Depression in advanced physical illness: diagnostic and treatment issues

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ABSTRACT

- Assessing and managing depression and other forms of psychological distress in patients with advanced physical illness (such as advanced cancer) can be complex clinical tasks.
- Assessment of distress is complicated by the contribution of the physical disease and side effects of its treatment to symptoms.
- Clinical evidence has indentified factors that increase vulnerability to experiencing distress and interventions that can improve wellbeing in patients with serious physical illness, yet there are significant gaps in current practice and challenges for health professionals in addressing the core emotional concerns of patients with advanced physical illness.
- The 2003 publication *Clinical practice guidelines for the psychosocial care of adults with cancer* provides evidence-based recommendations for providing psychosocial care.
- Implementing existing guidelines, including systematic assessment of risk and adapting interventions to reflect the precise needs of patients, requires strategies to help clinicians in the emotional dimensions of this caring role.

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Depression in patients with serious physical illness is common, with up to 35% of patients with cancer experiencing clinically significant distress.[1] Diagnosing depression requires consideration of the interacting biological consequences of illness and treatments on mood, behaviour and cognition, and the specific psychological and social impact of the disease.[2] However, rates of detection of depression among inpatients in internal medicine units are low.[3] Australian studies have found that oncologists identified only 17% of clinically anxious and 6% of clinically depressed patients;[4] 75% of patients with clinically significant anxiety or depression do not receive any counselling or psychological treatment.[5]

Clearly, clinical assessment is difficult in patients with poor prognoses and a high symptom burden. This is compounded by patients' reluctance to discuss their emotional concerns because they (and sometimes their clinicians) believe that distress is inevitable and little can be done to help.[6] Another problem may be that doctors find it difficult to respond to non-verbal cues from patients with cancer.[7] When faced with patients with poor prognoses, doctors may avoid discussing emotional issues as a means of protecting themselves from exposure to the distress of their patients.[6]

In this article, we draw on evidence-based guidelines and case examples with the aim of providing practical strategies to help health professionals better identify and respond to depression and distress in patients with advanced physical illness. We focus on the interactions of the patient with health professionals and their clinical context, rather than pharmacological treatments.

Guidelines for improving psychosocial care

There are clear benefits of psychosocial interventions to promote wellbeing in patients with advanced physical illness,[8] and some evidence that interventions may prevent the development of disorders such as major depression.[9] The 2003 publication *Clinical practice guidelines for the psychosocial care of adults with cancer* provides an algorithm and evidence-based recommendations for the provision of psychosocial care.[10] Similarly, the National Cancer Control Network (NCCN) has developed an algorithm including a distress thermometer, on which the patient indicates their distress level on a linear scale, listing specific sources of distress to help in determining treatment options.[11]

While all patients require appropriate information and good communication, only a minority require highly specialised interventions. Applying a tiered model of care, in which patients receive care tailored to their unique needs rather than a generic intervention, represents an efficient use of resources.[12] Hence, it is useful to identify patients at increased risk of experiencing depression or other forms of distress, and to have a structured approach to diagnosis and design of appropriate treatment.

Identification of risk factors

A number of risk factors for development of depression have been identified (Box).

The National Breast and Ovarian Cancer Centre has developed a structured checklist of these factors, supported by explanatory notes and suggested prompts to promote a systematic approach to the assessment of risk.[13]

Diagnosis of psychological disorder

Symptoms such as disturbed sleep, or reduced appetite or energy are less helpful in diagnosing depression in medically ill patients, so attention to the quality and severity of mood disturbance is essential. Pervasively impaired capacity for pleasure is typical of depression, as are feelings of guilt, worthlessness, helplessness and hopelessness. The sense of being oppressed and unable to function normally can be captured by asking patients to articulate their experience with questions like: "Does this feel like you?" Patients who are depressed almost invariably confirm their sense of being different from their normal selves, and unable to restore their usual attitudes and coping, despite their best efforts. In addition, use of assessment tools adapted for medically ill patients will help in recognising those with major depressive disorders who require specific interventions.[14]

