Chronic Conditions, Lung Disease, Cancer, the Palliative Care Settings, and the Dying Patient

27

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Contents

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27.1 Vignettes

1. A 50-year-old man was referred for psychiatric consultation because he refused a surgical procedure. He also had visual hallucinations of old friends and angels that were comforting for him. The patient was a homeless man who was brought in by the police after he was found on the street lying in a puddle of blood. He was bleeding from the rectum, was found to have a large rectal mass with extensive involvement of other pelvic structures. A hemicorpectomy was proposed, which the patient refused. The psychiatric consultant determined that the patient understood the nature, benefits, and risks of the proposed operation. As the hallucinations were comforting rather than frightening, no antipsychotic drugs were administered. Sufficient pain relief was recommended. The patient died in his sleep several days later.
2. An 84-year-old man who was recently placed in a nursing home was found with a plastic bag over his head in a suicide attempt. He was brought to a psychiatric facility, and then transferred to the general hospital as he was bedbound. His medical history revealed metastatic prostate cancer. The general hospital medically cleared him, as no immediate treatment for the carcinoma was planned. The nursing home refused to take the patient back because of his suicidal ideation. He was depressed, felt hopeless, and wished to die.

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The psychiatric consultant interviewed his wife, who told her that the patient was a self-made man, who was always independent, and she wanted nature to take its course. She was willing to have her husband at home, but had problems with constantly changing caregivers; also the bathroom door was too narrow to accommodate the patient's wheelchair. The consultant arranged a meeting with family, the responsible physician, and the social worker, in which arrangements were made for the patient to be cared for at home with a more reliable caregiver, and to provide a commode at the bedside. He was prescribed methylphenidate 5 mg in the a.m. and fluoxetine 20 mg in the a.m. The patient felt relieved when hearing these plans, and at follow-up a month later he was quite energetic with no symptoms of depression.

3. A 35-year-old woman was admitted for an overdose of sedatives in a suicide attempt. The patient was diagnosed with metastatic breast cancer about a year previously, and as she was experiencing increasing bone pain, she decided to take her "exit pills." As she survived the suicide attempt, she was interested in discussing the meaning of her cancer with the psychiatric consultant. Eventually, the patient became an outpatient of the consultant, who, at the patient's request, did a weekly exploratory psychotherapy. She gained insight concerning the meaning of the cancer in view of her own personal history, and died in about a year's time, feeling more in control with herself during the dying process.

27.2 The Chronically Ill and Disabled Patient

Chronic patients, patients with permanent disability, with chronic diseases such as obstructive lung disease, and the terminal patients all have in common the fact that their medical condition cannot usually be reversed. Such patients often engender a feeling of helplessness in the physician.

Physicians are trained to seek out the cause of the illness and cure it, and patients who do not fit this model are frustrating indeed. The physician must recognize that there is a need for a role adjustment, from that of an active fighter against disease to that of a comforter, in dealing with chronic and palliative care patients. This involves accepting that the patient's condition is not reversible, and, in terminal patients, letting go while providing maximum pain relief and comfort. Many physicians feel uncomfortable with this role adjustment, and may unconsciously tend to avoid or neglect such patients, or use heroic measures to "save" the patient (as in the first vignette above). The role of the consultant, then, is to help reduce the discomfort on the physician's part so that optimal medical care can occur.

27.3 Demoralization Syndrome

A term first coined by Jerome Frank (Frank 1961; Frank and Frank 1991) is often seen in chronic or palliative care settings, and is characterized by hopelessness, loss of meaning, and existential distress. It is associated with chronic medical illness, disability, bodily disfigurement, fear of loss of dignity, social isolation, feelings of dependency on others, and the fear of being a burden. Because of the sense of impotence or helplessness, many with the syndrome predictably progress to a desire to die or to commit suicide (Clarke and Kissane 2002; Clarke et al. 2005; Kissane et al. 2001). Demoralization syndrome is not an official DSM diagnosis and has many features of depression but it occurs in the context of medical disease and it is not usually accompanied with anhedonia, and patients with this syndrome may still feel hopeful and experience positive emotions if aspects of the disease, such as pain, are effectively treated. The physician can validate the patient's experience through empathic listening and enhance the patient's coping skills and resilience (Jacobsen et al. 2007). Stimulants such as methylphenidate or dextroamphetamine may be effective for patients with demoralization syndrome and provide some boost of energy as well as better appetite and sleep. (as in Vignette 2 above) (see Chaps. 8 and 15).

Psychiatric consultation may be requested on chronically ill and disabled patients for evaluation of comorbid psychiatric illness per se, psychological reactions to the chronicity, or disability such as demoralization and depression, for issues concerning possible addiction to pain or antianxiety medications, noncompliance with a chronic regimen (such as insulin self-administration), and suspicion that the patient is unwilling to get better. Any comorbid psychiatric conditions, if diagnosed, should be treated appropriately with psychopharmacologic agents when indicated, keeping in mind possible drug interactions with the medical condition.

Psychotherapeutic approaches for adjustment to chronic illness and disability include support groups, supportive psychotherapy and problem solving, and cognitive-behavioral therapy. Physical therapy is often an excellent psychotherapeutic tool as it instills a sense of hope and expectation for improvement or recovery. Web sites are available for most chronic illnesses and disabilities and can provide excellent educational material as well as information about support groups.

The issue of possible addiction to pain medication is discussed in Chap. 22. As for addiction to antianxiety agents, particularly benzodiazepines, the consultation liaison psychiatrist often encounters patients who have withdrawal symptoms in the hospital setting when they were receiving much higher doses chronically prior to admission (Fontaine et al. 1984). Such withdrawal symptoms may be seen by the medical staff as excessive anxiety. Caution is needed in elderly patients because benzodiazepines may cause sedation, disinhibition, delirium, and falls. Interactions with narcotic analgesics and alcohol should be kept in mind.

For chronic patients with liver, kidney, and HIV, see respective chapters on these topics.

27.4 Lung Disease

27.4.1 Asthma

The prevalence of asthma appears to be increasing, and about 300 million persons in the world suffer from it (Masoli et al. 2004).

While the notion that psychological factors are etiologic in bronchial asthma as one of the "classical psychosomatic diseases" is no longer accepted, psychological stress is well known to predispose to and trigger acute asthmatic attacks (Humeniuk et al. 2003; Iamandescu and Mihailescu 2008; Joachim et al. 2003).

Depression has been reported in as much as 50 % of patients with bronchial asthma (Mancuso et al. 2000). Depression in asthmatic patients may be associated with an increased risk for sudden death (Zielinski et al. 2000). Suicidal ideation was found to be increased in the asthmatic population compared to general population (Goodwin and Marusic 2004). Depression and anxiety tend to adversely affect both asthma control and quality of life and thus treating these conditions may improve both asthma and their quality of life (Urrutia et al. 2012).

Anxiety symptoms such as chest tightness and choking sensations are common in patients with both anxiety and asthma. Anxiety disorders in general, including generalized anxiety and panic disorder are more common among asthmatics than in general population (Goodwin et al. 2003). The close relationship between anxiety and asthma may be related to hyperventilatory panic attacks arising from an innate emotional response to severe breathlessness (dypenea-fear theory) (Ley 1989). Stress may also trigger vasoconstriction through vagal stimulation in certain individuals (Lehrer et al. 1993).

The mental health of children, as well as that of their caregivers, was closely associated with predicting morbidity in children with asthma (Weil et al. 1999).

