavioral therapy; end-of-life; palliative care; posttraumatic stress disorder; PTSD

Up to 84% of people encounter a traumatic event during their lives (Benjet et al., 2016; Frans, Rimmo, Aberg, & Fredrikson, 2005; Roberts, Gilman, Breslau, Breslau, & Koenen, 2011; Vrana & Lauterbach, 1994), making trauma an almost universal experience. Fortunately, most people who experience trauma do not develop Posttraumatic Stress Disorder (PTSD), as the disorder affects only about 8% of the general population (American Psychiatric Association, 2013; Breslau, 2001; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Estimates of PTSD among people facing life-threatening and life-limiting illnesses, however, are much higher. In some studies, up to 35% of people with cancer have been found to be diagnosable with PTSD (Alter et al., 1996; Amir & Ramati, 2002; Green et al., 2000; Kangas, Henry, & Bryant, 2005; Mundy et al., 2000). If individuals experiencing symptoms of PTSD without meeting full diagnostic criteria for the disorder are included, this number rises substantially—to 68% in one study of patients with breast

cancer (Matsuoka et al., 2005). According to a recent meta-analysis of 12 samples comparing cancer survivors to matched control participants (Swartzman, Booth, Munro, & Sani, 2016), cancer survivors had on average 1.66 times the odds of having PTSD, even though the control participants in many of these samples had potentially encountered other, noncancer traumatic events in the past. Moreover, all of the aforementioned studies included patients whose cancers may eventually be treated to a stage of remission. In a study of patients with terminal cancers, on the other hand, Kaasa et al. (1993) found that 82 to 88% scored in the high range for PTSD symptoms on the Impact of Events Scale, a commonly used trauma assessment (Horowitz, Wilner, & Alvarez, 1979). Of course, PTSD isn't found only in those with cancer. Systematic literature reviews have found PTSD rates of up to 64% in intensive-care patients with an array of life-threatening conditions (Griffiths, Fortune, Barber, & Young, 2007; Jackson et al., 2007; Tedstone & Tarrier, 2003).

In some cases, the life-limiting or terminal illness appears to serve as the primary traumatic event instigating PTSD (Butler, Koopman, Classen, & Spiegel, 1999; Kangas et al., 2005). Researchers have found, for instance, that the content of many patients' PTSD-related intrusive memories directly involve their struggles with illness (DuHamel et al., 2004; Kangas et al., 2005). Not surprisingly, however, many other cases of PTSD at the end of life originate in past trauma, the memories of which have been reactivated as patients enter the last phase of life (Macleod, 1994; Payne & Massie, 2000).

When considering the topic of trauma, most people immediately call to mind military and veteran populations. Indeed, epidemiological studies show that combat exposure is one of the leading causes of PTSD (Frans et al., 2005). Nonetheless, the event that is the most common origin of PTSD is sexual assault (Frans et al., 2005; Kessler et al., 1995). Other common causes include physical assault, childhood abuse, and other forms of criminal victimization. According to the *DSM-5* (American Psychiatric Association, 2013), any event that confronts a person with death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, can potentially cause PTSD. In addition to direct exposure, PTSD also can be caused either by witnessing such an event or through "indirect" exposure, such as by learning that a close relative or close friend has experienced a traumatic event. Using this definition, as mentioned previously, the vast majority of people have encountered a trauma during their lives that potentially could cause PTSD (Frans et al., 2005; Vrana & Lauterbach, 1994). However, traumas in which the individual perceives that his or her life is directly threatened are associated with the greatest risk of the disorder (Ozer, Best, Lipsey, & Weiss, 2003).

Regardless of the origin of the trauma symptoms or whether they lead to a "formal" diagnosis of PTSD, the symptoms can interfere with several aspects important in the experience of a "good" or "peaceful" death, including doctor-patient communication, emotional and practical support, life review,

and acceptance (Low & Payne, 1996; Pierson, Curtis, & Patrick, 2002; Steinhauser et al., 2007).

