Clinical review

ABC of palliative care: Depression, anxiety, and confusion

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Introduction

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.

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

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.

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**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

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

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**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.

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

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 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.

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
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.

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

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.
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

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.

References for screening instruments


> Prevention and management
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

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. 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.
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

Relatives also need explanation and support.

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.

"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

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.

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.
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