Treatment of depression and anxiety should include psychosocial modalities such as stress management, relaxation training, psychoeducation, cognitive behavioral therapy, as well as phamacotherapy. Beta-blockers such as propranolol are generally contraindicated in bronchial asthma patients. Antidepressants such as bupropion, mirtazapine, SSRIs, and SNRIs have been used widely in asthma patients (Brown et al. 2007; Krommydas et al. 2005). There have been reports, however, of overdose of SSRI resulting in serotonin syndrome precipitating an asthmatic attack (Carson et al. 2000). Antianxiety agents such as

benzodiazepines may be used to control acute anxiety symptoms in asthmatic patients (DeVane et al. 1998). There is one report of clonazepam relieving myoclonus caused by hypoxia due to prolonged asthmatic attack (Chee and Poh 1983).

27.4.2 Chronic Obstructive Lung Disease (COPD)

COPD is an essentially irreversible and progressive disease of air flow limitation in the lung caused by small airway disease and parenchymal destruction. COPD develops most often in long-term smokers, and is currently the 4th leading cause of death in the United States, afflicting about 14 % of adult population, and is expected to be the third leading cause of death globally by 2020 (Rabe et al. 2007). Depression, anxiety, and psychosis are significant factors in the morbidity and mortality of COPD, and COPD itself is a significant risk factor for psychiatric symptoms.

27.4.2.1 Depression

The life-time risk for depression in COPD patients is considered to be about 40 %, rising to about 60 % in severe COPD patients, and among patients who recently recovered from an acute exacerbation of COPD, the prevalence ranges from 19 to 50 %.

There is a bidirectional relationship between depression and COPD. As with schizophrenia, the higher rates of smoking seen in patients with depression could lead to the higher prevalence rate of COPD in depressed patients (Jain and Lolak 2009).

COPD may also be a risk factor for depression; chronic hypoxemia in COPD may lead to disruptions of noradrenergic and dopaminergic synthesis, release, and restoration that may ultimately lead to depression. Chronic hypoxemia may also lead to poor oxygenation in the periventricular and subcortical regions of the brain, which are vulnerable regions to hypoperfusion, and lead to similar brain changes as seen in patients with depression (Norwood 2006). The lower quality of life and decreased functioning capacity of COPD patients may also lead to depression.

27.4.2.2 Anxiety

As with depression, there is a bidirectional relationship between COPD and anxiety. As in depression, smoking plays a significant role in patients with anxiety. Panic disorder is a significant risk factor for nicotine dependence, and is associated with negative thoughts related to the illness, such as perceiving it to be long lasting, having a greater impact on daily life, and having worse consequences (Howard et al. 2009; Sartor et al. 2008). There may also be common pathophysiology between COPD and anxiety, such explanatory models include hyperventilation model, carbon dioxide hypersensitivity model, and cognitive-behavioral model (Mikkelsen et al. 2004).

27.4.2.3 Schizophrenia

Patients with schizophrenia may be more likely to have COPD (Carney et al. 2006). The increased COPD rate may be attributed to the increased smoking rates among schizophrenics, suggesting a "self-medication" hypothesis that stimulation of central nervous system (CNS) nicotinic cholinergic receptors may improve the negative symptoms of schizophrenia as well as overcome the dopamine-blocking effects of antipsychotics causing anhedonia (Dalack et al. 1998). Thus, second generation antipsychotics that have less D2 blocker activity, and especially aripiprazole which has a partial dopamine agonist action, may reduce nicotine dependence in schizophrenic patients (Brown et al. 2012; Kim et al. 2010; Ramaswamy and Bhatia 2006).

27.4.2.4 Treatment of Psychiatric Syndromes in COPD

Antidepressants including bupropion, SSRI, SNRI, and mirtazapine seem to be well tolerated in COPD patients. Drugs with strong anticholinergic side effects such as tricyclic antidepressants should be used with caution in COPD patients due to their mucus drying as well as potential cardiotoxic effect.

Cognitive behavioral therapy (CBT) has also been used effectively to treat depression in COPD patients (Hynninen et al. 2010).