Physician-patient communication

Surveys of patients and their families consistently cite communication with physicians as an important factor in quality of life (Steinhauser et al., 2007; Teno et al., 2004). Unfortunately, good doctor-patient communication at the end of life necessarily involves the discussion of mortality, which can serve as a trauma reminder. An important symptom of PTSD involves coping with trauma reminders through avoidance (Bryant & Harvey, 1995; Tiet et al., 2006); therefore, open doctor-patient communication can be significantly hampered. Not surprisingly, studies have demonstrated a relationship between avoidance coping and poorer health status in patients with cancer (Epping-Jordan, Compas, & Howell, 1994; Roesch et al., 2005). In addition, a common symptom of PTSD is anger (Castillo, Fallon, C'de Baca, Conforti, & Qualls, 2002; Jakupcak et al., 2007) and its related feature, mistrust (Glover, Peleski, Bruno, & Sette, 1990; Kubany, Gino, Denny, & Torigoe, 2005). Patients may thus be suspicious of medical advice, leading to heightened medical nonadherence (Boarts, Sledjeski, Bogart, & Delahanty, 2006; Woods & Terhaar, 2007).

Reliance on others for support

Patients with adequate social and instrumental support experience lower depression (Gençöz & Astan, 2006), lower pain levels (Steele, Mills, Hardin, & Hussey, 2005), better quality of life (Tang, Aaronson, & Forbes, 2004), and greater quantity of life (Herbst-Damm & Kulik, 2005) than those without such support. Unfortunately, features often associated with PTSD such as the aforementioned anger, irritability, and mistrust of others (Castillo et al., 2002; Jakupcak et al., 2007) can interfere with supportive relationships. Indeed, individuals with PTSD are more likely to have elevated levels of family dysfunction (Jordan et al., 1992) and to become separated or divorced (Afifi, Cox, & Enns, 2006; Riggs, Byrne, Weathers, & Litz, 1998) than the general public. Those with long-standing trauma issues may thus be more isolated than others and lack adequate caregiver support.

Life review

Decades ago, Butler (1963) observed that many older adults spontaneously engage in life review, a process of reminiscing and making meaning of their lives. Greater levels of such reminiscence are associated with better psychosocial adjustment (Ando, Tsuda, & Morita, 2007; Boylin, Gordon, & Nahrke,

1976; Haight, Michel, & Hendrix, 1998; Havighurst & Glasser, 1972; Serrano, Latorre, Gatz, & Montanes, 2004). In addition, engaging in life review has been shown to decrease depression and anxiety, as well as increase sense of life meaning, among older adults and those in palliative care settings (Chiang et al., 2010; Korte, Majo, Bohlmeijer, Westerhof, & Smit, 2015; Xiao, Kwong, Pang, & Mok, 2012; see Westerhof & Bohlmeijer, 2014). Unfortunately, the avoidant style of coping mentioned earlier (Bryant & Harvey, 1995; Tiet et al., 2006) can prevent patients from engaging in this process. Moreover, when individuals with PTSD do engage in life review, Westwood and McLean (2007) suggested that there is potential for re-traumatization given the presence of intense trauma memories, with some life reviews potentially involving negative emotional outcomes (Haight, 1995).

Acceptance of death

It is almost a “truism” in the death-and-dying literature that acceptance is a sign of psychological health in patients at the end of life (Kubler-Ross, 1969). Despite much productive theorizing (Wong & Tomer, 2011), surprisingly little empirical research addresses this topic, though at least two studies demonstrate a correlation between death acceptance and aspects of psychological well-being (Flint, Gayton, & Ozmon, 1983; Mack et al., 2008). Unfortunately, PTSD-related avoidance coping also can interfere with acceptance, often leading to denial. Goetzke (1995) observed that denial at the end of life “can cause harm. Patients or families may incur astronomical costs in search of a cure or a better prognosis” as well as “lose valuable time that could be spent on unfinished business” (p. 20).

Traditional approaches to treatment

Given the myriad ways that trauma symptoms can interfere with factors associated with a “good” dying process, access to effective treatment is essential. Evidence-based treatments for PTSD include Prolonged Exposure (PE; Foa, Hembree, & Rothbaum, 2007; Foa & Rothbaum, 1998), Cognitive Processing Therapy (CPT; Resick, Monson, & Chard, 2016; Resick & Schnicke, 1992), and Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 1995). Although the efficacy of these therapies for PTSD in physically healthy populations is well-established (see Cukor, Olden, Lee, & Difede, 2010), a variety of reasons exist that these treatments do not adequately address PTSD in dying patients (Feldman, 2011). Most significantly, because these interventions require 8–16 weekly sessions (Resick & Schnicke, 1992; Rothbaum, Foa, & Hembree, 2007; Shapiro, 1995), and the median length of stay in U.S. hospices is 17.4 days (National Hospice and Palliative Care Organization [NHPCO], 2015), many patients will die before treatment is complete.

