

APA RESOLUTION on Palliative and End-of-life Issues

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INTRODUCTION

Psychological science and psychologists have contributed greatly to understanding and addressing the needs of individuals and caregivers facing the end of life, as well as training and education in assessment and evidence-based interventions and the alleviation of suffering through basic and applied research. However, in the U.S. context, integration of psychologists into palliative care teams and scientific consensus groups has remained an aspirational goal of the American Psychological Association (APA) for more than a decade (Kasl-Godley et al., 2014). This document is an update of APA's 2017 resolution, focusing on contributions of psychology in palliative care and end-of-life issues in the United States due to differences in international law regarding these issues. Where appropriate, we use the acronym PEOL to refer to palliative care and end-of-life issues, and EOL when discussing end-of-life care. We spell out "end of life" when used as a noun (e.g., "at the end of life").

According to the International Association for Hospice and Palliative Care (IAHPC)'s consensus-based definition developed by health professionals (including one psychologist) from countries with all income levels, palliative care is the active holistic care of individuals across all ages with serious health-related suffering due to serious illness, especially nearing the end of life (Radbruch et al., 2020). Palliative care aims to improve the quality of life of individuals and their families/caregivers by managing symptoms and coordinating care effectively, so that people may better understand their treatment choices and treatment plans can reflect their goals and values. The World Health Organization (WHO) adds that palliative care improves quality of life through the prevention and relief of suffering across physical, psychosocial, and spiritual domains (2020).

Palliative care may begin at any stage of a person's serious illness/health condition (e.g., at the time of diagnosis) and may co-occur with other disease-related treatments (Kelly & Morrison, 2015). When the person is no longer benefiting from curative treatments, they may transition to hospice care if their life expectancy is 6 months or less. Palliative care may be provided when a serious illness that carries a high risk of mortality either negatively impacts a person's daily function and quality of life or excessively strains their caregivers. As such, palliative care broadly covers many EOL issues, including advance care planning (ACP), EOL care, hospice care, and bereavement support for caregivers (Riordan et al., 2020).

Because palliative care requires an interdisciplinary approach, it fits directly within psychologists' expertise and scope of practice, and an estimate of 25,000 palliative care service delivery teams existed globally in 2017 (Connor et al., 2021). Unfortunately, psychologists are often not fully integrated into palliative care teams and, thus, many of these teams function without psychologists. There are significant gaps in training psychologists for palliative care practice, as well as disparities in palliative care access by region and socioeconomic status (WHO, 2020). The clear need for psychologists in palliative care and significant gaps in training and access motivated the current extensive revision of the 2017 Resolution.

ETHICAL CONSIDERATIONS IN PRACTICE AND POLICY

Whether psychologists are part of a palliative care team or not, their work may involve PEOL, such as during the ACP process; working with people with advanced, serious illness, and/or family caregivers; and participating in or directing treatment preference and goals of care discussions about EOL care. Psychologists also may be called to provide formal evaluation of a person's decisional capacity in many domains: for example, to appoint healthcare power of attorney (HPOA), to consent or decline medical treatments and procedures (e.g., decisions related to "do not resuscitate" or "allow natural death"), and to execute an estate plan or engage in any form of planning for a person's remains and distribution of their assets following death. Psychologists also may conduct capacity evaluations in jurisdictions that provide Medical Aid in Dying (MAiD). Psychologists who are involved with ACP and decisional capacity evaluation abide by APA's *Ethical Principles of Psychologists and Code of Conduct* (2017) when working with families, caregivers, and interdisciplinary teams that guide ethical decisions in the PEOL context, especially potential ethical dilemmas involving protecting the welfare of all individuals, while respecting their rights and dignity (Principle E), with special consideration regarding privacy and confidentiality (Standard 4), multiple relationships (Standard 3.05), undue influence, and support versus surrogate decision making. Psychologists are particularly well-suited to contribute to evolving ethical guidelines in this area given competencies in evidence-based interventions and assessments, group dynamics, and social theory, among others.

In addition to ethical and legal considerations, psychologists are encouraged to familiarize themselves with policy considerations that contribute to significant barriers in access to palliative care. For example, health insurance in the United States, namely Medicare, typically only reimburses primary care physicians to complete ACP once a year, limiting the kinds of professionals who might be reimbursed for treating patients and families and reducing access to these goals of care planning sessions. Indeed, the status of reimbursement for ACP discussions reflects limitations in palliative care policymaking at the State and federal levels and globally (Ouyang et al., 2025; WHO, 2020).

