
REVIEW ARTICLE

Psychological and psychiatric aspects of palliative care: An annotated bibliography

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ABSTRACT

Articles from the last decade that have propelled the field of palliative care are reviewed. The areas of depression, anxiety, substance abuse, delirium, and grief are represented by seminal articles that define, explore, or thoroughly review these topics.

KEYWORDS: Palliative, Depression, Anxiety, Delirium, Substance abuse

As the empirical base of the field of palliative care has expanded, investigators have progressed in defining the important psychological concerns of the dying, the impact of mental illnesses on these patients' quality of life, and the effectiveness of treatments for psychological distress. This annotated bibliography includes articles which, in the view of the authors, have advanced knowledge about the psychological and psychiatric aspects of palliative care. Articles published in the last decade were selected if they defined and explored an important concept, such as dignity or meaning; settled an important controversy, such as the best way to diagnose depression in ill cancer patients, or whether psychotherapy prolongs survival in cancer patients; or reviewed an area in an exceptional manner. Articles on the most important psychiatric disorders were targeted, including depression, anxiety, substance abuse, and delirium. For some common psychiatric conditions, such as anxiety, no important studies were identified; well-written review articles were summarized when more rigorous studies were lacking.

Two omissions must be defended: dementia and physician-assisted death both fell to space limita-

tions. Increasingly, hospices accept patients whose primary diagnosis is dementia, such as Alzheimer's disease. Studies have helped delineate factors that predict the terminal state in Alzheimer's disease, making patients eligible for hospice enrollment. Although mental health professionals are involved in many aspects of care for demented patients, in general their direct role diminishes when the patient becomes mute and motorically restricted. A second issue that has received a great deal of focus in the last decade is death-hastening acts including patients' decisions to stop treatments, the effect of mental disorders on these decisions, and physician-assisted suicide and euthanasia. Recent studies about physician-assisted suicide have been comprehensively reviewed elsewhere (Emanuel, 2002).

The evidence base remains thin for many common clinical problems. For example, there are no rigorous randomized, double-blind clinical trials for treatment of depression or anxiety in terminally ill; the only clinical trial of delirium was not placebo controlled. Such studies are needed to support clinicians' therapeutic recommendations.

1. DEPRESSION

Chochinov, H.M., Wilson, K.G., Enns, M., & Lander, S. (1994). Prevalence of depression in the termi-

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nally ill: Effects of diagnostic criteria and symptom threshold judgments. *American Journal of Psychiatry*, 151, 537–540.

Clinicians may be confounded when attempting to diagnose depression, by the overlap between symptoms of physical illness and the somatic symptoms of depression. In a criterion-based model of depression, such as that used in the Diagnostic and Statistical Manual IV (DSM-IV) of the American Psychiatric Association (1994), symptoms such as poor appetite and low energy may be counted as criteria for depression or attributed to medical illness. Chochinov et al. report on a study of diagnoses comparing the Research Diagnostic Criteria (RDC) for depression (a set of research criteria that preceded DSM-IV), and diagnoses derived from revised (Endicott, 1984) criteria in which somatic symptoms are replaced with other types of nonsomatic distress, such as depressed appearance, social withdrawal, pessimism, or loss of pleasure. In addition, the effect of adjusting the severity threshold for essential symptoms such as low mood was examined. Interviews using items from the Schedule for Affective Disorders and Schizophrenia (SADS), which was at the time of the study the gold standard instrument for diagnosing major depressive disorders, were conducted with 130 cancer inpatients on a hospital-based palliative care unit.

Using low severity threshold cutoff scores, the Endicott system identified fewer depressed patients than the RDC system. When high symptom severity thresholds were applied, the prevalence rates for depression were identical for the two classification systems, suggesting that the high thresholds yield more reliable diagnoses. These high threshold criteria are the same as those used in the DSM-IV, suggesting that whether or not these clinicians attribute somatic symptoms to depression or to medical illness, the diagnostic outcome for major depressive disorder should remain the same. The authors note, however, that there is some risk that less severe depression may go undetected and untreated if only high severity thresholds are used for diagnosis.

Chochinov, H.M., Wilson, K.G., Enns, M., & Lander, S. (1997). "Are you depressed?" Screening for depression in the terminally ill. *American Journal of Psychiatry*, 154, 674–676.