There is also reason to believe that patients receiving existing treatments for PTSD may die in greater distress than had they not received treatment. This paradoxical effect is due to the fact that these interventions require patients to recollect and speak about their trauma experiences in relatively great detail, often causing PTSD symptoms to intensify before diminishing. Nishith et al. (2002) found that physically healthy individuals who underwent PE and CPT reported increased PTSD symptoms until about Session 6, after which symptoms begin to decrease. Given the short median length of stay in hospice, this timeframe may be a serious mismatch for some patients. Treatment with antidepressants (the most common pharmacologic intervention) may suffer from a similar timing mismatch, sometimes requiring six or more weeks to alleviate symptoms and leading to short-term agitation (Feldman & Periyakoil, 2006; Sinclair et al., 2009). Moreover, the guidelines of existing therapies for PTSD specify that sessions should be 50–90 minutes in length, a challenging and often-impossible duration for patients experiencing fatigue (Teunissen et al., 2007).

Finally, existing PTSD treatments are designed for use once a trauma has ceased. When exposure-based therapies are used in the midst of or very soon after a trauma, they can result in re-traumatization. To avoid this, Devilly, Gist, and Cotton (2006) suggest that traditional therapies for PTSD should be applied no sooner than 2- to 6 weeks posttrauma. This obviously is not possible when the primary trauma is an ongoing illness.

Social work palliative care guidelines

The treatment of psychosocial issues at the end of life is not a straightforward extension of evidence-based approaches for physically healthy individuals. Different standards and approaches may be necessary. As a result, various organizations, including the National Association of Social Workers (NASW, 2004), have published standards and competencies for palliative care. One of the most detailed sets of competencies resulted from the Social Work Leadership Summit on End-of-Life and Palliative Care, held in March of 2002 at Duke University. At the summit, leaders from 30 organizations representing 160,000 social workers gathered to discuss issues unique to seriously ill patients. The resulting palliative care competencies were then compiled and published by Gwyther et al. (2005). These competencies put forth that effective practice should involve a “role of social workers as clinicians, educators, brokers, advocates” (p. 92). Social workers should be able to assess the “impact of illness on the patient’s body integrity and functioning,” and provide interventions that take into account the ways in which physical illness can affect psychosocial well-being. Not surprisingly, the document supports the use of a variety of interventions, including case management and “environmental interventions, such as arranging for equipment, altering, or personalizing

the physical environment” (p. 99). In addition to treating specific mental health issues, competent practice also should broadly involve “advocacy for the needs, desires, and goals of the client, caregiver, and family members” (p. 100) as well as efforts at “enhancing communication to maximize effective and compassionate care” (p. 98).

It is apparent that existing treatments for PTSD fall far short of these aspirations. This is not necessarily a failing of these interventions since they were not designed to address the multiplicity of issues facing patients at the end of life. Existing treatments for PTSD fall short because they follow a curative care philosophy rather than a palliative care one. That is, they were designed for the long-term elimination of PTSD symptoms, rather than to address the impact of these symptoms on quality of life in the context of the dying process. In healthy patients, for instance, the potential for traditional treatments to “cure” PTSD renders it acceptable that these treatments require significant time and may lead to symptom increases in the short term. But this approach ceases to make sense when time is severely limited by a terminal prognosis. A palliative care approach to PTSD would require a more complex, multifaceted, and patient-centered model focused on rapidly increasing quality of life.

Such an approach would also be rooted firmly in the person-in-environment perspective (Karls, 2008) that undergirds much of social work practice. That is, unlike the aforementioned existing treatments for PTSD, it would be based on the notion that an individual cannot be understood outside of the context of his or her environment. In this case, environmental factors would particularly include the variety of circumstances surrounding the life-limiting illness, in addition to other variables. According to Kondrat (2015), however, it is important to note that the person-in-environment perspective is not a stand-alone theory or treatment approach. Expanding on this statement, Kondrat (2015) adds, “This is not to say that more specific formulations linking some aspect of the environment to behavioral outcomes have not been productive. Many of such formulations have formed the backdrop for much that goes by the name ‘evidence-based practice’” (para. 1).