Antianxiety agents are often necessary in treating anxiety associated with COPD but

benzodiazepines are often avoided as first-line therapy in COPD because of their potential respiratory drive depressive effects. Clinically, this is primarily a concern in patients who have COPD, who retain carbon dioxide (CO_2). Buspirone, which does not have the sedating effect may be effective in relieving anxiety in some patients. SSRIs are considered to be first-line therapies for anxiety disorders (Shanmugam et al. 2007).

Pulmonary rehabilitation can improve anxiety, health status, exercise tolerance, dyspnea intensity, and quality of life in COPD patients. Such a rehabilitation program is relatively inexpensive and well tolerated by patients (Guell et al. 2006; Kayahan et al. 2006).

27.5 Cancer

Until relatively recently, the diagnosis of cancer was almost tantamount to the diagnosis of a terminal disease. With recent advances in cancer detection and effective treatment modalities, however, many cancers are now considered to be either curable or, even in metastatic cases, chronic diseases with varying prognosis. Over two-thirds of some 11.4 million cancer patients in the United States can expect long-term survival (Irwin et al. 2013). In spite of this, many patients and their families still have the notion that cancer means death. Thus, an important role of the psychiatric consultant for the cancer patient is to ascertain the degree of information the patient and family have about the disease, the effectiveness of communication between the patient and the health care team, and the educational needs of the patient and family in relation to treatment and prognosis concerning the disease.

Clinical depression and anxiety are the most common causes of distress in cancer patients. Estimates of prevalence range between 5 and 50 %, depending on the screening method, diagnostic criteria used, and timing of assessment. In one study, 30 to 40 % of oncology, hematology, and palliative care patients experienced some combination of mood disorder, including depression, anxiety, adjustment disorder, or dysthymia. The results did not differ between the palliative and nonpalliative setting, and there were no consistent effects of age or gender, reinforcing the importance of vigilance for mood symptoms in all patients and at all stages of treatment (Artherholt and Fann 2011).

27.5.1 Anxiety

In a large-scale study of adult outpatients at a tertiary cancer center, 34 % endorsed clinically significant anxiety symptoms (Brintzenhofe-Szoc et al. 2009). Anxiety can range from mild to severe and fluctuate at critical points, such as before or after receipt of test results. If anxiety is both excessive, distressing, and impairs function significantly, an anxiety disorder should be considered. In one study of cancer care settings, adjustment disorders were present in about 20 %, and anxiety disorders in 10 % (Mitchell et al. 2011).

27.5.2 Depression

The estimated prevalence of depression was, in one metaanalysis, 5 to 16 % in outpatients, 4 to 14 % in inpatients, 4 to 11 % in mixed outpatient and inpatient samples, and 7 to 49 % in palliative care. Studies which used expert interviewers (psychiatrists or clinical psychologists) reported lower prevalence estimates (Walker et al. 2012).

Prevalence of depression varies based on the type of cancer involved, with depression rates generally reported to be highest for pancreatic, oropharyngeal, and breast carcinomas and lowest for lymphoma, leukemia, and gastric cancers. As with medical illnesses in general, rates of depression in cancer patients increase as disease severity intensifies (Raison and Miller 2003).

Symptoms of depression, including low mood, loss of interest in usually pleasurable activities, feelings of hopelessness or guilt, or suicidal ideation, are particularly important in recognizing depression in cancer patients. Neurovegetative symptoms such as fatigue, anorexia, weight loss, and sleep difficulty may be less reliable indicators of depression in cancer patients, as these

symptoms may be directly associated with cancer or its treatment such as chemotherapy.

Depression may be particularly prevalent in palliative settings. Risk factors for depression include younger age, antidepressant use at baseline, lower self-esteem, hopelessness, physical illness burden, and proximity to death. Approximately 15 % of palliative cancer patients have major depression (Rayner et al. 2011). Depression symptoms were three times more common in the final 3 months of life compared with a year or more before death (Lo et al. 2010).