Access barriers to palliative care are exacerbated for people of color, rural-dwelling individuals, people with disabilities, those of low socioeconomic status, and individuals with multiple intersecting identities associated with minoritized status (WHO, 2020). This reflects limitations implementing the ethical principle of justice (APA, 2017; Principle D) in accessible and affordable palliative and EOL care. Such inequities are caused by disparities in Social Determinants of Health (SDOH), such as safe housing, transportation, employment opportunities, and income, which are nonmedical factors that can be influenced by social policies; and contribute to health burdens across the life span and across medical conditions. Economic barriers to palliative care also are differentially experienced by individuals with minoritized status in the United States. Community-based palliative care (CBPC) programs are often reimbursed through privately managed health care plans that may be inaccessible to those of low socioeconomic status (Dussault et al., 2025). Medicaid, State-managed health care, may include CBPC, but only five States (i.e., California, Colorado, Hawaii, Maine, and Oregon) do so. Importantly, the role of U.S. States in supporting palliative care policy extends to the meaningful implementation of palliative care across health equity, access to quality care, workforce development, and education and training.

INDIVIDUAL, SOCIAL, AND SYSTEM CONSIDERATIONS IMPACTING ACCESS

Intersectionality and Health Disparities

Minoritized populations are at higher risk for chronic and acute illness and receive fewer palliative care services than White and nondisabled individuals (Bazargan & Bazargan-Hejazi, 2021; Cross et al., 2021; Velepucha-Iniguez et al., 2022). Common factors contributing to low use include: limited knowledge or lack of access to information about palliative and hospice philosophy, systemic challenges (e.g., access to care, historic distrust of medical systems), and implicit biases by healthcare providers, as well as cultural norms affecting prognosis and perceived quality of life, especially among people with disabilities (Adam et al., 2020; Bazargan

& Bazargan-Hejazi, 2021; Cross et al., 2021; Griffith et al., 2021; Velepucha-Iniguez et al., 2022). Factors also include patient's religious and cultural beliefs about discussing EOL planning (Ashana et al., 2021), healthcare provider's biases (e.g., presuming patient preferences, limited awareness about palliative care needs of LGBTQIA+ individuals), language (e.g., scarcity of qualified interpreter and translation services, inaccessible language for those with sensory impairments), obstacles to effective patient-provider communication for deaf and hard-of-hearing clients, and lack of information or health care knowledge among those who need palliative care (Adam et al., 2020; Bazargan & Bazargan-Hejazi, 2021; Javier, 2021; Velepucha-Iniguez et al., 2022). Inequities in access and quality of medical care, including palliative and hospice care, often arise in part due to social biases and stigmas related to demographic factors. These inequities affect where and how individuals receive treatment through their end of life, and their comfort and dignity.

Racial/Ethnic Minoritized and Immigrant Populations

SDOH contributes to higher rates of chronic illness in racially minoritized populations and lower rates of illness detection. For example, non-White populations (especially Black and Indigenous individuals) had the highest detected rates of cancer (American Cancer Society, 2021). Individuals from minoritized racial groups (especially Black and Indigenous groups) and lower socioeconomic statuses tended to receive diagnoses at later stages of cancer progression, and cancer mortality remained highest among Black individuals, those of low socioeconomic status, and those in the Southeastern region and Appalachia.

Language and cultural barriers can compound challenges to palliative care access, especially among and immigrant populations. Language background, access, and use are among numerous cultural dimensions of the healthcare context that play a significant role in palliative and EOL care (Ashana et al., 2021). Individuals with written and spoken English proficiency may need to or prefer to receive medical/health information in their first or primary native language. Religion, customs, and the role of families become critically important during palliative and EOL care. For example, some South Asian individuals and communities (e.g., India, Pakistan) are reluctant to engage in medical pain management. South Asian people may report having little awareness about palliative care, and that palliative care and discussions of death are against their values (Dosani et al., 2020). Similarly, qualitative research revealed limited knowledge about palliative and hospice care in a Hispanic community in the United States, where a "good death" depended on having the entire family physically and emotionally present (Gallo Marin et al., 2024). Such practices may contradict the approach of clinical teams that tend to value patient autonomy in decision-making. When palliative care practices ignore these cultural dimensions, healthcare

teams may not be able to fully respect the dying individual and their families' preferences about treatment, places to die, EOL rituals, and decision-making authority. All these considerations may lead to conflict, mistrust, and distress of health care providers, resulting in reduced satisfaction with palliative care (Aker et al., 2024).

Unauthorized or undocumented immigrants lack access to consistent medical care including palliative and hospice care. Many unauthorized immigrants face structural factors affecting their health (e.g., unsafe living conditions, lack of access to consistent health care, lack of formal labor protections, and limited social and financial support). In most of the United States, unauthorized immigrants are not afforded basic life-prolonging healthcare services including scheduled dialysis, resulting in emergency-only dialysis for life-saving purposes (Nguyen et al., 2019). More broadly, immigrants with advanced cancer were more likely to die in the hospital, away from their preferred place of death, and have a poorer quality of death than their nonimmigrant peers (Tergas et al., 2022).

