

## 3.3 Depression

### Key Points

1. Depression is common at Life's End.

While depression is common, it is not universal at Life's End. Sadness is common but, unlike depression, sadness is not overwhelming, continuous, and pervasive. If the sadness a patient experiences is interfering with other important activities, it is probably depression.

2. Depression is often best diagnosed by asking people if they are depressed.

Somatic symptoms like fatigue, appetite, and change in sleeping patterns cannot be used to diagnosis depression because they are present from other physical causes. Asking people directly to report if they are depressed is the most effective screening tool.

3. Anhedonia often accompanies depression.

Anhedonia is the inability to experience pleasure. Even people at Life's End should be able to identify things, like family or friends, which still bring pleasure to their lives.

4. Uncontrolled physical and social suffering worsens depression.

Good control of physical symptoms, especially pain and dyspnea, and social support in the residential setting at Life's End may help relieve depression.

5. Depression may respond to treatments like Selective Serotonin Reuptake Inhibitor (SSRI) and psychotherapy in the last months of life.

Patients who have a better functional status may respond to SSRI in the last few months of life.

6. Depression may respond to treatment with psycho-stimulants in the last weeks or days of life.

Methylphenidate (Ritalin) may be effective in treating depression within a few days of starting the medication. This might be helpful in the last few days of life or while waiting for an SSRI to work.

# Depression



## The Palliative Response

### Depression Is Common at Life's End

- Clinical depression is never “appropriate”
- Some surveys report depression in up to 50% of palliative care patients
- Unrecognized and untreated depression causes substantial suffering at Life's End

### Depression Can Be Diagnosed at Life's End

- Patients are often able to self-report if they are depressed
- Asking a patient “Are you depressed?” is a good screening test for depression
- Persons who say they are depressed probably are

### Somatic Symptoms

Somatic symptoms are poor indicators of clinical depression because they can almost always have other causes.

- Fatigue
- Weakness
- Change in sleep patterns
- Change or decrease appetite and weight loss
- Constipation

### Anhedonia

Marker for Depression

- Anhedonia  
(inability to experience pleasure)
- Can be a marker for depression regardless of whether the patient self-reports depression
  - A patient who cannot stand the sight of grandchildren, previously the light of his/her life, is depressed

### Suicide and Assisted Suicide

- Requests for assisted dying
- Depression is a factor in requests for assisted dying

Suicide assessment and prevention

- “Have you thought of suicide?”
- “Do you have a plan?”
- “Will you contract with me that you will not kill yourself?”

## Addressing Depression

Increase the capacity  
to bear suffering

- Good pain and symptom control  
*Uncontrolled pain or other symptoms contribute greatly to depression*
- Assist to maintain independence and Activities of Daily Life
- Social support  
*Home hospice*  
*Encourage increased contact to maintain ties*

## Treating Depression

Antidepressants

Serotonin re-uptake inhibitors

- A mainstay for treatment of depression in palliative care
- Be aware of side effects such as anorexia
- Use in patients whose prognosis offers time for the treatment to be effective (2 to 6 months and functional status)

*New atypical antidepressant holds promise*

## Treating Depression

Psychotherapy

- Formal psychotherapy is not commonly used in the palliative care/hospice setting
- Supportive counseling, listening, and attending to concerns can help support patients and families and increase the capacity to bear suffering
- Psychotherapy may be more directive and focused on problem-solving

## Treating Depression

Psychostimulants

- Sometimes helpful in the last few weeks or days of life when depression is a major contributor to suffering
- If effective, will usually help within a few days rather than weeks-to-months
- May be helpful in conjunction with SSRI to treat symptoms quickly while awaiting the effect of the SSRI

## Psychostimulants

Methylphenidate (Ritalin)

- Begin with 2.5–5mg at breakfast and lunch
- Titrate to effective dose at 5–15mg am and lunch
- Observe for adverse effects  
*Anxiety*  
*Insomnia*  
*Agitation*

## Depression

The Palliative Response

Unrecognized and untreated depression causes substantial suffering at Life's End.

Screen for it.  
Recognize it.  
Treat it.

*Clinical depression is never "appropriate."*

# Depression

## Selected Readings

### Overview

Barracough, J. “ABC of Palliative Care: Depression, Anxiety, and Confusion.” *British Medical Journal* 315 (1997): 1365–1368.

Massie, M. J. and D. K. Payne. “Depression and Anxiety.” In: *Principles and Practice of Supportive Oncology* edited by A. M. Berger, R. K. Portenoy, and D. E. Weissman. New York: Lipincott Williams & Wilkins Healthcare, 3 (2000): 1–11.

### Screening for Depression

Lloyd-Williams, M. “Is It Appropriate to Screen Palliative Care Patients for Depression?” *American Journal of Hospice and Palliative Care* 19 (2002): 112–114.

### Medical Treatment

Homsí, J., D. A. Nelson, N. Sarhill, L. Rybicki, S. B. LeGrand, M. P. Davis, and D. Walsh. “A Phase II Study of Methylphenidate for Depression in Advanced Cancer.” *American Journal of Hospice and Palliative Care* 16 (2001): 403–407.

Pereira, J. and E. Bruera. “Depression with Psychomotor Retardation: Diagnostic Challenges and the Use of Psychostimulants.” *Journal of Palliative Medicine* 4 (2001): 15–21.

Schwartz, L., M. Lander, and H. M. Chochinov. “Current Management of Depression in Cancer Patients.” *Oncology* 16 (2002): 1102–1115.