The Clinical Approach to Suicidality and Dignity at End-of-Life

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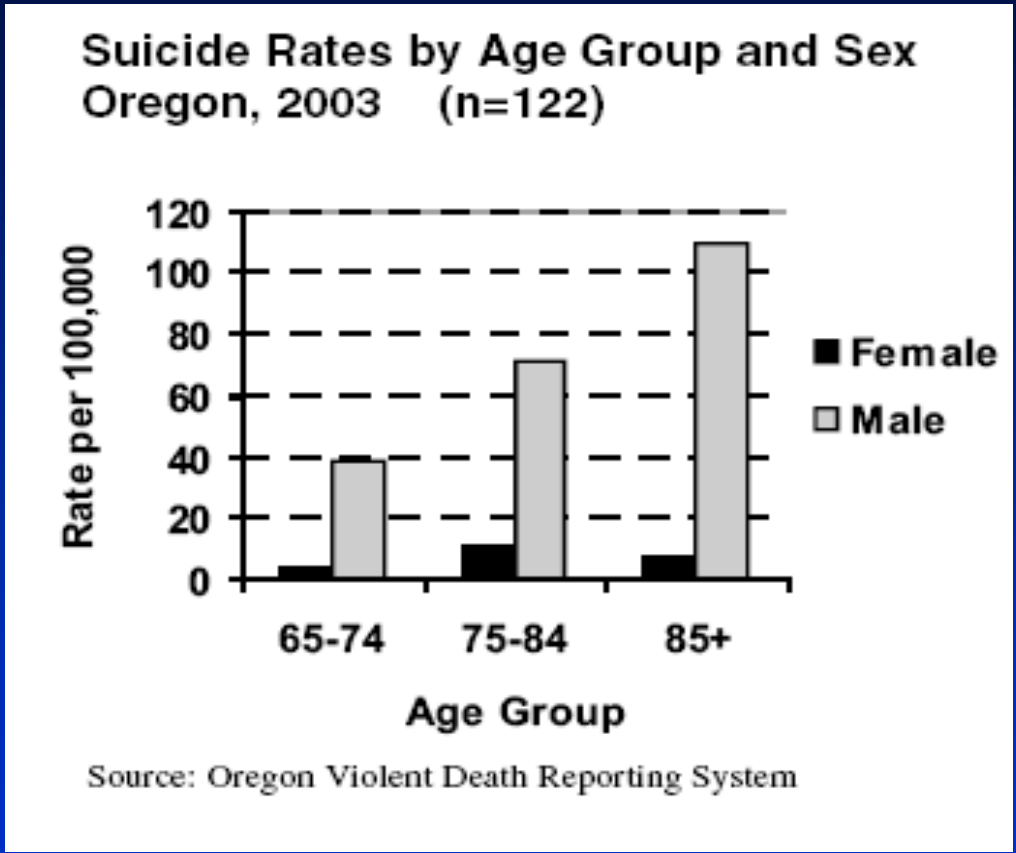
High Rates of Suicide

2003: Oregon has one of the highest rates of suicide in the elderly in the nation

Firearms were the lethal means to 80% of suicide deaths among elderly Oregonians.

Other mechanisms included suffocation, poisoning, and multiple mechanisms.



What happens when someone asks you about Assisted Suicide

- Don't avoid this conversation
  - If we respond by avoidance, this can be interpreted as rejection
  - Failure to hear a "cry for help"
  - Need to ask "Why?"
- They may just be curious
- May indicate a clinical depression

Late-Life Depression is often unrecognized, undiagnosed, and left untreated

- 5% of community (age > 65)
- Nursing home residents
  - Depressive Symptoms: 30% - 50%
  - Major Depression: 15% - 38%
  - Dysphoria is common at admission
  - Incidence is very high (15-30% each year)
  - Depression increases risk of death

NIH Consensus Development Panel on Depression in Late Life

Late-Life Depression:
Why is it so challenging for us ?

What makes depression in the elderly so insidious is that neither the victim nor the health care provider may recognize its symptoms in the context of the multiple physical problems of many elderly people.

