Providing good quality terminal care is what we would want for ourselves, our loved ones and our patients. Good psychological care must go hand in hand with good physical care. Psychiatric issues in terminal care are challenging; however, involvement in them is highly rewarding and generally a positive experience. This module described how psychiatric issues can affect terminal care, illustrating the most common psychiatric presentations in terminally ill patients and showing how to tailor management strategies to these conditions. The module also looked at prescribing issues that can crop up in treating terminally ill patients as well as the psychodynamic and psychological processes common in terminal illness care in patients and carers.

Sociodemographic changes and settings for terminal care

- People are, on average, living longer. There is a proportionate increase in the number of the elderly, often with complex physical comorbidity and social isolation. Most people say that they would wish to die in their home but in reality the majority die in a hospital.

- The Hospice concept originated through the work of Cicely Saunders. Early hospices in the UK were run by religious charities. More recently, palliative and terminal care has moved back into community focused services.

- There is increased awareness and involvement with a wider range of disease problems than just cancer, such as motor neurone disease and multiple sclerosis. Palliative care and terminal illness services have been keen to consider psychiatric aspects of their patients.

- A controversial school of thought considers certain psychiatric diseases as terminal conditions, such as dementia, severe eating disorders, depression, psychotic conditions and bipolar disorder which lead to suicide, and borderline personality disorder.

Psychiatric diagnoses – prevalence, aetiology and recognition

- Depression is no more common in the terminally ill than in the seriously chronically ill but can be difficult to differentiate from adjustment and other conditions.

- Delirium is much more prevalent in the terminally ill and is often missed because it can mimic depression, dementia and anxiety states.

- Adjustment reactions to the diagnosis of terminal illness are universal, self-limiting and associated with the stages of grief. The challenge exists for the clinician in distinguishing adjustment from depression and in deciding whether antidepressants are appropriate.

- Anxiety disorders in the terminally ill present in a similar way to those in the general population. They present with a combination of somatic and cognitive symptoms and are commonly comorbid with depression. Anxiety may be related to organic factors and medication.

- Dementia poses particular problems including: how to communicate information to allow truly informed choices, appreciation by clinicians of the success or not of palliative strategies, increased vulnerability to delirium, and behavioural disturbance.

- Specific rating scales exist to assist in diagnosis and measurement of symptom intensity.

Management strategies

- Reasonable attempts should always be made to optimise a patient’s physical state.

- Psychotropic medication is useful but should be thoughtfully prescribed.
• Electroconvulsive therapy (ECT) can be used.

• The best psychotherapy is supportive listening. Blanket counselling of cancer patients has no positive effect and can be harmful.

• Quality of life can be enhanced by improvement in practical issues to do with finance, housing, the reparation of relationships and preparation for death.

• Spirituality and religious issues should be explored if appropriate to the patient.

Psychopharmacology

• Antidepressants are effective but need careful choice to match the patient’s physical state and symptoms. Diazepam must be used with care owing to the build up of its metabolites – lorazepam is better for rapid tranquillisation in combination with haloperidol.

• Palliative care physicians are comfortable using antipsychotics as they use them commonly as antiemetics and they are familiar with delirium. Antipsychotics work for all sorts of delirium, not only as sedatives but also to reduce the length of the delirium. There is little advantage in atypical over typical antipsychotics in this regard. Palliative care physicians are familiar with the neuropathic analgesic actions of amitryptiline and lorazepam and anticonvulsants.

• Psychostimulants have an important place in relieving depression and can be safely used.

Some particular medical prescribing issues

• Pain relief is delivered using an analgesic ladder with opiates above non-steroidal inflammatory agents. Corticosteroids have important uses and side effects.

Psychodynamic and psychological processes

• Denial and shock, anger, bargaining, depression and acceptance are classic stages of adjustment to a terminal diagnosis.

• Freudian defence mechanisms can have positive and negative effects on patient and staff well-being.

• Spirituality and religious views are important.

Further reading


