ANXIETY AND DEPRESSION IN THE SETTING OF PALLIATIVE CARE

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THE EXISTENTIAL PLIGHT

Patients are inevitably immersed in their own existence, with a highly personal, private, idiosyncratic attitude to the dilemma of our own life and death.

THE THREAT OF SICKNESS

- Sickness threatens patients' freedom
  --to strive for their ego ideal
  --the ability to choose, control, and consummate what they intend.

  Sickness may get in the way of
  --their doing what is expected and what they aspire to do
  --their ability to choose one path over another.
PSYCHOLOGICAL ASSOCIATIONS WITH CANCER

- The specter of cancer makes patients think about:
  - death
  - deformity
  - loss of stature
  - loss of dignity
  - loss of control

DENIAL

- Acutely, the predicament doesn’t seem real.
- A patient can acknowledge cancer but deny facts, inferences, implications and the imminence of death.
- The patient may go forward doing what the doctor says to do—hoping for the best; only gradually do the facts seep through.

DENIAL IS INTERPERSONAL

- A patient may speak openly to the man who comes to clean the room but not to his wife.
- Not talking about the threat of separation or not acknowledging may be a way to preserve a relationship.
DENIAL AND MIDDLE KNOWLEDGE

• Patients may adjust to a certain level of illness and find a way of coping with the requirements of care, but a further adjustment may be required at times of transition to a worse state.
• Middle knowledge is somewhere between open acknowledgment of death and its utter repudiation
• Middle knowledge is more prominent at times of transition, like a recurrence
• Middle knowledge is hard to maintain and there is a gradual change to acknowledgement.

WEISMAN’S PARADOX

• A dying man believes in the fact of his own death but hopes that he is an exception.

PSYCHOSOCIAL ELEMENTS OF APPROPRIATE DEATH: THE DEATH WE WOULD CHOOSE IF WE HAD A CHOICE

• Preservation of self-esteem
• Facilitation of control: practical coping on as high a level as is possible with physical and psychological limitations
• Support of significant key others
• Gradual relinquishment of control to those who show themselves trustworthy
• Honest communication designed to support acceptance, reduce bitterness, and replace denial with the courage to confront what cannot be changed.
HOPE IS RELATED TO:

- The patient's desirable self image
- The patient's sense that he still has a personal ability to influence the world
- Sense of purpose adds value to life regardless of the time frame
- Respect for the patient sustains authentic hope

THE MEDICAL TASK

- To give patients a medical plan and the commitment that the medical team will stand by them
- The medical plan is the first treatment for initial anxiety
- We clarify the medical facts—what the most knowledgeable physician thinks and understands, well enough so that implications can be clarified when appropriate
- We clarify what is urgent and what is not

THE INTERVIEW

- We seek the patient's story, his view of what is meaningful, where he hurts, and what he fears.
- We meet the patient eye to eye at a moment of high vulnerability when relationships are in transition.
- We pay attention to feelings knowing that the effort to answer may modify feelings, acknowledge the respect of being heard, and signify a greater sense of control.
FACILITATING COPING

- We watch patients try to solve problems by trial and error; a mixture of cognitive appraisal and reappraisal.
- We are on the side of efficient use of emotional energy. (Efficiency is more important in the setting of cancer when energy is limited.)
- We act as ally or guide, with expectation of positive change, a sense that options are seldom exhausted.
- Further information and support can always be sought.

THE STRATEGY

- Clarify the problem; provide reliable information
- Reduce problems to manageable size
- Consider consequences
- Share concern but veto impulsive destructive acts
- Encourage expression, distraction, rest, doubts, what worked in the past
- Share silence

RELATIONSHIPS

- Good coping requires give and take and the ability to relate to doctors, nurses, the health care system
- Secure attachment means confidence about the availability of supportive relationships and the capacity to make use of them for emotional support
- Opportunity to tackle, for instance, marital issues and parental issues
ATTENTION TO THE TIMELINE OF PSYCHOLOGICAL ADJUSTMENT

- The first hundred days from diagnosis, patients’ acute distress as they grapple with the existential plight can come to an equilibrium (3 months is different than 3 days) (Weisman/Worden)
- Depressive scores (Beck Depression Inventory) in patients with metastatic cancer: compared to one year before death, moderate to severe symptoms tripled in final 3 months of life (Lo et al., 2010)

