

# Roles for Psychologists in End-of-Life Care: Emerging Models of Practice

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Professional psychologists are increasingly likely to encounter opportunities to work with patients and families facing end-of-life issues. Psychologists can provide psychological assessment, intervention for patients and families, consultation with and support of health care team members, grief therapy, and program development and evaluation. Psychological services are useful for healthy individuals who wish to make thoughtful plans about their own future care, patients with life-limiting illnesses, families stressed by providing end-of-life care, bereaved individuals, and health care providers who face issues of burnout and strain. Several challenges for psychologists working in end-of-life care are noted, including training, development of clear roles, and reimbursement.

“My mother is dying from breast cancer. Her oncologist told me that she will probably only live a few more months no matter what he does, but she is continuing her radiation and chemotherapy anyway. I think they both want to keep her hopes up. It’s so awkward not being able to talk with her realistically about her future. The stress of seeing her go through this and doing what I can to take care of her is so depressing. I wonder whether she would benefit from hospice care but I am afraid to raise the issue and don’t want to seem like I am giving up. All of this makes me very scared about my own aging—I don’t want to die in a hospital connected to a bunch of tubes and machines. What should I do?”

Professional psychologists are increasingly likely to have such conversations with their patients. As psychology increasingly demonstrates its value beyond traditional mental health areas, in such diverse fields as primary care and health psychology (Brown et al., 2002; Frank, McDaniel, Bray, & Heldring, 2004; Schneiderman, Antoni, Saab, & Ironson, 2001), end-of-life care will be an increasing area of practice.

Psychologists have made important contributions to the study of death, dying, palliative care, and bereavement, including not only basic scholarship but also work relevant to assessment and intervention among dying patients and their families (e.g., see Marwit,

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1997; Neimeyer, 1994; Rando, 2000; Stroebe, Hansson, Stroebe, & Schut, 2001). However, a recent report from the APA Working Group on Assisted Suicide and End-of-Life Decisions (2000) includes the rather sobering statement, "There is little evidence that the discipline of psychology as a whole has considered end-of-life issues to be an important area that deserves substantial professional time and attention." This report also notes evidence that other professions do not generally see psychologists as central to end-of-life decision-making and care.

The present article explains why end-of-life issues are gaining importance for clinical practice and describes roles and settings in which psychologists can make greater contributions. Several long-term issues that psychology must address are also noted.

### Defining End-of-Life Care

Effective end-of-life care includes both palliative and hospice care. The term *palliative care* is a broad concept, since it includes the management of the physical, psychological, social, spiritual, and existential needs of individuals with advanced disease without reference to a specified life expectancy of the patient. Palliative care is focused on treatment of conditions that are life-limiting or refractory to disease-modifying treatment. The term *hospice care* usually refers to a special type of comprehensive palliative care provided during the last 6 months of life, and is often linked to the specific programs offered under the Medicare hospice benefit. Both palliative care and hospice emphasize the importance of addressing the needs of both these persons and their families (National Hospice Organization Standards and Accreditation Committee, 1997; Task Force on Palliative Care, 1998).

This holistic approach to care required by hospice and palliative care, which recognizes the complex and multidimensional needs of patients and families, calls for an interdisciplinary team. Team members typically include nurses, physicians, and social workers, though others may be present, including psychologists, chaplains, pharmacists, dietitians, occupational or physical therapists, and volunteers. Conditions for which hospice and palliative care are appropriate include cancer, AIDS, congestive heart failure, chronic obstructive pulmonary disease, end-stage organ disease, and dementia and other progressive neurological diseases.

The goal of hospice and palliative care is to achieve the best possible quality of life for patients and their families. This goal is achieved through relief of suffering, pain and symptom management, psychosocial support, optimization of functional capacity, and respect for autonomy and the appropriate role of family and legal surrogates. While palliative care does not require the exclusion of all aggressive or curative therapies, hospice patients typically must agree to forego aggressive or curative treatments (though some interventions may be performed to maximize quality of life, such as blood transfusions to maintain energy level in leukemia patients). Specific goals of hospice include self-determined life closure, safe and comfortable dying, and effective grieving (National Hospice Organization Standards and Accreditation Committee, 1997).