Women

Women's experiences of serious illness and EOL care differ from men's, as women live longer on average, have higher rates of chronic illness (e.g., dementia, autoimmune conditions, pain syndromes), and are more likely to experience undertreated pain and fatigue due to gender bias in palliative care (Gott et al., 2020). Women as a population are at risk for inequities in access, diagnosis, pain management, and culturally responsive services as care recipients and caregivers. Older women, particularly women of color, are more likely to live in poverty, which impacts access to quality palliative care (Jawed & Comer, 2024). Moreover, the United States has some of the highest rates of maternal mortality/morbidity among high-income countries, especially for Black women (Khan et al., 2023). Maternal complications of pregnancy and bacterial sepsis increased in 2022. From an intersectional feminist lens, women at the intersections of multiple group identities, such as race, socioeconomic status, sexual orientation, gender identity, disability, and immigration status, experience compound disparities in palliative care access and outcomes because of overlapping forms of bias by health care providers uniquely affecting women in these contexts.

Across the lifespan, women are disproportionately likely to serve as unpaid caregivers, often balancing employment and parenting, with significant financial and health consequences (Shefeek et al., 2025). Psychologists have a unique role in supporting women and their families in caregiving contexts, including perinatal and maternal end-of-life care. Women caregivers face higher rates of depression, anxiety, and complicated grief. The gendered nature of caregiving highlights the importance of psychological support for women caregivers in palliative care context (Gott et al.,

2020). This includes helping women face terminal illness (e.g., aggressive cancer) during pregnancy and bereavement care for mothers experiencing miscarriage and infant loss.

Children and Youth

The 2023 National Hospice and Palliative Care Organization (NHPCO) report on pediatrics found children in age groups 1–5 and 6–14 comprise 69% of palliative and hospice care pediatric patients. Oncological (36%), genetic (36%), and neurodegenerative conditions (27%) constitute most illnesses requiring pediatric palliative care (NHPCO, 2023). Medicaid data from 2011–2013 indicated that of 6,195 children under age 21 with a diagnosis of a mental health and/or developmental disability who were admitted to hospice care, 66% had a single complex chronic condition (e.g., neurologic, cardiovascular, respiratory conditions), nearly half had multiple complex chronic conditions, and nearly a third of those aged 15–20 had diagnoses of anxiety, depression, behavioral disorders, or other affective disorders (Lindley et al., 2021). Furthermore, almost 50% of the entire sample was reported to have developmental delays, the majority of which were less than one year of age (79%) or under 5 years of age (77%), while over one quarter (26%) of those 15–20 years old had some other reported developmental disability (Lindley et al., 2021). Children living with serious illness and enrolled in Medicaid or Children's Health Insurance Program (CHIP) in the United States may receive disease-directed treatment and interdisciplinary hospice services at the same time because of the Concurrent Care for Children requirement under the Affordable Care Act (ACA; 2020). This enables parents/caregivers to choose both disease-directed treatment and comfort care when their child is facing a terminal illness (NHPCO, 2023). Although hospice is an optional benefit to adults in State Medicaid programs, its provision to children is mandated under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements. While pediatric palliative care often ranges from prenatal to young adulthood without a defined age limit, the ACA entitlement to concurrent care only applies to those under age 21.

In pediatric palliative care, psychological services are often provided to family members (e.g., parents, siblings, and other caregivers) in addition to the child. Parents/guardians and families report extraordinary emotional and financial strain caring for children in need of palliative care, including direct physical care, and advocacy and care coordination to navigate the healthcare systems, school systems, and larger communities (Bogetz & Lemmon, 2021). Integration of psychologists into pediatric palliative care settings could help improve outcomes among children and their families and reduce healthcare cost through developmentally appropriate and evidence-based assessment and intervention (Thompson et al., 2024).

Adults With Advanced Chronic Illness

Among adults, diseases requiring palliative care include heart disease, cancers, stroke, diabetes, end-stage kidney disease, Parkinson's disease, and Alzheimer's disease and other dementias (CAPC, 2014). These diseases mirror the leading causes of illness-related deaths in the United States, with COVID-19 being the third leading disease in 2022 (National Center for Health Statistics, n.d.). By 2016, 50% of all health care costs in the United States were attributed to the top 5% of persons ranked by their health care expenditures, who were disproportionately 65 and older, White, covered by Medicare, and/or paying for inpatient services (Mitchell, 2019). This group includes those with one or more serious medical illnesses, functional dependence on others to complete basic daily activities, cognitive impairment, medical frailty, and/or reliance on family and other caregivers. Only 11% of this group were within the last 12 months of their lives, highlighting the need for longer-term primary palliative care (CAPC, 2019). Conversely, this also suggests the need to better understand the experiences of individuals living with chronic serious illness who report good quality of life, and how palliative care may be beneficial.

Older Adults

Although serious illness may occur at any age, the likelihood of being diagnosed with a serious illness is higher among older adults and, therefore, older adults are more likely to need palliative care. By 2040, adults aged 65 and older will reach 80.8 million, with racially and ethnically minoritized older adult populations projected to increase to 27.7 million (Administration for Community Living, 2024). By 2050, 40% of LGBTQIA+ older adults are expected to be people of color (MAP & SAGE, 2017) and there is a clear need for enhanced culturally responsive palliative and EOL care for this population. One third of people age 85 and older (the fastest growing portion of the U.S. population) are expected to develop Alzheimer's disease or another neurocognitive disorder and will require significant support in their last two years of life (CAPC, 2019). Many opportunities for psychologists exist to improve palliative care for people living with dementia, including conducting capacity evaluations for participation in ACP, improving health literacy and palliative care literacy about the benefits and drawbacks of artificial nutrition and hydration, working with individuals and families in dyadic medical decision-making regarding infections and cardiac arrest, exploring values related to medical care and communication priorities, ethical assessments of pain, education regarding pain control, and spiritual care (Gupta & Patel, 2024; Weisbrod, 2022).

People With Disabilities

Studies reveal biases among medical providers who believed that people with significant disabilities have a lower quality of life than those without (Adam et al., 2020; Velepucha-

Iniguez et al., 2022). Additional barriers among healthcare providers to address the palliative care needs of those with disabilities included their limited knowledge of palliative care, questions regarding a patient's appropriateness for the service, and questions of decisional capacity and the involvement of surrogate decision-makers. Communication factors may create barriers for patients (e.g., limited awareness of serious illness among those with profound disabilities) and providers (e.g., low rates of detection related to severity of disability and communication; not communicating information in ways accessible to the patient). In the United States, deaf and hard of hearing people who primarily use American Sign Language (ASL) are at greater risk for chronic health disease compared with hearing people. This health disparity is driven in part by systemic inequities (e.g. lack of language-accessible informational materials, scarcity of competently trained health care professionals, limited health literacy, nonconcordant patient-provider communication, and limited availability of qualified interpreters) (Kushalnagar et al., 2018).

Disability rights activists have advocated for increased sensitivity around medical decision-making and disability culture (Ne'eman et al., 2021). For example, clinical practice guidelines at the institutional level have little information applicable to those with intellectual disabilities and their healthcare providers, who may have limited knowledge of primary palliative care (Adam et al., 2020; Velepucha-Iniguez et al., 2022). There remain few tools for detection of underlying emotional and psychological distress among persons with intellectual disabilities (e.g., anxiety, depression, grief). A systematic review of 52 studies revealed that most studies of palliative and hospice care for this population came from the United Kingdom, with an overall lack of direct feedback reflected in those studies from people with intellectual disabilities and families, and few strategies to improve their access to palliative care (Adam et al., 2020).

Sexual and Gender Minorities

LGBTQIA+ youth and adults report low use of healthcare services due to experiences of discrimination, provider bias, and fear (e.g., homophobia, transphobia), limited knowledge among patients and providers, and distrust of medical systems (Haviland et al., 2021). Barriers also include healthcare provider discrimination (e.g., withholding forms such as Advanced Directives to LGBTQIA+ adults), lack of psychological safety (e.g., heterosexist language/policies), family dynamics (e.g., strained relationships, estranged next of kin, hesitation asking friends to serve as surrogates), and systemic disenfranchisement (e.g., limited rights for same-sex couples, state statutes about default surrogate decision-makers) (Haviland et al., 2020). Barriers may be compounded further for minoritized individuals of intersectional group identities, including LGBTQIA+ people of color and LGBTQIA+ people with disabilities. For example, deaf LGBTQIA+ people who primarily use ASL are at risk for greater health disparity

for medical conditions (e.g. lung disease, arthritis, mood disorders) compared with deaf non-LGBTQIA+ adults (e.g. nondisclosure of gender or sexual health-related information to healthcare providers because of concerns about anti-LGBTQIA+ stigma and discrimination (Kushalnagar & Miller, 2019).)

Financial Barriers

A major barrier to palliative care access across the lifespan is financing, namely insurance coverage, reimbursement policies, out-of-pocket costs, service eligibility, and public-private coverage disparities. Although access to palliative care has generally expanded, reimbursement mechanisms may be inadequate and limiting, particularly for rural-dwelling individuals or those who self-identify as Black, Indigenous, or People of Color, along with their families (Delgado-Corcoran et al., 2024; Dussault et al., 2025; Suntai et al., 2021). Palliative care and healthcare systems may be fragmented and uncoordinated, and the public has limited knowledge and awareness of palliative care (Masoud et al., 2023; Patel & Lyons, 2020). Similarly, primary care providers need suggestions on how to integrate palliative care into their practices (Hughes et al., 2023). Most hospitals and establishments offering palliative care services are housed in urban/metropolitan locations (CAPC, 2020), highlighting access issues in rural communities.

SETTINGS AND INTERPROFESSIONAL COLLABORATION

Palliative care is provided in multiple settings, ranging from a person's home (including foster or group homes), independent outpatient and inpatient care facilities (short-term, rehabilitation, acute, or long-term), inpatient hospice care homes, or via telehealth. Psychologists are rarely integrated in many of these settings. Social work and chaplaincy have a longstanding presence as disciplines within palliative care teams to address psychosocial and spiritual needs, whereas psychologists are often introduced only when specialized psychological interventions are needed by a person receiving palliative care. The inclusion of psychologists on palliative care teams, who have a long history of working in a variety of settings with people who have serious medical illness, will increase and enhance the care provided, given psychologists' expertise in assessment, treatment, team dynamics, quality improvement, and program evaluation. *Guidelines for Psychological Practice in Health Care Delivery Systems* (APA COPPS, 2025).

