

Guidance on postgraduate education for psychologists involved in palliative care

What competences should psychologists working in palliative care possess? **Saskia Jünger** and **Sheila Payne** present an Expert Paper from the European Association for Palliative Care (EAPC) Task Force on Education for Psychologists in Palliative Care

The aim of this Expert Paper from the European Association for Palliative Care (EAPC) Task Force on Education for Psychologists in Palliative Care is to provide guidance on curriculum development with respect to the postgraduate education of psychologists involved in palliative care. The differences between European countries regarding the basic education of psychologists, the definition of palliative care, palliative care delivery, and the role of psychologists in palliative care are considered.

Our intention is to describe a general educational framework, including background, target population, core competences and key areas. The focus is on palliative care for people with advanced disease, not just those with cancer; psychoncology is therefore not treated as a specific topic, but made reference to where relevant. We also focus on adult palliative care: paediatric palliative care is beyond the scope of this paper, since it implies specific requirements for psychological assessment and intervention.

1. Background

Considering psychosocial aspects and offering psychological support to patients and families are essential parts of palliative care, according to the definitions adopted by the EAPC and the WHO.^{1,2} However, who is responsible for providing such services is not clearly defined. In contrast to medical and nursing care, which are clearly provided by physicians and nurses, psychological support in palliative care is not exclusively assigned to psychologists. On the contrary, it is expected that all professionals working in palliative care acquire basic

knowledge of the psychological dynamics at work in life-limiting disease, as well as related skills in communication and psychological risk assessment.^{3,4} Very few palliative care associations in Europe explicitly provide information about the role and tasks of psychologists in palliative care^{5,6} and, likewise, most psychology associations have not taken any stance on the subject so far.

It is often assumed that most patients and relatives are able to cope without professional support, by relying on their own inner resources and on emotional support from family and friends.⁷ In fact, claims regarding the relevance and effectiveness of psychological support provided to dying patients and their relatives should be made with caution. When defining their own professional role, tasks and responsibilities, psychologists should reflect critically upon the real benefits of their contribution. They should avoid a 'pathologisation' or 'psychologisation' of the normal intrapersonal and interpersonal challenges in the context of physical and existential suffering near the end of life.

In the past, different recommendations have been made on how the psychological needs of patients and families should be met.⁷⁻¹² For example, it has been suggested that all palliative care professionals should make use of basic psychological skills in their everyday practice, and that patients with complex psychological needs should be referred to mental health professionals.⁹ In its guidance *Improving supportive and palliative care for adults with cancer*,⁷ the National Institute for Health and Clinical Excellence (NICE) has proposed a differentiated model of

psychological assessment and intervention. The model delineates four levels of psychological assessment and intervention for all palliative care professionals, with specialist psychological interventions at the top (see Figure 1). The model has been modified to focus on psychologists.⁶

In practice, today, psychologists play an important role in palliative care – in care delivery¹³ as well as in policy. For example, in 2010, there were psychologists among the board members of 11 national palliative care associations in Europe out of the 45 that are collective members of the EAPC.

The British Psychological Society states that the core competences of psychologists in end-of-life care are:¹⁴

- Assessment
- Formulation
- Intervention or implementation
- Evaluation and research
- Communication.

So far, there is no scientific basis demonstrating the need for psychologists in palliative care. Systematic data on the tasks, work settings, specific competences and number of psychologists working in palliative care are not available – except in some countries where national surveys have been carried out, such as Spain, England and the USA.^{15–17} However, special interests groups have taken the initiative to develop a work description and professional profile for psychologists involved in palliative care, and to define their core issues and concerns.

In 2009, our Task Force undertook a survey of European psychologists working in palliative care. It comprised questions regarding their work setting, main tasks, professional profile and education opportunities. In total, 323 psychologists from 41 countries responded.^{18,19}

A large majority stated that clinical tasks such as consultations with patients, relatives and team members were the primary focus of their work (see Figure 2); they mentioned in particular assessments and interventions for depression, anxiety or adjustment disorders, as well as communication with the family regarding the needs, hopes and beliefs of the dying person. Further tasks that were often mentioned as being part of their daily work were educating other professionals, and contributing professional skills and perspectives to the multiprofessional team.