### Why End-of-Life Care Is Important to Psychological Practice

Psychological practice in end-of-life care is being shaped and encouraged by several key developments. First, psychologists al-

ready are extensively involved in the treatment of the chronic illnesses such as heart disease and cancer that are now the leading causes of death and health care expenditure in the United States (Federal Interagency Forum on Aging Related Statistics, 2000). People are living longer, and almost one half of all Americans and over 80% of individuals over age 65 report having a chronic illness (FACCT & Robert Wood Johnson Foundation, 2002). Chronic illnesses impose extensive coping demands on patients and families, and psychologists contribute significantly to treatment of the major disorders of our time: heart disease, cancer, AIDS, dementia, diabetes, chronic pain, chronic respiratory ailments, and multiple sclerosis, among others (Camic & Knight, 1998). Interventions with these populations include psychotherapy for adjustment reactions, anxiety, and depression, neuropsychological and other assessments, stress and pain management, relaxation training, and family and group psychotherapy (Camic & Knight, 1998).

The active role of psychologists in treatment of chronic and life-threatening conditions has been supported by a second key development: the emergence of the biopsychosocial model in medicine and clinical health psychology. With its attention to psychological and behavioral factors, the biopsychosocial (or biopsychosocial-spiritual) model underlies and guides the creative and vital role that psychologists can play in preventing disease, enhancing health, and improving care at the end of life (Sulmasy, 2002).

Finally, the evolution of psychological practice in end-of-life care also is being shaped by a third development: a broad-based effort currently underway to improve life's final passage for Americans and their loved ones. This movement to improve end-of-life care has been galvanized by research documenting major failures in hospital care of the seriously ill. This research shows that many patients are dying following prolonged hospitalization or intensive care, often in unrelieved pain, their preferences concerning life-sustaining treatments not adequately discussed, documented, or followed (The SUPPORT Principal Investigators, 1995). Although hospice and home care could address many of these shortcomings, referrals to these services too often occur late or not at all (Fox et al., 1999); and about half of deaths occur in hospitals, with unacceptable rates of undertreatment (e.g., inadequate pain medication) or overtreatment (e.g., excessive use of high-tech life-sustaining interventions) being common (Field & Cassel, 1997; Fins et al., 1999). The response to these discouraging findings has been a period of rapid growth and innovation in end-of-life care (Connor, 1999; Wilkinson, Harrold, Kopits, & Ayers, 1998), creating an expanding arena for the contributions of psychologists.

Psychologists already have demonstrated their value as service providers in this rapidly evolving field of end-of-life care. Below, we review examples of such contributions across different stages of illness and in diverse clinical settings, and we highlight promising directions for expanding these efforts.

### Clinical Roles for Psychologists in End-of-Life Care

Psychologists can contribute to end-of-life care through interventions at four times in the lives of patients and families: (a) before illness strikes; (b) after illness is diagnosed and treatments begin; (c) during advanced illness and the dying process; and (d) after the death of the patient, with bereaved survivors. The settings for these efforts include the community, private clinical practice,

outpatient medical clinics, hospitals, palliative care and hospice programs, and nursing homes.

### *Before Life-Limiting Illness Strikes*

Psychologists can make substantial contributions before life-limiting illness strikes. They can contribute to disease prevention and health promotion in healthy populations, and as noted earlier, they increasingly are involved in the care of patients with chronic illness. One key intervention is facilitation of advance care planning. Despite attempts to increase completion rates, fewer than one quarter of patients have an advance directive that specifies their personal choices about end-of-life care options (L. Emanuel, Barry, Stoeckle, & Emanuel, 1991). Psychologists are accustomed to speaking with patients about issues of their own mortality, and at appropriate times can encourage advance care planning and completion of advance directives that are consistent with their personal values and can later guide their medical care. The vignette presented at the beginning of this article provides an example of a circumstance in which discussion of advance directives may be clinically advantageous in helping a patient feel some sense of increased control over her own destiny.