The addition of psychologists to interprofessional palliative care teams would enrich care outcomes by integrating psychological science and implementing psychological assessments and interventions. Psychologists add a deep understanding of the ways in which mental health syndromes intersect with medical conditions and provide unique expertise in assessing capacity

for decision making, mood, personality, cognition, and family dynamics, all of which may influence a patient's or families' experience. Psychologists bring a lifespan developmental and socioemotional focus that can place a patient in context for other team members and have competency in developing, evaluating, and administering evidence-based treatments for nonpharmacological interventions for physical symptoms.

Psychologists also could contribute to interprofessional team functioning by supporting patient-provider communication and reconciling varying needs and perspectives in creating a culture of trust (Foo et al., 2024). Greater team support may foster better emotional adjustment among team members, a higher degree of effective collaboration, and stronger relationships among patients, caregivers, and healthcare providers (Bergenholtz et al., 2020). Psychologists may enhance communication given their understanding of group dynamics and social theories.

Telehealth delivery of palliative care would increase access for rural and other disadvantaged groups. A recent systematic review of 112 English-language articles on palliative care telehealth published between January 1, 1980, and July 25, 2024, indicated focus on telecoaching, an e-health app to monitor symptoms, and e-consultation (Hutchinson et al., 2025). Two-thirds of studies were published since 2020, but few focused on patient outcomes. In a review of 18 studies using PRISMA methodology in seven countries across five continents, videoconferencing was the typical modality for palliative telehealth, and most studies involved oncology patients (Gordon et al., 2022). Studies primarily focused on the structure or process of care delivery and symptom management, with few addressing spiritual, cultural or ethical concerns, particularly at the end of life. Moreover, quality metrics indicated study methodologies were poor as they rarely included control groups. In nursing homes, a scoping review of 11 articles found preference for live video as the preferred telehealth delivery modality, with five family and patient-centered themes of symptom management, ACP, quality of life, healthcare use, and evaluation of care (Walton et al., 2023). Benefits included increased goals of care discussions and documentation with diminished acute care use, whereas challenges included technological difficulties and increased financial burden to nursing homes.

Despite the ways in which psychologists may improve palliative care delivery in integrated teams across practice settings, there are longstanding obstacles to the full integration of psychologists on palliative care teams, including limited workforce training in palliative care (Domino et al., 2019). Other barriers include limited insurance coverage and reimbursement structures, and hospital or healthcare system infrastructure. Because specialty mental health providers are not routinely included in palliative care teams (O'Malley et al., 2021), physicians providing palliative care reported

that they had limited access to mental health providers, were unsatisfied with mental health training opportunities despite frequently encountering psychiatric comorbidities that they might be less comfortable managing (Shalev et al., 2024). These conditions included substance use disorders, suicidality, psychotic disorders, and personality disorders.

EDUCATION AND TRAINING

Education

Although educational opportunities in PEOL are underdeveloped before internship or postdoctoral training, evidence suggests students benefit from experiential learning opportunities in a palliative psychology research lab during their undergraduate studies (Hoerger, 2022). Death and dying topics are increasingly included as part of undergraduate psychology curriculum globally (Biancalani et al., 2023), as training to tolerate and manage death, dying, and bereavement concerns is a necessary prerequisite for ethical practice in grief work (Gamino & Ritter, 2012). Such opportunities provide undergraduate early exposure-level training to the role of psychologists in palliative care. Some psychology graduate programs (e.g., United States, Spain) have begun to embed palliative care content into their curricula. Leaders in palliative care have called for a national strategy to address policy and practice barriers to national adoption of interdisciplinary education and training guidelines that include psychology in the United States (Meier et al., 2017; Testoni et al., 2022). Such strategies may be particularly appealing to women, as even though psychology is a majority-female discipline, women and early-career psychologists often face additional barriers to entering palliative care including family responsibilities and gender and experiential inequities in academic medicine. More mentorship, leadership development, and equitable workforce policies are needed in palliative care settings to support all students and early career psychologists, including women psychologists, in pursuing palliative care careers.

Generally, few systematic efforts exist to educate psychologists about PEOL outside of the Veterans Health Administration (VHA) where veterans receive palliative care services as part of their veterans benefits, and a few academic medical centers (Abramson, 2022; Feldstain, 2024; Foo et al., 2024; Kasl-Godley et al., 2014). However, PEOL knowledge and skillsets are relevant for professional psychologists in most healthcare settings (e.g., health psychology, rehabilitation psychology, geropsychology, pediatric psychology, and neuropsychology). Early career psychologists increasingly forego specialized fellowship training (APA Workforce Center, 2021), making it crucial to identify and promote knowledge and experience through continuing education opportunities (e.g., APA webinars), as well as skills-based training opportunities and collaboration with and mentoring from palliative care physicians and social workers.

