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# Psychological Issues in End-of-Life Care

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## ABSTRACT

**This paper provides a systematic, evidence-based review of the psychological issues confronted by patients at the end of life, drawing on recent literature. The epidemiology, approach to clinical assessment, clinical presentation, and therapeutic options related to common psychological issues that arise in end-stage illness are described. The spectrum of normal and dysfunctional reactions are identified, and approaches to enhancing coping and quality of life are emphasized. The learner will be able to describe: (1) normal coping responses of patients at the end of life; (2) epidemiology of common psychiatric disorders at the end of life; (3) the approach to clinical assessment of psychological distress at the end of life; and (4) therapeutic approaches to common psychological problems at the end of life.**

## INTRODUCTION

PSYCHOLOGICAL SUFFERING is a virtually universal experience for patients at the end of life and their families. Suffering exists on a continuum and has many sources: grief about current and anticipated losses, fear and uncertainty about the future, unresolved issues from the past, and concerns about loved ones. Preexisting and new psychiatric disorders (depression, anxiety, posttraumatic stress disorder (PTSD), personality disorders, substance abuse, other major psychiatric disorders), difficult family dynamics, inadequate social support and/or coping resources, personal vulnerabilities related to past experiences, and existential and spiritual concerns may also amplify suffering. Physical symptoms, difficulties in relating to the health care team, financial concerns, and other practical matters may also contribute to patients' and families' distress. All physicians caring for the dying must be expert in assessing and differentiating the major types of psychological distress in the dying and their families, including common psychiatric illnesses arising at the end of life, and in treating these sources of suffering. In addition, in order to provide optimal care to the dying patient and his/her family, the expert palliative care physician will understand the personal impact of caring for the dying, as well as the impact of this work on clinical staff, and will be expert in addressing self-care and staff support.

### *Data quality and sources*

Our understanding of the psychological issues experienced by patients at the end of life derives primarily from studies of patients with cancer and patients with acquired immune deficiency syndrome (AIDS), and from the elderly; however, little research is focused specifically on the terminal phase of illness. There is also a scant literature on the end-of-life psychological assessment and care of patients with cardiac, pulmonary, re-

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nal, and neurologic disease. Data presented in this report, except where indicated, primarily represent level 2–5 evidence. For reference, level 1 evidence represents strong evidence from at least one systematic review that synthesizes data from multiple high-quality clinical studies (including randomized controlled trials); level 2 evidence requires at least one randomized controlled trial; level 3 evidence is based on well-designed nonrandomized experimental studies, including cohort, case-control, and time series studies; level 4 evidence derives from well-designed nonexperimental studies, and collective expert opinion; level 5 evidence represents expert opinion (⟨www.cebm.net/levels_of_evidence. asp⟩).

In this paper, I provide an overview of normal responses to and common psychological issues associated with terminal illness, the epidemiology of psychiatric disorders in the palliative care setting, and the assessment, clinical presentation, and management of common psychiatric disorders in the palliative care setting.

## THE SPECTRUM OF NORMAL RESPONSES

Feelings of grief, sadness, despair, fear, anxiety, loss and loneliness are present, at times, for nearly all patients facing the end of their lives. Yet, in spite of such painful feelings, many patients, even those with significant vulnerabilities, are able to achieve a high degree of equanimity and acceptance of their illness and its prognosis. The usual conditions for effective coping and the attainment of a degree of peace at the end of life include good communication and trust among patient, family, and clinical team, the ability to share fears and concerns, as well as meticulous attention to physical comfort and psychological and spiritual concerns. Each patient brings a characteristic mode of coping and an array of strengths and vulnerabilities to the experience of a life-threatening illness. Thus, each individual's psychological experience with a terminal illness will be unique and will be affected by multiple different factors.

All patients with a life-threatening illness benefit from a comprehensive psychological, social, and spiritual assessment, as well as evaluation of physical symptoms. Systematic psychological assessment allows the clinician to support effective coping, to identify persons at risk of experiencing high levels of difficulty during their illness, and to proactively address vulnerabilities. The basic domains of a psychosocial and spiritual assessment are:

- Developmental issues
- Meaning and impact of illness
- Coping style
- Impact on sense of self
- Relationships
- Stressors
- Spiritual resources
- Economic circumstances
- Physician–patient relationship

While there is a substantial literature on many of these areas, there are few intervention studies designed to evaluate strategies to treat problems in these domains. Most of the recommendations in this section represent Level 3–5 evidence.

### *Developmental issues*

The developmental stage of the patient has a significant impact on psychological responses to life-threatening illness. The issues are particularly apparent in pediatrics, but the emotional issues for adults differ dramatically over the life cycle. Young adults with a life-threatening illness, in the midst of separating from their families and establishing their own identities, commonly struggle with ambivalence about being thrust back into dependence on parents or other adult figures (including physicians), with anger about the unfairness of the illness, with sorrow and grief about all the experiences they will not have. For parents with young children, the overriding concern is usually about the impact of their illness and possible death on their offspring, how to maintain routine and normalcy, how to share and how much to share of information about their illness, and the sense of loss and anxiety about not having the opportunity to watch their children grow up. Some parents will submit themselves to extremely rigorous treatment regimens, even when the odds of success are low. For older adults, satisfaction or unhappiness with personal and professional achievements can mitigate or exacerbate emotional distress; worries about a spouse are often prominent, and a sense of "being robbed" of an opportunity to retire and enjoy the fruits of one's hard work are often frustrations. Patients who have reached an advanced age may view the approach of death as a relief, or not, depending on whether they are able to be at peace with the life they have led, and on the kind of attachments that still provide a sense of vitality and connection with life. An appreciation of these life-cycle issues will help the clinician to listen for and enquire about concerns and emotions, to normalize patient responses, and to explore areas of distress. The following types of questions can be useful in exploring developmental issues: *What is it like to be at this point in your life [finishing college, with young children, facing retirement, having lost your spouse] and facing a serious illness? What do you feel is the toughest loss for you at this stage in your life?*

### *Meaning, hope, and the impact of illness*

Each illness has its own set of practical challenges, as well as emotional meanings.[1] A patient with cancer may have to tolerate the side effects of chemotherapy and radiation, and may expect to die from the disease from the onset; another patient with heart disease may have to contend with major limitations in activity and repeated frightening hospitalizations but may never appreciate that heart disease will cause death. Each disease, too, has a unique emotional meaning for each patient. An understanding of what the meaning of the illness is to the patient and how the patient believes she or he got the illness, an appreciation of past experiences with similar illnesses in others and expectations of what is ahead with the illness allows the clinician to identify concerns, proactively address fears, provide focused reassurance, and to help the patient plan for the future.[2] Furthermore, the opportunity to share these meanings is, for most patients, therapeutic in itself.