NIH Consensus Development Panel on Depression in Late Life

We Don’t Diagnose Geriatric Depression

- Old people are depressed
- The nursing homes are depressing
- Sick people should be depressed
- Somatic complaints
- Lost in the biomedical issues
- Apathy is not bothersome for caregivers

Defining Depression (DSM-IV)

1. Two or more weeks of depressed mood or interest
2. Four of eight other symptoms: *SIGECAPS*
   - **S***leep increase/decrease*
   - **I***nterest pleasurable activities diminished*
   - **G***uilt, low self esteem*
   - **E***nergy poor*
   - **C***oncentration poor*
   - **A***ppetite increase/decrease*
   - **P***sychomotor agitation or retardation*
   - **S***uicidal ideation*

Geriatric Depression may be different

Symptom	Adult Presentation	Geriatric Presentation
Mood	Depressed Anhedonic Suicidal thoughts	Weary, Hopeless, Angry Anxious Thoughts of death
Somatic	↑↓ Sleep ↑↓ Appetite ↑↓ Psychomotor ↑↓ Pain	↑ Pain Somatic symptoms Co-morbid disease
Cognitive	↓ Concentration Indecisiveness	↓ Attention ↓ Working memory ↓ Processing Speed ↓ Executive Function

Geriatric Depression

- 80% improve with appropriate Rx treatment
- 50% are inadequately treated (< 6 months)
- Compliance (as high as 70%)
- For mild to moderate depression
  - Psychotherapy is equivalent to pharmacotherapy, and both are superior to no treatment or usual care
  - Combination treatment (psychotherapy & pharmacotherapy) is superior to either alone

Depression and Stroke

- 20-40% of post-stroke patients suffer from depression
- More than 40% experience depression within first month
- Has a negative impact on recovery
- Increases mortality (70% higher)
- Meta-analysis: SSRI, TCA, MAO inhibitors effective
  - Only 9 studies, SSRI showed significant improvement
  - Significant dropouts using TCA
  - Important to have long-term treatment

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Bhogal et al. JAGS. 2005 53:1-51-57

Bereavement

- 800,000 new widows (widowers) each year
- Most exhibit varying degrees of symptoms
- Most benefit from self-help / group support
- 30% meet criteria for major depression in the first month after the death, about half of those are still depressed at one year.

Medications for Depression

Drug	Dose	Usual	Side effects
Fluoxetine	10-60	20	Strong inhibitor of CYP2D6, CYP3A3/4; morning dosing
Sertraline	25-150	75	Diarrhea
Paroxetine	10-40	20	Strong CYP2D6 inhibition; nausea, anticholinergic effects, weight gain
Citalopram	10-40	20	Activating; morning dosing
Escitalopram	10-20	10	Activating; morning dosing
Bupropion	100-300	150	Weight loss, lowers seizure threshold
Venlafaxine	37.5-225	112.5	Initial nausea; 1% to 3% risk of elevated blood pressure
Mirtazapine	7.5-45	22.5	Sedation, weight gain
Tricyclic (nortriptyline or desipramine)	10-125	50	Anticholinergic effects (cardiac, GI, GU, orthostasis), sedation, weight gain

Antidepressants to Avoid

- Amitryptiline
- Doxepin
- Clomipramine
- Imipramine

Tertiary Amine Tricyclics.

- MAO Inhibitors

Pharmacotherapy of Late-Life Depression

- 80% improve on medication
- Drug interaction (P-450 system)
  - CYP2D6 mediates the metabolism of antiarrhythmic agents, antipsychotics, beta-blockers, TCAs, codeine
    - Inhibited by fluoxetine, and paroxetine.
  - CYP3A3/4 metabolizes calcium channel blockers, carbamazepine, pimozide, alprazolam.
    - Inhibited by fluoxetine and nefazodone.

Medication Therapy

- Treatment should be maintained for at least 6 months after remission of a first episode of major depression.
- Treatment should be maintained for at least 12 months after remission of a second or third episode of major depression.

Remember

- Not everything needs to be treated with medication
- Start at a low dose and titrate slowly
- Not everything needs to be treated with medication