The remainder of this article details one such formulation, known as Stepwise Psychosocial Palliative Care (SPPC; Feldman, 2011; Feldman, Sorocco, & Bratkovich, 2014), which builds on the broader person-in-environment perspective while integrating techniques drawn from evidence-based approaches to PTSD. It also provides a set of considerations for determining the optimal order such techniques should be deployed based on contextual factors. This treatment model is further consistent with the palliative care competencies set forth as a result of the Social Work Leadership Summit (Gwyther et al., 2005). That is, it emphasizes relief of suffering and improvement of quality of life, rather than long-term cure of PTSD, and addresses the ways in which symptoms of PTSD can become intertwined with difficulties arising from the dying process.

The stepwise psychosocial palliative care approach

The SPPC approach (Feldman, 2011) compensates for the shortcomings of traditional PTSD interventions by explicitly embracing a palliative care philosophy. Although the model utilizes techniques drawn from existing evidence-based treatments, they are re-ordered and deployed in a time-responsive, patient-centered manner that considers both environmental and health-related variables. When working with patients with life-limiting and terminal illnesses, number and duration of sessions necessarily vary dramatically, with prognosis and energy levels allowing some patients ample time for extensive therapeutic interventions, while allowing others little such time. This model maximizes the effectiveness of each therapeutic encounter, such that quality of life may be improved in either set of circumstances.

This is accomplished through a stepwise or staged approach. Treatment first addresses short-term concerns (Stage 1: Palliate immediate discomfort and provide social supports), then proceeds to medium-range (Stage 2: Provide psychoeducation and enhance coping skills), and finally to long-range concerns (Stage 3: Treat specific trauma issues). At each stage, providers carefully evaluate the effectiveness of their interventions and obtain information regarding patient prognosis. Providers always begin with Stage 1, moving to later stages only when two conditions are met: (a) earlier interventions did not sufficiently palliate psychological distress and PTSD symptoms, and (b) the patient's prognosis and energy levels allow sufficient time to implement later stages. This staged deployment is essential to the model, rendering it applicable to patients for whom death is imminent as well as to those much earlier in the disease trajectory. Thus, it has been used in both hospice settings as well as in other settings where palliative care is delivered (Feldman et al., 2014).

As a side note, the stepwise approach of the SPPC model differs significantly from other staged interventions, particularly those in the field of health promotion. Past staged interventions have been based largely on the Stages of Change Model (Adams & White, 2005; Prochaska & DiClemente, 1992), which assumes that individuals go through a predictable set of stages (i.e., precontemplation, contemplation, preparation, action, maintenance) as they seek to change behaviors such as smoking, diet, or exercise. The Stages of Change model is subject to much the same critique as traditional developmental models—namely, people do not actually appear to progress through such clearly demarcated stages (see Littell & Girvin, 2002; Pelaez, Gewirtz, & Wong, 2008). For this reason, it is important to note that the stages of the SPPC approach are not rooted in the Stages of Change model or any other model of development. The value of the stages in the SPPC model is primarily a heuristic one. That is, the approach's stepwise structure allows therapists to determine which types of interventions to use given factors such as patient prognosis and level of fatigue.

Stage 1: Palliate immediate discomfort and provide social supports

Because some patients (particularly in hospice settings) may live only days or weeks after curative treatments are halted, therapists should begin by offering techniques that maximize short-term quality of life. Stage 1 consists of techniques that rapidly alleviate distress. Although these techniques generally require only a few minutes to implement, it is worth noting that their effects are also normally somewhat short-lived. Because therapists often do not initially know how long a patient is likely to live, however, Stage-1 interventions are the safest ways to begin.

At Stage 1, as in all therapies, the therapist first attempts to develop a trusting relationship by employing active listening and expressing empathy (Larson, 1993). Through this listening, he or she both has the opportunity to offer social support as well as to learn from patients (and families) practical concerns that are distressing to them.

Stage-1 interventions then address these concerns primarily by making changes to patients' immediate environments. This suggestion is consistent with the encouragement of "environmental interventions" (Gwyther et al., 2005, p. 99) in the social work competencies discussed earlier. As one example, many patients with PTSD are hyper-vigilant to danger and experience increased sensitivity to being startled. Such symptoms can lead to a chronic sense of feeling "out of control" of their environments. A Stage-1 intervention may thus involve asking providers and other individuals to knock on the door or announce themselves before entering a patient's room or area, mitigating the chances of startling him or her. Hanging mirrors strategically on walls, ensuring that the patient can see all parts of the room, can further increase sense of control. As a second example, flashbacks to one patient's time in combat were triggered by the sound of aircraft. The provision of earplugs, particularly at night when he wanted to sleep, helped block out any triggering sounds.

