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

<table>
<thead>
<tr>
<th>Physical Issues</th>
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<tbody>
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<td>- Stage of illness particularly advanced stage &amp; type of illness.</td>
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<td>- Functional limitations.</td>
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<td>- Symptoms particularly pain &amp; weakness.</td>
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<td>- Anorexia/cachexia syndrome.</td>
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<td>- Neurological dysfunction.</td>
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<td>- Endocrine disturbances.</td>
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<td>- Organic psychological disturbances such as delirium and depression.</td>
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<td>- Changes in body image.</td>
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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.  

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### Possible Factors Influencing the Risk of Psychological Morbidity

<table>
<thead>
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<th>Treatment Issues</th>
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<td>■ Medications including opioids, chemotherapy, corticosteroids.</td>
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<td>■ Dependence on life-support machinery or other aids.</td>
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<td>■ Radiotherapy.</td>
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<td>■ Multiple physician care providers with lack of coordination and/or communication.</td>
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## Possible Factors Influencing the Risk of Psychological Morbidity

<table>
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<th>Social factors</th>
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<td>◼ Socioeconomic status.</td>
<td>◼ Financial issues.</td>
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<td>◼ Culture and ethnicity.</td>
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<td>◼ Religion and/or belief system.</td>
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<td>◼ Family history of illness.</td>
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<td>◼ Lack of supports.</td>
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<td>◼ Availability of medical support services such as palliative/hospice care, home care or other components of health care.</td>
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</table>
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 CARE 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 CARE 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 CARxE 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 CARE 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 **CARxE** 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 CARE Approach: Depression — Rx-Management

ANTIDEPRESSANT MEDICATION

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

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The CAR\textsubscript{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 CARxE 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 CARE 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 CAREX 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.

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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 — Rx: 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 — Rx - 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 — Rx-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 — Rx-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 — Rx- 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.