Psychological Issues

Ian Anderson Continuing Education Program in End-of-Life Care

General Issues

- It is not possible to die without having some psychological distress or suffering.
- However, those feelings need to be acknowledged and addressed and not seen as inevitable consequences of dying that cannot be managed.
- It is a matter of quality of life.

- People die as they have lived. It is not a realistic goal to try and change the personality of the patient or change families from dysfunctional to functional during an advanced progressive illness at the end of life.

Possible Factors Influencing the Risk of Psychological Morbidity

Physical Issues	■ Stage of illness particularly advanced stage & type of illness. ■ Functional limitations. ■ Symptoms particularly pain & weakness. ■ Anorexia/cachexia syndrome. ■ Neurological dysfunction. ■ Endocrine disturbances. ■ Organic psychological disturbances such as delirium and depression. ■ Changes in body image.

Possible Factors Influencing the Risk of Psychological Morbidity

Psychological and Family Issues	■ Previous psychiatric history and family dysfunction. ■ Individual and family coping strategies. ■ Substance abuse. ■ Family abuse and violence. ■ Unresolved grief. ■ Post-traumatic stress disorder. ■ Lack of preparation for death. ■ Spirituality.

Possible Factors Influencing the Risk of Psychological Morbidity

Treatment Issues	■ Medications including opioids, chemotherapy, corticosteroids. ■ Dependence on life-support machinery or other aids. ■ Radiotherapy. ■ Multiple physician care providers with lack of coordination and/or communication.

Possible Factors Influencing the Risk of Psychological Morbidity

Social factors	■ Socioeconomic status. ■ Financial issues. ■ Culture and ethnicity. ■ Religion and/or belief system. ■ Family history of illness. ■ Lack of supports. ■ Availability of medical support services such as palliative/hospice care, home care or other components of health care.

Importance of Treating Psychological Distress

- Impairs capacity for pleasure, meaning, and connection.
- Erodes quality of life.
- Amplifies pain and other symptoms.

Importance of Treating Psychological Distress

- Reduces patient's ability to do the emotional work of separating and saying goodbye.
- Causes anguish and worry in family members and friends.
- Psychological distress, particularly depression, is a risk factor for suicide and for requests to hasten death.

The CAR$_x$E Approach: Depression

Comprehensive Care Considerations :

- Do not assume that feelings of helplessness, hopelessness, and being depressed and/or miserable are inevitable consequences of advanced life-threatening illness.
- Prevalence of depression 27-77%.
- The earlier depression is diagnosed, the more responsive it is likely to be to treatment.

The CAR$_x$E Approach: Depression — Assessment

- Somatic symptoms are common in patients with advanced illness and are rarely useful in diagnosing depression.
- Rests on recognition of psychological and cognitive symptoms, of which the most reliable are persistent dysphoria, anhedonia, feelings of helplessness, hopelessness, and worthlessness, and loss of self-esteem.

The CAR$_x$E Approach: Depression — Assessment

- The most reliable symptoms of major depression are persistent dysphoria, anhedonia (loss of pleasure), feelings of helplessness, hopelessness, and worthlessness, and loss of self-esteem.
- The screening question, “Do you feel depressed most of the time?” is a sensitive and specific question.

The CAR$_x$E Approach: Depression — Assessment

- Suicidal thoughts are an important symptom of depression.
  - Patients with recurrent thoughts of suicide or serious plans should be considered at high risk.

The CAR_xE Approach: Depression — Rx-Management

- Psychotherapeutic interventions:
  - Individual and group counseling have both been shown to reduce depressive symptoms.
- Cognitive approaches:
  - Time spent talking with patients about their feelings and re-framing their ideas may be very helpful.
- Behavioral interventions:
  - e.g. Relaxation therapy, distraction therapy.
  - Complementary and alternative medical approaches may be useful adjuncts.

The CAR$_x$E Approach: Depression — R$_x$-Management

ANTIDEPRESSANT MEDICATION

- *Tricyclic Antidepressants* such as amitritpyline, nortriptyline, desipramine, imipramine, doxepin
- *SSRIs* such as sertraline, paroxetine, fluoxetine
- *Psychostimulants* such as methylphenidate, dextroamphetamine
- *Atypical Antidepressants* such as venlafaxine, trazadone

The CAR$_x$E Approach: Depression — Rx-Management

ANTIDEPRESSANTS

- The time available for treatment will strongly influence the choice of medication for initial therapy.
- When reversal of depression is an immediate short-term goal, a rapid-acting psychostimulant is the best choice. If a response in 2 to 4 weeks is acceptable, an atypical or SSRI may be an appropriate choice.