Recognition of individual concerns

A broad approach to assessment of distress helps focus on core concepts of importance to the individual, such as helplessness and the preservation of dignity,[15] rather than simply focusing on the diagnosis of disorder. Australian research has identified three types of symptoms of distress and depression: anhedonia (an inability to

Factors associated with increased risk of psychosocial distress

Patient characteristics	Disease-related factors
• Younger age (< 55 years) • Single, separated, divorced, widowed • Living alone • Children younger than 21 years • Economic adversity • Lack of social support, perceived poor social support • Poor marital or family functioning • History of psychiatric problems • Cumulative stressful life events • History of alcohol or substance misuse • Being female	• Times of diagnosis and recurrence • During advanced stage of disease • Poorer prognosis • More treatment side effects • Greater functional impairment and disease burden • Experiencing lymphoedema • Experiencing chronic pain • Fatigue

Adapted from *Clinical practice guidelines for the psychosocial care of adults with cancer.*[10] Reproduced with permission.

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feel pleasure); grief (a sense of loss); and demoralisation (a loss of morale).[16] Addressing these themes in therapy is likely to be helpful for patients.

Flexible approaches to treatment

Brief targeted therapy for medically ill patients who are experiencing demoralisation has been described,[17] and could be delivered by general health professionals in primary care services, or in specialist medical settings. Patients are likely to value psychosocial care that is integrated more fully into clinical care, as evidenced by high levels of acceptability of supportive psychological interventions provided by a breast cancer nurse.[18]

Clinical challenges

Effective treatment for depression and distress involves practitioners becoming emotionally engaged with patients, and this can be emotionally challenging if practitioners feel ill-prepared for this role.[19] The following case vignettes highlight the importance of considering the interpersonal issues for patients and their families, and the interaction of these with health professionals in the treatment setting.

"Imogen"

Imogen was a single 25-year-old woman with a chronic severe autoimmune disorder. She was admitted to hospital with decline in her level of functioning and self-care. Over 2 years, she had experienced life-threatening complications of her disease, including iatrogenic complications. As her pain increased, she had become less motivated and had eventually lost her job, leading to profound social isolation. She was dependent on her parents, who felt unsupported and frustrated by Imogen's "lack of interest"; this, in turn, was leading to marital strain. Imogen's prognosis was poor, but there had been limited discussion of this with Imogen and her parents. Clinicians were frustrated by Imogen's apparent lack of motivation, demonstrated in their sometimes critical responses: "She doesn't even try to do anything for herself!"

Interpersonal context: The care of a young patient with chronic and terminal illness presents a number of challenges. The distressing nature of such conditions in a young person, and confrontation with iatrogenic complications caused discomfort in the health professionals involved. Furthermore, the patient's withdrawal and poor adherence to treatment recommendations engendered feelings of frustration and therapeutic hopelessness, making it difficult for staff to express empathy and concern. Imogen's response to perceived disinterest or criticism was to withdraw further, compounding her distress and perpetuating the cycle of hopelessness and frustration.

Imogen's symptoms were indicative of major depression, compounded by both progressive physical debilitation producing marked fatigue, and the effect of immunosuppressive treatments. Understanding her longstanding response to her condition (withdrawal from others, with evident demoralisation and anger) was essential in developing a comprehensive approach to treatment.

Responding to Imogen: A key component of treatment (in addition to antidepressant medication) was understanding Imogen's perceptions and experiences of her illness. A major theme was her concern and guilt about the burden her disease represented to her family. As is common for patients with severe illness, Imogen was fearful that, as her dependency increased, those on whom she relied (including clinicians) would withdraw or become overwhelmed. This unspoken fear eroded her ability to motivate herself, leading to negative interactions with her parents and health professionals. Strategies to increase her control over key decisions were introduced, along with opportunities to discuss her experience of her illness, while greater support was offered to the family. It was valuable for clinicians to understand Imogen's responses, and to be aware of the effects of their own helplessness and frustration, which had coloured their initial assessment. Despite the obviously distressing nature of discussions about prognosis, Imogen and her parents felt relief to be able to speak more openly.