Recent data on risk of *suicide* in cancer patients revealed that the prevalence of suicidal ideation may be comparable to that of the general population but that prevalence of completed suicide is elevated in patients with cancer. Based on a large retrospective analysis of Surveillance, Epidemiology, and End Results (SEER) data, the risk of suicide may be highest in the first year, and particularly high in the first month, after cancer diagnosis. Risk factors for suicide include clinical depression, demographic factors such as older age and lack of social support, and factors related to the patient's illness, e.g., disease progression (Artherholt and Fann 2011).

27.5.3 Cytokines, Sickness Behavior, and Depression

In addition to the psychological stress of being diagnosed with cancer and of the unpleasant effects of cancer treatment, certain biochemical substances associated with cancer may contribute to depression.

Proinflammatory cytokines released during tissue damage and inflammation have been shown to affect neurotransmitter function, neuroendocrine function, and behavior (Dunn et al. 1999). The cytokine-related behavioral changes, called *sickness behavior*, include many features that overlap with major depression including anhedonia, fatigue, anorexia, weight loss, sleep disturbance, cognitive disturbance, social isolation, and decreased libido.

Thus, the cytokines released by the neoplastic process, as well as in treating the cancer, may contribute to the symptoms of depression in cancer patients. At least in one study, pretreatment with an SSRI resulted in a reduction in the occurrence of serious depression in melanoma patients receiving interferon-alpha therapy (Musselman et al. 2001).

27.5.4 Treatment of Anxiety and Depression in Cancer Patients

Interdisciplinary rehabilitation programs that include relaxation training, exercise, and individual and group psychotherapy have been shown to be effective in reducing emotional stress and improving the quality of life in cancer survivors (Braam et al. 2013; McClellan 2013; Walker et al. 2013). Hypnosis has been used effectively in treating nausea and vomiting in chemotherapy patients (Richardson et al. 2007).

27.5.4.1 Drug Therapy

There is conflicting evidence concerning whether antidepressants such as SSRIs and tricyclics have either detrimental or beneficial effects in cancer. A recent review suggests that antidepressants, particularly fluoxetine, may activate the immune system and induce apoptosis in tumor cells (Frick and Rapanelli 2013).

According to a recent survey of cancer survivors, antidepressants are most commonly used in cancer patients (14 %), followed by antianxiety agents (6 %), and antipsychotics (2 %). Stimulants were used in about 1 % of patients (Punekar et al. 2011).

An important consideration in the drug therapy of anxiety and depression in cancer patients is that relief of contributing physical factors such as pain and discomfort with appropriate pain medications. This may be as important as treating the psychiatric symptoms per se.

In treating cancer patients with psychotropic medications, the physician should be mindful of possible interactions of the drug with anticancer drugs, as well as adverse side effects such as sedation, gastrointestinal side effects such as nausea, vomiting, and diarrhea, anticholinergic

effects, and sedation/respiratory depression. For example, in breast cancer patients who receive tamoxifen, a prodrug that becomes active only when metabolized, drugs that inhibit cytochrome p450 2D6 such as fluoxetine, paroxetine, bupropion, and duloxetine should be avoided. Drugs that do not inhibit 2D6, such as mirtazapine, sertraline, escitalopram, and venlafaxine may be used (Andrade 2012).

On the other hand, some side effects may be beneficial. For example, antihistaminic side effects of olanzapine and mirtazapine reduce nausea and increase appetite, as well as enhance sleep, and are effective in cancer chemotherapy patients (Kast and Foley 2007). Duloxetine has been shown to be effective for neuropathic pain in cancer patients (Matsuoka et al. 2012; Torta et al. 2011; Yang et al. 2012).

Bupropion may be helpful in treating fatigue and sexual dysfunction of cancer patients (Breitbart and Alici-Evcimen 2007; Mathias et al. 2006; Moss et al. 2006).