Also consistent with the social work competencies (Gwyther et al., 2005), Stage-1 interventions involve "advocacy for the needs, desires, and goals of the client, caregiver, and family members" (p. 100). Environmental changes often cannot occur without such advocacy. Educating other providers about PTSD symptoms and how to avoid triggering them, mediating conversations with physicians, and finding direct answers to health/dying questions can provide immense comfort to patients. Furthermore, helping patients make funeral arrangements, re-establish contact with estranged loved ones, or achieve personal goals can substantially improve quality of life in the short term. Similar practical interventions can be applied to family caregivers.

A general rule that applies at Stage 1 is that, with the patient's permission, the provider should attempt to solve problems for the patient. This recommendation runs counter to many mental health professionals' training,

which traditionally emphasizes helping patients discover tools to solve their own problems. But, this traditional approach makes little sense for many dying patients, who may lack the necessary time, energy, and health to solve their own problems. Thus, this represents an important point of divergence between “curative care” approaches to psychosocial issues and the palliative care approach advocated here.

The length of this first stage of the model can vary considerably. As mentioned, though Stage-1 interventions are quick to implement, their effects are often relatively short-term. Thus, providers may choose to move quickly to Stage-2 interventions if Stage-1 interventions appear insufficient to address patient concerns. It is important not to skip Stage 1 altogether, however, because these short-term environmental interventions often can be surprisingly effective, rendering Stage-2 interventions unnecessary. It is also important to note that Stage-2 interventions (detailed subsequently) typically require a few weeks to know if they are effective. As such, any decision to move to Stage 2 requires that prognosis allow ample time for such medium-term interventions to function.

For most mental health professionals, the decision to move to later stages cannot be made without consultation with other members of the care team. As the social work competencies discussed earlier state, “Multidimensional assessment enables the social worker to plan bio-psychosocial-spiritual interventions ... in collaboration with care providers and/or the interdisciplinary team” (Gwyther et al., 2005, p. 98). Such collaboration, particularly with physicians and nursing staff, is often necessary to determine whether prognosis allows for Stage 2 or 3 interventions. Of course, the social worker also may determine that Stage-1 interventions sufficiently palliate distress and thus choose not to employ later interventions even when patient prognosis allows.

Stage 2: Provide psychoeducation and enhance coping skills

Stage 2 represents a therapeutic shift toward offering tools that patients can use to solve their *own* problems and cope more effectively with their PTSD-related distress. Although these strategies provide longer term gains than the previous stage, they also require more time to implement. It is important to note that stages of the SPPC model build on, rather than supplant, one another. Moving to Stage 2 does not necessarily mean discontinuing Stage-1 interventions, which may continue throughout the therapy process. As a general rule, providers should never discontinue strategies that are working to palliate distress.

Stage 2 is often the appropriate time to offer psycho-education to patients and families. This is consistent with the social work competencies discussed earlier (Gwyther et al., 2005), which emphasize the importance of

“educational interventions including information related to illness, pain and symptom management, insurance, and financial issues” (p. 99). Because PTSD symptoms are often intertwined with medical issues, providing information about care plans, care options, medications, and the dying process itself, in addition to many other issues, can be comforting. As mentioned previously, individuals with PTSD often find themselves feeling out of control of their lives (Dunmore, Clark, & Ehlers, 2001; Wilson, Smith, & Johnson, 1985), a perception that understandably can be compounded by serious medical illness. The provision of information can help render the complex situations in which patients and families find themselves more predictable, ultimately leading to a greater sense of controllability.

In contrast to therapies for PTSD in physically healthy individuals, which typically begin with education (e.g., Foa et al., 2007; Shapiro, 1995), this component is included in Stage 2 of the SPPC model because education may simply not be an effective use of time if quantity of life is severely limited. It should furthermore be noted that providing medical advice is beyond the scope of practice of most social workers and other mental health professionals, so consultation and collaboration with physicians and nurses is often necessary in order to communicate some categories of information.

