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Reflective Praxis of Clinical Psychology in Palliative and Hospice Care

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When patients' conditions become terminal, they often experience a sense of unfamiliarity and alienations at the physiological, psychological, interpersonal, and spiritual levels. Therefore, applying the knowledge and practice of clinical psychology to help them in returning to daily life as possible is a key issue. This article posits that in addition to physical treatment and symptoms control, there is a need for the palliative and hospice care system to emphasize the integration of the psychological, social, and spiritual aspects of the situation, thereby providing holistic care for patients and their family caregivers. A literature review was conducted to present the current status of research and clinical psychological services and to reflect the "biopsychosocial-spiritual" model. This model was then used to understand the needs and situations of "terminal patients" and their "family caretakers," on which based-empirical studies of holistic clinical psychological interventions are proposed. Subsequently, a reflective critique was employed, proposing that the contributions of clinical psychology to palliative medicine or terminal care are based on the integration of knowledge and praxis through a process of assisting patients and their family members to transition from "having" to "being." Knowledge as related objects (such as natural or artificial) is the essence of understanding practical activities (praxis). Hence, the process of converting "knowledge" to "being" is to disclose Dasein, the existence of human beings thrown into "being toward death". This article points out that palliative and hospice care in Taiwan, whether its focus on the stress model or existential approach, based on the outcomes of on-site clinical practice, showing the characteristics of multiple concepts and methods in order to enhance the quality of care. It is the subject act of knowledge as praxis, and theory and practice is not binary, clinical psychology knowledge is the embodiment praxis of palliative care, based on which future issues and suggestions are discussed.

Keywords: *anima care, biopsychosocial-spiritual model, clinical psychology, hospice palliative care, stress model*

Extended Abstract

When patients' conditions become terminal, they must eventually face the physical effects of their worsening condition, severe changes to their lifestyle, and ultimately accept that the end of their lives is near (Hinton, 1984). Svenaeus applied Heidegger's concept of "being-in-the-world" to his description of the state of human health and illness. consider that when we are on the health state which is a state of 'homelike being-in-the-world' characterised by being balanced and controllable; but once illness enters our world, we are in a state of 'unhomelike being-in-the-world' characterised by being 'off-balance' and alienated from our own bodies (Kayali & Iqbal, 2013).

Wu et al. (2019), looking back on the development of clinical psychology in Taiwan, stated, "In clinical practice, Professor Wu En-Chang proposed a stress model, which had a profound impact on the research and practice of health psychology in Taiwan. The stress model expanded the discussion on chronic disease research and the multidisciplinary integrated medical system for cancer patients at the Clinical Psychology Center of National Taiwan University Hospital. Moreover, the psychological

aspect of palliative medical care is also unique in Taiwan, such as "anima care,"'' established by Professor Yee Der-Huey in Tzu Chi Hospital, accompany patients and their families are accompanied based on existential phenomenology at the Koo Foundation Sun Yat-Sen Cancer Center, and it provides care based on the narrative approach on at Liouying Chi Mei Medical Center.'' Based on the aforementioned points, this article discusses the clinical psychology of palliative and hospice care in Taiwan.

Integrated Care Perspective: Biopsychosocial-spiritual Model

Engel (1997) proposed a biopsychosocial model, indicating that the medical model must also consider the patient's social context and the complementary system. Hiatt (1986) further expanded the model, suggesting that spiritual dimension could be added into it. Spiritual dimension constitutes the point of juncture of the person with the ground of being, which influences physical and social processes. Patients with terminal illness usually experience a decline in their physical condition, and as they approach death, they are confronted with a feeling of detachment from the world. Yee (2007) first proposed the concept of anima care, and Lee (2015) pointed out the experiential transformation of temporality and spatiality in anima care; that is, both the patient and caregiver enter the existential experience of circulating time and jointly frame the space of encounter. When psychological care is provided for terminal patients, the link between the patient and their life experience should not be understood separately. Clinical psychologists in the medical field comprehend the relationship between the "whole person" and their life experience based on the biopsychosocial-spiritual model, extract their possible issues and situations, and aim toward a comprehensive understanding.