Historically, depression has been both underrecognized and undertreated in the terminally ill (see Passik et al. below). This study presents a succinct screening method that enhances the likelihood that depression will be identified, yet is brief enough

that it can be used routinely in clinical practice. All 197 participants, who were inpatients on a palliative care unit, were evaluated with each of four screening methods for depression: (1) a single item interview asking "Are you depressed?" (2) a two-item interview targeting depressed mood and anhedonia, (3) a visual analog scale, and (4) the short form of the Beck Depression Inventory. The performance of these measures was evaluated against a gold standard diagnosis for each patient obtained from the SADS using strict severity thresholds. The use of the single interview question correctly identified every patient who was also diagnosed with depression based on the SADS. Moreover, the single question was a better diagnostic discriminator than the two-item interview, which ultimately included four patients who did not meet SADS criteria for depression. Both the one-item and the two-item interview were superior to the visual analog scale and the depression inventory. The authors caution that a positive response to the question, "Are you depressed?" should be followed with more in-depth interviewing and assessment for depression.

Passik, S.D., Dugan, W., McDonald, M.V., Rosenfeld, B., Theobald, D.E., & Edgerton S. (1998). Oncologists' recognition of depression in their patients with cancer. *Journal of Clinical Oncology*, 16, 1594–1600.

This study featuring oncologists highlights the tendency of physicians to underestimate the presence and severity of depression in their cancer patients. Twelve oncologists and their 1,109 cancer patients at varying stages of disease, all from health care centers in Indiana, were surveyed about the mood of the patients. Physicians were aware that patients had been screened with the Zung Self-Rating Depression Scale (ZSDS), but were not provided with the results of those screenings. Physicians rated their patients for depression and anxiety severity on a scale ranging from 0 (no depression/anxiety symptoms) to 10 (severe depression/anxiety). Moderate correlations were reported for physician ratings of their patients' mood with the patients' ZSDS scores. Physicians' assessment of their patients' level of depression underestimated the patients' self-report 26% of the time, especially for mild to moderate depression. The accuracy varied significantly across the 12 participating physicians. The authors recommend that oncologists routinely use depression screening tools in practice to facilitate recognition of depression in cancer patients.

Wallace, A.E., Kofoed, L.L., & West, A.N. (1995). Double-blind, placebo-controlled trial of methyl-

phenidate in older, depressed, medically ill patients. *American Journal of Psychiatry*, 152, 929–931.

Macleod, A.D. (1998). Methylphenidate in terminal depression. *Journal of Pain and Symptom Management*, 16, 193–198.

Many experts in palliative care psychiatry recommend psychostimulants such as methylphenidate for treatment of depression in the terminally ill. The primary advantage is onset of action within 1–3 days, as compared to 2–3 weeks for antidepressants such as selective serotonin reuptake inhibitors (SSRIs). Wallace et al. report on a small, double-blind, placebo-controlled crossover study of 16 inpatients with an average age of 72.3 years. All participants met DSM-III-R (American Psychiatric Association, 1987) criteria for major depression and were judged to be poor candidates for conventional antidepressant treatment based on any of the following: (1) vulnerability to side effects, (2) past history of failure to respond to antidepressants, or (3) a critically short life expectancy that would preclude antidepressant effectiveness. After attrition, 13 patients completed the 8-day protocol. Depression was measured with the Hamilton Depression Scale.

Despite the very small sample size, there were significant effects of order of treatment and treatment group, indicating that methylphenidate was effective relative to placebo. This study suggests that methylphenidate may be a promising option for terminally ill, depressed individuals, particularly if they are vulnerable to medication side effects and/or have a very short life expectancy.

The study by Macleod sounds a cautionary note. In this 2-year study, 26 hospice patients with cancer were diagnosed as clinically depressed and treated with standard clinical doses (5–20 mg daily) of methylphenidate. Due to ethical considerations, none of the patients received placebo alternatives. The author and trained nursing staff assessed change in mood with the Clinical Global Impression Scale. A significant improvement in mood was documented for half of the patients who lived longer than 6 weeks. However, only 7% of the participants who died within 6 weeks responded to psychostimulant treatment. Despite the design weakness, Macleod's study highlights the need for further studies of these agents. For the palliative care clinician, the final weeks of life continue to pose unique challenges in the treatment of depression.

Block, S.D. (2000). Assessing and managing depression in the terminally ill patient. *Annals of Internal Medicine*, 132, 209–218.

In this summary of depression in the terminally ill, case illustrations and a table are especially helpful for differentiating the symptoms of illness and grief from depression. Block emphasizes that the clinician must interview thoroughly for depression, and focus on emotions such as guilt, hopelessness, worthlessness, and suicidal ideation to aid in the differential diagnosis. Psychopharmacologic and psychotherapeutic interventions are reviewed; an individualized treatment strategy may require more or less emphasis on one of these modalities, but in general, a model of combined psychotherapy and pharmacological treatment is supported.

2. DELIRIUM

Breitbart, W., Marotta, R., Platt, M.M., Weisman, H., Derevenco, M., Grau, C., Corbera, K., Raymond, S., Lund, S., & Jacobson, P. (1996). A double-blind trial of haloperidol, chlorpromazine and lorazepam in treatment of delirium in hospitalized AIDS patients. *American Journal of Psychiatry*, 153, 231–237.

Delirium is highly prevalent in serious medical illness, can be distressing to patients and families, and is associated with increased morbidity and mortality. The most effective treatment of delirium is reversal of the underlying causes, such as infection, metabolic abnormalities, drugs, or end organ failure. Breitbart et al. published the first double-blind, randomized comparison of pharmacological management of delirium in medically hospitalized patients with AIDS. Consent to participate was obtained from 224 patients with AIDS who did not have delirium, but were followed prospectively. Thirty patients developed delirium and were randomized to treatment with haloperidol, chlorpromazine, or lorazepam. The authors did not include a placebo arm, arguing that nontreatment was not consistent with good clinical care. Patients received very low dosages of medications: a mean in the first 24 hours of 2.8 mg haloperidol, 50 mg chlorpromazine, or 3 mg lorazepam. Because the lorazepam group failed to improve, and developed treatment-limiting side effects, this arm was terminated early. Neuroleptic-treated patients, however, had improvements in both delirium symptoms and cognition. Improvement was measurable in the first 24 hours of treatment, usually before initiation of interventions directed at medical etiologies. Extrapyramidal symptoms were minimal. Limitations to this study were its underlying small sample size and lack of placebo arm such that improvements may reflect "regression to the mean." As only patients

with AIDS were included, the findings may not be generalizable to other delirious patients.

Lawlor, P.G., Gagnon, B., Mancini, I.L., Pereira, J.L., Hanson, J., Suarez-Almazor, M.E., & Bruera, E.D. (2000). Occurrence, causes and outcomes of delirium in patients with advanced cancer: A prospective study. *Archives of Internal Medicine*, *160*, 786–794.

There is considerable debate about whether or not to treat delirium aggressively in advanced terminal cancer. Delirium is considered an expected part of the dying process, and is evaluated less rigorously in home hospice care than in hospital care. Lawlor and coauthors attempted to measure the prevalence and incidence, precipitating factors, and reversibility of delirium in patients with advanced cancer. Of 104 patients with advanced cancer admitted to an inpatient palliative care unit, 42% had delirium. Delirium developed in another 26% during hospitalization, and 88% of deaths were preceded by delirium. A median of three precipitating factors per episode of delirium were identified but almost half of delirious episodes were reversible. In univariate analyses, reversible delirium was associated with psychoactive medications, including opioids, and dehydration. Nonreversible delirium was associated with hypoxia and metabolic factors. In multivariate analyses, psychoactive medications were associated with reversibility, and hypoxia and nonrespiratory infections associated with nonreversible delirium. This study highlights the need to recognize the multifactorial nature and reversibility of delirium. More studies are needed of alternative psychoactive medications, and low burden interventions such as hydration or adjustment of pain, which may improve quality of life in palliative care patients.

3. SUBSTANCE ABUSE

Bruera, E., Moyano, J., Siefert, L., Fainsinger, R.L., Hanson, J., & Suarez-Almazor, M. (1995). The frequency of alcoholism among patients with pain due to terminal cancer. *Journal of Pain and Symptom Management*, *10*, 599–603.

