ABC of palliative care

Depression, anxiety, and confusion

Jennifer Barraclough

A common mistake is to assume that depression and anxiety represent nothing more than natural and understandable reactions to incurable illness. When cure is not possible, the analytical approach we adopt to physical and psychological signs and symptoms is often forgotten. Excuse is found in the overlap of symptoms due to physical disease, depression, and anxiety. This error of approach and the lack of diagnostic importance given to major and minor symptoms of depression result in underdiagnosis and treatment of psychiatric disorder.

The emotional and cognitive changes in patients with advanced disease reflect both psychological and biological effects of the medical condition and its treatment. Psychological adjustment reactions after diagnosis or relapse often include fear, sadness, perplexity, and anger. These usually resolve within a few weeks with the help of the patients' own personal resources, family support, and professional care. A minority of patients, about 10-20%, develop formal psychiatric disorders that require specific evaluation and management in addition to general support. It is important to recognise psychiatric disorders because, if untreated, they add to patients' suffering and hamper their ability to come to terms with their illness, put their affairs in order, and communicate with others.

Emotional distress and psychiatric disorder also affect some relatives and staff.

Losses and threats of major illness

- Knowledge of a life threatening diagnosis, prognostic uncertainty, fears about dying and death
- Physical symptoms such as pain and nausea
- Unwanted effects of medical and surgical treatments
- Loss of functional capacity, loss of independence, enforced changes in role
- Practical issues such as finance, work, housing
- Changes in relationships, concern for dependants
- Changes in body image, sexual dysfunction, infertility

Risk factors for anxiety and depression

- Organic mental disorders
- Poorly controlled physical symptoms
- Poor relationships and communication between staff and patient
- Past history of mood disorder or misuse of alcohol or drugs
- Personality traits hindering adjustment—Such as rigidity, pessimism, extreme need for independence and control
- Concurrent life events or social difficulties
- Lack of support from family and friends

Causes

Depression and anxiety are usually reactions to the losses and threats of the medical illness. Other risk factors often contribute.

Confusion usually reflects an organic mental disorder from one or more causes, often worsened by bewilderment and distress, discomfort or pain, and being in strange surroundings with strange carers. Elderly patients with impaired memory, hearing, or sight are especially at risk. Unfortunately, reversible causes of confusion are underdiagnosed, and this causes unnecessary distress in patients and families.

Common causes of organic mental disorders

- Prescribed drugs—Opioids, psychotropic drugs, corticosteroids, some cytotoxic drugs
- Infection—Respiratory or urinary infection, septicaemia
- Macroscopic brain pathology—Primary or secondary tumour, Alzheimer's disease, cerebrovascular disease, HIV dementia
- Metabolic—Dehydration, electrolyte disturbance, hypercalcaemia, organ failure
- Drug withdrawal—Benzodiazepines, opioids, alcohol

Clinical features

Depression and anxiety

These are broad terms that cover a continuum of emotional states. It is not always possible on the basis of a single interview to distinguish self limiting distress, which forms a natural part of the adjustment process, from the psychiatric syndromes of depressive illness and anxiety state, which need specific treatment. Borderline cases are common, and both the somatic and psychological symptoms of depression and anxiety can make diagnosis difficult.

Somatic symptoms—These are often the presenting symptoms, and they overlap with symptoms of the physical illness. For example, depression may manifest as intractable pain, while anxiety can manifest as nausea or dyspnoea. Such symptoms may seem disproportionate to the medical pathology and respond poorly to medical treatments.

Psychological symptoms—Although these might seem understandable, they differ in severity, duration, and quality from "normal" distress. Depressed patients seem to loathe themselves, over and above loathing their disease. This

Symptoms and signs of depression

Somatic

- Reduced energy, fatigue
- Disturbed sleep, especially early morning waking
- Diminished appetite
- Psychomotor agitation or retardation

Psychological

- Low mood present most of the time, characteristically worse in the morning
- Loss of interest and pleasure
- Reduced concentration and attention
- Indecisiveness
- Feelings of guilt or worthlessness
- Pessimistic or hopeless ideas about the future
- Suicidal thoughts or acts

manifests through guilt about being ill and a burden to others, pervasive loss of interest and pleasure, and hopelessness about the future. Suicide attempts or requests for euthanasia, however rational they might seem, often indicate clinical depression.