THOSE MORE VULNERABLE TO DEPRESSIVE SYMPTOMS HAVE MORE PHYSICAL & PSYCHOLOGICAL SYMPTOMS

- Younger
- Antidepressant used at baseline (clue to history of major dep disorder)
- Lower self-esteem and spiritual wellbeing
- Greater attachment anxiety
- More hopelessness
- Greater physical burden of illness and proximity to death (Lo C, 2010)

PREVENT DEMORALIZATION

- Feelings of isolation, despair, impotence, damaged self-esteem, rejected by others because of not meeting expectations
- A combination of distress and subjective incompetence
- Uncertainty of what to do (helplessness)
- Loss of meaning and certainty in life (giving up)
PRINCIPLES ABOUT DEPRESSION IN ADVANCED ILLNESS

- Anchor the diagnosis in the criteria for major depressive disorder:
  - Dysphoria, anhedonia:
    - Too much sleep or too little,
    - Loss of interest,
    - Excessive guilt and low self-esteem,
    - Fatigue,
    - Poor concentration,
    - Poor appetite,
    - Psychomotor agitation or retardation.

PRINCIPLES RE: DEPRESSION

- Melancholia has distinct features
  - Like morning dread,
  - Speech latency
- Depression often accompanied by anxiety
- History of major depressive disorder makes a new episode more likely
  --perhaps the patient remembers what depression feels like

PRINCIPLES RE DEPRESSION

- Fatigue, poor stamina, can result from chemotherapy and the triathlon of treatment; at one year in breast cancer patients, 40% had fatigue and 25% had depressive symptoms. Fatigue was associated with having had chemotherapy and elevated inflammatory markers. Depressive symptoms and sleep dysfunction were not associated with elevated inflammatory markers (Bower, J.E., et al. 2011).
- Sleep: Risk of depression may be less if quality of sleep is preserved. Think about snoring, sleep apnea, restless legs, hot flashes.
CONSIDER ESTROGEN-DEFICIENCY: DYSPHORIA, INSOMNIA, HOT FLASHES

- In breast cancer patients: estrogen replacement stopped abruptly, tamoxifen, aromatase inhibitors, leuprolide
- In other cancers: alkylating agents affect ovarian function correlated with age and dose or radiation to abdomen
- Depression more likely in perimenopause, late menopausal transition

CORTICOSTEROIDS

- Mood destabilizer: jitteriness, insomnia, tearfulness, hypomania, depression, delirium, maniform psychosis
- Dose related
- Prednisone 60 mg = dexamethasone 9 mg, sufficient to have psychiatric side effects
- Uses: hypersensitivity with paclitaxel/taxotere, antiemetic, delayed emesis, CNS radiation, anti-lymphoma

SUICIDAL THOUGHTS

- 8% had SI in hospice, most clinically depressed (Chochinov)
- 8% SI in previous 2 weeks—3000 ambulatory patients in Scotland
- Of those cancer patients who committed suicide, more shortly after diagnosis when cancer seen as more serious and overwhelming
- In tumor registry: Highest rates in lung, stomach, head and neck, pancreatic; older white men
- Still rare 31/100,000 person years with cancer cf US pop 16.7/100,000 person years
PREVENTING DEPRESSION

• In head and neck cancer surgery, citalopram 40 mg given before surgery and continued 3 months led to fewer cases of depressive disorder (Lydiatt WM, 2008, 2013).

• Paroxetine 20 mg in first month of Kirkwood interferon protocol for melanoma lowered rate of depression.

STICK WITH IT

• Treatment of depression should be persistent. Severity of depression is measured repeatedly and treatment is intensified to insure targeted improvement. Ell found in a female predominantly Hispanic population of cancer patients including 114 with major depression, treated with antidepressant medication and/or problem solving therapy a response rate of 70% at 6 m. At 12 mo, 14% relapsed, another 17% had responded and 13% had not responded (Ell 2008).