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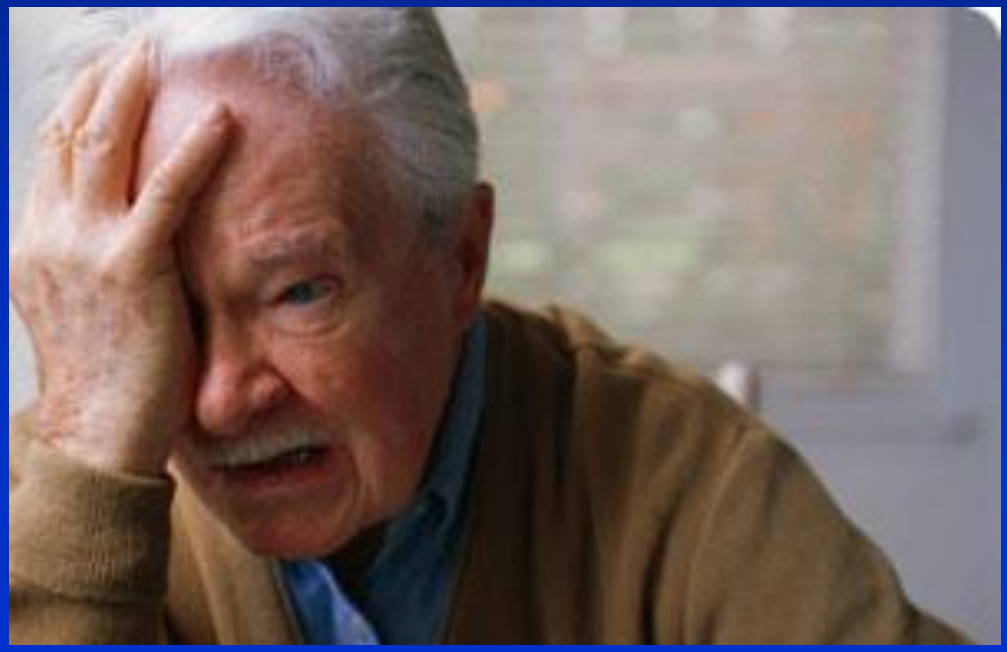
Severe Geriatric Depression

- Pharmacotherapy and combination therapy is superior to psychotherapy alone for more severe depression
- Electroconvulsive therapy is effective, but is typically reserved for patients who have not responded to pharmacologic interventions

When to Refer to the Psychiatrist

- Severe depression (weight loss or malnutrition)
- Severe depression with high suicide potential
- Failed trial(s) of antidepressant
- Psychotic Features



Suicide prevention

- Move severely depressed to a location where they can be monitored
- Monitor suicidal ideation – ask
- If suicidal plan, hospitalize
- Ensure they are not stockpiling medication
- Weapons out of the home

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Dementia vs. Depression

- Dementia can be an initial manifestation of a clinical depression
- Dementia can be associated with severe depression
- Depression that causes dementia is often associate with psychomotor retardation
- This type of dementia has abrupt onset
- You can have both dementia and depression

Depression vs. Dementia

- 30-40% of patients with dementia will have significant depression at some point
- High rates of depression in Parkinson's
- Misdiagnosis of dementia as depression
  - Failure to assess cognitive functioning
- NEED early diagnosis of dementia
  - Allows for specific therapy
  - Allows the family time to explore resources

Pseudo-Dementia

- Some sharp or compulsive persons notice a normal slipping with age
  - Slowed recall of new data
  - Problems with word-finding, misplacing things
  - Not interfere with normal daily functioning
  - Can be pre-occupied with this
  - No complaints from others
  - Younger patients
  - Difficult distinction (may need testing)

Depression vs. Dementia

Characteristic	Depression	Dementia
Mental Status	Able to follow directions, may refuse. "I don't know"	Worsens as disease progresses, frequent confabulation
Onset	Rapid onset, weeks to months	Insidious and gradual
Course	Self-limited, recurrent, often has periods of improvement	Slow and continuous
Affect	History of pervasive sadness	Depression follows decline, labile
Behavior	Apathetic, fatigued, complains	Agitated, aggressive, or apathetic. family more concerned than patient
Sleep	Early morning awakening, excessive sleep or insomnia	Normal early, later repeated awakenings and day to night reversal
Memory	Impairment inconsistent	Short-term memory loss early
Attention	Problems concentrating	Generally intact
Perception	Intact unless severe	Misperception, events are threatening
History	Previous psychiatric history	Psychiatric history less common

Dementia Definition

- Multiple cognitive deficits:
  - Memory dysfunction (especially new learning)
  - At least one additional cognitive deficit (aphasia, apraxia, agnosia, or executive dysfunction)
- Disturbances are sufficiently severe to cause impairment of occupational or social functioning
- Course shows gradual onset and decline
- Not due to other CNS conditions or substances
- Do not occur exclusively during delirium
- Not due to another psychiatric disorder

Diagnostic Criteria For Dementia Of The Alzheimer Type (DSM-IV, APA, 1994)

Differential Diagnosis: Top Ten

(mnemonic device: AVDEMENTIA)