Confusion

This may present as forgetfulness, disorientation in time and place, and changes in mood or behaviour. The two main clinical syndromes are dementia (chronic brain syndrome), which is usually permanent, and delirium (acute brain syndrome), which is potentially reversible.

Delirium, which is more relevant to palliative care, comprises clouding of consciousness with various other abnormalities of mental function from an organic cause. Severity often fluctuates, worsening after dark. Paranoid ideas can be exacerbated by the mental mechanisms of "projection" and "denial"—for example, attributing symptoms to poisoned food rather than a progressive illness. Dehydration, neglect of personal hygiene, and accidental self injury may hasten physical and mental decline. Noisy, demanding, or aggressive behaviour may upset or harm other people. So called "terminal anguish" is a combination of delirium and overwhelming anxiety in the last few days of life.

Recognition

Various misconceptions about psychiatric disorders in medical patients contribute to their widespread underrecognition and undertreatment. Education and training in communication skills, for both patients and staff, could help to remedy this.

Standardised screening instruments include the hospital anxiety and depression (HAD) scale for mood disorder and the mini mental state (MMS) or mental status schedule (MSS) for cognitive impairment. Though not sensitive or specific enough to substitute for assessment by interview, they can help to detect unsuspected cases, contribute to diagnostic assessment of probable cases, and provide a baseline for monitoring progress.

Knowledge of previous personality and psychological state is helpful in identifying high risk patients or those with evolving symptoms, and relatives' observations of any recent change should be heeded.

Prevention and management

General guidelines for both prevention and management include providing an explanation about the illness, in the context of ongoing supportive relationships with known and trusted professionals. Patients should have the opportunity to express their feelings without fear of censure or abandonment. This facilitates the process of adjustment, helping patients to move on towards accepting their situation and making the most of their remaining life.

Visits from a specialised palliative care nurse (such as a Macmillan nurse) or attendance at a palliative care day centre, combined with follow up by the primary healthcare team, often benefit both patients and families. Religious or spiritual counselling may be relevant. Psychiatric referral is indicated when emotional disturbances are severe, atypical, or resistant to treatment; when there is concern about suicidality; and on the rare occasions when compulsory measures under the Mental Health Act 1983 seem to be indicated.

Non-drug therapies, both "mainstream" and "complementary," share the common features of increasing patients' sense of participation and control, providing interest and occupation when jobs or hobbies have had to be discontinued, and offering a supportive personal relationship.

Symptoms and signs of anxiety

Psychological
- Apprehension, worry, inability to relax
- Difficulty in concentrating, irritability
- Difficulty falling asleep, unrefreshing sleep, nightmares

Motor tension
- Muscular aches and fatigue
- Restlessness, trembling, jumpiness
- Tension headaches

Autonomic
- Shortness of breath, palpitations, lightheadedness, dizziness
- Sweating, dry mouth, "lump in throat"
- Nausea, diarrhoea, urinary frequency

Symptoms and signs of delirium

- Clouding of consciousness (reduced awareness of environment)
- Impaired attention
- Impaired memory, especially recent memory
- Impaired abstract thinking and comprehension
- Disorientation in time, place, or person
- Perceptual distortions—Illusions and hallucinations, usually visual or tactile
- Transient delusions, usually paranoid
- Psychomotor disturbance—Agitation or underactivity
- Disturbed cycle of sleeping and waking, nightmares
- Emotional disturbance—Depression, anxiety, fear, irritability, euphoria, apathy, perplexity

Underrecognition of psychiatric disorders

- Patients reluctant to voice emotional complaints—Fear of seeming weak or ungrateful; stigma
- Professionals reluctant to inquire—Lack of time, lack of skill, emotional self protection
- Attributing somatic symptoms to medical illness
- Assuming emotional distress is inevitable and untreatable

References for screening instruments

Hospital anxiety and depression scale—Zigmond AS, Snaith RP. The hospital anxiety and depression (HAD) scale. *Acta Psychiatr Scand* 1983;67:361-70

Mini mental state—Folstein MF, Folstein SE, McHugh PR. "Mini-Mental State"—a practical method of grading the cognitive state of patients for the clinician. *J Psychiatr Res* 1975;12:189-98

Mental status schedule—Hodkinson HM. Evaluation of a mental test score for assessment of mental impairment in the elderly. *Age Ageing* 1972;1:233-8

Principles of psychological management

- Sensitive breaking of bad news
- Providing information in accord with individual wishes
- Permitting expression of emotion
- Clarification of concerns and problems
- Patient involved in making decisions about treatment
- Setting realistic goals
- Appropriate package of medical, psychological, and social care
- Continuity of care from named staff

Usually delivered in regular planned sessions, they can also help in acute situations—for example, deep breathing, relaxation techniques, or massage for acute anxiety or panic attacks.