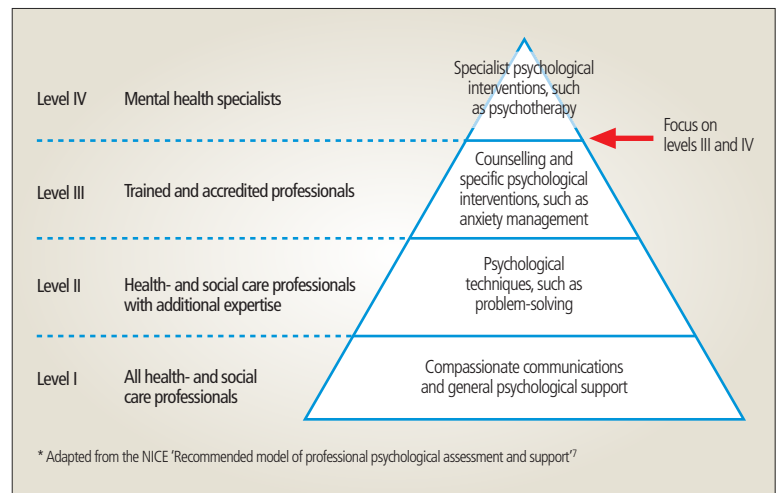


Figure 1. Levels of psychological specialisation in palliative care*

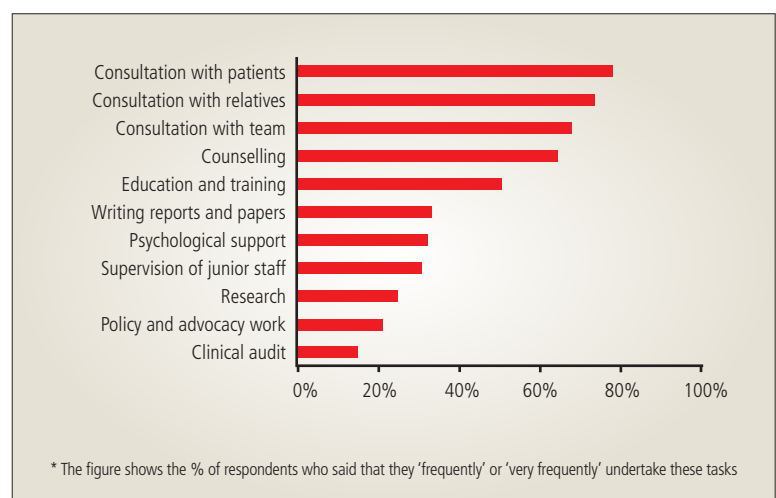


Figure 2. Common tasks in the daily work of psychologists working in palliative care*

Research, policy and audit work were mentioned less often.

Respondents said that their major contributions to palliative care were raising awareness of a psychological perspective on death and dying, and bringing their specific expertise to the team. Interestingly, an overarching helping role, comprising support to all those who are in some way affected by the patient's disease, was often mentioned. The majority of respondents thought that psychologists play an important role in palliative care in their country.^{18,19} The following quotation from a UK psychologist illustrates this professional self-image depicted by many: 'We are trained to understand predictors of behaviour, have a broad understanding of potential issues such as doctor–patient communication, patient satisfaction, coping, illness adjustment, information needs, pain perception, and so on. We also have theoretical knowledge and are able to apply this to our research'. However, the results of the survey also showed

that, despite the fact that there is a considerable number of psychologists working in palliative care, in many countries, their specific contribution is not clearly defined or sufficiently acknowledged. According to the respondents, the major challenge was a lack of recognition of the psychological aspects of care in a medically dominated field, and a lack of respect of the psychologist's role in the palliative care team. As one respondent put it, 'working in a medical setting with a medical view on the patients' problems and a doctor and nurse heading the team [means that people are] not always making room for the psychological aspects in palliative care'.

Often, when it comes to providing psychological support to patients and families, there are conflicts or overlaps between the roles of psychologists, volunteers, physicians, nurses, spiritual carers and social workers. A central challenge is therefore to delineate unique core competences, and agree on an unambiguous definition of the role of the psychologist that differs from that of other professionals and is acknowledged in the palliative care team.

Psychologists working in palliative care face specific challenges that are due, for example, to the limited time available for intervention when faced with complex patient situations near the end of life, or to the fact that the whole field of psychology in palliative care is still under development.

To give them a chance to be prepared for working in palliative care, 'it is necessary to determine the knowledge, skills, and abilities that are needed for psychologists to be effective contributors' in the hospice and palliative care environment, explained Nydegger, who further went on to say: 'Psychologists need to take advantage of what they already know, acquire the additional knowledge and skills that they need, and start finding opportunities to become more involved. To gain additional knowledge, psychologists who wish to get involved in hospice care will want to seek appropriate training to develop the competence to be effective and accepted into the hospice [and palliative care] environment'.¹⁷

During the last decade, psychologists in palliative care were pioneers, with the motivation to establish a professional presence in a young field and the need to cope with many uncertainties. In future, specific

education would help psychologists to anticipate the challenges of working in palliative care and acquire appropriate knowledge, skills and self-care strategies in order to be well-equipped for their professional remit.

The aim of this Expert Paper is to offer guidance on the postgraduate education, and enhance the professional profile and recognition of psychologists involved in palliative care. It strives to highlight the knowledge and skills that are specific to psychologists in palliative care. Some aspects – such as the basics of palliative care, ethics or self-care – are common to the postgraduate curriculum of all palliative care professionals.

2. Goals and framework

Developing an international core curriculum for psychologists involved in palliative care requires a reflection on the goals and framework. Basically, it is assumed that psychologists who are already working in the clinical area of palliative care have the appropriate education and experience in working with patients and their families. However, a specific education must be considered fundamental for psychologists working in hospice and palliative care services. Experience gained over the years has made it evident that the role of psychologists involved in palliative care is different from the role they have learned during their professional socialisation, and also different from their role in related fields such as, for instance, psycho-oncology.

When developing a palliative care curriculum for psychologists and establishing formal recognition (or even certification) of psychologists trained in palliative care, country-specific aspects, such as the national curriculum for psychology studies or the characteristics of palliative care delivery, have to be taken into account. In many countries, psychologists have to undergo additional clinical education and training in order to obtain the professional accreditation required for working in healthcare. The final curriculum for each country will have to take account of these national requirements.

2.1 Goals

The main goal of the core curriculum for psychologists involved in palliative care is to improve the educational and practical

training of psychologists, and in particular to ensure a uniform and evidence-based standard of clinical practice. Other goals are to improve the psychologists' skills and their ability to meet the demands of their role, and to improve the quality of their professional performance in the area of psychological care.

