Common Psychiatric Disorders at the End of Life

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My Background

Internal Medicine & Psychiatry board certified
Hospice & Palliative Medicine board certified
Hospice Medical Director certification
Certificate in Medical Education

Presentation Outline

1. Review common psychiatric disorders encountered at end-of-life
2. Pharmacologic treatment
3. Non-pharmacologic approaches
### Common Psychiatric Disorders

- Delirium
- Anxiety
- Depression
- Borderline Personality Disorder

### Example Case #1

Mr. Jones is a 93 yo man with dementia who has been on hospice at home for a few months. His family asked that he be transferred to the hospice house because "we just can’t deal with him anymore".

After arrival to the inpatient unit, you quickly notice that the patient is very agitated and repeatedly tries to get out of bed. He is pulling at his sheets, gown, and is mumbling incoherently. He also gets combative with personal care. He tends to get worse around evening shift change, and will sometimes sleep for a few hours at night.

### Delirium

Defined as an acute change in level of consciousness

Two main types: Hyperactive and Hypoactive

Poor prognostic indicator

**Signs/Symptoms**

- **Hyperactive**:
  - Pulling at gown
  - Picking at sheets
  - "Sleep all day, party all night"
  - Responding to unseen others
- **Hypoactive**:
  - Staring spells
  - Appears scared
Causes of Delirium

Always look for reversible causes!
- Pain
- Constipation
- Urinary tract infection/retention
- Electrolyte abnormalities
- Medications

May be due to terminal illness
- Dementia
- Sepsis
- Cancer
- Hypoxia
- Hepatic encephalopathy

Delirium Treatment

Haldol is the standard of care
- Can be given PO/SL/IM/IV/SQ
- Best when scheduled

Risperidone, quetiapine, olanzapine are additional options
- Best for patients with Parkinson’s and Lewy Body dementia

Chlorpromazine reserved for severe agitation

Avoid benzodiazepines in delirious patients
- May have paradoxical effect due to mechanism of action
- Can help if patient has anxiety component to delirium

Antipsychotics

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand</th>
<th>Dosage Range</th>
<th>Sedation</th>
<th>EPS</th>
<th>ACh effects</th>
<th>Equivalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlorpromazine</td>
<td>Thorazine</td>
<td>50-1500mg</td>
<td>High</td>
<td>++</td>
<td>++++</td>
<td>100mg</td>
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<tr>
<td>Quetiapine</td>
<td>Seroquel</td>
<td>100-750mg</td>
<td>High</td>
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<td>+</td>
<td>50mg</td>
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<tr>
<td>Haloperidol</td>
<td>Haldol</td>
<td>2-40mg</td>
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<td>2mg</td>
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<tr>
<td>Olanzapine</td>
<td>Zyprexa</td>
<td>5-20mg</td>
<td>Mid</td>
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<td>+</td>
<td>2mg</td>
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<tr>
<td>Risperidone</td>
<td>Risperdal</td>
<td>2-10mg</td>
<td>Low</td>
<td>+</td>
<td>+</td>
<td>2mg</td>
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<tr>
<td>Ziprasidone</td>
<td>Geodon</td>
<td>60-160mg</td>
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<td>++</td>
<td>10mg</td>
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<tr>
<td>Aripiprazole</td>
<td>Abilify</td>
<td>15-30mg</td>
<td>Low</td>
<td>+</td>
<td>+</td>
<td>2mg</td>
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</tbody>
</table>
Non-pharmacologic Treatment of Delirium

Orientation techniques
- Pictures of family in room
- Visits from family
- Visits from pets
- Familiar music
- Blankets and clothes from home
- Clock in room

Sleep hygiene
- Lights on during day, off at night

Monitor stimulation
- Soothing television shows
**Example Case #2**

Ms. Smith is an 83 yo woman with severe COPD and pulmonary hypertension. She was discharged home with hospice after her oxygen and pulmonary medications were optimized.

One morning Ms. Smith becomes acutely dyspneic and starts to panic. You are asked to visit the patient in her home. She states that she cannot catch her breath and states that she feels like she is about to die. Her family becomes anxious and states "you have to do something! We were told hospice would keep her comfortable! If you aren’t going to do anything we are going to call 911!"

