Suffering

• “An injury to the integrity of the person.”

• “Suffering occurs when an impending destruction of the person is perceived.”

—Cassel
Characteristics of Suffering

- Waxes and wanes
- Associated with will to live and with requests for assisted suicide
- Anxiety, depression, dyspnea are major symptoms
- As death grows nearer, psychological variables decline in importance and physical variables increase (Chochinov 1999)
Characteristics of Suffering (cont’d.)

- Patients oscillate between suffering and healing depending on level of:
  - Symptoms
  - Inner thoughts and feelings
  - Relationships with others

Characteristics of Suffering (cont’d.)

- Physical dimensions of suffering are relatively well-understood
- Psychiatric problems (e.g., depression, anxiety, delirium) that contribute to suffering are prevalent and distressing

Background

- Psychological symptoms and distress tend to be under-recognized and undertreated in palliative care
- Psychological symptoms are extremely distressing to patients and families
- While distress is inevitable, treating depression and anxiety can improve quality of life
Mediators of Psychological Response

- Developmental issues
- Meaning and impact of illness
- Coping style
- Impact on sense of self
- Relationships

Mediators of Psychological Response (cont’d)

- Stressors
- Spiritual resources
- Economic circumstances
- Relationships with health care providers

Why Treat Depression & Anxiety?

- Impair enjoyment of life
- Interfere with relationships
- Reduce ability to find meaning and purpose
- Cause anguish to family and friends
- Interfere with treatment adherence
Why Treat Depression & Anxiety?

- Depression shortens life span in some diseases
- Depression is a risk factor for suicide, request for PAS
- Bereavement outcomes worse in family members of depressed patients

If I were dying, I’d be depressed...

EPIDEMIOLOGY
Patients with advanced cancer

- 39% met criteria for psychiatric disorder OR were receiving treatment for psychiatric distress
- 7% have major depression
- 11% have minor depression

Patients with advanced cancer (cont'd.)

- 3% have generalized anxiety disorder
- 5% have panic disorder
- 2% have post-traumatic stress disorder (PTSD)

Treatment Patterns

- Half of patients who met criteria for psychiatric illness received no treatment
- Non-whites less likely to receive treatment than whites

—Prigerson
Psychological Symptoms Are Very Common

- Lack of energy: 74%
- Worrying: 71%
- Feeling sad: 65%

—Portenoy et al. Quality of Life Research 1994

Psychological Symptoms Are Very Common (cont’d.)

- Pain: 64%
- Feeling nervous: 61%
- Mean number of symptoms in inpatients: 14

—Portenoy et al. Quality of Life Research 1994

Grief

- Feeling or emotion and behaviors resulting from a particular loss
- Universal
- Associated with disease progression
- Patient retains capacity for pleasure
- Comes in waves
• Passive wishes for death to come quickly
• Able to look forward to the future
• Patients usually cope with distress on their own
• Somatic distress

• Loss of usual patterns of behavior
• Agitation
• Sleep and appetite disturbances
• Decreased concentration
• Social withdrawal

• Constellation of feelings, emotions, and behaviors that fulfill criteria for major psychiatric disorder
• Distress is usually generalized to all facets of life
• Prevalence of depression approximately 20%
• Increased prevalence with advanced disease
• Pain a major risk factor
• Nothing is enjoyable

Depression (cont’d.)
• Constant, unremitting
• Intense and persistent suicidal ideation
• No sense of positive future

Depression (cont’d.)
• Medical/psychiatric intervention usually necessary
• Hopelessness, helplessness, worthlessness, guilt, anhedonia, suicidal ideation, social withdrawal, dysphoria
Other Indicators

• Intractable pain or other symptoms
• Excessive somatic preoccupation
• Disproportionate disability
• Poor cooperation or treatment refusal

Other Indicators (cont’d.)

• Treatment with corticosteroids, interferon, etc.
• Personal or family history of depression
• Pancreatic cancer
• Hopelessness, aversion, lack of interest on the part of the clinician

Mood Disorders

• Major depressive disorder
• Bipolar disorder
• Mood disorder due to general medical disorder
• Mood disorder due to substance abuse
Mood Disorders (cont'd.)

• Dysthymia
• Sub-syndromal major depression
• Demoralization
• Grief
• Sadness

Probable Risk Factors for Depression

• Personal history of prior mood disorder
• Personal history of alcoholism, substance use, suicide attempt, anxiety disorders
• Pain
• Family history of all of the above

Probable Risk Factors for Depression (cont'd.)