Terminal cancer patients often experience high levels of pain, and alcoholism may be associated with inadequate pain control and diminished patient/family coping. To investigate the prevalence of alcoholism, various ways of assessing for alcoholism, and the relation between alcoholism and pain control, this study retrospectively reviewed medical records of 200 terminally ill cancer

patients. One hundred cases used the CAGE Questionnaire as well as a multidisciplinary assessment (performed in 1992) of the patient and family. The authors reported that a history of alcoholism was reported in approximately one-quarter of patients. They also concluded that multidisciplinary assessment and CAGE screening for alcoholism result in similar findings, but noted that a significant percentage of patients could not complete the CAGE Questionnaire because of sedation or cognitive impairment. Patients diagnosed with and without alcoholism received equivalent pain control after appropriate detection and multidisciplinary treatment. Notably, the authors did not determine current alcohol use; failure to establish whether alcohol abuse was active or in remission may have altered the conclusions of this study.

Lundberg, J.C. & Passik, S.D. (1997). Alcohol and cancer: A review for psycho-oncologists. *Psychoncology*, *6*, 253–266.

Alcohol and comorbid psychiatric disorders can greatly complicate cancer treatment as well as lower quality of life for cancer patients, but many health care practitioners feel inadequately prepared to treat patients with such complex combinations of disorders. The authors summarize the links between alcohol use and site-specific neoplasms (e.g., head/neck, liver, breast, colorectal/pancreatic), and possible biochemical mechanisms by which alcohol may affect cancer. Psychiatric disorders such as anxiety, depression, and antisocial personality disorder are highlighted as common conditions comorbid with alcohol abuse in cancer patients. The authors suggest that physicians identify and treat such disorders for the purpose of increasing cancer treatment compliance. Alcohol abuse is likely to be underestimated in major cancer centers due to socioeconomic barriers to reporting and misdiagnosis. Therefore it is vital to recognize the cancer patient's immersion into an atmosphere of stress/anxiety, lifestyle disruptions, and social isolation that can contribute to the development or recurrence of alcoholism and other psychiatric disorders.

Many disciplines must collaborate to care for a cancer patient with alcohol dependence. The first team goal should focus on proper assessment and acute management of withdrawal symptoms. Assessments may be improved with the use of brief screening tools such as the CAGE Questionnaire, combined with an accurate and detailed patient history of alcohol consumption and historical incidents related to alcohol abuse. Alcohol withdrawal can seriously affect cancer treatment and may lead to death. A basic approach to treating withdrawal

symptoms is presented, focusing on the use of hydration, nutritional supplements, benzodiazepines, and occasionally neuroleptics.

Treatment should emphasize crisis intervention and harm reduction (as opposed to complete abstinence), with the effective continuation of cancer treatment as a prime objective. Therapy is recommended to facilitate effective coping skills, which can replace the use of alcohol as a prime coping strategy. Relapse prevention and treatment compliance are additional critical therapeutic goals. Pharmacological treatment for comorbid psychiatric disorders is also recognized as a useful adjunct to therapy, and possible treatments for depression, anxiety, and alcohol cravings are discussed. Aftercare should consist of continuous support, a firm therapeutic contract addressing treatment compliance, and the judicious treatment of comorbid disorders.

Breitbart, W., Rosenfeld, B., Passik, S., Kaim, M., Funesti-Esch, J., & Stein, K. (1997). A comparison of pain report and adequacy of analgesic therapy in ambulatory AIDS patients with and without a history of substance abuse. *Pain*, 72, 235–243.

Pain is common in AIDS patients, with prevalence ranging from 40 to 60%. Approximately half of new HIV seroconversion occurs in the context of injection drug usage. Undertreatment of pain in some AIDS patients may result from physician distrust of pain reports as well as concerns regarding opioid misuse and abuse. Breitbart et al. compared pain levels in 270 injection drug users (IDUs) with HIV to 246 noninjection drug users (non-IDUs) with HIV. IDUs had similar levels of pain, but had less adequate pain treatment and reported less pain relief than non-IDUs. There was no difference in pain or pain relief between active IDUs and participants who denied current drug use. These data suggest IDUs do not exaggerate their pain reports, but are less likely to receive adequate pain treatment.