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**Anxiety**

Occurs frequently in dying patients, especially patients with CHF and COPD
- Fear of suffocating to death
- Often related to dying process
  - Will I be in pain?
  - Will my family be okay?
  - Where will I go after I die?

Signs/symptoms include:
- Sweating, palpitations, chest pain, difficulty breathing, tremor, nausea, abdominal pain, sense of impending doom, chest pain, "out of body experience"

May escalate to panic attack

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**Treatment of Anxiety**

Talk to patients about their anxiety and what they are worried about
- Ask how they have coped with difficult situations in the past
- Get help from social work, spiritual care, music therapy, massage therapy
- Talk to patient about fears of symptoms not being controlled at the end of life
Treatment of Anxiety

May need treatment with SSRI/SNRI, tricyclic antidepressant, or benzodiazepine depending on prognosis
- SSRI/SNRI take weeks to reach full effect
- TCA have anticholinergic effects, risk with overdose
- Benzodiazepines work quickly, may develop tolerance

Benzodiazepines

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand</th>
<th>Dosage Range</th>
<th>Rapidity of Absorption</th>
<th>Half-life (hours)</th>
<th>Equivalence</th>
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</thead>
<tbody>
<tr>
<td>Alprazolam</td>
<td>Xanax</td>
<td>0.25-4mg</td>
<td>+++</td>
<td>6-20</td>
<td>0.5-1mg</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>Ativan</td>
<td>2-6mg</td>
<td>+++</td>
<td>10-15</td>
<td>1-2mg</td>
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<tr>
<td>Diazepam</td>
<td>Valium</td>
<td>5-40mg</td>
<td>++++</td>
<td>20-50</td>
<td>5-10mg</td>
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<tr>
<td>Temazepam</td>
<td>Restoril</td>
<td>15-30mg</td>
<td>+++++</td>
<td>10-20</td>
<td>10-20mg</td>
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<tr>
<td>Clonazepam</td>
<td>Klonopin</td>
<td>0.5-4mg</td>
<td>+</td>
<td>80</td>
<td>0.25-0.5mg</td>
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</table>

Example Case #3

Ms. Smith is a 49 yo woman with metastatic breast cancer. She was admitted to home hospice for pain and symptom management.

Although Ms. Smith’s pain has improved, the staff has noted on their visits that she appears withdrawn and does not engage with her children and husband. She states that she feels hopeless about the future and “I wish I would just die already”. She also endorses poor sleep and a poor appetite. She states that she stays up all night worried about the future and what will happen to her family when she dies.
Depression

Difficult to assess at the end of life
Symptoms frequently overlap with symptoms of serious illness
- Low mood
- Decreased energy
- Decreased appetite
- Sleep disturbance

Distinguished by psychological symptoms
- Feelings of hopelessness and/or worthlessness
- Social withdrawal
- Suicidal ideation

Causes of Depression

Terminal illness
Medications
- Steroids
- Opioids
- Benzodiazepines
Illnesses misdiagnosed as depression
- Hypoactive delirium
- Anticipatory grief

Treatment of Depression

Talk to the patient
- Ask if they are feeling depressed
- Ask if they are having thoughts of suicide or wanting to hurt themselves
- If yes follow your organization’s policy

Offer the patient non-pharmacologic therapies
- Music, pets, social work, spiritual care visits
Treatment of Depression

If patient's prognosis is weeks, SSRI/SNRI may be prescribed
- Selection of SSRI/SNRI based on targeting specific symptoms and minimizing side effects

If patient's prognosis is days - weeks, then a stimulant may be ordered
- Example: methylphenidate 5mg po BID