1. Alzheimer Disease
2. Vascular Disease
3. Drugs, Depression, Delirium
4. Ethanol
5. Medical / Metabolic Systems
6. Endocrine (thyroid, diabetes), Ears, Eyes, Environment
7. Neurologic (primary degeneration, Lewy body dementia, Parkinson component)
8. Tumor, Toxin, Trauma
9. Infection, Idiopathic, Immunologic
10. Amnesia, Autoimmune, Apnea, AMI

Alzheimer's Disease

- A diagnosis of Alzheimer's Disease can be made with a high degree of certainty
- Accuracy in autopsy-verified cases is approximately 90%
- Diagnosis is a 2-step process:
  - Detection through screening (MMSE)
  - Confirmation through patient history and physical, caregiver interview, brain imaging, and appropriate laboratory studies

McKhann G et al. *Neurology.* 1984;34:939-944.
Kazee AM et al. *Alzheimer Dis Assoc Disord.* 1993;7:152-164.
Ashford JW et al, Psychiaric Annals, 1996;26:262-268

Dementia Assessment

- History
  - Patient and family, onset, unusual events (stress, trauma, surgery), progression, activities of daily living
- Complete Physical Examination
- Routine Tests
  - CMP, CBC, ESR,Thyroid, B-12, Folate, VDRL, HIV
  - EKG and CXR (if indicated)
  - URINALYSIS
- Brain Imaging
  - CT (cheapest)
  - MRI (preferred)
- Neuropsychological Assessment
  - Allen cognitive testing

What about Dignity?

dig·ni·ty: (dĭgˈnĭ-tē)

- The quality or state of being worthy of esteem or respect.
- Inherent nobility and worth:
  - Poise and self-respect.
  - Stateliness and formality in manner and appearance.
- The respect and honor associated with an important position.

American Heritage Dictionary

There are Two Kinds of Dignity

- Attributed Dignity (personal dignity)
  - Perception of autonomy, independence, and individualism
  - Factors that diminish attributed dignity
    - Pain
    - Bowel Dysfunction
    - Dependency Issues
    - Physical Appearance Changes

Chochinov, Lancet 1999

Intrinsic Dignity

Intrinsic Dignity is the moral quality inherent in human life which is inalienable from "core being" or "essence"

How to Preserve Dignity

- Need a "Dignity Conserving" approach to care
  - How patient/family perceive dignity
  - Symptoms: need to be vigilant
  - Bolster independence: equipment
- Dignity conserving strategy:
  - Hard to do in face of deteriorating health
  - Therapeutic stance: respect for whole person, feelings, accomplishments, and passions that are independent of illness

Dignity Model

- Illness- Related Concerns
  - Level of Independence
  - Symptom Distress
- Dignity Conserving Repertoire
  - Dignity Conserving Perspectives
  - Social Dignity Inventory
  - Dignity Conserving Practices

Chochinov CA: Cancer J Clin 2006

Illness Related Concerns

- Symptom Distress
  - Physical Distress
  - Psychological Distress
    - Medical Uncertainty
    - Death Anxiety
- Level of Independence
  - Cognitive Acuity
  - Functional Capacity

Chochinov CA: Cancer J Clin 2006

Dignity: Symptom Distress

Themes	Dignity-related questions	Therapeutic Interventions
Physical distress	"How comfortable are you?" "Is there anything we can do to make you comfortable?"	Vigilance in symptom management, Frequent assessment and comfort care
Psychological distress	"How are you coping with what is happening to you?"	Assume a supportive stance Empathetic listening Referral to counseling
Medical uncertainty	"Is there anything else that you would like to know?" "Are you getting the information you need?"	Upon request, provide accurate, understandable information and strategies to deal with future crises.
Death anxiety	"Are there things about the later stages of your illness that you want to discuss?"	

Dignity: Level of Independence

Themes	Dignity-related questions	Therapeutic Interventions
Independence	"Has your illness made you more dependent on others?"	Have patients participate in decision making, regarding both medical and personal issues
Cognitive acuity	"Are you having any difficulty with your thinking?"	Treat delirium When possible, avoid sedating medication
Functional capacity	"How much are you able to do yourself?"	Use orthotic devices, physical and occupational therapy

Dignity Conserving Perspectives

- Continuity of Self
- Role Preservation
- Legacy
- Maintenance of Pride
- Hopefulness
- Autonomy/ Control
- Acceptance
- Resilience

Chochinov CA: Cancer J Clin 2006

Dignity: Patient Perspectives

Themes	Dignity-related questions	Therapeutic Interventions
Continuity of Self	"Are there things about you that this disease does not affect?"	Acknowledge and take interest in those aspects of the patient's life that he/she most values See the patient as worthy of honor, respect, and esteem
Role preservation	"What things did you do before that were important to you?"	
Maintaining Pride	"What about yourself or your life are you most proud of?"	
Hopefulness	"What is still possible?"	Encourage and enable the patient to participate in meaningful activities
Autonomy / control	"How in control do you feel?"	Involve patient in treatment and care decisions
Legacy	"How do you want to be remembered?"	Life Project (video, audio, letters) Dignity psychotherapy
Acceptance	"How at peace are you with what is happening to you?"	Support the patient and encourage doing things that enhance sense of well being (meditation, exercise, music, prayer, etc…)
Resilience	"What part of you is strong now?"	