Passik, S.D. & Theobald, D.E. (2000). Managing addiction in advanced cancer patients: Why bother? *Journal of Pain Symptom and Management*, 19, 229–234.

Many doctors are ambivalent about treating patients in palliative care for drug addictions. This paper explores reasons why practitioners may be reluctant to provide such treatment, including the permissive view that drug misuse may be a source of pleasure when few pleasures remain and abstinence may in the short-term cause discomfort. Given

that a major goal of palliative care is the “alleviation of suffering for patients and their families,” the authors explain that untreated addiction runs contrary to that goal for multiple reasons. Addiction rarely provides pleasure, but instead complicates pain and illness symptom management, interferes with diagnosis and treatment of other psychiatric problems, and disrupts important social support networks. In place of traditional abstinence-focused treatment goals, alternate goals centered around reduced or controlled use of substances are endorsed.

4. ANXIETY

Payne, D.K. & Massie, M.J. (2000). Anxiety in palliative care. In *Handbook of Psychiatry in Palliative Medicine*, Chochinov, H.M. & Breitbart, W. (eds.), pp. 63–74. New York: Oxford University Press.

Empirical publications on anxiety at the end of life have been sparse. This chapter provides a general review of anxiety in palliative care. The authors report prevalence ranging from 21 to 28%, depending on the measures used and the terminal illness of the population under study. A number of medical situations historically linked to phobias in the general population may, in a small number of cases, precipitate the initial onset of phobia or panic disorder. Posttraumatic stress disorder (PTSD) may also emerge for the first time at the end of life or a recurrence from earlier trauma may be precipitated by heightened distress during terminal illness. A multimodal approach to treatment is recommended that incorporates cognitive-behavioral strategies, supportive psychotherapy, and psychopharmacology. The emphasis on emotional support and problem-solving approaches over insight-focused goals is appropriate. Text and tabulated information provide a review of the pharmacological treatment of anxiety in palliative care.

5. BEREAVEMENT

Prigerson, H.G. & Jacobs, S.C. (2001). Caring for bereaved patients: “All the Doctors Just Suddenly Go.” *Journal of the American Medical Association*, 286, 1369–1376.

Although physicians care for many bereaved people, they often fail to fully recognize the distress that these individuals experience. Prigerson and Jacobs distinguish uncomplicated grief from bereavement-related depression, anxiety, and complicated grief, providing explicit diagnostic criteria

for the latter. Unlike depression, complicated grief does not generally respond to usual psychotherapies or tricyclic antidepressants. Complicated grief is characterized by *separation* distress, seen as yearning for the deceased, and *traumatic* stress, characterized by numbness, disbelief, and bitterness for at least six months, causing substantial functional impairment. A case example is used to illustrate differences between uncomplicated and complicated grief. Guidelines on when to refer to a mental health professional and a table of strategies for communicating with bereaved patients should facilitate physician comfort with addressing grief. The authors tentatively recommend a combination of traumatic grief therapy and SSRIs as optimal treatment, offering support for this approach from preliminary studies.

Reynolds, C.F., Miller, M.D., Pasternak, R.E., Frank, E., Perel, J.M., Cornes, C., Houck, P.R., Mazumdar, S., Dew, M.A., & Kupfer, D.J. (1999). Treatment of bereavement-related major depressive episodes in later life: A controlled study of acute and continuation treatment with nortriptyline and interpersonal psychotherapy. *American Journal of Psychiatry*, 156, 202–208.

Conjugal bereavement is often associated with depressive symptoms, is a known risk-factor for suicide, and is linked to poor health and increased mortality. This study constitutes the first randomized, double-blind, placebo-controlled evaluation of a drug (nortriptyline) and psychotherapy treatment in the acute phase of bereavement-related major depression. Nortriptyline was chosen because at the time the study was designed, it was the antidepressant with the most favorable side effect profile in older adults. Eighty participants with a major depressive episode that began in the time period surrounding the death of a spouse/partner were randomly assigned to a 16-week treatment of (1) nortriptyline alone, (2) placebo alone, (3) nortriptyline plus interpersonal psychotherapy, or (4) placebo plus interpersonal psychotherapy. Nortriptyline was significantly more likely than placebo to reduce Hamilton Depression Scale ratings by half within 8 weeks. There was no significant difference between psychotherapy and medication placebo. The combination of nortriptyline and psychotherapy did not increase efficacy, but did result in the lowest rate of attrition and highest rate of treatment completion, suggesting that the combination may be especially effective in retaining patients for continued treatment. Grief symptoms, as opposed to depressive symptoms, did not respond differentially to treatment versus placebo conditions. Pharmacologic

treatment for a major depressive episode in the context of bereavement is recommended.