For bedridden patients who are anxious or confused as well as very sick, it is important to provide nursing care from a few trusted people; a quiet, familiar, safe, and comfortable environment; explanation of any practical procedure in advance; and an opportunity to discuss underlying fears.

Relatives also need explanation and support.

Some psychological and practical therapies

- Brief psychotherapy—Cognitive-behavioural, cognitive-analytic, problem solving
- Group discussions for information and support
- Music therapy
- Art therapy
- Creative writing
- Relaxation techniques
- Meditation
- Hypnotherapy
- Aromatherapy
- Practical activity—Such as craft work, swimming

Psychotropic drugs

For more severe cases, drug treatment is indicated in addition to, not instead of, the general measures described above.

Depression

Drugs should be prescribed if a definite depressive syndrome is present or if a depressive adjustment reaction fails to resolve within a few weeks. The antidepressant effect of all these drugs may be delayed for several weeks after starting therapy.

Tricyclic antidepressants produce a worthwhile response in about 80% of patients, and their sedative, anxiolytic, and analgesic properties may bring added benefits. However, they have considerable anticholinergic side effects, and they are toxic in overdose. Amitriptyline is the standard compound; dothiepin is similar but is sometimes better tolerated. For both drugs, low doses in the range 25-50 mg at night are sometimes effective, but many patients need 75-150 mg or more. Lofepramine, at doses of 70-210 mg daily, has lower toxicity.

Specific serotonin reuptake inhibitors such as sertraline (50 mg daily) or paroxetine (20 mg daily) have few anticholinergic effects, are non-sedative, and are safe in overdose. However, they may cause nausea, diarrhoea, headache, or anxiety. Several newer related antidepressants have recently become available.

Other treatments—Many alternative compounds are also available, and the less widely used ones—including monoamine oxidase inhibitors, psychostimulants, lithium, and various combinations of antidepressants—may be tried on psychiatric advice with due regard to their interactions with other drugs. For severe depression only, electroconvulsive therapy is safe and rapidly effective. Organic mental disorders do not necessarily contraindicate the use of antidepressant drugs or electroconvulsive therapy.

Anxiety

Benzodiazepines are best limited to short term or intermittent use; prolonged administration may lead to a decline in anxiolytic effect, and cumulative psychomotor impairment. Low dose neuroleptic drugs such as haloperidol 1.5-5 mg daily are an alternative. β blockers are useful for autonomic overactivity. Chronic anxiety is often better treated with a course of antidepressant drugs, especially if depression coexists.

Acute severe anxiety can present as an emergency. It may mask a medical problem—such as pain, pulmonary embolism, internal haemorrhage, or drug or alcohol withdrawal—or it may have been provoked by psychological trauma such as seeing another patient die. Whether or not the underlying cause is amenable to specific treatment, sedation is usually required. Lorazepam, a short acting benzodiazepine, can be given as 1 mg or 2.5 mg tablets orally or sublingually, or intravenously as 25-30 μg/kg. Alternatively, midazolam 5-10 mg can be given intravenously or subcutaneously. An antipsychotic such as haloperidol 5-10 mg may be better if the patient is also psychotic or confused. Medical assessment needs to be repeated every few hours, and the continued presence of a skilled and sympathetic companion is helpful.

Examples of art therapy—The painter of these figures is a man with cancer of the larynx. Having lost his voice, his partner, and his hobby of playing the trumpet, he was depressed, angry, and in pain. He likened himself to an aircraft being shot down in flames or to a frightened bird at the mercy of a larger bird of prey. He has since improved, and wrote to tell his doctor how much it helped to draw his "awful thoughts." (Pictures and case history courtesy of Camilla Connell, art therapist at Royal Marsden Hospital.)

Confusion

It is best to identify any treatable medical causes before prescribing further drugs, which may make the confusion worse. In practice, however, sedation is often required. For mild nocturnal confusion, an antipsychotic such as thioridazine 25-50 mg or haloperidol 1.5-5 mg at bedtime is often sufficient. For severe delirium, a single dose of haloperidol 5-10 mg may be offered in tablet or liquid form or by injection. This may be repeated hourly until a calming effect is achieved, with the dose increasing to 20 mg if necessary. If it does not work a benzodiazepine or a barbiturate can be added.