The CAR_xE Approach: Depression — Rx-Management

- With all antidepressant medications, dosing should "start low and go slow"
  - Titrate the dose to effect and tolerability.
  - Warn patients about possible adverse effects, which will usually ameliorate within a few days.
  - If patients are not responding as expected, seek consultation with an experienced colleague, such as a psychiatrist.

The CAR$_x$E Approach: Depression — Rx-Management

ANTIDEPRESSANTS

- The psychostimulants methylphenidate & dextroamphetamine are under-appreciated and under-utilized.
  - Act quickly (in days) and produce minimal adverse effects. Some patients report increased energy and an improved sense of well being within 24 hours. Methylphenidate is usually started at 5 mg in the morning and at noon, and then titrated to effect.
- Psychostimulants can be used alone or in combination with other antidepressants.

The CAR$_x$E Approach: Depression — Rx-Management

- Selective serotonin reuptake inhibitors (SSRIs, eg, fluoxetine, paroxetine, sertraline) usually begin to act within 2 to 4 weeks.
  - They are highly effective (70% of patients report a significant response).
  - Low doses may be sufficient in advanced illness. Once-daily dosing is possible.
  - SSRIs cause less constipation, sedation, and dry mouth than the tricyclic antidepressants, though nausea may be worse with the SSRIs.

The CAR$_x$E Approach: Depression — Rx-Management

- Tricyclic antidepressants may not be first choices as first-line therapy to manage depression unless they are being used as adjuvants to control neuropathic pain.
  - Titration to achieve an adequate dosage may take 3 to 6 weeks, delaying the onset of therapeutic action.
  - Anticholinergic adverse effects .
  - If a tricyclic antidepressant is to be used, the secondary amines nortriptyline and desipramine are preferable as they tend to have fewer side effects.

The CAR$_x$E Approach: Depression — Evaluation

- Patients who are depressed should be followed regularly and fairly frequently by team members.
- Any patient with suicidal ideation may require psychiatric evaluation and/or hospitalization.
- Lack of response to medication should be documented and changes made quickly.

Anxiety — Comprehensive Care Considerations

- Anxiety is commonly experienced over fears and uncertainties about the future and therefore some degree of anxiety is common in all patients and families.
- Their distress may be related to any of a number of physical, psychological, social, spiritual, or practical issues, or it may be a component of many other syndromes (e.g., an underlying panic disorder that is unmasked by advanced illness).
- All patients will require counseling and support as well as medication.

Anxiety — Assessment

- Usually presents with 1 or more symptoms or signs including agitation, restlessness, sweating, tachycardia, hyperventilation, insomnia, excessive worry, and/or tension.
- May have many different origins, assessment may be complex. Input from family, friends, and other members of the interdisciplinary team may be invaluable.

Anxiety — Assessment

- Attempt to differentiate between primary anxiety and delirium, depression, bipolar disorder, and medication side effects.
- Look for insomnia and other reversible causes of anxiety such as alcohol, caffeine, or medications.

Anxiety — R_x-Management

- Non-pharmacologic management must always be a part of the management of anxiety.
- Counseling is necessary to address concerns about finances, family conflicts, future disability, and dependency, and existential concerns that will not resolve with medication.

Anxiety — R_x-Management

- Involve other appropriate disciplines such as nursing, social work, and chaplaincy.
- Complementary and alternative medical approaches may help some patients.
- Issues of grief and loss are important dimensions to understand, particularly in evaluating anxiety and psychological distress. See the section on grief that follows.

Anxiety — R_x-Management

- Benzodiazepines are generally the medication class of choice.
  - Choose an agent based on the desired half-life.
  - Longer–half-life medications have a more sustained effect, but may accumulate.
  - Shorter–half-life medications may have a greater risk of withdrawal and rebound anxiety.
- Start with low doses and titrate to effect and tolerability.

Anxiety — R_x-Management

- PRN medication may suffice for most patients with intermittent mild anxiety. Severe anxiety states will require regular medication in appropriate doses.

Anxiety — R_x-Management

- Benzodiazepines may worsen memory, particularly in the elderly, or cause confusion and agitation in patients with preexisting cognitive impairment.
- When discontinuing benzodiazepines, taper them slowly.

Anxiety — R_x-Management

- Atypical antidepressants like trazadone may be useful for patients with mixed anxiety and depression, or for patients with chronic anxiety, or panic disorder. If only a hypnotic effect is needed, trazodone is a useful alternative (25–100 mg po q hs).
- Severely anxious or agitated patients may require major tranquilizers for control of symptoms particularly if delirium or cognitive dysfunction is present.

Anxiety — Evaluation

- All palliative care patients should be monitored for increased anxiety.
- All benzodiazepines have a risk of tolerance, dependence and withdrawal symptoms.
  - Patients on these medications on a regular basis require careful and regular monitoring.