Finding a sense of meaning in life, and in an illness arises from the belief that one's life has a purpose, that life is a gift, and that one has a responsibility to work towards personal growth, peace, and transcendence through connection with something beyond the self.[3] Others describe the process of seeking to understand the meaning of events (e.g., illness) as a way of coping and a general life orientation.[4] Some patients are able to achieve an enhanced sense of meaning, purpose, and peace in life as a result of a serious illness.[5] Others experience a loss of a sense of meaning. Being able to find and maintain a sense that life has purpose and meaning is associated with ability to tolerate physical symptoms and satisfaction with one' s quality of life,[6] and appears to protect against depression and desire for hastened death.[7,8,9]

Meaning is closely allied with hope for patients with advanced illness. Hopes, whether they can be fulfilled or not, reflect what is important to the patient, what they are wishing for, and how they understand their illness.[10] Exploration of hopes and wishes provides, not only an opportunity to understand personal values and expectations of the illness, but also concerns and goals for the future. For example, a patient saying,"I am hoping to be there for my daughter's graduation, but I'm not sure I'll make it" is expressing a wish, a goal, her uncertainty about her prognosis, as well as an indication of her values and her concern about her anticipated illness trajectory.

Specific questions that are useful to explore illness meanings and hopes include: *How have you made sense of why this is happening to you? Do you have a theory about why you got sick? What is it? What do you think is ahead? What are you hoping for? What are the things that are most important to you as you think about the future?*

### *Coping style*

When confronted by a serious emotional challenge, such as life-threatening illness, a person is required to make psychological adjustments to preserve equilibrium. Coping, according to Avery Weissman, a distinguished psychoanalyst who studied this phenomenon extensively, is "a strategic effort to master a problem, overcome an obstacle, answer a question, dissipate a dilemma—anything that impedes our progress." Examples of coping responses include: seeking information, keeping busy, redefining options, resigning one's self, examining alternatives, expressing feelings.[11] Effective coping takes place when the patient is able to use active problem-solving strategies to deal with problems.[12] A recent preliminary study suggests that as patients become sicker, their ability to perform cognitive tasks and process information may decline,[13] reducing one of the resources people rely on for coping. This study, if confirmed, has important ramifications for our understanding of the way patients respond to illness, and the resources that are (and are not available) to them in coping with a significant illness. While many researchers have examined whether certain coping styles are associated with improved or worsened outcomes, results of these studies are equivocal. A recent meta-analytic review that examined “fighting spirit” and helplessness/hopelessness as predictors of recurrence and mortality in patients with cancer found no evidence of an effect of these different coping styles.[14]

In other situations, the patient may defend against the new realities of illness by avoiding them. While coping tends to move a problem towards resolution, defending tends to avoid the problem, primarily to fend off emotional distress.[12] These defenses may be either adaptive (by reducing stress and allowing time for fuller psychological adjustment) or maladaptive (preventing necessary adjustments). Most patients use a combination of these responses, coping with what they can, defending when they become overwhelmed. There is a dynamic tension between coping and defending. When there are new and overwhelming realities (e.g., when the patient receives ominous news about the presence of new brain metastases), defending may predominate; when the patient has some time to live with and process the news, he or she may be able to invoke more effective coping strategies. In general, patients’ defenses are at a height when they are most stressed; generally, under these circumstances, such defenses should be supported. When the crisis has passed, it may then be more appropriate to try to work through the defenses towards a more effective adaptation.

Denial is a common defense in life-threatening illness. Denial refers to the negation of difficult information. Its purpose is to preserve psychological equilibrium. Patients may refuse to accept the possibility of death, disbelieve their physicians about their prognosis, focus on unrealistic treatment goals, or fail to make necessary legal, financial, and health care arrangements. On the other hand, denial can also be a highly adaptive defense, allowing patients to live in the present, to enjoy times when they feel well, and to appreciate the time they do have. In this form of adaptive denial, patients recognize that they have a terminal illness, or a serious life-threatening illness, but choose consciously to set that awareness aside in favor of living. Maladaptive denial, in contrast, is characterized by rigidity of belief that one is not seriously ill, and by a form of denial that is not an active choice. While milder denial may offer some short-term benefits, in allowing patients time to cope with painful realities, intense forms of denial may impair adjustment and distort care[15] and can be an indicator of depression. Recent research suggests that severe denial occurs in 10% of hospitalized patients with advanced cancer, with more moderate levels of denial occurring in an additional 18% of patients. When extreme, denial may also be a marker for depression.[16] The following questions can be useful in understanding coping and defenses: *How have you coped with hard times in the past? What has worked? Not worked? What are the times you feel most overwhelmed by your illness? What tends to help you cope at those moments?*

### *Impact on sense of self*

Serious illness has a profound impact on the sense of self; continuing to feel like one’s self is highly valued by patients at the end of life.[17] The physical and psychological losses that often are part of illness challenge one’s sense of wholeness and integrity, which are key ingredients of emotional health.[18] Being independent and in control are characteristics that some patients value highly and become important elements of a person’s identity; illness challenges these personal values profoundly, and may contribute to requests for hastened death in patients with life-threatening illness. The constructs of control and independence have been brought together in the literature under the concept of “dignity,” or “ the quality or state of being worthy, honored, or esteemed.” Multiple constructs of dignity have evolved in the literature, subsuming such varied topics as autonomy and self-determination, personhood and self-worth, bodily integrity and hygiene, and continuity of relationships.[19] Chochinov and colleagues,[20,21] describe a model of dignity that is related to illness-related concerns (symptoms, psychological distress, uncertainty, death anxiety, and independence), as well as the individual’s own psychological and spiritual milieu (ability to preserve a sense of self, to preserve valued roles and pride, hopefulness, control, generativity, acceptance, resilience), and the social factors that impinge on the self (privacy, support, concerns about being a burden, care tenor, and concerns about loved ones after death). Interventions to support and enhance the sense of dignity in the terminally ill are currently being developed and evaluated.

A key goal of palliative care is helping a patient continue to feel like him- or herself all the way until death. Understanding the impact of illness on the patient's sense of him- or herself can allow the clinician to develop strategies that support the patient's wholeness. For example, a woman who has prided herself on her caretaking of others may only be willing to accept care from her children if accepting care is framed as an opportunity for her to help her children by allowing them to care for her. A CEO who is used to calling the shots may benefit from being presented with several different options among which he is able to choose, rather than being told what to do. Supporting patients' sense of themselves, while also encouraging them to consider the possibilities that illness represents a new opportunity for growth and self-reflection can help patients negotiate these challenging issues. Useful probes for exploring these issues include: *How is your illness affecting your sense of yourself? Are you able to notice ways you are changing inside yourself in response to your illness? How can we best honor who you are and what is important to you as we take care of you? As someone who has clearly invested herself in showing her children how to live, I wonder whether you see yourself as also having an important role in teaching them how a person can die in a dignified way that honors her connections. What do you think?*

### *Relationships*

Life-threatening illness changes relationships. Illness can both create strain on relationships, as well as enhanced appreciation of the importance of loved ones and a wish to connect more deeply.

Worries about family members are a major feature of life-threatening illness for most patients. In one study of terminally ill patients with cancer, between 92% and 97% rated the following domains as extremely or very important: "feeling appreciated by my family," "saying good-bye to people closest to me," "expressing my feelings to my family," and "knowing that my family will be all right without me."[22] Family caregivers also experience significant strains related to their roles, including an adverse impact on work and finances,[23] as well as elevated rates of depression.[24] Helping the family cope with these severe stressors is not only a humane component of end-of-life care, but is also an important step in facilitating a good death for the patient. Attending to the caregiver's experience and concerns is associated with reduced rates of depression and enhanced coping.[24] Furthermore, preparation of family members for the patient's death appears to be associated with reductions in rates of psychiatric disorder, as well as mortality in bereaved survivors, demonstrating an important linkage between the patient's experience and outcomes of survivors, and attesting to the critical importance of considering patient and family as the unit of care.[25,26]

The clinician can explore relationship issues through direct questioning and observation of family interaction in the clinical context. Useful questions include: *Who are the most important people in your life? How are they dealing with your illness? How much are you able to communicate with the important people in your life about your illness and what might be ahead? What are your worries about your (wife/husband/children) now and after you are gone? It is sometimes helpful for patients to participate in preparing loved ones for the possibility that they will die. What kinds of thoughts have you had about this?*

### *Stressors*

Because life-threatening illness represents such a major adaptational challenge, the presence of other stressors, superimposed on the illness, has a major impact on how an individual copes. For example, psychosocial stressors enhance the likelihood that a person will become depressed.[27] Stresses related to relationships, work, finances, housing, transportation, legal matters, etc., are likely to impair the individual's ability to cope with serious illness. Patients, over the course of a lifetime, develop their own characteristic ways of dealing with stress; an understanding of how the patient has coped with stress and hardship at other times of life can yield important information for the clinician that can be applied to the palliative care context. Several questions can help identify major stresses that can impact psychological well-being: *What are the things that are causing the most stress in your life right now? How well do you feel you are able to manage them? How do you usually cope with stress? What do you do when things just feel like they are too much?*

### *Spiritual resources*

Religion, faith, spirituality, and/or a personal belief system represent important sources of strength for some people as they face a life-threatening illness. In addition to belief systems that derive from religious teachings or a personal spirituality, individuals may have other ways of making sense of their experiences, and in particular, coming to terms with suffering. Some persons invoke a belief in science, in relationships, or individualized blends of the above constructs that give meaning to their lives. Other patients may also experience significant suffering related to religious and spiritual issues. Feelings of spiritual emptiness, being abandoned by or angry at God, or that one is being punished by God, or that one's spiritual practices are not working to maintain a sense of peace can create great inner turmoil that can amplify psychological distress.[28,29] Spiritual care is addressed in depth in a future article in this series. Questions that can be useful in beginning an exploration of these issues include: *What role does faith or spirituality or a personal belief system play in your life? Are you able to find comfort in your faith or belief system as you deal with your illness? Do you have times where you wish you were closer to your faith or to God?*

### *Economic circumstances*

Life-threatening illness can have a major impact on family economic circumstances. Conversely, a family's economic resources will influence stress levels, availability of medical care and support in the home, access to medications, etc. Researchers have demonstrated that serious illness often results in a decline in family economic well-being.[30] In the SUPPORT study, Covinsky et al.[23] found that 20% of family members of seriously ill adult patients had to make a major life change (including quitting work) to provide care for their loved one, and that 31% of families lost all or most of their savings in the process of caring for their ill relative. An understanding of patients' and families' concerns about financial issues is a basic element of a psychosocial assessment. Basic questions to open a conversation about these topics include: *How much of a concern are financial matters for you right now and for the future? Are there any ways in which your financial situation is acting as a barrier for you to get help you need?*

### *Physician–patient relationship*

The physician–patient relationship frames the patient's and family's experience with life-threatening illness. Through providing honest information that sustains a sense of realistic hope, demonstrating competence, dependability, and commitment, eliciting and responding to concerns, treating the patient as a whole person and involving the family in the care process, anticipating problems and proactively identifying solutions, and showing care and connection, the physician creates the conditions for the patient and family to cope effectively with serious illness. An understanding of how the patient views the relationship with his/her primary physician and/or team will allow the palliative care clinician to serve as a liaison to the primary team, to address unmet needs, and to help the patient better negotiate his/her illness and treatment. Questions that can be helpful in eliciting information about the status of the physician–patient relationship include: *How secure are you that your medical needs are being met? How do you want me, as your physician to help you? How can we best work together?*

With an appreciation of some of the factors influencing psychological well-being in patients at the end of life, we will turn our focus to a discussion of the common psychiatric disorders arising in patients at the end of life. These include depression, anxiety, substance abuse, PTSD, personality disorders, and schizophrenia and bipolar disorder. Delirium, a critical psychiatric syndrome that is common at the end of life, is addressed elsewhere.

## EPIDEMIOLOGY OF PSYCHIATRIC DISORDERS IN THE TERMINALLY ILL

The literature on prevalence rates of psychiatric disorders or distress should be scrutinized to evaluate: (1) does the entity being studied (e.g., depression) have distinctive phenomenology, risk factors, correlates, and response to intervention); (2) are the diagnostic criteria for the disease clearly specified?; (3) are the patients studied similar in terms of diseases and stages?; (4) are populations studied broadly representative in terms of race, ethnicity, socioeconomic status?; (5) are patients studied using self-report questionnaires, or rigorous structured clinical interviews with demonstrated reliability? Answers to these questions will allow the reader to interpret the data presented and assess its applicability to his or her setting. While conditions 1 and 2 are usually met, few epidemiologic studies of psychiatric disorders in palliative care include broadly representative patient populations, focus on patients with advanced disease, and use rigorous evaluation methods, such as structured clinical interviews.