COLLABORATIVE CARE IN CANCER PATIENTS

• Collaborative care programs for psychosocial aspects of cancer treatment have been shown effective in 4 randomized controlled trials in settings as diverse as a California public health clinic, an academic medical center, and a single institution. Programmed psychiatric consultation also can be linked to primary medical providers in the more liplining patients for support as well as to provide brief evidence-based psychosocial treatment.

• EMPHASIS
  • Population-based approach — identifying needs,
  • Measuring outcomes, Measurement-based care and clinical rating scales — identify patients who require treatment or are at risk,
  • Sustained follow-up,
  • Vigorous outreach, and
  • Treatment to remission.
ANXIETY SYNDROMES

• Needle phobia
• Claustrophobia re: MRI and other procedures
• Anxiety syndrome at end of intensive upfront treatment
• Anxiety syndrome before restaging
• Anxiety with each post-treatment symptom—is it cancer?
• Anticipatory anxiety—those who live 6 months ahead
• Catastrophizers

DIFFERENTIAL DIAGNOSIS ACUTE ANXIETY

• Think about:
  • Heart failure
  • Pulmonary embolus
  • Hyperthyroidism (thyroiditis)
  • Akathisia—“I can’t sit down” as side effect of Compazine (prochlorperazine)

CONDITIONED ANXIETY

• Related to highly emetic treatment
• More common in younger patients and those with history of motion sickness
• Residual symptoms like numbness and tingling of peripheral neuropathy can be triggers
ANXIETY AND DELAY TO DIAGNOSIS

Fear of embarrassment
- Fear of being seen as a time waster or as neurotic
- Fear that symptoms are psychosomatic
- Men view help seeking as unmasculine
- Embarrassment of sensitive or sexual area

Fear of cancer: pain, suffering and death
- Serious and painful symptoms that mandate disease.
- Previous negative experiences with cancer.
- Fear of unpleasant treatment.
- Shame associated with dirt and uncleanness.


PATIENTS WITH ANXIETY DISORDERS

• More likely to believe that oncologists would offer futile therapies and not adequately control their symptoms (Spencer RJ, 2010)
• Those with high levels of cancer stress and concurrent anxiety disorder begin and end treatment with more depressive symptoms (Brothers, 2011)
• Those with current panic disorder and PTSD, sad, lacking self-efficacy, spirituality and perceived support were more likely to have suicidal ideation (Spencer et al, 2010)

PSYCHOPHARMACOLOGY

• If patients have major depressive disorder: end with history, treatment should be methodical and persistent with adequate and sequential trials of antidepressants as would apply without cancer.
• Serotonin reuptake inhibitors may cause nausea initially in some patients; desvenlafaxine or other SNF3 blockers can facilitate initiation until patient adjusts to serotonergic side effects.
• Venlafaxine and paroxetine more effective than sertraline and fluoxetine for hot flashes. Citalopram similar to propranolol. Citalopram also works in non-cancer population for menopausal symptoms.
• Duloxetine benefit for neuropathic pain secondary to chemo.
• Citalopram, escitalopram, venlafaxine preferred with tamoxifen as not as much a 2D6 cytochrome inhibitor.
PSYCHOPHARMACOLOGY

- Olanzapine works for nausea, mood stabilization and psychotic fear.
- Gabapentin for anxiety, neuropathic pain, hot flashes (900 mg)

SPECIFIC CBT FOR ANXIOUS CANCER PATIENTS CAN BE ADDED TO OTHER TREATMENTS

- Realistic and biased elements of anxiety in cancer patients (Greer 2012)
- Negative thoughts
- Adaptive thinking skills supplemented with acceptance-oriented coping like mindfulness.
  What seems realistic? Get more information when data is missing.
- Some patients are less anxious because they avoid what makes them anxious; for them activating treatments in CBT and supportive-expressive treatments may help.

EVIDENCE BASED PSYCHOTHERAPY INTERVENTIONS

- CALM Managing cancer living meaningfully: brief, semi-structured individual psychotherapy for patients with advanced cancer.
  - Symptom control and communication with health care providers
  - Self concept and relations to close others
  - Spiritual well being and values, beliefs that provide meaning and purpose in life
  - Preparing for the future, sustaining hope and facing mortality
FORMAL PSYCHOTHERAPIES EVIDENCE BASED