In palliative care, it is generally expected that all professionals will deliver psychological care to some extent. Therefore, competences that are exclusive to psychologists – beyond those already offered by other professionals – need to be mapped out.^{6,7} Specific challenges, such as working on an agreed common compendium of psychological concepts and psychotherapeutic methods suitable for palliative care, have to be taken into consideration. The curriculum proposed here aims at the highest possible level of specialisation for psychologists (see Figure 1).

2.2 Framework

Setting up an educational programme involves determining the target population (and hence whether basic or specialised education is needed); the required academic entry level and other prerequisites of participants; the contents of the programme; the balance between theoretical knowledge and practical training; and other requirements, such as the theoretical models used, and the number of sessions comprised, in the programme.

National and cultural characteristics, and differences between healthcare systems, need to be taken into consideration and addressed adequately. Other points to consider are how psychologists working in other fields will manage the transition to a palliative care setting, and how their general professional socialisation will help them meet the demands of work in the palliative care setting. Last but not least, general principles regarding adult learning approaches and teaching methods should be included.

2.3 Formal recognition and certification

Putting in place mechanisms for the formal recognition (or even certification) of psychologists who have undergone specialised training in palliative care is an important step. To a large extent, this will have to be planned at a national level to take into account country-specific standards. At the same time, the European Certificate of Psychology

(EuroPsy), a qualification standard developed by the European Federation of Psychologists' Associations (www.efpa.eu/europsy), constitutes a possible formal recognition for a postgraduate curriculum for psychologists involved in palliative care, and may help to overcome barriers of national differences in the future. EuroPsy is only in its beginnings, but adherence to its standards might ensure an adequate level of recognition and standardisation as well as integration into existing curricula in under- and postgraduate studies.

3. Syllabus

This section describes the specific areas of competence that could be included in the postgraduate curriculum for psychologists involved in palliative care. The suggested modules cover basic and background knowledge of palliative care; the social, cultural and legal framework; and specific psychological skills and interventions.

3.1 Basics of palliative care – history, philosophy, definitions

General goals/learning objectives

Throughout the development of palliative care, its philosophy – relieve suffering and improve quality of life – has always been paramount.²⁰ However, its rapid growth in the last four decades has contributed to some important changes in the understanding of what it actually is.²¹ Those changes are clearly reflected in clinical practice. Therefore, gaining knowledge about the history, philosophy and definitions of palliative care is one of the most fundamental learning objectives of this curriculum. Just as important is practical training in hospices, palliative care units and other care environments such as the patient's home, where visits should be undertaken under the supervision of a senior psychologist.

Knowledge

- WHO definition of palliative care, EAPC definition of palliative care.
- History, philosophy and definitions of hospice and palliative care; an understanding of the changing role of palliative care over time (at the beginning, palliative care was synonymous with end-of-life care,²² today it is synonymous with care over the entire

course of a life-threatening illness, from diagnosis to death);²³⁻²⁵ an understanding of the consequences of these changes (integration with active treatment, significance of transition periods, differences in the courses of different illnesses, and so on).

- General principles and values of palliative care, such as: recognising dying as a normal process in life and seeking neither to hasten death nor to postpone it;^{24,25} relieving all aspects of suffering, including physical, psychological, social and spiritual aspects,^{20,24,25} by continuous communication and collaboration between the different professions and disciplines²⁵ involved in the multidisciplinary (or interdisciplinary) palliative care team;²⁶⁻²⁸ respecting each person as an autonomous individual with unique personal, cultural and religious values, beliefs and practices;²⁵ and also offering support to patients' caregivers during the illness trajectory and in bereavement.^{24,25}
- Symptomatology of the dying patient.
- Psychological aspects of dying, care-giving and bereavement.
- Evidence base of psychological care in palliative care.
- Knowledge of the delivery of palliative care in different settings and with different levels of specialisation (from settings not specialised in palliative care to general and specialist palliative care settings).²⁴
- Issues regarding research in palliative care and psychology.
- Ethics, the law and professional regulations.
- Cultural diversity.
- Politics, organisation and strategy.

Skills and attitudes

- Ability to understand the logic and implications of the gradual integration of palliative care over the whole course of a life-threatening illness.
- Ability to understand and manage the general and specific challenges associated with delivering palliative care within multidisciplinary teams in various settings and at various levels of specialisation.²⁹
- Ability to apply in daily practice the general principles and values of palliative care, including ability to recognise and develop their own specific professional and personal contributions (compared with those of

other members of the multidisciplinary team);³⁰ to advocate on behalf of patients and caregivers; to educate them on the available options in order to help them make informed choices and advance care planning decisions; and so on.

- Acceptance of, and identification with, the philosophy of palliative care.

Self-reflection/self-awareness

The self-awareness of psychologists working in palliative care can be systematically cultivated by searching for answers to questions such as:

- What is my own attitude towards the general philosophy of palliative care?
- Are the general principles and values of palliative care in accordance with my own personal views and values?
- What are the possible points of divergence and how do they influence my professional involvement in palliative care and my personal life?