### *Depression*

Prevalence rates of depression in patients with cancer range widely, depending on diagnostic criteria used and patient population studied. Rates of depression range from 3%–38% among patients with cancer.[31,32,33] The wide variability in reported rates is explained by the lack of agreement on appropriate criteria for diagnosis of depression, differences in patient populations (both in relation to disease and staging), and variation in assessment methods used.

Research by Derogatis and colleagues[34] showed that 47% of patients with cancer (all types, all stages) fulfilled diagnostic criteria for psychiatric disorders. Of those 47%, 68% had adjustment disorders with depressed or anxious mood, 13% had major depression, and 8% had organic mental disorders. Akechi et al.,[35] in a prospective study in a Japanese palliative care setting, found that, using the Structured Clinical Interview for DSM, 16% of patients had adjustment disorder, 7% had major depression, and none had PTSD. They also found that 31% of patients in their study either developed a new diagnosis of adjustment disorder and/or major depression, or experienced a remission in follow-up with a median of 58 days. More recent data, using the Structured Clinical Interview for DSM-IV, and including diverse patient populations, showed that 39% of advanced cancer patients either fulfilled criteria for a major psychiatric disorder and/or utilized mental health services for psychological distress after the cancer diagnosis. Twelve percent of the patients met criteria for a major psychiatric disorder: 7% major depression, 3% generalized anxiety, 5% panic disorder, 2% PTSD. An additional 11% of patients fulfilled criteria for minor depression. Over one third of patients with a psychiatric diagnosis met criteria for two or more diagnoses.[36] Prevalence rates appear to increase as patients become sicker.[37,38] The highest rates of depression are seen in patients with cancers of the pancreas, oropharynx, and breast.[39] Recent data suggest that depression is associated with an elevated risk of death in patients with cancer.[40,41,42] In addition, depression is associated with decreased adherence to treatment, prolonged hospital stays, and reduced quality of life[43,44]; it is a major risk factor for suicide and for requests to hasten death[45] and influences will to live in patients with cancer receiving palliative care.[46] As many as 59% of patients requesting assisted suicide are depressed.[47] Lloyd-Williams[48] carried out a prospective study to evaluate incidence of suicidal ideation in a palliative care population, mostly with very late stage disease, and found that 3% had such thoughts often, 10% experienced them sometimes, 17% hardly ever experienced them, and 70% never had thoughts of self-harm. Younger patients were more likely to report suicidal thoughts.[49] Several studies suggest that the prevalence of depression in cancer has declined over the past twenty years, perhaps related to improvements in medical care and outcomes, and destigmatization of the diagnosis of cancer.[50]

Similarly, patients with other medical illnesses, also appear to have elevated rates of depression.[51,52] Patients seeking to stop dialysis have rates of depression of between 5% and 25%[53]; those with end-stage heart disease are reported to have prevalence rates of 36% for major depression and 22% for minor depression.[54] Fewer than half received treatment for depression.[55] Depression in patients with heart failure is associated with elevated hospital readmission and mortality.[56]

### *Anxiety*

Significant anxiety symptoms are found in approximately 25% of patients with cancer[34]; recent research shows that 3% of patients with advanced cancer meet diagnostic criteria for generalized anxiety disorder and 5% meet those for panic disorder.[36] Elevated rates of anxiety are found, as well, in patients with heart failure.[57] Anxiety and depression commonly coexist[58]; other syndromes, including adjustment disorder, obsessive-compulsive disorder, phobias, delirium, panic disorder, and PTSD, also may be manifested as anxiety.[59]

### *PTSD, substance abuse, personality disorder, schizophrenia, and bipolar disorder*

PTSD refers to an anxiety disorder caused by exposure to a traumatic stimulus, usually involving the threat or experience of death, injury, or loss of physical integrity; traumatic stimuli include diagnosis with a life-threatening illness.[60] Symptoms of PTSD (intrusive thoughts, reexperiencing of distressing events, avoidance of reminders of the traumatizing event, high levels of emotional arousal, etc.) may occur in patients with cancer; rates range from 2% to 35%, with lower rates in studies using *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*) criteria as opposed to studies based on symptoms that do not meet full diagnostic criteria and on self-report.[36,61,62,63] Studies of adult patients with cancer using the Structured Clinical Interview for DSM (SCID) show rates of PTSD of 3%–10%.[64] The relationship between disease stage and PTSD has not been adequately evaluated. In patients at the end of life, reexposure to traumatizing stimuli, for example pain,[65] may lead to more intrusive thoughts; similarly, cancer recurrence that reawakens emotions associated with the original diagnosis is thought to lead to increased PTSD symptoms in patients with advanced disease.[66] Both classic conditioning and instrumental learning are thought to mediate the relationship between fear responses and anxiety. Avoidance, a common symptom of PTSD, as well as distrust of health professionals who may be seen as the "inflictors" of emotional distress may delay help-seeking and treatment; high levels of anxiety may impair proactive planning for end-of-life care needs, and may be distressing for family members who are caring for loved ones with PTSD. Previous trauma is thought to be a significant risk factor for PTSD in the presence of cancer, social support is thought to be a protector in patients undergoing bone marrow transplant[67] (please see ⟨www.nci.nih.gov/cancertopics/pdq/supportivecare/post-traumatic-stress/HealthProfessional⟩ for an up-to-date evidence review on this topic in cancer.)

The prevalence of alcoholism ranges between 7% and 27% in studies in different palliative care clinical settings.[68,69] Unrecognized alcohol withdrawal has been postulated, based on a small number of case reports, as a contributor to terminal delirium at the end of life.[70] Few data are available about the prevalence of other forms of substance abuse in palliative care.

Reliable data are not available about the prevalence of personality disorders in patients with medical illness. However, in a 2001–2002 representative national sample, 14.8% of community-dwelling adults met diagnostic criteria for at least one personality disorder: 8% had obsessive-compulsive disorder, 4% paranoid personality disorder, 4% antisocial personality disorder, 3% schizoid personality disorder, 2% avoidant personality disorder 2% histrionic personality disorder, and .5% had dependent personality disorder.[71] The population of patients receiving palliative care can be expected to demonstrate similar prevalence rates of personality disorders.

Patients with major psychiatric disorders (e.g., schizophrenia, bipolar illness), when medically ill, may be at special risk of psychiatric decompensation; however, some of these patients may also do surprisingly well. Little is known about how patients with major mental illness face the end of life. Patients with chronic mental illness have elevated rates of serious medical illness and premature death[72]; often illness is detected late.

### *Other syndromes*

In recent years, Kissane[73] has proposed that demoralization syndrome be considered a separate entity. He characterizes demoralization as "incompetence through loss of meaning or purpose"; additional proposed criteria for demoralization include existential distress, pessimism, helplessness, hopelessness, absence of drive, isolation and lack of support. However, evidence in support of this as a distinct syndrome is lacking.

### *Rates of mental health service use*

A small number of studies have examined how clinicians assess and manage mental health issues in patients with advanced disease. Lawrie et al.[74] found that 73% of palliative care physicians routinely assess patients for depression, and that 75% prescribed selective serotonin reuptake inhibitors (SSRIs), 25% prescribed tricyclic antidepressants, 6% prescribed psychostimulants, and 3% prescribed St. John's wort. When asked whether they would prescribe complementary or psychological therapies for depression, 35% reported that they would refer patients for aromatherapy, and only 8% would refer for counseling. Kadan-Lottick et al.[37] found that nearly half of patients who met criteria for psychiatric illness did not receive mental health services, and that nonwhite patients were significantly less likely to receive mental health services than white patients.

## ASSESSMENT AND CLINICAL PRESENTATION OF PSYCHIATRIC DISORDERS IN THE TERMINALLY ILL

In addition to the general elements of psychosocial assessment described above, the palliative care physician is also responsible for assessing patients for the presence or absence of psychiatric disorder. While anxiety and depression are the most commonly encountered psychiatric syndromes in this setting, the expert palliative care clinician will also be familiar with the general approach to assessment and treatment of patients with PTSD, substance abuse disorder, personality disorders, and major psychiatric illness (e.g., schizophrenia and bipolar illness) in the palliative care setting.

### *Depression*

Depression impairs the patient's ability to enjoy life, interferes with connection, is associated with feelings of emptiness and meaninglessness, causes anguish to family and friends, interferes with treatment adherence, shortens life span in some diseases, and is a major risk factor for suicide.[75] Differentiating depression from grief is a major clinical challenge in palliative care. Characteristics of grief and depression are presented in Table 1.

There is considerable overlap between the neurovegetative symptoms of depression and those associated with any serious illness. Different approaches to diagnosis have been espoused; most experts agree that for clinical purposes, using an "inclusive" set of diagnostic criteria that incorporates both neurovegetative and psychological symptoms of depression is most appropriate for this patient population.[76,77] Asking patients directly about depressed mood has been shown to be sensitive and specific for the diagnosis of depression, although there are differences across populations.[77,78,79] Some patients may readily verbalize that they are depressed; others, no matter how despairing, may never acknowledge it, or may call it something else (e.g., nervousness). Although some clinicians may be concerned that exploration of feelings of depression may worsen

TABLE 1. CHARACTERISTICS OF GRIEF AND DEPRESSION

| | *Grief* | *Depression* |
|---|---|---|
| Definition | Feelings and behaviors that result from a particular loss[153] | Depressed mood, decreased interest and pleasure, appetite and sleep disturbance, psychomotor agitation or retardation, decreased concentration, loss of energy, feelings of worthlessness, guilt, hopelessness, helplessness, and thoughts of death with impairment of functioning lasting at least two weeks |
| Symptoms and signs | Somatic distress, sleep and appetite disturbance, diminished concentration, social withdrawal, sighing | Hopelessness, helplessness, anhedonia, worthlessness, guilt, suicidal ideation most useful diagnostic clues<br>Somatic distress, sleep and appetite disturbance, diminished concentration, social withdrawal, sighing are also common |
| Other differentiating factors | Patient retains capacity for pleasure | Nothing is enjoyable |
| | Comes in waves | Constant |
| | Passive wishes for death | Intense, persistent suicidal thoughts |
| | Able to look forward to the future | No sense of anything to look forward to |

patient distress, recent research suggests that this is not the case.[80] Hopelessness, helplessness, worthlessness, guilt, lack of pleasure, and suicidal ideation are the key psychological symptoms of depression. In addition, social withdrawal, irritability, and anxiety may also be present. Pain, as well as a personal or family history of substance abuse, depression, or bipolar illness, are major risk factors for depression.[81] Similarly, treatment with particular medications, for example, interferon, corticosteroids, cyclosenrine, L-asparaginase, tamoxifen, vinblastine,[82] also predispose to the development of depression. Prophylaxis with antidepressant medication has been shown to be effective in dramatically reducing the incidence of depression in patients receiving interferon.[83] Recent research suggests that depression in patients with cancer may be part of a larger "sickness syndrome" that involves depression, pain, fatigue, and sleep disturbance, and that is believed to be associated with chronic immune activation.[76]

In addition to these diagnostic criteria, other clues to the presence of depression are: insomnia (particularly with early morning awakening), intractable pain and/or other symptoms, excessive somatic preoccupation, disability out of proportion to the patient's medical condition, and hopelessness, aversion, or lack of interest in the clinician.[84] Poor adherence or treatment refusal have also been associated with depression[85,86] however, other studies have shown increased adherence to cancer treatment in depressed patients.[87] The use of complementary therapies by patients with cancer may also be an indicator of feelings of desperation, fear, hopelessness, depression, and increased symptom burden as patients recognize advancing illness.[88,89,90]

Recent data suggest that palliative care clinicians and oncologists tend to underrecognize and underestimate the severity of patients' depression.[91,92]

### *Anxiety*

Anxiety is often seen as a natural consequence of confrontation with or awareness of mortality. Manifestations of anxiety may include autonomic hyperactivity, hypervigilance, worry, apprehension, insomnia, and somatic symptoms including diarrhea, sweating, palpitations, and dyspnea.[93,94,95] High levels of anxiety that create intense distress or interfere with functioning are clearly problematic. Low levels of anxiety, however, can energize the patient and spur adaptation and coping.

However, it is also critical for the clinician to recognize that anxiety in palliative care may also be the result of a preexisting anxiety disorder, substance abuse, medications, delirium, or undertreated symptoms, especially pain. In the palliative care setting, multiple drugs can contribute to anxiety. Phenothiazines and butyrophenones frequently used to control delirium and nausea and vomiting, and metoclopramide are common, and frequently unrecognized predisposing factors to anxiety symptoms through causing akathisia. Precipitous withdrawal of opioids, corticosteroids, anticonvulsants, benzodiazepines, nicotine, and clonidine can also precipitate anxiety.[95] Insomnia is a common symptom in terminal illness; about one third of patients ascribe their insomnia to worry or anxiety, often about the future, about family, and about death; insomnia is also highly associated with depression, and its presence should alert the clinician to carry out a thorough assessment for undertreated anxiety and depression.[96]

Concerns about future pain control and the course of the disease, the impact of the illness on family members, separation from loved ones, unfamiliar caretakers, loneliness and isolation may be significant factors that contribute to anxiety. Stiefel[97] has developed a typology of anxiety syndromes in patients with life-threatening illnesses; these include situational anxiety, organic anxiety, psychiatric anxiety, and existential anxiety.

Anxious patients often cannot take in information they have been offered and ask the same questions over and over again. They may overreact to symptoms or treatments, or behave unexpressively and stoically. Their behavior may seem inconsistent and impulsive. They may seek detailed information or not ask reasonable questions. They may be suspicious of the physician's recommendations or not ask questions because of regression or high levels of fear.

### *PTSD, substance abuse, personality disorders, schizophrenia, and bipolar illness*

Patients with preexisting psychiatric illness may present unique management challenges. A patient with a history of substance abuse may be extremely reluctant to use pain medications for appropriate indications; a patient who is actively using substances may overmedicate himself/herself as a way of coping.[98] Denial is a prominent feature of patients with substance abuse problems.[99] Patients with personality disorders may distort information and misinterpret the actions and behaviors of others, creating distress in those around them. A patient with major mental illness, such as schizophrenia, may not adhere to treatment recommendations, frighten staff, or make decisions that are influenced by unusual beliefs or fears. Patients with PTSD may show high levels of anxiety and be difficult to reassure, or may fail to develop a trusting relationship with the physician. To assess psychiatric vulnerabilities, the clinician should ask questions about past experiences with psychiatric illness and treatment. The use of a screening instrument for alcohol abuse, such as the CAGE or AUDIT questionnaires, is useful in identifying patients with substance abuse problems.[100,101] Personality disorders are usually appreciated through observation and interaction. These individuals have been described by some as "hateful" patients, reflecting their ability to create ill-feeling in their caregivers.[102] They may interact in unpleasant ways, behaving manipulatively, demandingly, impulsively, angrily, or disruptively. Patients with personality disorders may seem to be complaining, while rejecting help; blaming, while avoiding personal responsibility; and self-involved, without awareness of the impact of their actions on others. They are also identified through the often intense negative responses of others to them, as well as by the externalization of responsibility for problems (e.g., "There is nothing wrong with me, it is just that everyone else is causing all of the difficulties I am experiencing . . .").

### *Physician responses*

Each clinician tends to have a characteristic response to different kinds of patients. For example, an anxious patient with a new diagnosis and detailed and repeated questions about pages of information that he or she has tracked down on the Internet might be particularly troublesome to a clinician who prefers a high degree of control of the clinical encounter. A patient who berates staff and questions their competency while asking for special favors will irk almost every clinician, but the intensity of the clinician's response and his or her ability to set appropriate limits on the patient's behavior will be influenced by past experiences with similar persons. Over time, the expert clinician learns how she or he characteristically responds to different types of patients, and can use these personal responses as valuable data about the patient.

Over time, the expert palliative care physician gains an appreciation of the patterns of psychological responses that characterize these distinct psychiatric syndromes, and also recognizes how presentations of these syndromes may interact and overlap.

## THERAPEUTIC OPTIONS: GENERAL ISSUES

The primary therapeutic response to psychological distress at the end of life is to listen, using standard communication techniques (using open-ended questions, following up on affectively intense comments made by the patient, tracking with patient associations and expressed concerns, reflecting on patient emotions, etc.) The physician, through offering the patient an opportunity to explore fears, concerns and feelings, to reflect on important relationships, past experiences with loss, and hopes for the future, and to share the unique meanings of illness, can provide the patient with a sense of being understood. Being heard and understood, even in sharing the darkest thoughts and feelings, provides a way for the patient to mourn losses, to counteract the existential isolation of serious illness, to connect with past strengths and coping resources, and to gain a sense security and mastery.

Multiple models of psychotherapeutic support for patients at the end of life have been proposed, including the psychodynamic life narrative,[103] supportive psychotherapy,[104] insight-oriented psychotherapy,[105] cognitive-behavioral therapy,[106] interpersonal therapy,[107] existential therapy,[108] and dignity-conserving psychotherapy.[20,21] Current research does not support the value of one approach over others.[109] In general, however, most terminally ill patients benefit from an approach that combines emotional support, flexibility, appreciation of the patient's strengths, a warm and genuine relationship with the therapist, elements of life-review, and exploration of fears and concerns. The physician's ability to communicate that there are possibilities for meaning, connection, reconciliation, and closure at the end of life may facilitate the patient's ability to accept the approach of death, and to use remaining time well. Profoundly depressed patients, however, may not be able to effectively engage in any of these therapeutic tasks; antidepressant medication is often necessary to mobilize a depressed patient to do psychotherapeutic work.

## OVERALL ASSESSMENT OF EVIDENCE FOR PSYCHOLOGICAL INTERVENTIONS IN PALLIATIVE CARE

Level 1 evidence demonstrates that psychosocial interventions reduce depressive symptoms, particularly among patients who had high preintervention levels of depression.[110,113] Earlier data from Spiegel[112] suggesting a survival advantage in patients undergoing supportive group therapy were not confirmed in the recent and more robust study by Goodwin and colleagues,[112] although both studies demonstrated positive effects on quality of life. The study by Goodwin and colleagues showed effects on both mood and pain perception, especially in the most seriously distressed patients. Bordeleau et al.[111] found that supportive-expressive psychotherapy did not have an effect on health-related quality of life, as measured by the EORTC QLQ-C30. Other studies suggest the benefits of opportunities for open expression of feelings, direct confrontation with fears and concerns (as opposed to avoidance and denial), and active coping, rather than passive acquiescence.[111,114] Only a small number of randomized controlled trials comparing antidepressants to placebo have been reported in the literature; there is a trend towards support for the value of antidepressant therapy, but these data are limited by small sample size, short follow-up, and diversity of outcome measures. Several meta-analyses of psychological interventions for depression have been reported; cumulatively, their results are equivocal.[115]

### *Depression*

Contrary to much popular and professional opinion, depression is a treatable condition, even in patients who are terminally ill. Effective treatment of depression in the context of distressing symptoms, however, is difficult; thus, the first step in treating depression is effectively controlling physical symptoms. Some patients may be concerned that being labeled as "depressed" will lead their physicians to take their physical problems less seriously, to treat them less aggressively, or to stigmatize them; it is often essential for the physician to address these issues before the patient will be willing to accept treatment. A combination of antidepressant medication, supportive psychotherapy, and patient and family education are viewed as the gold standard of treatment.[116]

Because antidepressant therapy is usually relatively well-tolerated, a recent expert consensus statement recommends having a low threshold for initiating treatment.[115] Psychostimulants, SSRIs, and tricyclic antidepressants are the main pharmacologic treatment modalities for depression at the end of life. Evidence about the effectiveness of antidepressants in patients at the end of life is poor; although one study describes some effectiveness in as many as 80% of patients with cancer,[117] the lack of clear criteria for effectiveness and appropriate study design significantly compromise these data. There are no randomized, controlled trials of antidepressants in the palliative care setting; thus, trials from the primary care, geriatrics, general oncology, and human immunodeficiency virus (HIV) evidence base provide much of what we know about antidepressant effectiveness in palliative care.

Randomized controlled trials in primary care have demonstrated the effectiveness of mirtazapine and paroxetine.[118] Randomized controlled trials in geriatric settings demonstrate the effectiveness of combined modalities (community-based psychosocial interventions and antidepressant medication) for major and minor depression[119,120]; the results of these studies have been incorporated in recent treatment guidelines and algorithms for geriatric depression.[121,122,123] Several randomized controlled trials comparing antidepressants to placebo for depression in patients with cancer suggest a benefit of treatment[124,125,126]; high dropout rates and narrow patient populations (women with breast and gynecologic cancers) limit generalizability. A recent randomized controlled study of paroxetine in an ambulatory oncology population demonstrated effectiveness for fatigue and depression.[127] A trial of a simple two-question symptom screening tool for depression followed by fluoxetine treatment for depressed patients demonstrated improvement in patients' quality of life and depressive symptoms. A recent meta-analysis of SSRIs for the treatment of HIV-associated depression suggested some therapeutic benefit and acceptable tolerability, but did not identify any agent(s) as particularly effective.[128] Other investigators have demonstrated effectiveness of treatment with sertraline, paroxetine, mirtazapine, and citalopram in open-label trials.[129,130,131]

Several nonrandomized studies document the effectiveness of methylphenidate in patients with cancer.[132,133] In patients with HIV, a randomized controlled trial has shown stimulants to be effective in patients with low energy and apathy.[134] Another recent randomized, double-blinded, controlled trial of psychostimulants for fatigue in patients with HIV showed statistically significant improvements in fatigue, quality of life, and psychological distress (including depression), with minimal side effects.[135] A recent open-label study of HIV-positive patients that evaluated modafinil as a treatment for fatigue showed evidence of effectiveness for both fatigue and depression.[136]

Because of their rapid onset of action, psychostimulants (methylphenidate, dextroamphetamine, pemoline) deserve special consideration in treating depression near the end of life.[137] Therapeutic benefits can be achieved within 24–48 hours of starting medication. SSRIs are also valuable drugs in the palliative care setting and may be used alone, or in combination with a psychostimulant. Choosing among SSRIs is not yet an evidence-based decision in this setting. Tricyclic antidepressants are not first-line agents for depression in the terminally ill because they are not as well-tolerated as SSRIs, because of autonomic and sedating effects. Electroconvulsive therapy is a highly effective treatment for depression and should be considered in patients with psychotic depression, those who cannot tolerate antidepressant medications, or treatment-resistant depression who have a prognosis of several months or more.[138,139]

In general, patients with suicidal ideation, treatment-resistant depression, diagnostic uncertainty, comorbid psychiatric disorder (e.g., anxiety, substance abuse, etc.) should be referred to a psychiatrist.[140] Refractory, treatment-resistant depression may occur in the palliative care setting. Appropriate treatment planning for such patients requires not only an intensive interdisciplinary dialogue including a psychiatrist, but involvement of the patient and his/her family, in defining appropriate care. Very occasionally, in spite of state-of-the-art medication, psychotherapy, and palliative care, depression may be intractable; in such circumstances, clinicians are called upon to respond to depression as a terminal illness that is causing profound suffering. In these rare circumstances, limitation of further aggressive intervention, as well as other standard palliative care approaches (e.g., palliative sedation, voluntary cessation of eating and drinking) to the patient with extreme and irremediable suffering, should be considered.

Table 2 describes antidepressants commonly used in palliative care.

### *Anxiety*

Most patients with mild to moderate anxiety can be treated effectively with supportive psychotherapeutic interventions.[94] Higher levels of anxiety, or anxiety that does not respond to psychotherapeutic interventions is usually best treated with an SSRI or benzodiazepine.[59] SSRIs are highly effective agents for anxiety, particularly when accompanied by depressive symptoms. Clonazepam (0.5 mg orally three times daily) is a useful agent, at low doses, for treatment of chronic, high levels of anxiety. Other medications, including atypical antipsychotics (e.g., olanzapine, risperidone) have also been recommended, but have not been adequately evaluated.[141,142] Patients with cancer with relatively good functional status (Karnofsky performance scores $>60$), in a randomized controlled trial comparing alprazolam with progressive muscle relaxation, experienced significant improvements in anxiety symptoms with both modalities.[143] A recent Cochrane review concluded that there is no systematic evidence of the effectiveness of pharmacologic treatment of anxiety in the palliative care setting.[59]

Guidelines for the management of anxiety in the critical care setting have been promulgated.[144] Benzodiazepines, especially lorazepam, are recommended as the drugs of choice for anxiety with an anticipated duration of more than 24 hours; for shorter term use, propofol or midazolam are the recommended agents.

### *PTSD, substance abuse, personality disorders, schizophrenia, and bipolar illness*

While patients with major psychiatric disorder can sometimes cope well with end-stage illness, the clinician managing such patients should be