Consistent with its emphasis on equipping individuals with tools to help *themselves*, Stage 2 involves teaching patients coping skills that they can use to palliate PTSD symptoms. Such skills, drawn from traditional evidence-based approaches, include, but need not be limited to, relaxation training (Goldfried & Davison, 1994) or breathing retraining (Guell et al., 2006) to reduce hyper-arousal as well as to regulate anxiety and frustration; cognitive restructuring (Beck, 1995) or thought-stopping (Wolpe, 1973) to address distorted thinking and worry; mindfulness-based skills (Kabat-Zinn, 1990; Linehan, 1993) to address negative thoughts, emotions, and somatic symptoms; and assertiveness or communication skills training (Lieberman, DeRisi, & Mueser, 1989; McKay, Davis, & Fanning, 1995) to improve relationships with health care providers, family members, and others. These tools are included in Stage 2 because they often require at least 2–3 sessions to teach as well as at least moderate patient energy levels (i.e., relatively low levels of fatigue) to support consistent practice. Nonetheless, they can lead to relatively durable palliation of trauma-related symptoms. Of course, such coping tools also can be useful for many family caregivers given the immense stress often experienced as part of the caregiving process (Hebert & Schulz, 2006).

Stage 3: Treat specific trauma issues

Stage 3 marks a transition to trauma-focused interventions. Up to this point, therapy has not involved direct discussion of trauma memories. This approach may seem counterintuitive. After all, in traditional treatments for PTSD,

systematic discussion of trauma-related memories is viewed as necessary for long-term resolution of symptoms. But long-term resolution may be irrelevant for patients with only weeks or months to live. Thus, the lack of focus on exposure to trauma memories during the first two stages reflects the SPPC model's palliative care philosophy. This approach ensures that therapy will be unlikely to trigger PTSD symptoms such as intrusive memories, nightmares, or flashbacks in the limited time many patients have remaining.

As with the transition to Stage 2, one should proceed to Stage 3 only when (a) earlier interventions have not adequately alleviated suffering, and (b) prognosis and energy levels permit the use of longer term strategies. For patients with prognoses of months to years, trauma-focused interventions may be indicated.

An additional criterion pertains specifically to this stage: Patients must be open to speaking about the trauma. As reflected in the competencies discussed earlier (Gwyther et al., 2005), important principles in social work are "autonomy, self-determination (Galambos, 1998; Reinardy, 1999), and informed consent" (Kastenbaum, 2001). In cases of terminal illness, it is particularly important to respect patients' choices regarding how to spend the very limited time remaining.

Any trauma-focused approach may be utilized at Stage 3—including Prolonged Exposure (PE; Foa & Rothbaum, 1998), Cognitive Processing Therapy (CPT; Resick & Schnicke, 1992), and Eye-Movement Desensitization and Reprocessing (EMDR; Shapiro, 1995). It is beyond the scope of the present article to detail these interventions, and appropriate professional training should be undertaken before implementing any of them. It is worth noting, however, that therapists may wish to alter the procedures of these approaches given logistical considerations. As one example, to accommodate patients' levels of fatigue, therapists should consider shortening session duration. Of course, shortened sessions may limit the depth and detail about which patients can discuss their trauma memories, leading therapy to progress more slowly from session to session than with physically healthy individuals. Thus, therapists also should consider the possibility of meeting more frequently to offset this difficulty.

Case example

To illustrate the SPPC approach, the case of "Mr. P," a 72-year-old with multiple myeloma is presented. Mr. P was a divorced, White, combat veteran of the Vietnam conflict, who had been referred to the palliative care team of a Northern California VA medical center due to deteriorating health and increased pain. Since being diagnosed with multiple myeloma 2 years earlier, his physical symptoms had been manageable at home. A psychotherapist on the palliative care team arranged to speak with Mr. P during an outpatient

visit to the oncology/hematology clinic where he had been receiving treatment.

Mr. P had a history of PTSD symptoms stemming from combat exposure more than four decades earlier. Though he took antidepressant medication for a brief period ending 15 years prior, he never received psychotherapy. He indicated that, over the years, he had experienced waxing and waning nightmares, intrusive combat-related memories, anxious and depressed affect, and anger issues, among other symptoms. Very few of these symptoms had been present during the preceding 5–7 years, however. During the meeting with the therapist, Mr. P appeared calm, displayed good understanding of his health condition, and appeared to be coping appropriately. Though not opposed to psychosocial services, he indicated no current desire or need for such services. As such, the therapist determined that, although frequent contact was not necessary, further assessment should occur if and when Mr. P's health status changes significantly.