Antidepressants

<table>
<thead>
<tr>
<th>Class</th>
<th>Drug (Brand)</th>
<th>Indication</th>
<th>Dosing Range</th>
<th>Sedation</th>
<th>ACH</th>
<th>Insomnia</th>
<th>Orthostasis</th>
<th>GI</th>
<th>Weight Gain</th>
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<tbody>
<tr>
<td>SSRI</td>
<td>Citalopram (Celexa)</td>
<td>MDD</td>
<td>20-40mg</td>
<td>0</td>
<td>0</td>
<td>+</td>
<td>+</td>
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<tr>
<td></td>
<td>Escitalopram (Lexapro)</td>
<td>MDD, GAD</td>
<td>10-20mg</td>
<td>0</td>
<td>0</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
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<tr>
<td></td>
<td>Fluoxetine (Prozac)</td>
<td>MDD, OCD, Panic</td>
<td>10-80mg</td>
<td>0</td>
<td>0</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td></td>
<td>Paroxetine (Paxil)</td>
<td>MDD, OCD, GAD, PTSD</td>
<td>10-50mg</td>
<td>+</td>
<td>+</td>
<td>++</td>
<td>++</td>
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<td>++</td>
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<tr>
<td></td>
<td>Sertraline (Zoloft)</td>
<td>MDD, Panic, PTSD</td>
<td>25-200mg</td>
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<td>0</td>
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<td>SNRI</td>
<td>Duloxetine (Cymbalta)</td>
<td>MDD, Fibromyalgia, GAD</td>
<td>20-60mg</td>
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<td>0</td>
<td>++</td>
<td>+</td>
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<tr>
<td></td>
<td>Venlafaxine (Effexor)</td>
<td>MDD, GAD, Panic</td>
<td>37.5-225mg</td>
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<td>+</td>
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Other medications

<table>
<thead>
<tr>
<th>Class</th>
<th>Drug (Brand)</th>
<th>Indication</th>
<th>Dosing Range</th>
<th>Sedation</th>
<th>ACH</th>
<th>Insomnia</th>
<th>Orthostasis</th>
<th>GI</th>
<th>Weight Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serotonin Modulator</td>
<td>Trazodone (Desyrel)</td>
<td>MDD</td>
<td>50-300mg</td>
<td>++++</td>
<td>+</td>
<td>0</td>
<td>++</td>
<td>++</td>
<td>0</td>
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<tr>
<td>Atypical</td>
<td>Bupropion (Wellbutrin)</td>
<td>MDD</td>
<td>100-150mg, 150-200mg, 200-250mg, 300mg</td>
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<td>0</td>
<td>++</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>Mirtazapine (Remeron)</td>
<td>MDD</td>
<td>15-45mg</td>
<td>++++</td>
<td>+</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>++++</td>
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</tbody>
</table>

Adapted with permission from Kristen Clark, MD
Example Case #4

Mr. Jenkins is a 26 yo man who is a paraplegic from a gunshot wound sustained years ago. He is brought to the inpatient unit for uncontrolled pain, wound care, and caregiver breakdown.

Although Mr. Jenkins was admitted for acute care, he often refuses to take his medications or to allow the nurses to do his dressing changes. He presses his call bell button every 15 minutes. He has also been belligerent with staff members to the point they have threatened to quit. He tells you "you're the best *fill in the blank* and the only one who really understands me". Your social worker has attempted to call his family, only to have his calls not returned.

Borderline Personality Disorder

Characterized by emotional dysregulation
- "I hate you, don’t leave me!"
- Splitting behaviors
- Burned bridges with friends and family

Elicit strong emotions from staff
- Increased time discussing patient on daily rounds, IDG
- Time intensive patients
- Frequent visits
- Easily angered when requests are not fulfilled
- Staff feel urge to help, but recognize they are being manipulated by patient

Borderline Personality Management

There is NO PILL to treat personality disorder
Boundaries work best for patient AND staff
- Set schedule for patient and stick to it
- Minimize number of providers involved in care to reduce risk of splitting
- Communicate plan of care to have a unified front

Validate and pivot
- Acknowledge that patient has true disease and physical and emotional symptoms
- Focus on current problem and address directly
- Redirect their behavior to things they can change and have control over
Summary

Psychiatric disorders are common at the end of life
Selection of pharmacologic treatment is influenced by prognosis
Non-pharmacologic treatment should always be considered
Patients with borderline personality disorder do best with a structured plan of care

Questions?

References