PALLIUM

Module 6
DEPRESSION, ANXIETY AND SUFFERING

"It was true, as the doctor said, that Ivan Ilych's sufferings were terrible, but worse than the physical sufferings, were his mental sufferings, which were his chief torture."
Leo Tolstoy, The Death of Ivan Ilych

"The care of the patient must be the entire person."
Francis Peabody

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Module 6
Outline

Section 1: Theory Burst
Section 2: Videos and Discussion

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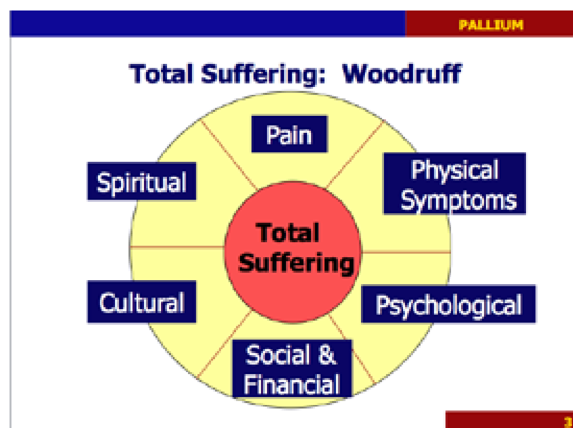

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Prevalence of Major Depression in Palliative Care

What is the prevalence of major depression in palliative patients?

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Prevalence of Major Anxiety and Depression in Palliative Patients

From a study of patients with advanced cancer:

- about 50%: had normal responses
  - Includes mild to moderate anxiety and sadness
  - Fluctuate in intensity
- 35 – 40%: adjustment disorder
  - ± Anxiety
  - ± Depression
- ± 10% to 15% major depression

Derogatis et al. 1987

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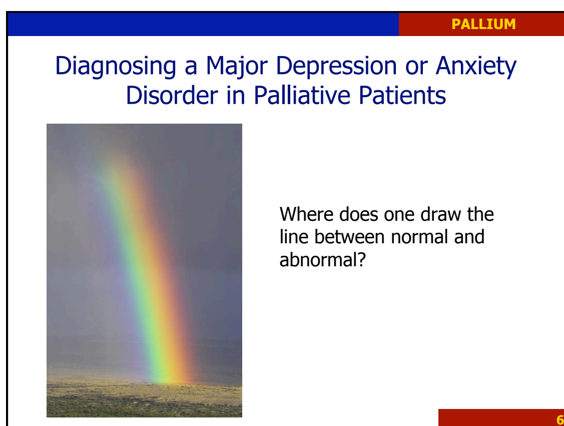
Diagnosing a Major Depression or Anxiety Disorder in Palliative Patients



Where does one draw the line between normal and abnormal?

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Diagnosing Depression in Advanced Illness

- Psychological symptoms are pervasive feelings of:
  - worthlessness, hopelessness, guilt, desire for death, despair, anhedonia
- Somatic symptoms are not specific:
  - Weight loss
  - Somatic retardation
  - Sleep disturbance
  - Loss of appetite
  - Fatigue

Risk Factors for Depression

- Pancreatic cancer
- Uncontrolled pain and other symptoms
- Advanced disease
- Progressive physical impairment
- Medications (e.g. steroids)
- Preexisting risk factors
  - prior personal and family history of depression
  - social stress
  - suicide attempts
  - substance use and abuse

Management of Adjustment Disorder

- Supportive counseling alone often suffices
- If prolonged or worsening, consider adding pharmacological agent, for example
  - clonazepam for anxiety
  - antidepressant for sadness

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Management of Depression in Palliative Care

Combination of psychotherapy and pharmacological management for those with a major depression.

Psychotherapeutic interventions include:

- Supportive counseling
  - Listen
  - Validate
  - Empathize
- Cognitive approaches
- Behavioral interventions
- Pharmacologic management should be considered if level of sadness affects ability to function

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Supportive Counseling Goals

- Explore feelings, fears, and goals
- Identify strengths and coping strategies
- Re-establish self-worth
- Reframe hope
- Provide ongoing support

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Pharmacologic Management of Depression in Palliative Care

- SSRIs
  - e.g. citalopram, fluvoxamine
- SNRIs
  - e.g. venlafaxine
- Tricyclic antidepressants
  - e.g. amitriptyline, desipramine, nortiptyline
- Dual action antidepressants
  - E.g. mirtazapine
- Psychostimulants
  - e.g. methylphenidate