• Current alcohol or drug use
• Inadequate social support
• Multiple losses
• Advancing illness
• Lack of discussion with MD in setting of poor prognosis
ASSESSING PSYCHOLOGICAL SYMPTOMS AT THE END-OF-LIFE

Questions to Ask

• How are you holding up emotionally?
• Are you feeling depressed, downhearted, discouraged?
• Do you sometimes feel like giving up?

Questions to Ask (cont’d.)

• What do you imagine is ahead?
• What are you most frightened about?
• What helps you cope?
Medications that May Induce Depression

- **Steroids**: mania or depression
- **Interferon**: neurasthenia fatigue syndrome, intractable depression
- **Tyrosine Kinase Inhibitors** (e.g., *imatinib*)

Medications that May Induce Depression (cont’d.)

- **Interleukin-2**: depression, delirium
- **Zidovudine**: mania, depression
- **Vinblastine**: depression, cognitive impairment

Treatment: Basic Principles

- Depression in terminally ill is treatable; *avoid therapeutic nihilism*!
- Establish a trusting relationship
- Remove medications potentially causing symptoms
- Formal mental status testing to evaluate organic factors
Treatment: Basic Principles (cont’d.)

- Explore fears, concerns, sources of distress/despair
- Control physical symptoms
- Review and monitor substance use and CNS symptoms

Treatment: Basic Principles (cont’d.)

- Low threshold for treatment: *if in doubt, treat*
- Psychotherapy + medication = “gold standard”
- Explore patient’s concerns about prognosis

Treatment: Basic Principles (cont’d.)

- Address stigmatization
- “I’m not sure we can make this better, but we are going to do everything we can.”
- 70% of patients improve with treatment
Psychostimulants

Most commonly used agents:
- Methylphenidate
- Dextroamphetamine
- Rapid onset of action (days)
- Well-tolerated

Psychostimulants (cont’d)

Multiple therapeutic benefits—
- Mood
- Appetite
- Energy
- Sedation
- Pain
- Cognition
Psychostimulants (cont’d)

Side effects—
- Cardiac decompensation
- Confusion
- Tolerance

Treatment Strategy

- Start low, go slow & titrate upwards (e.g., methylphenidate 2.5–5 mg at 8 am and noon)
- Most patients respond at relatively low doses (less than 30 mg/day)

Psychostimulants: Advantages

- Rapid onset of action
- Well tolerated in elderly and debilitated patients
- Effectiveness 70 % to 82%
- Useful in treating cognitive impairment in AIDS, brain metastases
Psychostimulants: Disadvantages

- Cardiac decompensation can occur in elderly patients, patients with heart disease
- Can cause confusion in old or cognitively impaired patients
- Tolerance may develop

SSRIs

- Well-tolerated, easy to titrate
- 2–6 week onset of action
- No clear evidence of superiority of one agent or class of agents; match drug to desired side effect

SSRIs (cont’d)

- Can be used in combination with psychostimulants
- Some drug-drug interactions, for example: tamoxifen
SSRIs: Advantages

- Safe and effective
- Few side effects
- Little orthostatic hypotension, urinary retention, sedation
- No effects on cardiac conduction
- Easy to titrate

SSRIs: Disadvantages

- Inhibit P4502D6 causing interactions with other drugs
- Take 3–6 weeks to work
- Nausea common initial side effect and poorly tolerated in this population
- Sexual dysfunction is a problem for about half of patients
- Interaction with tamoxifen

Novel Antidepressants

Bupropion (75–150 mg bid)

- Weak inhibitor of NE, dopamine, serotonin
- Avoid in persons with advanced HIV or dementia
Novel Antidepressants (cont’d.)

Venlafaxine (75–150 mg bid)
- Serotonergic and noradrenergic activity
- Withdrawal an issue

Novel Antidepressants (cont’d.)

Mirtazapine (7.5–45 mg)
- Central serotonergic and noradrenergic effects; 5-HT2 and 5-HT3 inhibitor
- Low affinity for P450, sedating, weight gain

Novel Antidepressants (cont’d.)

Duloxetine (20–60 mg)
- Serotonergic and noradrenergic
- May be especially useful in patients with chronic pain
Tricyclic Antidepressants

• Effective anti-depressants, but not first line
• More side effects (sedation, autonomic)

Nortriptyline, desipramine have fewer side effects than amitriptyline, imipramine

Tricyclic Antidepressants (cont’d.)

• Less effective for younger patients
• Effective for neuropathic pain
• Some drugs (eg nortriptyline) need monitoring for therapeutic window

Tricyclic Antidepressants (cont’d.)

Side effects
• Weight gain
• Constipation
• Orthostatic Hypotension
• Dry Mouth
• Sedation
Tricyclic Antidepressants (cont’d.)

