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SOME NOTES ON TREATING DEPRESSION AND ANXIETY IN THE SERIOUSLY ILL

Use tact and timing in delivering the diagnosis and prognosis for patients with serious illnesses to help prevent depression and anxiety. Some suggested approaches include:

Speak with clear, honest directness without fearing the truth.

Listen and watch for the patient's reaction.

Respect the patient's style of coping, as well as their own strength and ability to deal with adversity (Zerbe, 1999a, p. 209).

Honestly acknowledge that nothing is known with 100% certainty in medicine. "Anyone who has practiced medicine very long has seen surprising outcomes."

Help the patient "prepare for the worst and hope for the best." Reassure the patient that you will be with them; this is an acknowledgment of your commitment to them as a human being and to the fact that you provide twenty-four-hour-a-day medical coverage through your practice or clinic. Your reassurance will not be misinterpreted as a promise to personally remain in day and night personal attendance. "Most fundamentally, clinicians can serve the dying person by being present"
(Byock, 1996, p. 250)

Empathize when appropriate. Remember, the patient's talking and the clinician's listening has been repeatedly documented to be associated with more functional and meaningful days, less pain, fewer physical symptoms, less depression and anxiety, and even longer life (Spiegel, 1993, 1999; Spiegel et al., 1989).

Tolerate whatever feelings of helplessness or loss you may have without needing to take abrupt or definitive action (Hamilton, 1996; Hamilton & Hamilton, 1999).

Always remember that simply listening and understanding is a clinical action.

Respect and encourage the patient's healthy defenses. The most healthy defenses (Vaillant and Vaillant, 1990; Soldz and Vaillant, 1998) are: suppression, sublimation, humor, altruism, and anticipation.

Suppression is the ability to recall and focus on adversity while also being able to set it aside temporarily to attend on other things (i.e.. sources of satisfaction, meaning, joy, and love). Suppression is more adaptive than other forms of putting something out of mind, because it is more flexible and does not deny reality.

Denial is the sweeping, emergency psychological defense of recognizing a fact while simultaneously denying its very existence. "I do not have this cancer and I am not going to die from it."

Repression does not deny the existence of something but unconsciously and automatically relegates it to the realm of the forgotten. "I can't remember our ever talking about the likely outcome of this illness." Suppression is the healthy setting aside of difficulty in order to get on with life. "Yes, my daughter and I have talked about the fact that I may not be with her very much longer, and we have shed our tears and will again. But I am not there yet. For now, we would rather talk about how my granddaughter is doing at her figure skating. Did I tell you she ... "

Supportive psychotherapy is not confined to the offices of psychiatrists; it is a common, if often unnoticed part of everyday clinical practice. It encourages healthy defenses (Gabbard, 1994), such as suppression, humor, anticipation (realistic, hopeful planning for the future), sublimation (work, creative activity, spiritual endeavors), and altruism (helping others), while helping patients overcome anxieties and fears which may lead to maladaptive defenses.

Support and, when appropriate, encourage religious devotion. While it should not be imposed, clinicians should recognize that religious devotion has been empirically demonstrated to be associated with improved recovery from depression and with numerous other health benefits (Koening et al, 1998. Mitka, 1998).

Encourage self-help efforts in the areas of healthy behaviors (Zerbe, 1999b). Many of these behaviors are the very ones people find difficult to do when they are depressed, anxious, or medically ill. It is best to refrain from admonishing the patient to do these things; just remind them that if they can bring themselves to do these things, they are likely to help.

Some behaviors which clinical experience has shown to help include: Eating regular, small, healthy meals whether or not you are hungry. Going to bed and getting up at the same time daily whether you sleep well or not. Light, regular exercising, such as walking, or even physical therapy for those restricted to bed. Working, even a very reduced amount. Engaging in social activities, even if they are superficial and brief. Pursuing creative activities such as painting, drawing, writing, crafts or hobbies. Engaging in prayer or organized religious services. And helping others, even if only through a telephone call or word of encouragement.

When helping a patient look for meaningful interests and activities as they adjust to diminished capacities, consider looking at their previous interests with an eye to changing their scale in time and space. A potted plant can be as beautiful as a terraced garden. An inspired moment can provide a window to eternity. A still, small moment can make all the difference. Ask your patient for what they have discovered. What have they learned to find meaningful in their new circumstances? What goals have they set for themselves in considering their new limitation of physical ability and perhaps of time?

A diagnostic evaluation is the foundation for good treatment. Consider depression or anxiety early and often. Treatable depression and anxiety of clinical relevance is dramatically under

diagnosed in the elderly and medically ill (Lebowitz et al., 1997). Consider despondency or anxiousness symptoms requiring diagnosis, as you would with a non-medically ill person.