Psychologists also can be involved in the development of community awareness and education programs. One recent community education project that can serve as a model for future work is the *Finding Our Way: Living With Dying in America* newspaper series ([www.findingourway.net](http://www.findingourway.net)). The series, launched in 2001, appeared in more than 160 newspapers and reached millions of Americans, and was funded by several major foundations.<sup>1</sup> Fifteen experts wrote articles on end-of-life topics; the senior editor for the series was a psychologist (Dale Larson), and three of the articles were authored by psychologists (Stephen Connor, Dale Larson, and Donald Schumacher). Community education projects like the *Finding Our Way* series assist people to approach end-of-life issues with the same kind of planning, emotional preparedness, active involvement, and efficacy they strive for in other life domains.

### *After Life-Limiting Illness Is Diagnosed*

The time of diagnosis can be difficult and uncertain for patients, associated with a range of emotional reactions. Psychologists can assist individuals in managing these feelings, making sense of their diagnosis, communicating their treatment preferences to their medical providers and family, using effective coping responses, and mobilizing social support and other services. They can also teach physicians to attend to patients' and caregivers' psychosocial distress, via didactic instruction, informal clinical consultation, and modeling during joint meetings with patients and families.

One of the most widely studied life-threatening diseases that causes significant psychological distress is cancer (Baum & Anderson, 2001). Distress occurs across all types and stages of cancer (Zabora et al., 1997), underscoring the need for psychological support as an important goal for patients and families (Levy, 1993). Among the most common psychological symptoms for which psychologists may intervene are depression, anxiety, and fatigue (Jacobsen & Weitzner, 2003). Depression in cancer patients can be successfully treated with a combination of supportive psychotherapy, cognitive-behavioral techniques, and antidepres-

sant medications (Breitbart, Chochinov, & Passik, 1998; Holland & Chertkov, 2001).

The hospital setting provides many opportunities for working with patients and families immediately after life-threatening illness is diagnosed and treatment begins. Psychologists' responsiveness to psychological and emotional issues can decrease the distress and suffering of patients and families. Nonpharmacological stress-management approaches for managing symptoms such as pain and anxiety can be taught to patients and integrated into the plan of care, providing increased comfort and a sense of control (Jacobsen et al., 2002).

### *Advanced Illness and the Dying Process*

Individuals whose disease has progressed undergo a change from curative treatment to care focused on disease and symptom management. This transition requires significant adjustment for patients and family members. Psychologists can provide support and psychosocial interventions to assist with anticipatory grief and adjustment reactions, mental disorders, existential and spiritual issues, advance care planning, life review, and unresolved issues that are likely to surface as meaningful concerns.

As physical symptoms and disability increase, so does the incidence of pain, depression, and delirium (Breitbart et al., 1998). Psychological factors such as anxiety and expectation also can influence the experience of physical symptoms (Turk & Feldman, 2000). Those individuals with advanced disease frequently experience anxiety as a result of shortness of breath, ongoing symptoms, medications, fear of pain, and uncertainty about the future (Holland & Chertkov, 2001). Psychologists can provide a number of interventions that decrease symptom intensity and increase a sense of control. They can help patients and family members to explore their fears and apprehensions and to communicate their needs and concerns to their medical team. They also can teach cognitive coping skills (e.g., relaxation and breathing techniques, meditation, distraction, or imagery; Turk & Feldman, 2000), communication skills, and goal setting. Family members can be taught these techniques and enlisted as coaches as a way of providing additional active support.

Some psychological issues relevant to care of the dying can be subsumed under traditional diagnostic headings such as depression or cognitive dysfunction; others are more elusive, though equally important. Among these are existential concerns such as the patient's attitudes toward his or her impending death, which encompass the individual's conceptions of the meaning of death as well as associated emotional reactions regarding its eventuality. Psychologists can play a vital role in identifying factors that contribute to existential distress and fears at the end of life and in developing and evaluating intervention approaches, as illustrated by work on death attitudes and death anxiety (e.g., Neimeyer & Van Brunt, 1995).

Psychologists can expand care for dying patients and their families by facilitating a good death for patients. E. J. Emanuel and Emanuel (1998) present a conceptual framework for "a good death" that suggests six major modifiable dimensions of the pa-

<sup>1</sup> Robert Wood Johnson Foundation, Fan Fox and Leslie R. Samuels Foundation, and Charitable Leadership Foundation.

tient's experience: physical symptoms, such as pain and fatigue; psychological and cognitive symptoms, such as depression, anxiety, and confusion; social relationships and support; economic demands and caregiving needs; hopes and expectations; and spiritual and existential beliefs. Interviews with patients with life-threatening illnesses suggest similar priorities, with an additional value placed on achieving a sense of control (Singer, Martin, & Kelner, 1999) and on personal identity. Unfortunately, these needs often go unaddressed. It is estimated that 20–70% of dying patients experience inadequate pain relief, that over one third of dying patients are depressed, and that 35% have unmet emotional needs (Bradley, Fried, Kasl, & Idler, 2000). The high rate of unaddressed needs and suffering is particularly troublesome because most of the dimensions outlined by E. J. Emanuel and Emanuel (1998), as well as patients themselves, are amenable to psychological assessment and intervention.

Families providing care for patients with terminal illness also have important psychological needs. Caregiving can be an extensive activity: Spouses providing end-of-life care for patients with lung cancer in hospice report an average of over 120 hr per week of caregiving (Haley et al., 2001). Caregiving can lead to high levels of psychological distress and increased physical health problems (Schulz, O'Brien, Bookwala, & Fleissner, 1995). Haley and colleagues (2001) found that spouses caring for terminally ill patients with lung cancer or dementia showed rates of depression about three times those in noncaregiving populations. Highly stressful caregiving may even heighten risk for mortality (Schulz & Beach, 1999).

Studies of family caregivers suggest that psychosocial interventions can yield potent benefits for caregivers, decreasing depression and even delaying nursing home placement (Bourgeois, Schulz, & Burgio, 1996). Hospice care (which includes attention to family caregivers) is found to be consistently related to higher caregiver satisfaction with end-of-life care, and some studies also suggest lower anxiety during caregiving and lower depression during bereavement when families receive hospice care (Miller, Mor, Gage, & Coppola, 2000).

Several different settings provide the opportunity for psychologists to work with patients with advanced or terminal illness and their families. These settings include hospital-based palliative care units or consultation teams, hospice, and nursing homes.

As noted previously, most deaths in the United States occur in institutional settings, including hospitals (50%) and nursing homes (25%; National Hospice and Palliative Care Organization [NHPKO], 2001), where the dying experience generally receives little specialized attention. At present, psychologists typically are absent from acute care hospital settings or hospital-based interdisciplinary palliative care teams, though team composition varies depending on the setting or model of care (e.g., consultation service team, dedicated inpatient hospice or palliative care unit, dedicated beds in a long-term care setting, combined consultative service team and inpatient unit, outpatient palliative care clinic, home hospice, or other home health without hospice; Field & Cassel, 1997; Hallenbeck, 2001).

Psychologists increasingly are involved in long term care settings where they can work to improve the care of the dying. In nursing homes, psychologists' roles can include direct services such as assessment and intervention, consultation and attention to organizational issues, and training staff to deliver behavioral in-

terventions (Smyer & Qualls, 1999), as most nursing home residents have high rates of cognitive impairment and mental disorders in addition to chronic or advanced disease (Smyer & Qualls, 1999). Clinical geropsychologists may be in the best position to take the lead and focus on symptom management in nursing home settings, since psychologists have greatly increased their involvement in nursing homes over the past decade.

Individuals dying at home account for another 25% of deaths, most under the care of hospice (NHPKO, 2001), where greater attention is given to psychosocial needs, though hospices rarely employ psychologists because of financial incentives (discussed in greater detail below). Typically, core members are physicians, nurses, social workers, chaplains and volunteers. Traditionally, social workers, chaplains, and nurses address psychosocial issues. When psychologists are involved, they are often thought of as consultants rather than core members of the team (e.g., Smith, 2000). However, palliative care and hospice consultation teams are one of the most rapidly growing types of palliative care programs, and could in the future provide more opportunities for psychologist involvement in end-of-life care. For example, an innovative demonstration project is being conducted at The Ireland Cancer Center in Cleveland using an interdisciplinary team based on principles of hospice care and using extensive psychological consultation.

Increasing the presence of psychologists on interdisciplinary teams could result in improved patient care and overall team functioning, as psychologists have unique perspectives and skills to offer to the team (Abraham, Callahan, Rossetti, & Pierre, 1996). Psychologists can broaden staff's understanding of patients and families and can use this understanding to alleviate or assuage negative interactions between patients and staff. They can contribute to the quality of care by teaching interpersonal helping and communication skills to end-of-life professionals, introducing standardized screening instruments, and doing critical incident debriefing. They can facilitate interdisciplinary rounds focused on psychosocial and bioethical issues in patient care. Psychologists also can draw on skills in stress management and conflict resolution to enhance the performance and health of the team.

### *Bereavement*

The ending of the patient's life marks the beginning of a changed life for survivors. Psychologists need to recognize the biopsychosocial impact of bereavement, to be alert to the signs of complications in the grieving process, and to be capable of assisting more profoundly distressed survivors in adapting to a world in which their loved one is absent.

Although the majority of bereaved men and women cope effectively with bereavement, bereavement has been associated with serious neuroendocrine disturbance and sleep disruption (Hall & Irwin, 2001), generalized anxiety or panic syndromes in over 40% of spouses at some time during the first year (S. Jacobs, 1993), and a 40–70% increase in mortality among surviving spouses in the 6 months following loss (Parkes, 1996). Such findings argue persuasively that the many stresses associated with profound loss can have a serious, and even lethal, impact on a sizable minority of bereaved persons.

In view of these findings, psychologists have attempted to determine factors that identify persons at risk for negative outcomes associated with protracted and intense grief. Some of these

risk factors can be objectively assessed through a review of the circumstances surrounding the death, as more chronic and unremitting grief is typically associated with sudden, unexpected, and traumatic death (Rando, 1995), the deaths of children or young people (Gamino, Sewell, & Easterling, 1998), and closeness of the kinship tie to the decedent (Parkes, 1996). Others, however, call for clinical judgment, such as the level of conflict or ambivalence in the premonitory relationship with the decedent or mourner liabilities (such as a history of depression) that impede adaptation to loss (Worden, 2002).

There is considerable controversy about whether efforts to conceptualize complications in the grieving process as mental disorders distinct from major depression, panic disorder, and posttraumatic stress disorder are necessary (Bonano & Kaltman, 2001; Horowitz et al., 1997). Promising alternative conceptions of the psychopathology of grief include work by D. Jacobs, Mazure, and Prigerson (2000) who have recently garnered empirical support for a set of diagnostic criteria for "complicated grief," marked by efforts to avoid reminders of the deceased, purposelessness and futility, a shattered world view, and clinically significant disruption in life functioning. Moreover, diagnosis of complicated grief 6 months following the loss has been associated with a range of deleterious long-term outcomes, both psychological and medical (Prigerson et al., 1997).

In addition to identifying bereaved persons at risk, psychologists can help survivors adapt to both the short-term and long-term challenges of loss. In the immediate aftermath of the death, for example, the bereaved may benefit from coaching in symptom management techniques, such as relaxation skills and thought-stopping (Meichenbaum, 1994). In the longer run, however, what seems called for is opportunities for emotional self-expression (Pennebaker, 1996) and a deeper processing of the significance of the loss for their ongoing lives (Neimeyer & Levitt, 2001). In addition, in the case of complications in the grief process (e.g., complicated or traumatic grief), interventions targeting distress associated with separation from the loved one may be required (Shear et al., 2001).

Recent advances in grief theory and research are leading to changes in the nature of grief therapy (Neimeyer, 2001; Stroebe et al., 2001). Research increasingly suggests that the attempt to reaffirm or reconstruct a world of meaning that has been challenged by loss is a core process in grieving (Davis, Nolen-Hoeksema, & Larson, 1998; Neimeyer, Prigerson, & Davies, 2002). Interventions to assist survivors in making sense of the loss and perhaps even eventually finding a "silver lining" in it may be especially helpful to troubled survivors. Indeed, current data suggest that many bereaved people find new and sustaining meanings in their lives and losses, experiencing "posttraumatic growth" (Tedeschi, Park, & Calhoun, 1998) with or without professional help. A small but growing literature has begun to demonstrate that grief therapy can make a positive contribution to these outcomes (S. Jacobs & Prigerson, 2000), although much of the literature on grief counseling and therapy suggests more equivocal results (Al-lumbaugh & Hoyt, 1999).

Grief counseling can be provided in a number of settings, primarily private practice and outpatient medical clinics. However, many bereaved individuals are unwilling to identify themselves as having a mental disorder requiring treatment. Consequently, programs need to provide outreach to vulnerable bereaved individuals,

incorporating criteria for those at risk. Cummings (1998) provides an example of an innovative program to address problems related to bereavement in older adults. Through an HMO plan, widowed individuals were identified, and 85% received services through aggressive yet sensitive outreach. Intervention included 14 group sessions and was found to be clinically effective and to substantially reduce health care costs.

## Challenges

For psychology to fulfill its potential in delivering end-of-life services, a number of challenges must be addressed. These include reimbursement issues, training issues, and articulation of the unique roles psychologists can play as part of interdisciplinary teams.

### *Reimbursement for Psychological Services*

Psychologists have demonstrated their effectiveness in delivering psychological services across a variety of end-of-life settings. However, reimbursement issues are important problems limiting access of consumers to psychological services. There are no limitations particular to end-of-life care on providing psychological services for patients with terminal illness, although psychologists face increasingly complex issues with patients with medical and psychological problems in managed behavioral health systems that may reimburse separately for mental health services (Mihalik & Scherer, 1998). Because psychologists in the Veterans Affairs (VA) system are salaried, they have been very active in providing end-of-life care without financial barriers found in other settings. However, Medicare is the primary funder of hospice care in the United States, and current Medicare regulations pose serious barriers to non-VA psychologists wanting to practice with patients enrolled in hospice programs. Psychological services are bundled with all services paid for with the Medicare hospice benefit. Hospices receive a set per diem that includes psychosocial, nursing, pharmacy, and other health services (NHPCO, 2001). Hospices use salaried providers, typically social workers, to provide psychosocial services. Psychologists hypothetically could function in these roles, but to date there has been little incentive for psychologists to be hired (at higher rates of pay). A number of psychologists have worked as consultants for hospice programs, providing educational, research, program evaluation, and clinical consultation services (Lentz & Ramsey, 1988). In most cases, psychologists cannot bill Medicare for services delivered to a hospice patient receiving the Medicare hospice benefit. In some circumstances, hospices might be able to make more referrals to psychologists—for example, in providing psychotherapy for bereaved individuals who need more intensive services than hospice can provide—thus Medicare should not be a barrier.

There are several options for psychologists to be reimbursed by Medicare that are not commonly used. For example, psychologists who provide psychological services for preexisting conditions or conditions not arising from the terminal illness may be reimbursed by Medicare Part B. In addition, the new health and behavior assessment and intervention CPT (current procedural terminology) codes, which focus on patients whose primary diagnosis is physical ("APA wins approval," 2000), may provide a new avenue for reimbursement of services for symptom management and adjust-

ment to illness. These services are reimbursed from funding for medical, rather than psychiatric, services. Psychologists sometimes have been reimbursed by hospices to continue seeing patients after their acceptance into hospice in order to facilitate continuity of care. Psychologists interested in receiving referrals from hospices may find that their best approach is initially to offer their services on a voluntary basis. This arrangement is part of a long-standing tradition in hospice. After demonstrating effectiveness, referral could follow.

