

AIHPC Education Fellowship Report

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Theme: Cognitive Behavioural Therapy in Cancer and Palliative Care

Visit: St Christopher's Hospice, London

Dates: 12-14th June, 23rd-24th September 2013.

Overview of aims and purpose of the visit:

My overall aim was to enhance and adapt my previous experience as a Mental Health Social Worker with training in Cognitive Behavioural Therapy (CBT) for the palliative care setting.

The purpose of the site visit was to:

1. Attend the course Cognitive Behavioural Therapy in cancer and palliative care 'first aid training' delivered at St. Christopher's Hospice, Sydenham, London.
2. To learn about facilitation and delivery of the programme, gaining insight into the key areas addressed in training for 'first aid' CBT.
3. To share the information and knowledge I have gained on my visit with the wider Palliative care community, initially within Galway Hospice and to help facilitate education and delivery of cognitive behavioural therapy approaches if sufficient interest.

Objectives developed prior to the visit:

1. To understand the delivery, funding and roll out of the CBT programmes to professionals working in palliative care in the UK setting.
2. To share innovative methods and mixed method resources (video, audio) for continuing healthcare education in psychological approaches to patients and families/carers.
3. To develop collaborations with staff involved in the delivery of CBT approaches with patients within a Palliative Care and Bereavement setting.
4. To gain knowledge of the CBT clinic operating at St Christopher's hospice.
5. To develop my own skills and capacity as an educator by observing Kathy Burn (facilitator of the programme).

Outcomes achieved as a result of visit

The following section provides a summary of key learning from the Fellowship visit.

Emotional distress is common in palliative care and is frequently encountered among patients and their family/carers by staff working in palliative care. Providing holistic care for physical and psychological symptoms can be very challenging for staff working with such patients. Burn (2013) highlights that patients with a life limiting illness may struggle with very realistic negative thoughts such as 'I am going to die' or 'this is my last breath'. This can be very distressing for patients approaching the end of their life who may often be severely compromised by their physical condition.

In the UK, a Department of Health Innovations grant was obtained by Marie Curie Cancer Care and St Christopher's Hospice to cascade CBT skills training to multidisciplinary team members over three years (2009 -2012). This CBT training was specifically designed to focus on issues within palliative care. Over a number of years, they have developed, evaluated and cascaded a brief training in CBT skills for palliative care practitioners (predominantly nursing staff) that enables them to address patient distress and enhance coping, with referrals made to skilled practitioners for individuals with more complex needs. After training and with ongoing supervision, staff were able to use a repertoire of CBT-based skills in their usual practice to improve emotional distress and enhance coping with physical symptoms, changes in body image and physical ability, and to reduce dysfunctional coping strategies (Mannix et al 2012).

Moorey (2013) notes that Cognitive Behavioural Therapy (CBT) has established itself as an effective intervention for managing anxiety, depression and distressing symptoms such as pain, nausea and insomnia in people with cancer. In reality, attendance at formal counselling services may not be desirable or practicable for very ill people with small energy reserves and a limited capacity for new therapeutic relationships, which adds considerably to the cost of delivering care. Although widely used and evidenced within the mental health field, the challenge in a physical health setting, is that flexibility and adaptation of the CBT model is required due to the changing course of physical illness. A central notion in cognitive models of emotional disorder is the idea that it is not what happens that matters, but rather people's expectations and interpretations of events that are responsible for the production of negative emotions, including anxiety and sadness (Clark, 1999). CBT can help patients explore how problems are conceptualized and re-evaluate symptoms, enhance the individual's sense of control and promote engagement in coping (Dein, 2005).

- The three day course attended by approximately thirty participants from the palliative care setting included medical , nursing, pastoral care, social work, occupational therapy and physiotherapy. The course is particularly suitable for those practicing at Level 2 of the Nice Guidance in Supportive and Palliative care. Course content related to the following: Ability to use the cognitive model in understanding emotional reactions to physical illness and enabling patients to gain new insights and perspectives on distress by recognising thinking and behavioural 'traps'
- CBT style' of collaboration, questioning and assessing problems using Socratic questioning and simple formulation technique e.g. 'hot cross bun'.
- Familiarity with a range of cognitive and behavioural skills
- A range of examples of end of life care where CBT was effective

- how to apply CBT techniques in the management of emotional distress and to improve tolerance of physical symptoms techniques for
- Due to the changing course of physical illness, flexibility is required in the application of CBT techniques –consideration was given to how professionals may select the most appropriate interventions to use in various situations.

Training involved a combination of didactic teaching, experiential learning, demonstration and discussion. Delegates had the opportunity to practise CBT skills in paired role-plays. The time period between day two and three is designed to allow delegates to practice acquired skills in their various settings with emphasis on the third day of trainees' own cases as learning materials and its diverse application.

An unexpected learning from the group training led me to gain further insight into multidisciplinary team members' fears and anxieties in responding to patients in a 'curious manner through the use of Socratic questioning'. Socratic questioning seeks to get the person to answer their own questions which in turn

- A) The client has the knowledge to answer
- B) Draw the clients attention to information which is relevant to the issue being discussed which may be outside the client's current focus
- C) Generally move from the concrete to the more abstract which
- D) The client can, in the end, apply the new information to either re-evaluate a previous conclusion or construct a new idea.
- E) Questions may include: *What alternative ways of looking at this are there? What are the implications of...? How does ... affect...?*

Padesky (1993) states that if therapists are too confident with where they are going, "you only look ahead and miss a detour that can lead you to a better place". Wells (1997) writes "a combination of knowing where to go, but allowing time to explore the patients' evidence for thoughts and for the patient to generate solutions is desirable".

This can often be a very hard shift in attitude for health care professionals to make. In some professions, there appears to be an unspoken pressure to respond to patients distress/questions with answers which can include advice giving and reassurance giving. The professional's own expectations of self and /or cultural norms within a profession/organisation may influence this. In order to do the task properly getting used to adopting this attitude and becoming comfortable with asking questions from a standpoint of complete naivety and ignorance, trying to make as few assumptions as possible and offering no advice or opinions except in the form of options for consideration is required.

The development of the CBT clinic in St Christopher's is primarily for patients who are physically able to attend for treatment for 30minutes-hour and offered by a trained CBT therapist. Referrals may relate to panic, anxiety, depression etc. Collaborative work between the therapist, nurse, patient and family is important for appropriate behavioural experiments to be successful.

So what next in terms of 'First aid' CBT. The model used in the UK is impressive, and while it may not be replicable to the same level throughout Ireland currently due to funding restraints we can certainly learn from their experiences. The hope and key is to making therapeutic approaches available to as many patients and families members as possible.

Potential outputs to be delivered as a result of the visit:

- Presentation of learning outcomes (via report and presentation) to All Ireland Institute of Hospice and Palliative Care (AIHPC)
- Presentation of learning outcomes to staff at Galway Hospice Foundation to support knowledge transfer locally.
- Revise the Service Improvement Initiative in Galway Hospice- 'Coping with a life limiting illness' seminars and integrate new pieces of information, videos and delivery as a result of information and educational resources shared.

References

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