

CBT in palliative care

CBT for Chronic Illness and
Palliative Care. Wiley.

Sage, Sowden, Chorlton and
Edeleanu (2008)

Today we'll consider:

- Cognitive Behavioural Therapy as an approach to the understanding and treatment of psychological disorders
- The use of CBT in palliative care
- CBT at St David's Foundation
 - Training CNSs
 - Psychological referral scheme

Cognitive Behavioural Therapy

History of the development of CBT:1

- Interest in animal and human behaviour and learning grew during the 20th century, leading to the development of learning theory in the 1960s
- The ways in which humans learn and behave started to be understood, and its earliest applications in psychiatry were in the use of “token economies” in psychiatric wards. The behaviour of psychiatric patients was modified using a system of rewarding “desired” behaviour and withdrawing reward from undesired behaviour.
- This was termed “behaviour therapy”. If you were psychiatrically ill in the 1960s the main treatments were medication and behaviour therapy
- More sophisticated applications of behaviour therapy came with looking at the behavioural aspects of specific conditions such as anxiety (systematic desensitisation) and depression (activity scheduling)

History of CBT: 2

- Behavioural treatments of anxiety and depression met with success
- Simple behavioural treatment did not however always work, and by the 1970s, cognitive psychology started to offer a way of increasing the power of behaviour therapy by taking into account people's thinking patterns. Aaron Beck described how people develop ways of thinking about themselves and the world over the course of their formative years. He noted that early on in life we form assumptions about ourselves and the world and that if these are fairly benign and accurate they will cause little trouble.
- If however our assumptions about ourselves are negative they can produce depression ("I am bad", "I am unlovable" etc) or anxiety ("I cannot cope with things", "I am weak" etc) or other disorders.
- Since the 1980s there has been a growing recognition that as well as our conscious thoughts, unconscious thought processes play an enormous part in our mental activity, so theory and practice continue to evolve

Current understanding of human mental activity

- Behaviour
- Thoughts
- Emotions
- Physical sensations

All affect each other, consciously and unconsciously all the time. When one or more of these becomes a problem, the others may all be playing a part

- Our thoughts, behaviours, emotions and sensations allow us to comprehend the information we are taking in about the world around us and our internal state. They allow us to respond and to plan what to do next

Functions of physical sensations, emotions, behaviour and thoughts

- Physical sensations... provide the raw data our bodies register about the world around us AND our internal state
- Emotions... are our brain's automatic response to those physical sensations. They are AUTOMATIC and unconscious interpretations of the physical data
- Behaviours... are the ACTION responses to these emotions
- Thoughts...are the higher cortical processing of all of this information as it arrives in the conscious mind (thinking also takes place in the unconscious). Organised chunks of thought become built up into beliefs, which are thus accumulated knowledge and expectations based on thoughts, behaviours, emotions and sensations

- The operation of these aspects of human activity is continuous, and it is what keeps us alive and functioning.

Examples;

- * A child pricks her hand on a rose thorn
- * A man hears a car approaching fast as he is about to cross a road
- * A boy is punched in the playground
- * A woman sees a friend in the street who ignores her

Symptoms

- In Cognitive Behavioural terms, psychological symptoms are being maintained by maladaptive patterns of behaviour and by distorted thinking patterns

The cognitive behavioural approach

Symptom reduction can be achieved by

- identifying and modifying unhelpful patterns of behaving
- Identifying unrealistic beliefs and biased patterns of thinking and opening those beliefs and thinking patterns to critical examination with a view to developing more realistic and adaptive ways of thinking

Therapeutic Style

- Sharing the CBT model of understanding psychological symptoms with the patient and working collaboratively
- Empiricism, by which is meant a scientific-type search for evidence for and against beliefs etc and then testing what that evidence means.
- Focus on specific goals
- Guided discovery or “Socratic Questioning”

Assessment

- What is the problem the person would like help with?
- What are the situations, thoughts, emotions, behaviours and physical sensations associated with the problem?
- What are the immediate and longer-term consequences of the problem?

- The overall assessment is made up of
 - Record forms (diary/ log)
 - Interview
 - Questionnaires

Formulation

- An understanding or explanation of the patient's identified problem and the factors which contribute to its maintenance
- It describes a specific sequence of thoughts, sensations, emotions and behaviours which start with a triggering event and lead to a particular outcome
- It will be as simple as possible

Example

- A 30 year old woman is needle phobic following a needlestick injury sustained when working on a medical ward.
- When she sees any sort of needle she experiences increasing levels of fear (emotion) and notices her heart pounding (physical sensation). She thinks of the danger of being pricked by a dirty needle and dwells on how the injury could have led her to contract HIV or hepatitis (cognitions).
- She goes out of her way to avoid any contact with needles and has given up her hobby of dressmaking (behaviour=avoidance).
- This problem is being maintained by the behavioural avoidance of needles and the catastrophic thinking.