3.2. Professional role and self-image

General goals/learning objectives

On the one hand, the holistic approach of palliative care means that all professionals use basic counselling skills in their daily practice. On the other hand, psychologists have a specific contribution to make to the interdisciplinary team.^{31,32} In some countries, psychologists are not regarded as essential members of that team.^{24,28} Psychologists working in palliative care should therefore always be aware of their specific tasks and competences.^{5,33,34} They should aim at:

- Being sensitised to their own professional self-image
- Attaining a point of view that allows them to position themselves constructively.

Knowledge

- Knowledge of the bio-psycho-social model prevalent in medicine and clinical health psychology, and of the implications for the role of psychologists in palliative care.
- Knowledge of the historical development and role of psychology, and of the related challenges and limitations of psychology in medical disciplines.
- Knowledge of the historical development and role of psychology in palliative care, in their own country and internationally, in the context of changing healthcare systems and the adoption of a holistic model of care.

- Basic knowledge of the professional and organisational context (associations, special interest groups, other psychosocial professions involved in palliative care).
- Knowledge of the normal role and tasks of psychologists in palliative care, in their own country and internationally.

Skills and attitudes

- Ability to represent own profession within the interdisciplinary team as well as in the wider work context (at institutional level).
- Ability to represent own profession in the field of palliative care, in other medical disciplines, at conferences, within committees, and so on.
- Ability to share psychological knowledge with non-psychologists.
- Ability to work within an interdisciplinary team, including communicating effectively, educating others, differentiating between the different roles, and dealing with inappropriate expectations of psychologists.
- Ability to communicate effectively with people who have intellectual and sensory impairments and are in poor physical state and/or going through an emotional crisis.

Self-reflection/self-awareness

- Psychologists in palliative care should ask themselves: do I agree with the ethical guidelines in palliative care? How do I see my career? How do I feel as a member of the palliative care team? Do I consider myself an expert? Am I aware of my professional role and tasks? What do I do to establish my role among team members?
- Reflection on the specific contribution of psychologists in palliative care, compared with the contribution of other professionals and/or volunteers.
- Reflection on role limitations and conflicts.
- Reflection on unrealistic expectations and assignments.

3.3 Psychological assessment and documentation

General goals/learning objectives

Psychologists should be able to provide specialist psychological assessments of patients based upon the appropriate use, interpretation and integration of complex data from a variety of sources, including psychological and neuropsychological tests, self-reported measures, rating scales, direct

and indirect structured observations, and semi-structured interviews with the patient, family members and others involved in the patient's care. They should be competent to diagnose and formulate the difficulties of patients with highly complex and multiple clinical conditions/problems.³⁵ Good psychological assessment guides psychological treatment and allows critical evaluation of its effectiveness.

Knowledge

Psychologists should acquire knowledge (theoretical background, rationale, different perspectives) in the following domains:

- Developmental psychology over the lifespan, family systems psychology, models of psychopathology, clinical psychometrics and neuropsychology
- Pre-assessment counselling, and neuropsychological, psychological and functional assessment
- Diagnostic criteria and diagnostic systems of psychopathology, and classification of mental disorders
- Differential diagnosis of symptoms and reactions related to life-limiting disease and mental/psychiatric disorders; distinction between psychological disorders and transient adjustment disorders related to a specific life event
- How to formulate patient difficulties based upon up-to-date knowledge of psychological theory, taking into account the need to adjust to life-limiting illness, the multiplicity and complexity of problems, lives and family histories, and cultural and historical contexts
- How to communicate in a highly skilled and sensitive manner with patients, their families, carers and a wide range of lay and professional persons within and outside the healthcare system, in a way that is consistent with their level of understanding, culture, background and preferred ways of communication
- Legislation, national and local policies, and issues in relation to palliative care, mental health and clinical record-keeping
- Cultural issues.

Skills

- Analytical and judgement skills.
- Ability to work autonomously within professional guidelines.

Psychologists have a specific contribution to make to the interdisciplinary team

- Ability to apply different assessment tools/diagnostic interviews for assessing psychological symptoms and establishing a differential diagnosis.
- Planning and organisational skills.
- Ability to establish a rapport with patients and their families.
- Warmth and empathy.

Attitudes

- Regarding people as individuals and valuing difference.
- Flexible attitude in using assessment tools and methods in the light of the constraints imposed by patients' poor physical health.
- Willingness to accept change and to explore new approaches and ways of doing things.
- Respecting people's dignity, wishes and beliefs, involving them in decision-making and obtaining their consent.

Self-reflection/self-awareness

- Awareness of, and sensitivity to, one's own needs and feelings; awareness of, and responsiveness to, other people's needs and feelings.
- Reflection on own ability to contain and work with stress.
- Reflection on own ability to decide which patient- and family-related information is appropriate to be shared with other members of the treatment team.
- Awareness of one's own limitations and willingness to engage in continuous professional development.