Although psychological issues such as grief, pain, and fatigue are core practice domains in palliative care, psychologists remain largely absent from professional work groups involved in developing these competencies (Ferrell et al., 2018). However, competencies for adult palliative and EOL care are embedded within Geropsychology competencies (APA, 2024; Karel et al., 2010). The Council of Professional Geropsychology Training Programs (CoPGTP) recommends an exposure level of training in EOL care for any psychologist who serves older adults, whether these professionals identify as geropsychologists, specialists in other areas, or generalists (Hinrichsen et al., 2018).

Since providing care to someone nearing the end of life could involve significant uplifts (Johannesen et al., 2023) and potential for psychological, physical, and economic strain (Gardiner et al., 2019; McAndrew et al., 2024), it is strongly encouraged that PEOL education and training include foundational and functional competencies in working with families and caregivers (Feldstain, 2024). Accreditors are encouraged to consider the inclusion of death and dying content standards for graduate coursework in psychology, as this content is not currently a required component in most professional psychology graduate programs, either through didactics or experiential learning (Feldstain, 2024; O'Malley et al., 2021). It is crucial to educate psychologists at all training levels about the difference between palliative and hospice care in relation to the timeframe of service, insurance coverage, goals of care among patients and caregivers, stigma, and cultural implications. Training on healthcare navigation and best practices to promote health literacy related to PEOL are critical to psychologists in guiding individuals and caregivers through EOL decision making, especially among those from minoritized/marginalized populations.

Assessment

Psychologists have specific professional strength in assessment. Relevant to PEOL are clinical interviewing, cognitive/personality evaluation, functional/behavior analysis, and observation. Much research on palliative care assessment focuses on adults and physical symptoms of imminent death, communication among hospice team members, and when to notify family members (Lee et al., 2021). In the *Assessment Tools for Palliative Care*, Aslakson's (2017) workgroup identified 152 tools organized into eight domains from the National Consensus Project Clinical Practice Guidelines for Palliative Care. Despite this comprehensive compendium of measures, key assessment gaps exist. Few tools were included that measure 1) structure and process; 2) cultural, ethical, and legal domains; 3) spiritual experiences; and 4) patient-reported experiences. Measures such as the Palliative Performance Scale (PPS), modified based on the Karnofsky Performance Scale, are often used to assess a patient's overall status and functionality (Baik et al., 2018) to guide treatment decisions, monitor progress, enhance

communication, guide EOL care, and identify ways to maintain or improve quality of life.

Another comprehensive measure is the Palliative Distress Inventory-Revised (Rossi et al., 2022), a psychometrically sound measure of psychological distress encouraged for use with oncology patients in clinical settings. It has measurement equivalence for men and women and for those less than or greater than 65 years of age. Because PEOL issues include caregiving stress and burden and bereavement care, equally important are measures related to caregiver burden, anticipatory grief, and complicated and prolonged grief, such as the CAREPAL-8, a multidimensional screener of family caregiver burden in palliative care (Ullrich et al., 2024), and the PG-13 Revised Scale for prolonged grief (Prigerson et al., 2021). In addition, psychosocial constructs such as mental health and wellbeing, two unique but overlapping constructs, also need to be measured in palliative and EOL care on a more regular basis.

Intervention

Psychologists have specific professional competency in the implementation of evidence-based interventions, especially in health care delivery systems (APA COPPS, 2025). Much of the research on palliative care intervention has focused on pain management, feeding and hydration, and other medical and medication interventions (Huffman & Harmer, 2023). In recent years, there is an increasing emphasis on the role of applied psychological intervention in palliative care (Feldstain, 2024) because nonpharmacological and behavioral interventions are effective for relief of distress from physical symptoms such as dyspnea and pain. Management of spiritual, emotional, and social suffering is also important to the management of physical symptoms in EOL care, highlighting the need for psychological interventions (Feldstain, 2024).

Psychological contributions in palliative and EOL care include interventions designed specifically to address common issues (e.g., hopelessness, feelings of burden, loss of dignity, death anxiety, depression, and measures of positive psychological experiences such as meaning in life) in a holistic manner, namely Dignity Therapy (Chochinov, 2012), meaning-making creative activity dyadic interventions such as Legacy Intervention Family Enactment (LIFE; Allen et al., 2014; Allen et al., 2016), and Meaning-Centered Psychotherapy (Rosenfeld et al., 2017; Saracino et al., 2019). Other evidence-based psychotherapies could be adapted to address anxiety, depression, and trauma within EOL care for people living with advanced serious illness, their caregivers, and palliative care staff, namely cognitive-behavioral therapy (CBT), acceptance and commitment therapy (ACT), and other mindfulness-based interventions (Abramson, 2022; Feldstain, 2024; Gibson Watt et al., 2023). These interventions could be adapted to address spiraling thoughts about death, negative emotions such as fear and shame, physical symptoms such as pain (e.g., ACT for chronic

pain; Ye et al., 2024) and fatigue, and social withdrawal and aggression that may occur towards the end of life (Beck & Fleming, 2021).