Approximately two months later, Mr. P was admitted to the same medical center's inpatient hospice unit. Mr. P's illness had progressed considerably, resulting in increased fatigue, weakness, pain, and decreased mobility. He and his primary physician agreed that his condition was "terminal" (a word used by the patient). Mr. P lived alone, "off the grid" in a cabin in a wooded area close to a major metropolitan center. Because of this isolation and the presence of few family members, friends, or other caregivers, he was no longer able to care for himself at home.

Within 2 days of admission, hospice staff reported that Mr. P was having numerous difficulties. He had begun experiencing problems sleeping due to nightmares about being attacked, disturbing thoughts and memories that he could not put out of his mind, vivid hallucination-like episodes (i.e., flashbacks), mild paranoia, and intense frustration and negative mood. He became increasingly confrontational with staff (often yelling at them upon their entering the room), began refusing medication, and displayed extreme agitation. Medical and nursing staff initially labeled this behavior with words like "delirium" and "anxiety." However, the unit's psychotherapist assessed more thoroughly, identifying Mr. P's symptoms as a recurrence of his PTSD. As such, he decided to utilize the SPPC model.

One of the challenges in working with trauma issues within an interdisciplinary team is that knowledge of PTSD and its symptoms can vary widely. Other providers may misconstrue PTSD as general anxiety, depression, or delirium, conditions that may be more familiar (Feldman & Periyakoil, 2006; Samson, Bensen, Beck, Price, & Nimmer, 1999; Woods, 2003). As a result, patients may not receive appropriate care for PTSD (Martinez, Israelski, Walker, & Koopman, 2002). Part of the role of mental health professionals is to engage team members in education regarding PTSD (and other mental health issues). Daily team meetings can present good opportunities to provide such

education, as long as it is brief, occasional, and in the context of current patient issues. For example, after assessing Mr. P, the therapist reported to the team that the patient qualified for a diagnosis of PTSD and briefly explained how the diagnosis fit the symptoms and behaviors the nursing staff had observed. He also provided brief information about the prevalence of PTSD and invited staff to consult him in the future should they observe such symptoms in other patients.

In addition to assessment for PTSD, the initial meeting between the therapist and Mr. P focused on developing therapeutic rapport and identifying specific difficulties experienced by the patient. The patient reported significant difficulty with the noise level on the unit. His room was located directly next to the nurses' station, and noise would frequently startle him, particularly when sleeping. Also, he was not able to see people entering his room, as the bed did not face the door. As a result, when staff members entered the room unannounced, this triggered an intense startle response, which turned quickly to frustration, anger, and treatment refusal. Relatedly, he noted difficulty being able to remember staff members, especially their particular specialties and responsibilities. All of this resulted in Mr. P feeling out of control of his environment and generally unsafe, a feeling somewhat reminiscent of his time in combat.

Consistent with Stage 1, this information was used to identify environmental interventions that could quickly palliate his distress. Noise reduction was achieved by moving him to a lower traffic area, as well as by keeping his door closed. To enable him to see who was entering the room, a mirror was placed on a table opposite the door. Furthermore, in team meetings, the therapist spoke with staff, asking them to announce themselves, their disciplines, and the purpose of their visit upon entering the room. A sign to this effect was placed on the door to his room. Given that the therapist previously provided education to the team regarding the symptoms of PTSD (including the startle response) they were willing to try these changes as an "experiment."

Mr. P also indicated a lack of trust in his physician, suspecting that she did not have his best interests in mind. As previously mentioned, mistrust, particularly of those in authority, is a common feature associated with PTSD, particularly in combat veterans (Glover et al., 1990; Kubany, Gino, Denny, & Torigoe, 2005). In this case, Mr. P had many medical questions that he felt the doctor was not adequately answering, and he attributed this to possible mal intent. As such, the therapist suggested that he could serve as an intermediary between Mr. P and the physician. Session time was spent discussing the medical questions that Mr. P felt had been unanswered. The therapist then communicated these questions to the physician, who visited the patient the next day.

During this visit with the physician, the therapist was present to mediate the discussion. Some physicians are initially reluctant to agree to a mental

health professional's presence at such a meeting because of fears that he or she may "interfere" with the medical conversation. As such, prior to the meeting, the therapist clarified his role with the doctor, emphasizing that he would be present primarily to provide emotional support to Mr. P and to ask occasional questions to help clarify what both parties were saying. During the meeting, the therapist took great care not to practice outside of his scope. Finally, after the meeting, the therapist met with Mr. P to assess the patient's understanding of the conversation and provide additional support.