3.4 Counselling and psychotherapy

General goals/learning objectives

Psychologists should be aware of the benefits, but also of the limitations and risks, for patients and families, of counselling and psychotherapeutic interventions.¹⁴ They must have in-depth knowledge of the therapeutic relationship, with emphasis on non-judgmental listening, warmth, empathy and understanding.³⁶⁻³⁸ They should recognise the importance of appropriate assessment for psychological therapy, and the importance of detecting and supporting resilience in individuals, families and groups near the end-of-life and during bereavement.³⁹⁻⁴²

Knowledge

- Client-centred approaches to the development of a therapeutic relationship;

this includes knowledge of meta-analytic studies demonstrating that the therapeutic relationship is necessary, but not always sufficient, for change.^{43,44}

- Various formal and informal ways of assessing the value and effectiveness of a given intervention; this includes knowledge of rating scales; of formal psychological assessments for depression, anxiety and prolonged bereavement reactions; of family dysfunction; and of psychometric assessments for neurological and/or cognitive damage.
- Limitations of the above in palliative care patients and their families, including ethical and clinical limitations.
- Effectiveness of psychological intervention, of (psycho-)pharmacological treatment, and of both combined.
- The different psychological therapy models that have an evidence base in physical illness, palliative care and bereavement; these include cognitive behavioural therapy; narrative therapy; existential therapy; family therapy; mindfulness-based cognitive behavioural therapy; and psychodynamic interpersonal therapy.^{35,45,46}
- The different therapeutic modalities and their relative efficacy.
- The relative benefits and potential costs of choosing one therapeutic modality over another when working with a potentially vulnerable client group.
- The various methodologies used to evaluate the effectiveness of an intervention.

Skills

- Ability to establish and maintain a good therapeutic relationship.
- Ability to develop a clear therapy plan and a therapeutic intervention that is consistent with it.
- Competence in the chosen therapeutic model, and in others as necessary.
- Ability to manage the end of the therapeutic intervention.

Attitudes and self-reflection

- Being open and self-reflective.
- Being non-judgmental and client-centred.
- Not being too formal.
- Being open to correction through the therapeutic relationship and supervision.
- Ability to offer support and encouragement.
- Ability to demonstrate expertise.

- Awareness of the importance of self-care and supervision (see subsection 3.7 on self-awareness and self-care).

3.5 Consultation, supervision and staff support

General goals/learning objectives

Professionals in palliative care are faced with many challenging situations and intense feelings that can affect them.⁴⁷ Supervision is a good way to facilitate the expression of emotions and feelings that can arise within the group or in some individuals.

Psychologists should:

- Recognise the sense, usefulness and benefits of counselling, supervision and staff support as valid tools for improving the performance, self-care, and professional and personal development of the palliative care team members.⁴⁸
- Be able to identify different areas where support can be provided.^{49,50}
- Be able to provide consultation to individuals, teams and organisations with regard to developing a coherent psychological framework for understanding the needs of patients and families.⁵¹⁻⁵⁴

Knowledge

- Awareness of the team as a living system with multiple conscious and/or unconscious interrelations and interactions occurring at different levels.
- Awareness of how traumatic/intense work situations may affect members of the team in their personal and professional lives.
- Knowledge of how to detect risks or dysfunctional situations within the team or for individual members through profound listening as a tool for information analysis.
- Knowledge of functional and dysfunctional signs that may appear within the team or in individual members regarding task development, interpersonal relationships, professional role and self-satisfaction.
- Knowledge of how to facilitate communication and promote the expression of emotions and feelings, in order to improve the management of traumatic situations.
- A clear understanding of theories and models of change and change management in both individuals and systems.
- An understanding of how health- and social care organisations work.

Skills

- Listening as a diagnostic tool.
- Empathic communication.
- Ability to clarify and rank information.
- Ability to prioritise required interventions according to their nature and level.
- Ability to detect early signs of burnout.
- Ability to understand and relieve the psychological and emotional suffering induced by pain, loss or a complex situation in the context of palliative care.
- Ability to think about and discuss cases, and ability to assess the needs in each case before considering possible interventions.
- Ability to provide techniques for stress and anxiety relief.
- Capacity to be positive, flexible, creative, communicative and imaginative in finding solutions.
- Ability to communicate with staff members at all levels, and regarding all aspects, of the organisation.

Attitudes

- An open and unbiased approach.
- A non-judgemental and inclusive attitude towards a broad variety of individual expressions.
- Valuing and respecting different perspectives and emotional manifestations.
- Stimulating and facilitating group elaboration, integration and cohesion.
- Being compassionate, thoughtful, analytical and supportive.

Self-reflection/self-awareness

- Psychologists must remember that they can be enriched and nourished by patients, families and colleagues.
- Psychologists must recognise that they can be affected by the situations they have to cope with in their work.
- It can be useful for psychologists to create a relationship graph in order to 'map' the palliative care team as a social system and observe the dynamics of the team members' interactions.

3.6 Research

General goals/learning objectives

There is a need for psychologists in palliative care to conduct, and disseminate the results of, leading-edge research. Research in palliative care has sometimes been criticised as small-scale, descriptive and lacking the

necessary methodological quality to contribute to evidence-based medicine. This is, in part, due to the ethical and practical difficulties of conducting research with terminally ill and bereaved persons. Psychologists should be aware of these challenges and know how to overcome them; have knowledge of a range of methods suitable for research in palliative care; and understand how to critically evaluate and develop sound research studies in the field.⁵⁵

Knowledge

- History of the development of research in palliative care.
- Knowledge of the major research questions relevant to psychologists in palliative care; for example, how to facilitate end-of-life decision-making; how to reduce psychological and existential distress; and how to promote effective communication about advance directives.
- Knowledge of a range of research methods, and when and how to use them, including:
 - Randomised controlled trials and other experimental methods (sampling, quantitative analysis, outcome measurement)
 - Qualitative research methods (major theoretical approaches, sampling, collecting and analysing data, ensuring robustness)
 - Mixed methods (how and when to combine qualitative and quantitative methods)
 - Epidemiological research methods (observational and quasi-experimental studies, assessing incidence and prevalence)
 - Action research
 - Consensus studies
 - Case studies.
- Knowledge of how to conduct surveys, including sampling, design, testing and piloting; and of systematic review methods for qualitative and quantitative studies.
- An understanding of psychometrics, their validity and reliability.
- Knowledge of the evaluation/monitoring of psychotherapeutic interventions.
- Knowledge of economic/cost-effectiveness analyses; knowledge of service evaluations and audits.
- Ethical and practical issues around research in palliative care.