It may be possible to withdraw the drugs after one or two days if reversible factors such as infection or dehydration have been dealt with. Otherwise, sedation may need to be continued until death, preferably by continuous subcutaneous infusion, for which a suitable regimen might be as much as haloperidol 10-30 mg with midazolam 30-60 mg per 24 hours. These drugs can be mixed in the same syringe.

"Lifting the heart"
A week ago nothing mattered
I didn't want to do anything
I just wanted to die.
Today something lifted my heart up
Somebody had built some flowers
The newness of new crocuses.

These words were written by a man who had been both confused and suicidally depressed after diagnosis of a brain tumour, but whose mental state improved after prescription of amitriptyline

Outcome

Emotional disorders in patients with incurable disease should never be dismissed as inevitable or untreatable. Worthwhile improvements in psychological state can often be achieved even though the physical illness continues to advance. We must be wary of projecting any sense of hopelessness onto our patients and avoid dismissing anxiety and depression as understandable, thereby denying appropriate treatment in many cases.

Jennifer Barraclough is consultant in psychological medicine, Churchill Hospital, Oxford Radcliffe NHS Trust.

The ABC of palliative care is edited by Marie Fallon, Marie Curie senior lecturer in palliative medicine, Beatson Oncology Centre, Western Infirmary, Glasgow, and Bill O'Neill , science and research adviser, British Medical Association, BMA House, London. It will be published as a book in June 1998.

A patient with a message

Unacknowledged depression

It was not clear from the notes what the initial complaint had been, but the story was depressingly familiar. The patient, a man born in 1946, had undergone numerous investigations since 1992. Several conditions had been identified, which were mainly laboratory abnormalities. The patient was used to relating his diagnoses, which he was now doing to me, his locum general practitioner.

Firstly, there was the polycythemia, which after detailed investigation had been found to be "pseudopolycythemia." The condition had settled when he stopped smoking, but he told me that he still needed to have regular checks. Then there was the hiatus hernia, which was no longer causing problems thanks to ranitidine. Thirdly, there was the hypertension, which had settled nicely with low dose captopril. Fourthly, he had been diagnosed as suffering from diabetes, but the glucose levels had been good with the start of a diabetic diet. His cholesterol level had been too high, but this had been brought down with benzfibrate medication.

The main complaint seemed to have been dizziness, and no cause had been found for this despite repeated ear, nose, and throat examinations. Then in 1993 came what must have been a terrible, though not unexpected, blow. His driving licence was being revoked because of "disabling giddiness and fainting." His world was falling apart, and he developed the need, quite literally, to hold on to something. There had been no falls or blackouts, but he started to use a walking stick, and he would no longer leave the house without his wife. The latest entry in the notes was vitamin B12 deficiency, and he had now been started on three monthly injections of vitamin B12, presumably for life.

All medical students know the meaning of iatrogenesis, and the term is usually equated with damage caused by the surgeon or the prescriber, but how much damage is caused by doctors who fail to address a psychiatric condition? Instituting cycles of anxiety inducing investigations in such cases will only exacerbate the underlying problem.

My patient had symptoms of depression with poor sleep, poor concentration, and loss of interest, but there was no reference to his mental health in the notes. Although I should have done, I did not dwell on the mental health symptoms for long on this my first meeting with the patient. After all, when for years he has been told (by inference) that he is sick, will he ever believe a doctor who tells him that he is physically fit and will most probably lead a long, if unfulfilled, life?

The cost to society and individuals of cases such as this is enormous. Unnecessary investigations apart, the patient is likely to satisfy the all work test for incapacity benefit, and he is unlikely to be employed again.

I would like to make a plea for doctors of all specialties to show more psychiatric awareness. Fear of missing something inevitably leads to a degree of overinvestigation and narrow focusing, but specialists are wrong if they think general practitioners are not guilty of this too. Patients are not disabled if their blood pressure or cholesterol levels are moderately raised, but they are disabled if they become incapable due to poor mental functioning. Surely we do not want to wait until negligence cases start to occur against doctors who fail to make psychiatric diagnoses.

D C Owen, *locum general practitioner, Cardiff*

We welcome articles up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake,* or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk.