Depression and Anxiety

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Objectives

- Identify depression and anxiety near end of life
- Describe management plans for depression and anxiety

Definition

- Depression can be described as a broad spectrum of responses that range from “expected, transient, and nonclinical sadness to extremes of major depressive disorders and suicidality (Pasacreta et al., 2006).

Definition

- Depression and anxiety are frequent co-morbid factors in chronic medical illness.
- Symptoms are frequently unrecognized and undertreated.

Depression

- Occurs in about 25% to 77% of terminally ill population
- Distinguish normal vs. abnormal
- Should not be dismissed
- Treatable in most cases
- Early treatment is better

Causes of Depression

- Disease related
- Psychological or existential factors to impending death
- Medication related
- Treatment related

Risk Factors

- Particular diseases
  - pancreatic cancer
  - stroke
- Spiritual Pain
- Preexisting risk factors
  - prior Hx, family Hx, social stress
  - suicide attempts substance use

Assessment

- Situational factors
- Somatic complaints
- Previous psychiatric history/treatment
- Uncontrolled pain, and presence of multiple deficits

Example Questions for Depression Assessment

- Have you felt down or blue in the last month?
- How have your spirits been lately?
- How are you sleeping lately?
- What is your energy level?
- What do you see in your future?

(Chochinov et al., 1998)

Suicide Assessment

- Patients with immediate, lethal, and precise suicide plans and resources to carry out the plan should be immediately evaluated by psychiatric professionals.

Suicide Assessment

- Do you ever think that life is not worth living?
- Have you ever thought about killing yourself?
- Are you thinking about that now?
- Have you thought about how you would kill yourself?

Management of Depression

- Psychotherapeutic interventions
  - Cognitive approaches
  - Behavioral interventions
  - – Medications
  - – Combination of psychotherapy, medication

Counseling goals

- Weave counseling into routine interventions
- Improve patient understanding
- Create a different perspective
- Identify strengths, coping strategies

Counseling goals

- Reestablish self-worth
- New coping strategies
- Educate about modifiable factors

Pharmacologic Interventions

- Antidepressants
- Psychostimulants
- SSRIs
- Tricyclic and atypical antypical antidepressants
- Steroids

Pharmacologic management

- Choose by time to effect
- days-psychostimulants
  weeks/months-SSRIs, tricyclic/
  atypical antidepressants
- Start dosing low, titrate slowly

Psychostimulants

- Rapid effect
- Methylphenidate, 5mg every am + every noon, titrate to effect
- Alone or in combination
- Continue indefinitely

Psychostimulants

- Diminsh opioid sedation
- Not usually an appetite suppressant
- May exacerbate
  tremulousness
  anxiety
  anorexia
  insomnia

SSRIs

- Latency 2-4 weeks
- Highly effective 70%
- Well tolerated
- Once daily dosing
- Low doses may be effective in advanced illness

Tricyclic Antidepressants

- Not recommended as first-line therapy
- Latency 3-6 weeks
- Adverse effects are common

  nortriptyline, desipramine, have fewer adverse effects
- Atypical antidepressants still being studied

Non-Pharmacologic Interventions for Depression

- Promote autonomy
- Grief counseling
- Draw on strengths (faith and belief systems)
- Use cognitive strategies

Anxiety

- Subjective feeling of apprehension, tension, insecurity, and uneasiness, usually without a known specific cause.
- Presentation

  agitation, insomnia, restlessness, sweating, tachycardia, hyperventilation, panic disorder, worry tension

Resources on Anxiety

- Anxiety Disorders at www.nci.nih.gov/cancertopics/pdq/supportivecare/anxiety/healthprofessional
- Drug Therapy for Anxiety in Palliative Care at:

  www.cochrane.org/cochrane/revabstr/ab004596.htm)

Anxiety

- Assessment complex
- Differentiate from
  delirium, depression
  bipolar disorder
  medication effects
  insomnia
  alcohol, caffeine

Causes of Anxiety

- Evaluate medications

  Thyroid replacement hormones, neuroleptics, digitalis, antihypertensive, antihistamines, antiparkinsonian, and anticholinergics

Causes of Anxiety

- Patients with life-limiting diseases often face uncertain futures
  - Lifestyle changes
  - Challenges about finances
  - Dependency and disability

Pharmacologic Interventions for Anxiety

- Antidepressants
- Benzodiazepines
  short vs long half life
  diazepam
  lorazepam
  alparazolam, oxazepam
- Anticonvulsants
- Neuroleptics

Nonpharmacologic Interventions for Anxiety

- Empathetic listening
- Assurance and support
- Concrete information/warning
- Relaxation/imagery

Imagery

- Practice time with Guided Imagery
- Please start to relax and unwind during this session
- Deep Breaths in through your nose out through your mouth
- Relax your facial muscles, shoulders,
- Relax your arms, fingers, legs and your toes

Case Study

Psychological Conditions in Palliative Care

Beatriz H. a 55 year-old divorced woman with stage IV breast cancer presents to the ED confused, agitated and in obvious pain. Her sister reports that she has been noticeably more anxious that usual. Assessment reveals mild dehydration, as demonstrated by poor skin turgor and a heart rate of 110. An IV is started and hydromorphone 1 mg IV is given for pain and agitation. Lab values are normal, as is oxygenation level (93% on room air). Less agitated but still confused after 90 minutes, Ms H is transferred to the oncology unit.

Her nurse is surprised to hear that Ms. H had been so agitated. During prior admissions for treatment of bone pain (primarily in several ribs and the right femur), Ms. H. appeared sad and withdrawn, yet she consistently denied being depressed.

Case Study cont'd

When last hospitalized 3 weeks ago, Ms. H described right –upper-quadrant pain and was found to have liver metastases. She was placed on an analgesic regimen of long-acting morphine 60mg every 12 hours, with immediate-release morphine 20mg for breakthrough pain as needed. She required only 2 or 3 doses of breakthrough pain medication daily until a week ago, when her pain intensified, requiring as many as 8 doses of immediate-release morphine daily. In response, her oncologist had ordered dexamethasone 16 mg. po daily, which she has taken for two days. Her sister and two teenage daughters are at the bedside, as they have been during previous hospitalizations, witnessing Ms. H.'s confusion tearfully.

Managing Psychological Conditions in Palliative Care

- Anxiety and depression are often under diagnosed & undertreated.
- Causes are multifactorial
- Comprehensive assessment is vital
  - History
  - Symptoms and predictors
  - Assessment tools
    - HDRS-Hamilton Depression Rating Scale
    - PHQ-9 depression questionnaire
    - Geriatric Depression Scale
    - Beck Depression Inventory
  - Other factors (lack of support, pain)

Case Study Revisited

- What are some of the possible causes of Ms.H's symptoms?
  - Physical/medical causes
  - Reactions to medications
  - Psychological distress
- What are some non-pharmacologic interventions?
- What are some pharmacologic interventions?

Questions?

- Take Aways
- Listen carefully to your client/patient