"Stephen"

Stephen was a 53-year-old married man recently diagnosed with cerebral metastases from lung cancer. His wife, Erica, was angry about a perceived delay in diagnosis and was irritable and demanding with staff. Stephen was reluctant to discuss his prognosis, insisting that things would be OK, but seemed withdrawn and was sleeping poorly. He had adult children from a previous marriage who lived interstate, but did not want to discuss his diagnosis with them. Erica was concerned about finances and wanted Stephen to access his superannuation, which he insisted was unnecessary.

Interpersonal context: Erica was resentful, feeling that she was being "short-changed" as they had only recently married. She felt powerless and isolated, and was angry with Stephen about his previous smoking. Erica's frustration and irritability spilled over into interactions with staff, whom she criticised over apparently trivial matters. Stephen felt confused and exhausted, and could not cope with Erica's anger. His avoidance was an apparent effort to protect his family from confronting the grief and pain of the current situation, exacerbated by guilt that Erica was right about his smoking. Accessing funds from his superannuation would mean acknowledging the gravity of the situation and refusing to do this protected him from confronting the enormity of his situation. His depressed mood related to the burden of trying to deal with things on his own.

Responding to Stephen: A short delay in diagnosis is unlikely to have adversely affected Stephen's prognosis, but challenging Erica about this would probably increase her anger and sense of isolation. Erica needed acknowledgement of the pain and grief the diagnosis caused, and of the unfairness of this in terms of their recent marriage, and of the incongruity in view of his relatively young age. Openly stating that the situation would make anyone frustrated and angry can help irritable relatives feel understood, and diminish the intensity of their responses. Avoidance and denial by the patient should not automatically be challenged; however, in this case, they were leading to tension in the marriage and financial hardship, so needed to be addressed. Being generous, and appealing to his concern for his family, helped Stephen to be more open: "Stephen, I can see how much you care about Erica and your family, and how you want to protect them from distress. But it must be hard for you if you feel you can't talk with them about how things really are."

Discussion

A substantial barrier to implementing evidence-based psychosocial interventions is the personal challenge clinicians face in caring for seriously ill patients — confronting suffering, debilitation and death, the sense of hopelessness and futility, or frustration and anger about the limitations of treatments. Although guidelines provide evidence-based recommendations about assessing and treating psychological distress and disorder, and communication about end-of life issues,[10,20] it is clear that the dynamics of the clinical interaction in the care of a severely ill patient also need to be addressed.[21]

Exploring patients' distress is a fundamental ingredient in assessing the common forms of psychological disorder in this population of patients with advanced physical illness, and necessitates engaging with patients at an emotional level. In addition to the process of "being with" the person, a crucial component of care for depressed patients with medical illness is a comprehensive approach to assessment, and an understanding of the nature and impact of physical symptoms, including side effects of any treatment for the medical condition.[16] Furthermore, recognition of distress among family members is fundamental, given the high levels of distress among key family members and carers.[22] Reducing the distress of family members may have a significant beneficial impact on the patient.

Health professionals lack confidence about raising difficult discussions, and worry about saying the "wrong thing".[19] However, there is evidence that clinicians' responses powerfully affect adjustment by patients to their disease.[21] Australian research indicates a close association between clinician factors and the distress of terminally ill patients, suggesting the potential benefits to patients of improved support from their clinicians.[23] Initiatives have been undertaken to enhance the confidence of health professionals in their supportive care role.[24,25] Education that includes reflective and clinical problem-solving exercises can help with translation of knowledge into a clinical context, and enhance understanding of the personal impact.[25] Another strategy has involved clinical case review for general practitioners, focusing on assessment and responses to the psychological needs of patients with advanced physical illness, including the impact on the clinician of providing care for such patients.[24]

The structure of health care systems is another important aspect of the clinical context. A system of care that supports continuity of care across general and specialist systems, and provides for longer-term clinician involvement, will be better able to support tiered approaches to providing the full range of psychosocial interventions recommended in current clinical guidelines, including development of models of care applicable to rural and remote districts where there is limited access to specialist services.

Competing interests

None identified.

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