While common, depression and anxiety are not inevitable concomitants of serious illness. Many patients adjust to this life circumstance while finding hope and meaning to the last moment. And many patients who temporarily lose hope regain it when their anxiety or depression lifts (Chochinov et al., 1999). Take a thorough history of the symptoms including onset and course of illness, concomitant symptoms, previous episodes of similar symptoms, family history, history of alcohol or drug abuse, and physical illnesses or medicines which can cause psychiatric symptoms. Take a history of current and past losses and the patient's reactions to those losses, including their successful coping strategies. Obtain appropriate laboratory studies, including complete blood count, chemistry screen, and thyroid profile, as well as other appropriate tests.

When symptoms of depression or anxiety might be caused either by psychiatric illness or physical illness or its treatment, make both diagnoses. An either/or approach to diagnosing physical or psychiatric illness can lead to overlooking important diagnoses of therapeutic relevance. When in doubt about whether you are treating an anxiety disorder or a mood disorder with anxiety as one of its symptoms, error on the side of placing mood disorder ahead of anxiety disorder in your differential diagnosis. Anxiety is often a symptom of depression. Inquire about suicidal ideation or feelings and take any such symptoms seriously. These symptoms should be diagnosed and treated in seriously ill individuals with the same care that they are addressed in other individuals. Do not hesitate to obtain psychiatric consultation about diagnosis even if you intend to treat the patient yourself. Most patients experience referral for psychiatric consultation a sign of competent and thorough medical care.

Treatment takes place within a confidant and compassionate doctor-patient relationship (Hamilton, 1996; Hamilton et al., 1998). Consider the patient's depression or anxiety disorder within an overarching biopsychosocialspiritual model of human functioning to avoid overlooking important areas of treatment. Reassure your patient that treatment is likely to be helpful. The triad of "empathy, psychotherapy, and medication" can usually alleviate even the most serious symptoms of depression and anxiety, such as the wish to die (Hendin, 1998, p. 158).

Most primary care clinicians prefer to begin treatment with careful listening and empathy combined with psychotropic medication, because of time considerations and their training. Only a few minutes of respectful and careful listening by the doctor, nurse, or social worker can help the patient feel valued and cared about enough to alleviate their depression or anxiety to a significant extent. Caring about the patient and valuing them as a human being can have a beneficial effect in itself (Hamilton et al., 1998; Zerbe, 1999b). When social factors such as family discord, social isolation or economic distress complicate the treatment, attend to these difficulties with as much vigor as to physical causes of distress.

When necessary, obtain consultation and assistance from experts in this area. When in doubt as to whether symptoms arise from physical illness or medication or from primary depression or anxiety, most clinicians treat both the psychiatric disturbance and the potential physical causes simultaneously. When in doubt as to whether the primary diagnosis is of a depressive disorder or an anxiety disorder, most clinicians prefer to begin a trial of treating the depression, since

antidepressants can alleviate many kinds of anxiety disorders, but some treatments of anxiety (such as higher doses of benzodiazepines over an extended period of time) can at times exacerbate depression.

When using antidepressants or antianxiety medications, pay careful attention to potential dangerous interactions with other medications in these medically vulnerable patients. Pay careful attention to any side effects. If a new symptom arises shortly after beginning a new psychotropic medication in a medically ill patient, it may be best to consider the new symptom to be caused by the medication, instead of attributing that symptom to physical illness which may also cause such symptoms. There are enough available antidepressants with differing side effects that there should be low tolerance for uncomfortable side effects. Most depressions or anxiety disorders rapidly respond to listening, empathy and medication. If the patient is not improving in six weeks, or if the patient is getting worse, do not hesitate to refer to a psychiatrist for re- evaluation and possible combined pharmacotherapy and psychotherapy.

Remember the caregiver. Caregivers can be the key to the well being of the patient, yet they often feel neglected (McSkimming et al., 1999). Maintaining hope in the caregiver can be as crucial to the caregiver as it is for the patient (Zerbe, 1999b).

Take care of yourself. Remember that discouragement and anxiety are to some extent contagious. When faced with discouraged or anxious feelings about a depressed or anxious patient, consider the possibility that the patient may have communicated with you in such a way that you have empathized with and identified with their plight. Such feelings can be used in the service of empathic understanding (Hamilton, 1996). If you are tempted to base decisions or take action on feelings of discouragement or anxiety instead of containing (Hamilton, 1996; Hamilton and Hamilton, 1999) those feelings and using them clinically to help the patient improve, seek consultation with a trusted colleague and postpone decision making until you can regain your clinical balance.

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