Psychostimulants such as methylphenidate, amphetamine, and modanafil may be useful in increasing energy and improve cognitive function in cancer patients with fatigue (Breitbart and Alici 2010; Joly et al. 2011; Minton et al. 2011).

27.6 The Dying Patient and Palliative Care

Health care professionals are naturally reluctant to disclose to their patients that they are dying—that the professional is powerless to prevent the inevitable. In this information era, however, health care professionals are ethically and legally required to disclose all important medical information to the patient. In making these disclosures, the ethical principle of beneficence suggests that physicians should disclose information in a way that benefits and does not harm patients (see Chap. 10). Surveys of terminally ill patients show that most patients do want to know the truth about their illness (Kelly and Friesen 1950; Noone et al. 2000; Seo et al. 2000).

For the terminally ill patient, the most important *approach* for the consultant to keep in mind is that, from the patient's perspective, here-and-now comfort, relief of pain, and small pleasures including not having to think about his or her terminality are the important concerns. Elisabeth Kübler-Ross (1969) proposed that there are five stages of psychological adaptation to dying: denial and isolation, anger, bargaining, depression, and acceptance. Though these stages are useful in understanding dying patients who show one or more of the characteristics of these stages, the health care professional should be aware that these stages do not necessarily occur in sequence, and, in fact, many patients may never undergo some of the stages, such as bargaining or acceptance. Some patients may adaptively fight to the end, even by engaging in an exploratory psychotherapy (as in vignette 3) (Leigh 1974).

For some patients, having the option or means of suicide, such as consulting the book *Final Exit* (Humphry 2002), gives a sense of mastery and control so that they gain the courage to live for today in spite of pain and discomfort. Thus, the possession or acquisition of a lethal medicine or weapon is not ipso facto evidence of immediate suicide risk requiring psychiatric certification. Executing an advance directive, appointing a durable power of attorney, and drawing up a will all provide a sense of mastery and autonomy for the terminal patient. Pleasurable activities and any distraction from illness should be encouraged for the terminally ill patient.

Patients' individual coping strategies should be respected and supported. Thus, one patient may choose to avoid discussing the disease and prognosis entirely, while another may read voluminously about the disease and become an expert in it, and another may find solace in philosophy or literature. Patients should be asked about whether they would like visits by clergy.

There is controversial evidence that psychotherapy may prolong survival of metastatic cancer patients (Chow et al. 2004; Goodwin et al. 2001; Spiegel et al. 2002), but there is a consensus that psychotherapy and psychoeducation can reduce the pain and depression associated with terminal cancer (Boesen and Johansen 2008, Daniels and Kissane 2008, Kissane 2009).

Many terminal patients feel comforted by simply being with another human being. For dying patients with no relatives or friends, volunteers can provide needed support and nonprofessional human contact. Where applicable, pets can also provide comfort and companionship, as well as a sense of usefulness for the patient.

For further discussion of psychotherapeutic (particularly "narrative") approaches for seriously ill patients, see Psychosocial Treatments Relevant to Consultation-Liaison Psychiatry in Chap. 29.

Hospice care, either as an inpatient or as an outpatient, may be particularly helpful for the terminally ill patient as it can provide expert care and support for both the patient and the family.

Pharmacologically, immediate comfort and pain relief is the utmost goal of treatment, even if there is attendant risk of delirium, respiratory depression, and other consequences. Narcotic analgesics, which are also good antianxiety agents, should be administered liberally, as well as antianxiety and antidepressant drugs as needed. Historically, the Brompton cocktail, consisting of morphine, cocaine, and alcohol, had been used in Great Britain for treatment of pain in terminal cancer patients (also used in modified form in many hospices). As one oncologist remarked, "There is no drug test at the pearly gate to Heaven."