Skills and attitudes

- Ability to critically evaluate qualitative and quantitative research and reviews.

- Ability to formulate research questions and develop study protocols.
- Ability to write sound grant applications.
- Ability to manage a research study.
- Ability to disseminate research findings (papers, conference presentations, feedback to participants and the public).
- Ability to involve service-users effectively.
- Curiosity.
- Non-judgemental approach.

Self-reflection/self-awareness

Since research in palliative care can involve empathic relationships with patients and their families, self-awareness and self-care are very important (see section 3.7 below).

3.7 Self-awareness and self-care

General goals/learning objectives

Psychologists in palliative care need to be able to have close, empathic and meaningful relationships with team members and with patients and families (who can be adults or children), while at the same time maintaining their internal congruence. Dying patients face difficult existential (that is, spiritual and emotional) issues that can make the psychologist feel uneasy or helpless, or remind them of their own existential issues. One way of dealing with this is to create an emotional distance, rather than just a healthy professional distance, between oneself and the patient/family. However, this may hinder the psychologist's attempt to empathise, which could contribute to feelings of professional insufficiency and would not be beneficial for the patient. Becoming fully aware of the existential issues in their own lives will allow psychologists to understand and integrate their feelings, while still being fully present in the moment and centred on the patient. Self-awareness is a powerful tool for self-care.

Knowledge

- An understanding of existential issues that affect dying patients and their families.⁵⁶
- An understanding of one's own resolved and unresolved existential issues.^{54,57}
- An understanding of the influence of one's individuality (personality and temperament traits, cognitive styles, and so on) on the relationship with the patient.⁵⁸
- An understanding of the meaning of one's role as a professional who cares for the dying and their families.

- Literature regarding burnout, vicarious traumatisation and compassion fatigue.⁵⁹⁻⁶³
- Relaxation and meditation techniques to manage stress.

Skills

- Ability to empathise with patients/families while maintaining one's own internal congruence.
- Awareness of one's own existential issues, as well as those of patients/families and the effect they can have on one's own feelings.
- Ability to detect symptoms of burnout in any of its dimensions in oneself and seek help when needed.⁶⁴⁻⁶⁶
- Ability to maintain physical and emotional presence with a patient suffering from physical pain and degradation.
- Ability to use relaxation techniques on oneself to manage stress.
- Ability to use behavioural methods to cope with death and suffering.⁶⁴
- Ability to ask meaningful questions regarding the care provided.
- Ability to work in a team, giving to and receiving from it.⁶⁷

Methodology

- Maintenance of a reflexive diary.
- Sharing within group therapy.
- Creating a team vision.
- Relaxation sessions.
- Clinical supervision/regular exchange and reflection with colleagues in the same field.

Self-reflection/self-awareness

Psychologists working in palliative care need to reflect on/deal with the physical and existential issues listed below.

- What am I doing to keep myself physically healthy (diet, exercise, relaxation)?
- Natural aging (accepting signs of aging and loss of beauty).
- Prospect of losing own independence and mobility; accepting dependency in others.
- Prospect of living with pain, physical degradation and deformity; own feelings when caring for patients suffering from pain, physical degradation and deformity.
- Acceptance of own dead body: how do I imagine my body after death? How would I like my body be treated after death?
- Relationships with loved ones: meaningful relationships, communication and expressing feelings; time dedicated to family

and friends; issues of forgiveness and gratitude; how would I like to be remembered after my death, and what am I doing to contribute towards this?

- Role in one's own family: being a child, a parent, a relative; how do I react when one of my loved ones is suffering?
- How do I deal with emotional/physical suffering when I am on my own? Do I feel helpless, or do I have resilient strengths?
- Living a meaningful life: do my present activities contribute towards a sense of fulfilment and meaning? Am I wasting a lot of time on activities that are meaningless to me? What are my goals in life? What is really important to me? If I knew that I were to die shortly and looked back on my life, would I have a sense of having lived well? If not, what can I change?⁶⁸
- Uncertainty and lack of control: how do I deal with uncertainty? What are my personal resources and coping mechanisms to deal with difficult situations? An analysis of past obstacles (losses, difficulties, traumatic experiences) and how we dealt with them will help us get to know our personal strengths and resources, which may reduce our fear of the unknown.
- Personal bereavement: am I in bereavement? When someone I loved died, what were my needs? What do I think my needs would be if someone I loved died? What would I need around me to feel comforted?
- Own death: if I was dying, how would I like to feel? What would I need around me to die well?
- Dignity: what are the cornerstones of my own dignity? When is my body in dignity? When am I in dignity? How can I help preserve the dignity of patients?
- Religious and spiritual beliefs and needs: understanding the difference between beliefs and certainties; my own beliefs and spirituality; how do I nurture my spiritual self? How do I ensure that I do not impose my beliefs on patients?⁶⁹
- Work motivation: why did I choose to work in palliative care? If I just happen to work in palliative care, where does my work motivation stem from? Work motivation in palliative care as a process.
These issues should be worked on in a group setting, which will allow psychologists not only to explore their own views of what

'good care', 'good family', 'good death' or 'good life' are, but also to better understand the views of others. This will in turn help them to accept their patients as they are and prevent them from imposing their views on them. Psychologists could also explore their own views on life and death by creating a personal narrative.