To address caregiver stress and long-term psychological outcomes, evidence-based psychological interventions such as meaning-making interventions may improve caregiver's wellbeing by increasing meaning in life and reducing existential distress (Allen et al., 2014; McAndrew et al., 2024). Other interventions for families and caregivers seek to address grief, psychoeducation around the dying process and procedures, and conversations on how to address ACP (Kishino, 2022). Because palliative care patients' caregivers, especially working caregivers, are at risk for experiencing increased burden and economic strain, burnout prevention may involve additional support and interventions from employers to accommodate caregiving needs (Bijnsdorp et al., 2022). As grief is embedded throughout all phases of EOL care, anticipatory grief interventions help to address separation anxiety, anticipation of loss, denial, and relational issues for care patients and their families or caregivers (Coelho et al., 2018). Because up to 25% of caregivers of palliative care patients experienced prolonged grief (Ribera-Asensi et al., 2025), grief-focused CBTs, namely Prolonged Grief Therapy (Shear & Gribbin Bloom, 2017), would appear beneficial (Komischke-Konnerup et al., 2024).

Abuse, Neglect, Exploitation, and Trauma

Psychologists have expertise in addressing and working with the effects of abuse, neglect, exploitation, and trauma across the lifespan (APA, 2025). Individuals nearing the end of life, especially those with other identities that present with vulnerabilities, may be at increased risk for abuse and neglect at home and in care settings. Abuse may include physical and sexual abuse, neglect of basic needs, and financial exploitation among older adults in nursing homes (Myhre et al., 2020). Children receiving pediatric palliative care may experience medical neglect in addition to other forms of childhood abuse (Cleveland et al., 2021; Levy et al., 2019). Older women and women with disabilities may also be at heightened risk of abuse and neglect by caregivers and in institutional settings (UN Women, 2022; Walter et al., 2024). Outside of the context of direct abuse and neglect, there is increasing recognition that medical events preceding admission into palliative and hospice care may constitute traumatic experiences for patients and families (Ganzel, 2018). Gender-based violence and trauma histories can resurface at the end of life through late onset posttraumatic stress disorder, impacting trust and decision-making (Ramos et al., 2022). Later-adulthood trauma reengagement may stem from multiple neurobiological pathways, including decreased cognitive reserve and increased search for meaning and life-narrative coherence (Smid et al., 2022). These changes may dovetail with recently experienced medical traumas and greatly amplify the need for trauma-informed palliative care

(Mydin et al., 2021). As such, trauma-informed and gender-sensitive psychological care nearing the end of life are crucial.

RESEARCH AND ADVOCACY

Much of the psychology research on palliative care has focused on psychological interventions for adults receiving care. Despite the documented unmet psychological needs of palliative care patients (Antunes et al., 2020), recent meta-analyses revealed significant gaps surrounding psychological care in palliative care settings, with most multicomponent palliative care interventions showing no effect on psychological distress (Nowels et al., 2023). Psychological care in palliative care research and practice is highly variable and infrequently includes evidence-based strategies (Kozlov et al., 2018) despite the psychological and psych-oncological sciences demonstrating many effective mental health interventions for seriously ill patients and their caregivers (Lichtenthal et al., 2024; Rodin et al., 2020; Schweighoffer et al., 2022).

Current Trends and Future Directions

Psychological research in decision science is highly relevant to ACP and during acute medical circumstances. However, there is a research gap and a significant need to explore the social and psychological factors influencing decision-making related to PEOL, such as spiritual and cultural beliefs of the individual nearing the end of life, their families and healthcare providers, as well as family dynamics and decisional capacity. Importantly, psychologists' own bias and beliefs about death and dying may shape our knowledge about palliative care and related research priorities (Chiew et al., 2025).

An important area of research to advance psychological intervention in PEOL contexts are factors that impact the mental health of individuals adjusting to serious illness and loss including loneliness and social isolation (Maciejewski et al., 2022). In addition to effectiveness, studies now explore the feasibility, accessibility, and long-term outcome of interventions designed to reduce depression, anxiety, and existential distress that are often prevalent in individuals and caregivers needing palliative care; and support meaningful transformation, spiritual care, and meaning making at the end of life. Additionally, multicomponent palliative care interventions need to be reexamined, with an emphasis on refining those approaches that have shown little or no effect and identifying strategies that may exacerbate psychological distress.

Psychedelic-assisted psychotherapy and MAiD are two topics that warrant further psychological research because of growing interests in these options, as well as increasing interest in prescriptive authority among psychologists. Psychedelic-assisted psychotherapy has consistently reduced

death anxiety and end of life anxiety in cancer patients (Kim et al., 2024; Ross et al., 2022). Psilocybin, a psychedelic, has been legalized in Oregon since 2020. Research on MAiD has primarily focused on demographic factors associated with pursuing MAiD and clinician attitudes about MAiD (Becker et al., 2024; Kozlov et al., 2025). More research on MAiD is essential to understanding the role and influence of psychological care within the EOL healthcare landscape.