27.7 Care of the Caregivers

The caregivers of seriously chronically ill and dying patients suffer from as much, if not greater, stress as the patients themselves. Epel et al. (2004) showed that healthy mothers who cared for chronically ill children showed premature cellular aging (telomere shortening) in proportion to the number of years of such caring, and cellular aging also correlated with the amount of perceived stress.

A recent study showed that depression among the caregivers of terminal cancer patients was high—63 % percent of females and 38 % of males had depression. Factors independently associated with mood disorders included emotional burden, problems in social involvement, and nonattendance of meeting places; help and assistance from public local services (for patients) decreased the risk of mood disorders in caregivers. Females, compared to males, were found to use emotional-oriented coping strategies more frequently (Mazzotti et al. 2012).

Psychiatric symptoms are common in caregivers of asthmatic children. Approximately 50 % of caregivers of inner-city children who have asthma have significant psychiatric symptom severity. Depression and anxiety disorders were much more common among asthma caregivers than in the general public. Additionally, depression in the caregiver was associated with a 58 % increase in unscheduled clinic visits by the child, and an anxiety disorder in the caregiver was associated with a 31 % increase in asthma-related hospitalizations for the child (Wade et al. 1997). Treatment of the depressed caregivers with antidepressants (sequential response dependent series of escitalopram, bupropion, and mirtazapine) resulted in significant reduction in the self-reported depression ratings of the caregivers as well as significant correlations between improvement in caregiver depression scores and quality of life in the caregiver as well as objective measurement of asthma-related symptoms and lung functioning in the child (Brown et al. 2008).

Psychological support should be provided for the caregivers of chronic and/or terminal patients, which may include support groups, classes, and scheduled holidays (with someone else taking over the caring). Enhancing a sense of coherence of the caregiver family member by the nursing staff may also be helpful in reducing or preventing depression and distress (Tang et al. 2012).

A recent review concerning the care of cancer caregivers (Applebaum and Breitbart 2012) showed that psychoeducation had positive impacts on caregivers' knowledge base and ability to provide care, and also led to improvements in psychological correlates of burden (i.e., depressive and anxious symptomatology) and patient functioning, even when patients were not the direct recipients of the intervention. Problem solving/skills building interventions were also largely successful in improving caregivers'

ability (and confidence in these abilities) to provide care, including the ability to assess and manage patients' symptoms, identify solutions to problems that arose during caregiving, and enhance their overall ability to cope with this role. Overall, the family and couples interventions led to clinically significant improvements in caregiver functioning, in addition to the functioning of the couple or family unit as a whole. CBT and IPT were also effective in reducing psychological distress in caregivers and patients. Combining elements of psychoeducation and support or communication skills training conferred multiple benefits for caregivers.

Respite care, which entails hospitalization of the patient for a short period during which the caregiver can rest and recoup, or day care for the patient, may be essential, especially for caregivers of patients with advanced dementia (Payne 2006; Miyashita et al. 2008; Ryan et al. 2008).

In one study, differences were found between the perceived needs of staff caring for terminal cancer patients and dementia patients. For caregivers of terminal cancer patients, listening to the family member, being available, creating a sense of security, and supporting the family after the patients' death were rated higher while for dementia, forming support groups for families, offering respite care, educating families, and relieving the family's feeling of guilt was rated to be more important (Albinsson and Strang 2003).

For the caregivers of patients with dementia, the issue of placement of the patient in a nursing home can bring much psychological conflict, guilt feelings, and indecision that may call for professional counseling. The psychiatric consultant, as well as the responsible physician, neurologist, or a member of the nursing home staff, can provide such counseling by discussing various options, what can be expected in the nursing home, and reassuring the caregivers that psychological conflicts and guilt feelings are universal in such situations, and that patients with advanced dementia are usually better cared for by professionals who are accustomed to meeting their specific needs.

Hospice care, either as an inpatient or as an outpatient, may be particularly helpful for the terminally ill patient as it can provide expert care and support for both the patient and the family.

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