### Training Issues

As our knowledge about end-of-life issues expands, so too must our efforts to stay abreast of newer models and methods that address the needs of those we serve. Many of the skills necessary for psychological practice in end-of-life are similar to those in related areas of health psychology, with some important additional areas of critical expertise. For example, older theories of grieving as a relatively predictable series of emotional stages have been seriously questioned and replaced by theories emphasizing issues of meaning (Neimeyer, 2001; Stroebe et al., 2001; Worden, 2002). Likewise, psychological assessment has become more refined, resulting in growing criticism of popular but problematic instruments for assessing death anxiety (Neimeyer, 1994) and grief (Neimeyer & Hogan, 2001) and the development of more valid and clinically useful alternatives. In addition, the validity of psychological assessment tools in terminally ill individuals and the identification of appropriate outcome measures for palliative care interventions are only beginning to be examined. Clearly, psychologists have both an obligation and an opportunity to augment their skills and update their tools as they offer assessment and intervention services in this rapidly changing area.

Success in end-of-life settings challenges psychologists to use their existing skills in new ways and to develop new skills. Problem-centered interventions and skills training compatible with services offered in medical settings are likely to become a central feature of one's clinical work (Carmin, Roth-Roemer, & Kurpius, 1998), as are hospital and home visits and telephone contact with patients. Specialty training at the postdoctoral level might be needed for some work.

At present, specialty psychology postdoctoral training in palliative and hospice care is rare. Psychologists lag behind medicine and nursing in establishing relevant education curricula and clinical competencies. For example, major end-of-life curricula have been developed for physicians (the AMA's Project to Educate Physicians in End-of-Life Care; [www.epec.net](http://www.epec.net)) and nurses (the End-of-Life Nursing Education Consortium project; [www.aacn.nche.edu/el nec](http://www.aacn.nche.edu/el nec)). Although psychologists can use these curricula to inform their knowledge and skills, many competencies unique to psychology need to be elucidated and developed. One project undertaking this task is the Interprofessional Fellowship in Palliative Care now being established at select VA facilities ([www.va.gov/oa/fellowships/palliative.asp](http://www.va.gov/oa/fellowships/palliative.asp)). In addition, APA's current Ad-Hoc Committee on End-of-Life Issues is seeking funding for development of a comprehensive program to educate psychologists in important issues related to end-of-life practice.

### Misperceptions of the Role of Psychologists

Psychologists have had little presence on interdisciplinary palliative care teams. There may be several reasons for this absence. For one, psychologists often are absent from the settings in which end-of-life care are offered and may feel uncomfortable offering their services, given limited training in end-of-life issues. A second reason for the relative absence of psychologists may be that the psychologist is considered only for complicated or pathological conditions. A third reason may be that standardized assessments often are not performed (e.g., brief mood, cognitive screens), and more comprehensive evaluations (e.g., competency) may be thought to be the purview of psychiatrists only. We believe that these barriers to psychologists' involvement in end-of-life care are weakening and new arenas for involvement are emerging. Psychologists who have worked in end-of-life settings in palliative care settings and within the VA have found wide acceptance and play important roles that should be more widely disseminated.

### Conclusion

We have explored the many roles psychologists can play in end-of-life care. Psychologists bring much to the table: clinical, research, and organizational development skills that can uniquely enhance current end-of-life care. Already, psychologists have dramatically expanded our understanding of coping with and adaptation to loss and advanced illness as part of the ongoing expansion of our roles in health psychology (Brown et al., 2002). Extant work in the AIDS and HIV area illustrates the power and range of contributions psychologists can make across time, from prevention to bereavement, and across settings. The potential for psychologists' contributions to end-of-life care is tremendous; however, both the end-of-life field and psychologists themselves have only just begun to tap this potential.

If more psychologists begin to explore end-of-life care, we believe that the compelling nature of the work, and its fit with the unique skills and expertise these professionals bring to it, could inspire a significant cohort of psychologists to help transform what is perhaps the greatest touchstone of our humanity: the way we care for people at the end of life.

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Manuscript submission patterns make the precise date of completion of the 2004 volumes uncertain. Current editors, Mark B. Sobell, PhD, and James L. Dannemiller, PhD, respectively, will receive and consider manuscripts through December 31, 2003. Should 2004 volumes be completed before that date, manuscripts will be redirected to the new editors for consideration in 2005 volumes.