Table 2. Antidepressants for Use in Terminally Ill Patients

| *Class of agent* | *Quality of evidence* | *Advantages* | *Disadvantages* | *Onset of action* | *Starting dose* | *Usual daily dose* | *Maximal dose* | *Side effects* | *Schedule* |
|---|---|---|---|---|---|---|---|---|---|
| Psychostimulants | Anecdotal reports, retrospective case reviews, small controlled perspective trials, RCT in HIV[154,155] | Rapid onset of action; well tolerated in elderly and debilitated patients; effective adjuvant analgesics,[156,157] counter opioid-induced fatigue; improve appetite[158] and energy; effectiveness 70%[159] to 82%[160]; useful in treating cognitive impairment in AIDS[161,162] | Cardiac decompensation can occur in elderly patients, patients with heart disease; confusion in old or cognitively impaired patients); tolerance may develop, but occurs infrequently | <24 hours | Start low, titrate upwards q 1–2 days until therapeutic response, side effects, or maximal dose reached | | | Mean % side effects =11%: restlessness, dizziness, nightmares, insomnia, palpitations, arrhythmia, tremor, dry mouth; psychosis rare; Pemoline produces minimal cardiac stimulation | |
| Methylphenidate | | | | | 2.5–5 mg | 10–20 mg | 60–90 mg/d | | 8 am and 12 noon |
| Dextroamphetamine | | | | <24 hours | 2.5 mg | 5–10 mg | 60–90 mg/d | | Once daily |
| Pemoline | | | Hepatocellular injury and choreoathetosis; hepatic function must be monitored regularly; use with caution in patients with renal failure | 1–2 days | 18.75 mg | 37.5 mg | 150 mg/d | | |
| SSRIs | Controlled, double-blinded studies demonstrate superiority over placebo in depression,[164] HIV-related depression,[163] depression with heart disease[165]; SSRIs are as safe and effective as TCAs[166]; no controlled studies in terminal illness; RCTs and controlled trials show no single agent superiority,[167] although recent data | Safe and effective with few side effects; Little orthostatic hypotension, urinary retention, sedation; no effects on cardiac conduction; easy to titrate. Anxiolytic effects. All except venlafaxine available as liquids (mirtazapine as oral disintegration tablet) | Inhibit P4502D6 causing interactions with other drugs; fluoxetine has long half-life[169] | 2–4 weeks | | | | Paroxetine and sertraline better tolerated than fluoxetine; nausea, GI distress, insomnia, headache, sexual dysfunction, anorexia; | Once daily |
| Sertraline | | | | | 12.5–25 mg | 50–100 mg | 200 mg/d | | |
| Citalopram | | | | | 10 mg | 20–40 mg | 80 mg/d | | |
| Escitalopram | | | | | 10 mg | 20–40 mg | 80 mg/d | | Once daily |
| Fluoxetine | | | | | 5–10 mg | 20–40 mg | 100 mg/d | | Once daily |
| Paroxetine | | | | | 10 mg | 20–40 mg | 100 mg/d | | |
| Non-SSRIs<br>Mirtazapine | | Promotes sleep and weight gain, earlier response,[170] less sexual side effects[171] | Somnolence | | | | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Venlafaxine (selective serotonin and noradrenergic reuptake inhibitor (SNRI)) | suggest superior efficacy of SNRI (venlafaxine)[168] | Little potential for drug interactions;<br>Positive effects on pain[172] | Can raise BP at higher doses[173] | 2–3 weeks | 50–75 mg | 75–225 mg | 250 mg/d | GI distress, agitation hypertension, | |
| Wellbutrin | | | | 2–4 weeks | 75–100 mg | 200–300 mg | 300 mg/d | GI distress, agitation seizures | |
| Tricyclics | Multiple studies demonstrate efficacy in depressed medically ill pts,[174] but none are controlled | Therapeutic response often seen at low dose; Effective for treatment of neuropathic pain;[175] can be given parenterally or compounded for rectal administration; drug levels can be monitored[176]; nortriptyline available as liquid | Nortriptyline and desipramine better toleated than amitryptiline and imipramine; amitriptyline and doxepin can be used as sleep meds | 2–4 weeks | | | | Adverse effects occur in as many as 34% of cancer patients[80]; Not well tolerated in terminally ill due to anticholinergic side effects (dry mouth, delirium, constipation etc.); cardiac conduction abnormalities, orthostasis | |
| Amitriptyline | | | | | 10–25 mg | 25–100 mg | 150 mg/d | | Qhs |
| Imipramine | | | | | 10–25 mg | 25–100 mg | 150 mg/d | | Qhs |
| Doxepin | | | | | 10–25 mg | 25–100 mg | 150 mg/d | | Qhs |
| Desipramine | | | | | 10–25 mg | 25–100 mg | 150 mg/d | | Qhs |
| Nortriptyline | | | | | 10–25 mg | 25–75 mg | 125 mg/d | | qhs |

RCT, randomized controlled trial; HIV, human immunodeficiency virus; AIDS, acquired immune deficiency syndrome; SSRI, selective serotonin reuptake inhibitors; TCA, tricyclic antidepressant; BP, blood pressure; GI, gastrointestinal.

prepared for patients to need extra psychotherapeutic and psychopharmacologic support. Although some patients with major psychiatric illness may lack decision-making capacity for decisions about end-of-life care, psychiatric illness should not be viewed as a justification for ignoring or failing to elicit patients' end-of-life care wishes and values.[145] If possible, ongoing involvement and contact with the patient's mental health provider and/or community resources is helpful.

Little is known about treatments for patients with PTSD and advanced illness. "Debriefing" interventions have been widely used to treat PTSD and the psychological sequelae of traumatic events. However, a recent Cochrane review concluded that there was no basis for continuing this practice, as no improvements in psychological morbidity, depression, or anxiety were found.[146] Antidepressants, antianxiety, and antipsychotic agents are sometimes used to manage intense symptoms. Support groups and psychoeducational approaches are also often used, but evidence of their effectiveness in this setting is lacking.

Terminally ill patients with active substance abuse problems represent a significant management problem, particularly because many of them also have comorbid psychiatric illness (e.g., personality disorder, major depression). Collaboration among palliative care and mental health professionals, as well as involvement of community resources such as Alcoholics Anonymous is usually essential to successful management of these complex patients. Key management strategies include repeated assessments of pain and analgesic use, contracts, frequent follow-up, cautious drug selection, and urine toxicology as needed.[147,148] Patients with personality disorders require targeted treatment strategies.[149] Even the best strategies are frequently ineffective. Often, goals of treatment are constrained by the patient's psychopathology, and clinicians need to accept limitations on their ability to provide optimal medical treatment. All clinicians managing such patients are helped by having a team, including a mental health clinician, with whom to share the challenges and frustrations of caring for such patients, as well as a safe setting in which to reflect on the personal emotional responses evoked by the patient. While medications and psychotherapy can both be helpful, involvement of a mental health clinician is usually necessary to help identify appropriate interventions. In recent years, several randomized controlled trials have supported the benefits of dialectical behavior therapy for patients with borderline personality disorder.[150] Patients with schizophrenia and bipolar illness are best managed in collaboration with a psychiatrist to assure appropriate use of medications, as well as psychological support for the patient; other resources (e.g., community mental health programs) may also be necessary.

## CONCLUSIONS

All patients with progressive life-threatening illness require attention to psychological issues. Compassionate listening, expert assessment, and skillful intervention will reduce suffering, enhance quality of life, and create the conditions for growth at the end of life.[151] While these issues are beginning to emerge as core clinical concerns of palliative care, there is an urgent need for intervention research to better delineate optimal psychological treatment strategies for patients at the end of life.

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