A key to implementing the SPPC model is to allow sufficient time to assess the effectiveness of Stage-1 techniques before moving to later-staged interventions. As mentioned in the earlier discussion of traditional interventions for PTSD, certain techniques can temporarily increase distress (particularly exposure-based interventions); as such, these are reserved for later in the SPPC model should earlier staged interventions not sufficiently palliate symptoms.

In this vein, a follow-up visit was conducted 4 days after completing Stage-1 interventions. Mr. P noted feeling more comfortable in his room and getting along better with staff. He felt more in control of his environment and his medical care, significantly reducing PTSD symptoms such as hyper-arousal, irritability, exaggerated startle response, and negative mood. However, he still was experiencing occasional intrusive memories and the resultant anxiety. Though these symptoms had been palliated somewhat due to the reduction in environmental PTSD triggers, they still occurred sporadically. Given these remaining symptoms, the therapist consulted with Mr. P's physician to determine whether his prognosis would allow sufficient time for Stage-2 interventions. Because the physician indicated that Mr. P was likely to live for "weeks to months," the therapist determined that it would be appropriate to proceed to Stage 2 of the SPPC model.

The therapist began this stage by providing limited psycho-education, speaking with Mr. P about the nature of PTSD, how it may affect him in the context of his physical illness and how end-of-life experiences can trigger past stressful memories. Consistent with Stage 2's emphasis on offering patients tools that they can use to help themselves, the therapist offered training in coping skills to help Mr. P manage his distress. In particular, to aid Mr. P both with sleeping and emotion regulation during the day, deep breathing and visualization-based relaxation skills were taught. In addition, to help Mr. P maintain good communication with his physician and other staff members, tools drawn from assertiveness/communication skills training (McKay et al., 1995) were utilized. These communication tools were framed as tips for "how to talk to doctors."

Over the course of five biweekly sessions, each lasting approximately 20–30 minutes in length, Mr. P began reporting better sleep, decreased nightmares, improved ability to self-soothe during the day, and increased comfort with his physician. Moreover, feedback from the care team indicated that his

mood had improved considerably and that he was establishing more amiable relationships with them.

At this point, the therapist again assessed Mr. P's symptoms. As mentioned, the patient and staff reported that his PTSD symptoms had reduced substantially. As a result of this improvement, the therapist deemed Stage-3 interventions unnecessary. Of course, if Mr. P were a medically healthy patient likely to live for many years, it would not make sense to stop here. After all, the interventions offered thus far are unlikely to "cure" PTSD. However, careful consultation with Mr. P's physician indicated a prognosis of only a few weeks to perhaps a few months, as previously mentioned. Thus, given that his trauma symptoms had been adequately palliated, it was determined that it would not be worth the risk of increased distress to implement exposure-based Stage-3 techniques.

Conclusions

In their introduction to the social work palliative care competencies discussed throughout this article, Gwyther et al. (2005) wrote,

Social workers are uniquely qualified and positioned to work in the fields of palliative and end-of-life care Historically, a core professional value has been the need for a multidimensional approach to problem solving This is a frame of reference replicated in the provision of quality palliative and end-of-life care. (p. 104)

The SPPC model is just such a multidimensional approach, integrating environmental, problem-solving, and other psychosocial interventions with patient advocacy in a patient-centered, time-sensitive manner. This model is firmly set within existing general frameworks, including the person-in-environment perspective and palliative care philosophy. Moreover, it incorporates techniques drawn from evidence-based approaches to PTSD, deploying them in a stage-wise manner appropriate for patients at the end of life.

Social work professionals in palliative care and hospice settings have a great burden of knowledge, given that patients may suffer from an array of mental health diagnoses in addition to a wide variety of debilitating medical issues. Gwyther et al. (2005) specified that "knowledge of the symptoms, treatment, and impact of various [mental health] diagnoses" (p. 93) is necessary to good psychosocial care at the end of life, and they specifically included PTSD among these diagnoses.

Given that social work professionals often do not have long relationships with palliative care patients, the SPPC model provides a framework for considering how to nimbly address PTSD in the context of a life-limiting disease. By utilizing this model and developing other models like it, effective "management of distress, symptoms, and suffering to maximize quality of life" (Gwyther et al., 2005, p. 93) can be achieved in whatever time remains for our patients.

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