Psychological research is also vital to increase funding and support for PEOL behavioral and psychological sciences, integration of PEOL didactic and experiential content into psychology education and training, support for integrating palliative care into current professional psychology practice, and policy efforts to maintain and improve access to timely palliative care and interprofessional collaboration.

IN SUMMARY,

WHEREAS psychologists have many areas of competence including, but not limited to, assessment, intervention, teaching, consultation, research, and advocacy skills that could contribute to the science of PEOL and to the treatment and support of people with advanced serious illness, their families, caregivers, and other health care providers; and

WHEREAS psychologists embrace and elevate ethical practice in palliative care, including addressing important decisional capacity concerns and policy considerations that impede equitable access to palliative care; and

WHEREAS psychologists recognize the critical need to provide palliative care across the lifespan in diverse populations and communities the experiences of which do not always directly inform palliative care research, practice, and policy priorities; and

WHEREAS psychologists contribute to interprofessional team functioning across many settings in palliative care, including telehealth, by integrating psychological science, assessments, and interventions, and by increasing health literacy and awareness of issues related to palliative care among patients and families in pediatric, adult, and geriatric care; and

WHEREAS psychologists could assume a significant role in the education and training of trainees, practicing psychologists across the career span, and other healthcare professionals through understanding of assessment, intervention, and approaches to abuse and neglect within PEOL settings; and

WHEREAS psychologists and psychological science have contributed to the development, evaluation, and dissemination of evidence-based psychological interventions in palliative care and have contributed to theories in decision

science that are relevant to advance care planning and during acute medical circumstances;

THEREFORE, be it resolved that the American Psychological Association:

1. Encourages psychologists' participation in national, state, and local interdisciplinary efforts to inform the development of policy and standards for palliative care and end-of-life issues to advocate for public policy initiatives that promote understanding and availability of the continuum of palliative care in all treatment settings, for all populations.
2. Advocates for improved palliative care policies and reimbursement mechanisms through Medicare, Medicaid, and private insurers to ensure the sustainability of psychological services in palliative care settings across the lifespan. This includes public and private financial support for psychology and interprofessional training in palliative care and end-of-life issues at the undergraduate, graduate, predoctoral, internship, postdoctoral, and postlicensure level.
3. Encourages psychologists to be familiar with the impact of individual, social, system characteristics, and intersectionality that contribute to health disparities and affect palliative care access and quality, and advocate for the inclusion of palliative care patient and caregiver experiences, especially from marginalized populations, in shaping psychological care, research agendas, training curricula, and policy development.
4. Supports integration of psychologists into interprofessional palliative care teams by encouraging psychologists to:
 - a. Familiarize themselves with ways to navigate complex healthcare systems and the roles and competencies of, and clinical care provided by, medical, social work, nursing, chaplaincy and others related to EOL issues, decision making, and care.
 - b. Provide support and training to other healthcare professionals about psychological determinants of health that impact access to and quality of palliative care.
 - c. Support the dissemination and implementation of evidence-based psychological interventions to address physical and psychological symptoms that arise in serious illness, effectively integrating these interventions for individuals, families/ caregivers, and healthcare professionals into the existing palliative care infrastructure.
5. Supports development and implementation of education and training within psychology in the areas of palliative and EOL care across the educational/vocational span through didactic and experiential content, including telehealth initiatives, in:
 - a. Encouraging undergraduate and graduate psychology curricula to include death, dying, and EOL issues.
 - b. Encouraging the offering of continuing education programs and lifelong consultation/mentoring opportunities for psychologists to increase access to psychological services for individuals near the end of life and their families;
 - c. Encouraging the offering of palliative care skills-based workshops, on palliative care assessment, specific interventions for addressing existential distress at the end of life, and a key sign of abuse that may go unnoticed among those receiving palliative care.
 - d. Engaging in community outreach, in-service training, and consultation to paraprofessional and peer support specialists to increase the availability of palliative care services in person or via telehealth to increase access issues in communities where very few or no psychologists are present.
6. Promotes the scientific exploration and prioritization of well-designed interdisciplinary and team-based studies:
 - a. Exploring how social marginalization, health disparities, and stigmatization affect EOL decision making and psychological distress.
 - b. Conducting research on interdisciplinary palliative care team compositions/ structures that include psychologists to deliver comprehensive palliative care, effectively addressing physical, behavioral, existential, and psychological needs, and addressing systemic barriers that keep psychologists from being a formal part of palliative care teams.
 - c. Discovering the most pragmatically efficacious methods for implementing evidence-based psychological treatments within palliative care settings (e.g., psychedelic-assisted psychotherapy) and exploring patient-centered delivery systems for psychological telehealth.
 - d. Examining the role of psychological care in decisions and preferences regarding MAiD among patients, families, and healthcare providers, to have more

data backed by psychological science to support the development of ethical frameworks, culturally responsive practices, and clinical guidelines for psychologists working in jurisdictions where MAiD is legal.

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