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Psychostimulants in Palliative Care

- Latency period (time for onset of action) is just a few days
- Methylphenidate:
  - Test dose of 2.5 mg or 5 mg. If no severe agitation or anxiety, proceed with regular dose.
  - Maintenance dose: 5 mg at 8 am and noon
  - Causes insomnia therefore avoid after noon time
  - Over time, dose increases may be required
  - Maximum dose: 20-30 mg per day
- Methylphenidate alone or in combination with SSRI or SNRI
- Consider switching over to more traditional antidepressant if life expectancy is longer

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Suffering

- Suffering occurs when there is a perceived threat to the integrity or continuing existence of the person
- It is individual in its origins and expressions
- It is intensely private

Cassell E.J. NEJM 1984

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"Soul Pain"

Soul pain is the experience of an individual who has become disconnected and alienated from the deepest and most fundamental aspects of himself or herself.

Michael Kearney. Mortally Wounded

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Total Suffering
How do we recognize it?

- Patients use the terms "suffering" or "anguished"
- Symptoms that do not respond to usually successful treatments
- Sense of emptiness, hopelessness, meaninglessness

Michael Kearney. Mortally Wounded

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How Do We Care for Someone with Total Suffering

- Optimize symptom control
- Create opportunities for patients to begin their "inner journeys"
  - For example, dignity-conserving work
- Explore spirituality as a source of hope or burden
- We do not and should not necessarily have answers for these patients, but we should at least accompany them
- Collaborate with colleagues in other disciplines
  - nurses, chaplains, ministers and priests, social workers, psychologists, etc

We do not and should not necessarily have answers for these patients, but we should at least accompany them

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Spiritual Assessment Tool

F = Faith or Beliefs
What things do you believe give meaning to your life?
Do you consider yourself spiritual or religious?

I = Importance and Influence of Beliefs
How important is your faith or belief in your life?
What influence does your faith and belief have on your illness?

C = Community
Are you part of a spiritual or religious community?
Does the community provide support for you? If so, how?

A = Address Care Issues
- How would you like me to address these spiritual issues while caring for you?

Puchalski MC, Rorner AL. J Palliat Med 2000; 3: 129-137

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Dignity-conserving work
Illness-related repertoire

- "How comfortable are you?"
- "Is there anything we can do to make you more comfortable?"
- "How are you coping with what is happening?"

Chochinov H. *JAMA.* 2002

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Dignity-Conserving Work
Illness-Related Repertoire

- "Is there anything further about your illness that you would like to know?"
- "Are you getting all the information you feel you need?"
- "Are there things about the later stages of your illness that you would like to discuss?"
- "Has your illness made you more dependent on others?"

Chochinov H. *JAMA.* 2002

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Dignity-Conserving Work
Dignity-Conserving Repertoire = Narrative

"Can you tell me a little about your life history, particularly those parts that you either remember most or think are the most important?"

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Dignity-Conserving Work
Dignity-Conserving Repertoire

- "Are there things about you that this illness does not affect?"
- "What about yourself or your life are you most proud of?"
- "What is still possible?"
- "How in control do you feel?"
- "How do you want to be remembered?"
- "How at peace are you with what is happening to you?"

Chochinov H. *JAMA*. 2002

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Dignity-Conserving Work
Dignity-Conserving Repertoire

- "What part of you is strongest at this time?"
- "Are there still things you enjoy?"
- "Are there things that offer you comfort?"
- "What have you learned about life that you would want to pass on to others?"
- "What advice or words of guidance would you wish to pass along to your… (son, daughter, spouse, family, etc.)?"

Chochinov H. *JAMA*. 2002

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Dignity-Conserving Work
Social Dignity Inventory

- "Is there anything in the way you are treated that is undermining your sense of dignity?"
- "Do you worry about being a burden to others?"
- "What are your biggest concerns for the people you will leave behind?"

Chochinov H. *JAMA*. 2002

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Take Home Messages

- Sadness and anxiety are common phenomenon in the context of a progressive incurable illness
- A major depression or anxiety occurs less commonly but may be overlooked
- Identify patients who would benefit from pharmacological and psychological support
- Attending to the spiritual needs of patients may begin with narrative
- Colleagues' skills in providing spiritual care should be be part of the interdisciplinary team approach in patients with spiritual needs