3.8 Ethics

General goals/learning objectives

Psychologists working in palliative care should be familiar with the basics of healthcare ethics as a system of moral principles that applies to practice in clinical settings as well as to theoretical, scientific, policy and advocacy work.⁷⁰⁻⁷³ They should be aware of the core values of healthcare ethics, which can provide a framework for understanding conflicts, including:

- Patient autonomy (the patient's right to refuse and/or choose their treatment)
- Non-maleficence (avoid doing anything that can harm the patient)
- Beneficence (act in the best interest of the patient), justice (fair and equal distribution of healthcare resources), dignity, truthfulness and honesty.⁷⁴

Psychologists should be capable of:

- Identifying the main ethical dilemmas that may occur during palliative care practice^{75,76}
- Participating in discussions about ethical dilemmas in end-of-life care
- Discussing ethical dilemmas with both patients and staff, and helping the palliative care team to build an appropriate answer in the interest of patients' well-being.⁷⁷⁻⁷⁹

Knowledge

Psychologists should master the following theoretical background:

- Ethical dimension of palliative care (meaning of dying and death, human dignity, ethics of care)
- Palliative care, euthanasia and physician-assisted suicide
- Ethical aspects of, and ethical principles involved in, palliative care decision-making (for example, expectations at the end-of-life, hope, confidentiality, autonomy, integrity, vulnerability, justice)
- Areas of palliative care where ethical issues arise (for example, withdrawal from treatment, advance care planning, 'do not attempt resuscitation' orders).

Skills

- Ability to identify the psychological and emotional structure of patients, which may affect their autonomy and capacity to give consent.
- Capacity to deal with complex situations, in particular when the patient expresses a wish for hastened death or assisted suicide.
- Ability to understand and accept patients' decisions and points of view.
- Capacity to tell someone that something is not possible, despite the fact that the person's request is understood.
- Ability to support team members who are particularly involved in decision-making processes.

Attitudes

In their relationship with patients and families, psychologists should adopt a non-judgemental attitude. They should also adopt an ethical approach; that is, fully respecting patients' wishes (and helping them to discuss and reconcile their wishes with those of their loved ones), while at the same time working within the ethical framework that circumscribes their daily practice.

Psychologists need to be loyal to the palliative care team, upholding the concerted team position on concrete ethical problems and representing it in the discussions with patients and relatives.

Self-reflection/self-awareness

In addition to the issues mentioned in subsection 3.7 on self-awareness and self-care, psychologists need to reflect on their own concept of ethical behaviour, as well as on their own concepts of life and death, including personal preferences for advance care planning.

3.9 Cultural diversity

General goals/learning objectives

There are many definitions of culture used in the context of palliative care.^{80,81} According to one definition, culture encompasses aspects such as gender, age, differing abilities, sexual orientation, religion, financial status, where one lives, employment and educational level.⁸² Culture plays a vital role in a person's experience of dying, death and bereavement. Therefore cultural competence is essential in end-of-life care, where complex cultural beliefs, values and customs come to the fore.

In palliative care, cultural considerations are especially important with regard to issues such as medical decision-making, experience, meaning and expression of pain, and symptom management. The challenge is to make services available to different communities and 'provide culturally sensitive services in respect of language, religion, spirituality and dietary needs'.⁸³⁻⁸⁶ Doorenbos and Schim showed that the cultural competence of hospice staff varies widely depending on the amount of education and previous cultural diversity training; they demonstrated that staff members who had had prior training were significantly more culturally competent than those who had not.⁸⁷ All palliative care professionals should receive training to improve their cultural competence and expand their cultural awareness and sensitivity.^{88,89}

Knowledge

In the different cultural groups they are in contact with, psychologists working in palliative care should learn about:

- Religions, spirituality and belief systems
- Beliefs regarding health and illness
- Appropriateness of touch
- Verbal and non-verbal communication styles and customs
- Eating habits and appropriate foods at the end of life
- Death rituals and mourning practices
- Culturally acceptable expressions of grief.

Skills

- Ability to recognise and respect cultural difference.
- Ability to conduct cross-cultural communication (for example, when asking key assessment questions).⁸⁵
- Ability to perform cultural interpretation.
- Ability to carry out culturally appropriate interventions.
- Ability to undertake culturally appropriate pain assessment (including understanding non-verbal pain indicators).
- Ability to undertake culturally appropriate symptom management.

Methodology

- Working with articles from 'specialty practice journals'.⁹⁰
- Reflecting on cross-cultural encounter stories.

- Discussing case studies.
- Role play and practice with simulated patients.
- Reading about other cultures and being a conscious traveller.

Attitudes

- Respecting, allowing and supporting cultural difference.
- Understanding the development of cultural competence as a process.
- Respecting rituals and customs associated with the transition from life to death.
- Supporting spiritual, religious and cultural practices and appropriate care of the body after death.
- Respecting mourning rituals.