Social Dignity Inventory

- Privacy Boundaries
- Care Tenor
- Social Support
- Burden to Others
- Aftermath Concerns

Chochinov CA: Cancer J Clin 2006

Social Dignity

Themes	Dignity-related questions	Therapeutic Interventions
Privacy boundaries	"What about your privacy or your body is important to you?"	Ask permission to examine patient, proper draping to safeguard privacy
Social Support	"Who are the people most important to you?" "Who is your confidant?"	Liberal polices about visitation and rooming-in, enlist others for wide support network
Care tenor	"Is there anything that is undermining your sense of dignity?"	Treat the patient as worthy of honor, esteem, and respect. Adopt a stance conveying this
Burden to others	"Do you worry about being a burden to others?"	Encourage explicit discussion about these concerns with those they fear they are burdening
Aftermath concerns	"What are your biggest concerns for the people you leave behind?"	Encourage the settling of affairs, an advanced directive, making a will, funeral plans

Dignity Conserving Practices

- Living in the Moment
- Maintaining Normalcy
- Seeking Spiritual Growth

Chochinov CA: Cancer J Clin 2006

Dignity Preserving Practices

Themes	Dignity-related questions	Therapeutic Interventions
Living in the moment	"Are there things that take your mind away from illness and offer you comfort?'	Allow the patient to participate in normal routines or take comfort in momentary distractions (daily outings, exercise, music,etc…)
Maintaining normalcy	"Are there things you still enjoy doing on a regular basis?"	
Finding spiritual comfort	"Is there a religious or spiritual community that you are, or would like to be involved with?"	Make referral to chaplain or spiritual leader, Enable participation in spiritual practices

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JOURNAL OF CLINICAL ONCOLOGY

ORIGINAL REPORT

Dignity Therapy: A Novel Psychotherapeutic Intervention for Patients Near the End of Life

Harvey Max Chochinov, Thomas Hack, Thomas Hassard, Linda J. Kristjanson, Susan McClement, and Mike Harlos

- Pre and post-intervention measures after a 30-60 minute bedside session for 100 terminally ill patients in Canada and Australia
  - 91% reported being satisfied with dignity therapy
  - 76% reported a heightened sense of dignity
  - 68% reported an increased sense of purpose
  - 67% reported a heightened sense of meaning
  - 47% reported an increased will to live
  - 81% reported that it had been or would be of help to their family.
- CONCLUSION: This shows promise as a novel therapeutic intervention for suffering and distress at the end of life.

Conserving Dignity Psychotherapy Protocol

- Tell me a little about your life history; particularly the parts that you either remember most or think are the most important?
- When did you feel most alive?
- Are there specific things that you would want your family to know about you, and are there particular things you would want them to remember?
- What are the most important roles you have played in life (family roles, vocational roles, community-service roles, etc)? Why were they so important to you, and what do you think you accomplished in those roles?
- What are your most important accomplishments, what do you feel most proud of?
- Are there particular things that you feel still need to be said to your loved ones or things that you would want to take the time to say once again?
- What are your hopes and dreams for your loved ones?
- What have you learned about life that you would want to pass along to others? What advice or words of guidance would you wish to pass along to your (son, daughter, husband, wife, parents, other[s])?
- Are there words or perhaps even instructions that you would like to offer your family to help prepare them for the future?
- In creating this permanent record, are there that you would like included?

Chochinov HM, et al. Journal of Clinical Oncology. 23(24):5520-5, 2005 Aug 20.