The Situation of Patient and Family Members: Understanding them through a Biopsychosocial-spiritual Model

Sulmasy (2002) describes the twofold experiences of disturbances that terminal patients experience based on the biopsychosocial-spiritual model. First, the terminal disease can break the line of patients' internal status, and they are likely to face changes or imbalances in the relationships between them and physiological and biochemical processes; this could further impact or fracture their cognitive understanding of their symptoms and emotions after the physiological change in their condition. Second, there can be a fracture of the relationship between the individual patient and their environment, including interpersonal relationships such as familial and social relationships, or the physical environment of their ecosystem and, therefore, the relationship between the patient and the caregiver. In other words, the patient may face the break of a dual experience at the same time. The first break is the fracture of the continuity of the body, and the second is the fracture of the world of Das Man. When a patient experiences a fracture or the root is lost, they may fall into the abyss, which is the case in many end-of-life patients (Yee, 2000). Tsai and Lin (2016) indicated that terminal cancer patients faced certain existential issues. The perception of body not only belongs to the physiological field of body medicine but is also part of the life experience, acknowledges the place of self, and responds to all possible changes with a life attitude.

The situation of family caregivers could be further understood through Wang (2003), who stated that people have a nature of "caring"/"worrying" about the world, including how they handle things, how they take care of others, and worry about their own illness and death, which are necessary for human existence. An ethical relationship that responds to the call of responsibility is the cause of family caregivers' care and worry (van Manen, 2002).

Psychological Care Service of Palliative Care: The Empirical Aspect of the Biopsychosocial-spiritual Model

There are multiple psychosocial care approaches in the field of hospice palliative care, and in accordance with the clinical issues, needs, and physiological or disease state of patients, a distinct corresponding care

mode is chosen. Kasl-Godley et al. (2014) reviewed and summarized the recommended psychotherapies or interventions for hospice palliative care, including motivational interviewing, cognitive-behavioral therapy, acceptance, and commitment therapy, and so on. Fulton et al. (2018) conducted a meta-analysis consisting of 32 studies of psychotherapy in palliative care populations and found that cognitive-behavioral therapy and acceptance and commitment therapy delivered by mental health providers showed significant mitigating effects on feelings of depression and anxiety for terminal patients. Other studies also support the effectiveness of short-term cognitive-behavioral therapy in alleviating anxiety symptoms (Greer et al., 2012) or the severity of physical symptoms (Sherwood et al., 2005) in patients. Additionally, patients usually experienced depression, anxiety, and physical symptoms at the later stages of the disease, at the same time experiencing feelings of suffering, feeling the collapse or damage of the essence of meaning, an impact on their sense of self and the world that they are familiar with. Recent research has found that psychotherapy promotes the search of meaning, sense of purpose, and sense of self-worth for patients with terminal illness through Dignity Therapy, Meaning Centered Psychotherapy, Supportive-expressive group therapy, life review, and other psychotherapeutic approaches (LeMay & Wilson, 2008; Saracino et al., 2019). Bauereiß et al. (2018) reviewed 24 studies and analyzed the effects of spiritual or existential-related psychological interventions on cancer patients' adaptation. Supporting spiritual intervention or existential-related psychological intervention could enhance short-term existential well-being, quality of life, hope, and self-efficacy.

For the state of being, Yee et al. (2006) proposed a dual model of patterns for companionship with regard to the relationship between the dying patient and the family caregiver at the same time, that is, "ego mode of companionship" and "existential mode of companionship," which could simultaneously exist in companionship during the process of dying.

Conclusion

Reflective Praxis of Clinical Psychologist in Palliative and Hospice Care

Clinical psychologists provide services based on the biopsychosocial-spiritual model and possess prior knowledge of each part of the model to promote clinical care services. According to the psychological study of palliative medicine in Taiwan, there remains a diversity emphasis on thinking under this model, which could present the epistemological and ontological issues of the palliative and hospice fields, such as stress models (Wu et al., 2019; Cheng et al., 2013; Cheng, 2018) and the praxis of existential approach (Lee, 2015; Yee et al., 2006; Tsai & Lee, 2016). Presently, even with medical and health insurance systems and the establishment of an interdisciplinary team, there are still relatively limited opportunities for full-time clinical psychologists working in the medical field of palliative and hospice care in Taiwan. In the future, we hope that more opportunities will rise for clinical psychologists to expand their knowledge, improve together, and devote themselves to this field. We suggest that we continue support the building of palliative and hospice-related professional training of clinical psychologists, and continue to accumulate indigenous palliative and hospice-related psychological care data and research. In this study, we proposed that the contributions of clinical psychology to palliative medicine or terminal care are based on the integration of knowledge and praxis through a process of assisting patients and their family members when transitioning from "having" to "being." Knowledge as related objects (such as natural or artificial) is the essence of understanding practical activities (praxis). Hence, the process of converting "knowledge" to "being" is to disclose Dasein, the existence of human beings thrown into "being toward death".