6. SPIRITUALITY/MEANING

Block, S.D. (2001). Psychological considerations, growth, and transcendence at the end of life. *Journal of the American Medical Association*, 285, 2898–2905.

This paper advocates that physicians engage in a comprehensive end-of-life treatment plan that extends beyond physical treatment to psychosocial and spiritual needs. Core domains of such a plan are presented with supporting questions to facilitate the process. An example of a patient navigating end-of-life challenges in an extraordinary manner serves to illustrate opportunities for physicians to intervene appropriately. Loss with resulting grief is posited to be one major challenge at the end of life, and information is provided to help practitioners differentiate between normal grieving and pathological responses including depression. Active coping and denial both help patients balance adjustment with preservation of equanimity; however, denial at times may impede the dying person from accepting appropriate care from significant others. The author emphasizes that psychiatric disorders must be frequently reassessed in terminally ill patients, and highlights three common but treatable conditions (depression, anxiety, and delirium). Opportunities for optimizing living while dying through maintaining a sense of continuity of self, maintaining relationships, finding a sense of meaning, addressing control, and preparing for death are also examined. Several tables include helpful questions to initiate important conversations. Ultimately, physicians not only help patients to navigate emotional and physical challenges successfully at the end of life, but also experience tremendous personal challenges and rewards as they assist patients through this intimate experience.

Breitbart, W. (2002). Spirituality and meaning in supportive care: Spirituality- and meaning-centered group psychotherapy interventions in advanced cancer. *Supportive Care in Cancer*, 10, 272–280, DOI: 10.1007/s005200100289.

Greenstein, M. & Breitbart, W. (2000). Cancer and the experience of meaning: A group psychotherapy program for people with cancer. *American Journal of Psychotherapy*, 54, 486–500.

The authors propose that the need for meaning, often discussed within the context of spirituality, is a crucial and primary force in people. They follow

Victor Frankl's suggestion that suffering can act as a catalyst to needing and finding meaning. *Spirituality* is composed of two elements: faith (belief in a higher power, which is often, but not necessarily, connected to organized religion) and meaning (conviction that one has a unique role/purpose in life and is connected to something greater than oneself). Group interventions developed for cancer patients are reviewed, such as psychoeducational groups and cognitive restructuring, with emphasis on strategies and targets for therapeutic change. Despite the known relationship between meaning and psychological health, meaning was not often an outcome variable of interest for previous cancer patient psychotherapy groups. The authors propose a meaning-centered 8-week group intervention focused on what is meaningful in life and reframing a terminal cancer experience from one of dying to one of living. The group incorporates Frankl's three sources of meaning: creativity, experience of relationships/beauty, and attitude. Other themes explored in groups include integrating meaning into a historical life-story, time limitations within life, and the "detoxification of death" through discussion, transcendence, and therapist countertransference. This intervention has undergone pilot testing with cancer patients and is viewed as a promising intervention for people at the end of life.

Chochinov, H.M., Hack, T., McClement, S., Kristjanson, L., & Harlos, M. (2002). Dignity in the terminally ill: A developing empirical model. *Social Science and Medicine*, *54*, 433–443.

Chochinov, H.M. (2002). Dignity-conserving care—A new model for palliative care. *Journal of the American Medical Association*, *287*, 2253–2260.

The concept of dignity, as experienced by people at the end of their lives, is poorly defined and has not been examined empirically. The authors studied the concept of dignity from the perspective of 50 terminally ill cancer patients. Semistructured interviews were utilized to assess participants' definitions of dignity, factors and experiences that could undermine or support dignity, importance of dignity, and perceptions of internal versus externally derived dignity. Using qualitative methods, codes were developed, then grouped into broader categories and definitions were written for all terms.