Narrow therapeutic index:
✓ one month supply is enough for suicide

Intractable Depression
Electroconvulsive therapy (ECT) is an extremely effective treatment. It may be especially useful for:
• Patients too medically-ill to tolerate antidepressants
• Severely suicidal patients
• Psychotic patients
• Treatment resistance

Intractable Depression (cont’d)
• Confusion and memory loss are side effects, but usually short-lived
• Caution needed in presence of Central Nervous System (CNS) disease
Psychotherapy for Depression

- Psychodynamic
- Interpersonal therapy
- Cognitive behavioral
- Supportive
- Group/couples/family
- Combination

Common Themes

- **Loss**: relationships, work, physical well-being, physical appearance, future
- Anger
- Control (decision-making)

Common Themes (cont'd.)

- Death and dying
- Impact on partner, children, etc.
- **Fear**: rejection, dependency, dementia, pain
- Dealing with uncertainty
**Common Themes (cont’d.)**

- Spiritual/existential concerns
- Making meaning
- Contributing

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**Assessing Suicidality in the Terminally-ill Patient**

- Examine patient’s reasons for wanting to end his/her life *now*
- *Are depression, anxiety, delirium contributing to patient’s desire to die?*
- Explore meanings of patient’s desire to die

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**Assessing Suicidality in the Terminally-ill Patient (cont’d.)**

- Age, male gender, co-morbid illness, smoking, drinking all increase risk
- Refer to psychiatrist
Indications for Psychiatric Referral

- Uncertainty about psychiatric diagnosis
- Past history of major psychiatric disorder
- Patient suicidal

Indications for Psychiatric Referral (cont’d.)

- Patient requesting assisted suicide/euthanasia
- Patient psychotic/confused

- Patient unresponsive to first line antidepressants
- Dysfunctional family dynamics
Anxiety Disorders

• Generalized anxiety disorder
• Panic disorder
• Agoraphobia
• Post traumatic stress disorder
• Adjustment disorder with anxious mood

Diagnosing Anxiety

• Autonomic hyperactivity
• Hypervigilance
• Worry
• Apprehension
• Insomnia

Diagnosing Anxiety (cont’d.)

• Somatic symptoms
• Also—
  ✓ Can’t take in information
  ✓ Asks too many/too few questions
  ✓ Overreacts/behaves overly-stoic
Differential Diagnosis in Palliative Care

• Pain
• Delirium
• Dementia
• Substance Abuse

Differential Diagnosis in Palliative Care (cont’d)

• Medications
  ✓ Metoclopramide => akathisia
  ✓ Withdrawal of opioids, steroids, nicotine
• Worsening disease (especially without acknowledgement)

Medications for Anxiety

• No systematic evidence regarding treatment for anxiety in palliative care
• SSRIs highly effective for chronic anxiety, especially when accompanied by depression
• Avoid use of benzodiazepines, if possible, in elderly or cognitively impaired
Medications for Anxiety (cont’d.)

- **Olanzapine**, haloperidol can be highly effective for anxiety in the elderly and those with cognitive impairment/delirium

- However, **use of low dose benzodiazepines** (e.g., clonazepam 0.5–1 mg po tid, or lorazepam 0.5–1 mg po qid) can be helpful

Other Interventions for Anxiety

- Talking, emotional support
- Meditation, relaxation
- Cognitive behavioral therapy

Other Interventions for Anxiety (cont’d)

Identify specific concerns and address them

- Advance care planning
- Hospice
- Address needs of dependent children
Meaning-Making to Enhance Psychological Well-Being

- Models—
  - "Meaning-centered psychotherapy"
  - "Dignity-enhancing psychotherapy"
- Provides positive focus for patient and family

Meaning-Making to Enhance Psychological Well-Being (cont'd.)

- Provides antidote to hopelessness
- Allows patient to create meaning/retain purpose in the face of progressive disease

Meaning-Making to Enhance Psychological Well-Being (cont’d.)

- Provides opportunity for patient to have positive effect on bereavement outcomes of survivors
- Not all patients are interested
Conclusions

• Depression/anxiety significantly reduce quality of life in the terminally ill
• Depression is not normal and is treatable in the terminally ill
• Anxiety is common, and often helped significantly by talking therapy, with use of medications as adjuncts if necessary

Conclusions (cont’d.)

• Exploration of feelings and concerns is a key element of therapy
• There is a need for additional intervention research to identify best practices for treatment of depression and anxiety in palliative care

Congratulations!

You have successfully completed the learning material for this module.

Thank you,
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