What to do when faced with a request for doctor-assisted suicide

- Most important thing is to connect with this person
- First priority is relief of suffering and symptoms
- Screen for depression, treat if indicated
- Use the dignity conserving interventions
- Establish short term goals
- Explore options for end of life care
- Involve care manger, family, and caregivers
- Withhold / Withdrawal of life sustaining measures
- Walk with them on this last part of their journey

PCCEF Clinical Resources

Download PDF file at www.pccef.org

Dignity-Conserving Interventions at End of Life

Factors and Themes	Dignity-related questions	Therapeutic Interventions
Symptom Distress		
Physical distress	*"How comfortable are you?"* *"Is there anything we can do to make you more comfortable?"*	Vigilance to symptom management Frequent assessment Application of comfort care
Psychological distress	*"How are you coping with what is happening to you?"*	Assume a supportive stance Empathetic listening Referral to counseling
Medical uncertainty	*"Is there anything further about your illness that you would like to know?"* *"Are you getting the information you need?"*	Upon request, provide accurate, understandable information and strategies to deal with future crises.
Death anxiety	*"Are there things about the later stages of your illness that you would like to discuss?"*	
Level of Independence		
Independence	*"Has your illness made you more dependent on others?"*	Have patients participate in decision making, regarding both medical and personal issues
Cognitive acuity	*"Are you having any difficulty with your thinking?"*	Treat delirium When possible, avoid sedating medication
Functional capacity	*"How much are you able to do yourself?"*	Use orthotics, physical and occupational therapy
Dignity Perspectives		
Continuity of Self	*"Are there things about you that this disease does not affect?"*	Acknowledge and take interest in those aspects of the patient's life that he/she most values See the patient as worthy of honor, respect, and esteem
Role preservation	*"What things did you do before you were sick that were most important to you?"*	
Maintenance of Pride	*"What about yourself or your life are you most proud of?"*	
Hopefulness	*"What is still possible?"*	Encourage and enable the patient to participate in meaningful or purposeful activities
Autonomy / control	*"How in control do you feel?"*	Involve patient in treatment and care decisions
Legacy	*"How do you want to be remembered?"*	Life Project (making video, audio, writing letters) Dignity psychotherapy
Acceptance	*"How at peace are you with what is happening to you?"*	Support the patient in his/her outlook Encourage doing things that enhance his/her sense of well being (meditation, light exercise, listening to music, prayer, etc…)
Resilience	*"What part of you is strongest right now?"*	
Dignity Practices		
Living in the moment	*"Are there things that take your mind away from illness and offer you comfort?'*	Allow the patient to participate in normal routines or take comfort in momentary distractions (daily outings, exercise, music,etc…)
Maintaining normalcy	*"Are there things you still enjoy doing on a regular basis?"*	
Finding spiritual comfort	*"Is there a religious or spiritual community that you are, or would like to be involved with?"*	Make referral to chaplain or spiritual leader Enable participation in spiritual practices
Social Dignity		
Privacy boundaries	*"What about your privacy or your body is important to you?"*	Ask permission to examine patient Proper draping to safeguard privacy
Social Support	*"Who are the people most important to you?"* *"Who is your closest confidant?"*	Liberal polices about visitation and rooming-in Enlist involvement of wide support network
Care tenor	*"Is there anything in the way you are treated that is undermining your sense of dignity?"*	Treat the patient as worthy of honor, esteem, and respect. Adopt a stance conveying this
Burden to others	*"Do you worry about being a burden to others?"*	Encourage explicit discussion about these concerns with those they fear they are burdening
Aftermath concerns	*"What are your biggest concerns for the people you leave behind?"*	Encourage the settling of affairs, preparation of an advanced directive, making a will, funeral plans.

Adapted from Chochinov MH. Dignity-Conserving Care. JAMA 2002. 287(17):2253-60

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Dignity Preserving Psychotherapy Protocol and Legacy Discussion

These questions are to be used as a starting point for a discussion or as a way to stimulate further discussion of Legacy issues for patients near the end of life. Please put these into your own words. Do not consider this as a complete list, but rather as a launching point. Remember that your patient's life has inherent value, and your job is to discover this and help families and loved ones to do the same.

Can you tell me a little about your life history?

When did you feel most alive?

Are there specific things that you would want your family to remember about you?

What are the most important roles you have played in life?

What are your most important accomplishments, and what do you feel most proud of?

Are there things that still need to be said, or that you would want to say once again?

What are your hopes and dreams for your loved ones?

What have you learned about life that you would want to pass along to others?

What advice or words of guidance would you wish to pass along to your (son, daughter, husband, wife, parents, other[s])?

Are there words or perhaps even instructions you would like to offer your family, in order to provide them with comfort or solace?

In creating this record, are there other things that you would like included?

Adapted from Chochinov HM, Hack T, Kristjanon LJ, McClement S, Harlos M. Journal of Clinical Oncology, 2005. 23(24):5520-5