Goal Setting

- Goals follow directly from the formulation
- They need to be
 - Specific
 - Measurable
 - Achievable

CBT in palliative care

Prevalence of psychological problems in palliative care patients

- Approx half of patients receiving a diagnosis of cancer experience levels of anxiety and depression severe enough to affect their quality of life adversely
- Half of these patients then manage to make a satisfactory adjustment, but half continue to be so affected after 6 months
- In the year following diagnosis approx 1 in 10 patients will experience symptoms severe enough to warrant psychiatric/ psychological services intervention

Use of CBT in palliative care

- Treating psychological symptoms which pre-date the illness (anxiety, depression, OCD, eating disorders, psychotic symptoms etc)
- Managing the physical symptoms of the illness and its treatment (such as fatigue and pain)
- Helping with problems in adjustment to life limiting illness and the losses involved.

The following are examples of
psychological interventions
using CBT

CBT for depressive type symptoms

- In depression the pattern of behaviour which maintains the depression once it has started is lack of Response-contingent positive reinforcement. Treatment is “Activity Scheduling”
- In depression the person’s thinking patterns are biased in a variety of ways towards negative self appraisals. Beliefs about the self relate to lack of worth or to being a “bad” person. Treatment involves cognitive restructuring

CBT for Anxiety and Panic

- In anxiety and panic, the behaviour which maintains the anxiety/ panic symptoms is avoidance .The behavioural treatment of anxiety and panic is systematic desensitisation
- The person's thinking is distorted towards an over-estimating the danger inherent in a situation and simultaneously under-estimating their ability to manage or cope with it. Therapy involves cognitive restructuring

CBT for “Overdoing it” symptoms

- Pain and fatigue can be helped with behavioural and cognitive methods
- The behavioural technique of “Pacing” is a method of self-management which is aimed at reducing the risk of self-induced fatigue or pain. It aims to heighten awareness of signals from the body.

Adjustment Problems: Facing crises

- When any of us is faced with a crisis, we bring to it all our strengths and weaknesses.
- Those strengths and weaknesses are a product of our personality and our experiences up to that point.
- As we have grown up, we have faced a sequence of challenges/ life stages
- The way that we faced these, and the help we had with them, determines in what state we will go on to the next challenge/ life stage

Life Span Development

- Erikson (1950) proposed 8 stages in the psychological development of the individual, from birth to old age.
 - Just as we grow and change physically over the decades, so we change and grow psychologically.
 - Each stage of psychological development has its own features.
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- 1-6 years Early childhood
 - 6-10 Play age
 - 0-1 year Infancy
 - 10-14 School age
 - 14-20 Adolescence
 - 20-35 Young adulthood
 - 35-65 Maturity
 - 65+ Old age

Stage 8: Ego integrity v despair

- The task from 65 onwards is to accept one's life for what it has been and has not been.
- Good outcome is that the person looks back on their life, is satisfied with what has been achieved, and ready to face death. It involves acceptance that one's life is one's own responsibility. Recognition of the smallness of one's place in the universe. Wisdom is achieved
- Poor outcome includes excessive regret that the person's life has not been different. For example, they have not had loving relationships, have not met personal goals and feels they have no choice but to face death as a failure. They may feel there is no time to alter anything.

Dealing with stage 8

- People who are ready for it and manage it
- People who aren't ready, but with help and guidance can begin to deal with it because they have the necessary psychological resources (trust, autonomy, competence, sense of identity, intimate relationships etc)
- People who aren't ready and seem unable to negotiate it because previous stages have not been negotiated successfully and they do not have the necessary psychological resources

Dealing with loss

- Dealing with change and loss requires being able to:
 - *Retain hope that things will be manageable
 - *Retain a positive sense of yourself and belief in your ability to cope
 - *Feel that you won't disintegrate as a person...the person you have always been is still there
 - *Recruit and accept help and be able to depend on others
 - *Feel that you still have things of value to give others

Denial

- Denial offers a defence against the pain of loss
- Denial is a psychological way of protecting oneself from something which feels too anxiety-provoking to accept
- It may be more healthy than the alternative for some people, if facing the reality would precipitate a mental breakdown or collapse of functioning (eg for someone who has difficulty “trusting” the world, a diagnosis could spark a fear that there is nothing to rely on)

Psychological therapies at St David's Foundation

NICE guidance

Level 1	All health and social care prof'ls	Recognition of psychol. needs	General psychological support
Level 2	Health & social care prof'ls with extra expertise	Screening for psychol. distress	Psychological techniques eg problem solving
Level 3	Trained & accredited prof'ls	Able to diagnose some psychopathology	Specific interventions eg anxiety management. Explicit, theory-driven
Level 4	Mental health specialists	Diagnosis of psychopathology	Specialist interventions (CBT, psychotherapy etc)

Psychological therapies at St David's Foundation

- CBT training for CNSs and Social Worker
- Clinical Psychology referral scheme