Self-reflection/self-awareness

- Awareness of how one's own values, practices and beliefs may influence the care given.
- Examining one's own cultural heritage, experiences, religious beliefs and spiritual practices.
- Differentiating between one's personal cultural values and those of others, and raising awareness of cultural difference to avoid discrimination and prejudice.

3.10 Policy, organisation and advocacy

General goals/learning objectives

According to the WHO, adequate policy, education and drug availability are the three fundamental requirements for the delivery of an effective palliative care service. All three aspects are crucial for a holistic intervention in palliative care and need to be part of psychologists' education. Another important aspect is advocacy, which is defined as seeking to influence policy-makers to design, adopt, implement or change policies and practices, in order to ensure the availability of effective and qualified palliative care for all.

Knowledge

- Awareness of national and international psychologists' associations and palliative care associations, their aims, goals and strategic approaches.
- Awareness of the activities of the EAPC and its advocacy work for improving information, education, research and multiprofessional collaboration.
- Knowledge about the role of palliative care

within the healthcare system (in their own country and internationally).

- Knowledge about palliative care services and the institutional/political/structural context of organisations that provide palliative care.
- Awareness of current debates, scientific publications and of how palliative care is depicted in the media.
- Awareness of education opportunities.
- Awareness of what determines the quality of palliative care.
- Awareness of work conditions and resources in the palliative care sector (in their own country and internationally).

Skills

- Presentation skills for active participation in congresses and meetings.
- Education skills to inform both experts and lay people about palliative care and the needs of patients/families.
- Campaigning skills to alert the media about the importance of providing palliative care to all those who need it.
- Advocacy skills to promote a culture of death with dignity, where the suffering of terminally ill and dying patients is not neglected.

Attitudes and self-reflection

- Critical reflection on the different points of view and approaches within the palliative care community in order to refine one's own position.
- Willingness to engage in advocacy work in order to improve the conditions in which palliative care delivery, education and research are carried out.

4. Outlook

This Expert Paper focuses on the core competences that psychologists need to work in palliative care. The proposed syllabus outlines the related knowledge, skills, competences and attitudes specific to psychologists, but also some that are common to all those involved in palliative care, whether professionally or as volunteers.

In addition to the syllabus proposed in this Expert Paper, general recommendations made by the EAPC regarding curriculum development, educational strategies and curriculum evaluation should be taken into account. These have been described in detail

in the *Recommendations of the European Association for Palliative Care for the Development of Postgraduate Curricula leading to Certification in Palliative Medicine*.⁹¹

Moreover, the knowledge and skills that psychologists need to work effectively in palliative care should be compared with the current curricula for psychologists in the different countries, in order to determine what they already possess and what they still need to acquire to be able to contribute meaningfully to the palliative care team.¹⁷

Future curricula will have to take account of the Bologna Declaration, issued in 1999 by the European Ministers of Education to unify undergraduate teaching in all disciplines across Europe;^{92,93} the Bologna Declaration is an important basis for the development of common postgraduate training across European countries.

Overall, the professional profile of psychologists in the field of palliative care is still under construction and the spectrum of tasks, roles and competences will have to be more clearly delineated in future. This process will have to occur in the multiprofessional context of palliative care. It will have to consider the expectations of patients and their relatives, as well as the contribution of other healthcare professionals, including mental health professionals.

Future research could focus on the perception of psychologists by patients, relatives and other professionals – what do they know about psychologists' background and expertise, and what do they think psychologists may bring to palliative care.¹⁷

The range of tasks and the scope of the psychological profession in palliative care will have to be further explored and acknowledged. Nydegger states that 'psychology has made contributions to end-of-life care, but the profession has not made what it has to offer as visible and available as it could'.¹⁷ The survey our Task Force conducted in 2009 among psychologists working in palliative care showed that the major focus of their work today seems to be on clinical tasks.¹⁹ However, according to Nydegger, they could also become more involved as team members or leaders, at management level, in the design and conduct of staff support and training programmes, in institutional and clinical research, and in management and organisational consulting.¹⁷

With the definition of core competences and a proposed syllabus, the profile of psychologists in palliative care is likely to gain strength in the near future. Efforts to systematically document what tasks are carried out by psychologists in palliative care (for example, psychological assessment and intervention) will also contribute to strengthening their profile.

At the same time, palliative care as a whole is experiencing a growing level of professionalisation, with a corresponding acknowledgement of various disciplines and increasing integration into general healthcare. The need for psychologists in palliative care must also be considered against the background of continuously evolving structures of palliative care delivery, research and advocacy.

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Declaration of interest

The authors declare that there is no conflict of interest.

Saskia Jünger, Health Scientist, Department of Palliative Medicine, University Hospital Bonn, Germany; Sheila Payne, President, European Association for Palliative Care (EAPC), and Director, International Observatory on End of Life Care, Lancaster University, Lancaster, UK; Members of the EAPC Task Force on Education for Psychologists in Palliative Care (Jan Ablett, Gema Costa-Requena, António Manuel Fonseca, Anna Giardini, Carol Gouveia Melo, Mai-Britt Guldin, Sue Hall, Christine Kalus, Agnieszka Karpowicz, Karen-Inge Karstoft, Christina Liossi, Katarzyna Ludwin, Katarzyna Makara, Sandra Martins Pereira, Martina Pestinger, Elzbieta Pozarowska, Gustavo Francisco Rodio, Anja Simonic, Claudia Wenzel, Elzbieta Wesolek)

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