The resulting model for dignity among people at the end of life consisted of three major categories: *illness-related concerns*, *dignity-conserving repertoire*, and *social dignity inventory*. *Illness-related concerns* characterize factors that directly stem from a patient's illness, particularly various forms of symptom distress and level of independence. The

dignity-conserving repertoire encompasses factors unique to the individual in terms of psychological and spiritual resources. These are functionally represented by dignity-conserving perspectives, such as ways of seeing the situation that can promote a continued sense of self and dignity, and dignity-conserving practices, such as techniques used to maintain dignity. The *social dignity inventory* addresses environmental factors that can affect perceptions of dignity, such as privacy, social support, and burden. Clinical examples illustrate each of the three categories and also show how individuals with similar end-of-life situations can uniquely prioritize the various components of this model. The model is then used to demonstrate how clinicians can explicitly target the promotion of dignity by paying attention to each of the three areas. Ultimately, the dignity model categorizes sources of distress that patients may experience, with the goal of helping care providers recognize and implement a wider range of interventions that may be helpful in promoting dignity.

7. ASSESSMENT/PSYCHOTHERAPY

Chochinov, H.M. (2000). Psychiatry and terminal illness. *Canadian Journal of Psychiatry*, *45*, 143–151.

Toward the goal of assisting "a good death," Chochinov offers a thorough literature review of the small base of publications on the role of psychiatrists in palliative care, outlining the physical, social, spiritual, and psychological needs of dying patients, their caregivers, and their health care providers. The author emphasizes that the role of psychiatry is very appropriately expanded to palliative care in aiding exploration of patients' fears and concerns about dying, disability, and loss of control. Moreover, the establishment of therapeutic rapport in the psychiatrist-patient relationship provides a strong framework of support for dying patients at a time when fears of abandonment and becoming a burden to loved ones can arise. As reviewed here, caregivers of dying persons experience emotional, physical, financial, social, and existential challenges, and are at risk for depression. Mental health professionals can ideally address anticipatory grief as well as clinical depression reported at rates approaching 50% in the first month of bereavement. The review also highlights the potential role of psychiatry in supporting other providers of palliative health care. The literature on depression, anxiety, and delirium is also reviewed by Chochinov, and provides a source for several of the articles reviewed here.

Goodwin, P.J., Leszcz, M., Ennis, M., Koopmans, J., Vincent, L., Guthrie, H., Drysdale, E., Hundleby, M., Chochinov, H.M., Navarro, M., Speca, M., & Hunter, J. (2001). The effect of group psychosocial support on survival in metastatic breast cancer. *New England Journal of Medicine*, *345*, 1719–1726.

This multisite study attempted to replicate an earlier report of increased survival in female breast cancer patients who received a psychotherapeutic intervention. Women with metastatic breast cancer were randomly assigned to a therapy intervention group ($N = 158$) or to a nonintervention control group ($N = 77$). Exclusion criteria included major psychiatric disturbance, severe disease progression, and those who were non-English speakers. The treatment groups were led by trained professionals, who encouraged expression of emotions and the formation of supportive bonds within the group. The control group was not offered any therapy from the study. The main finding was that survival rate was not influenced by treatment. However, mood and pain reports improved significantly for women in the treatment condition who endorsed the most extreme distress at baseline. Although not necessarily life-prolonging, expressive-supportive therapy can play a key role in improving the quality of life for women with metastatic breast cancer.

Rodin, G. & Gillies, L.A. (2000). Individual psychotherapy for the patient with advanced disease. In *Handbook of Psychiatry in Palliative Medicine*, Chochinov, H.M. & Breitbart, W. (eds.), pp. 189–196. New York: Oxford University Press.

This chapter describes the components of successful coping with serious illness, including: the preservation of self-esteem and self-concept; reach-

ing a state of acceptance that permits appropriate treatment; continued involvement in social, family, and work activities to the extent possible; and maintaining functional levels of grief that do not develop into a disabling mood disorder. Examples of interventions for individuals who are struggling with some aspect of coping with serious or terminal illness are presented. The goals of therapeutic intervention are to build or reinforce effective coping strategies, and to provide a platform for review and examination of feelings related to the illness. The importance of tailoring the therapeutic approach to the varied needs of the individual is underscored. The authors outline supportive psychodynamic therapy, insight-oriented psychotherapy, and interpersonal therapy, providing case illustrations for each. Cognitive-behavioral strategies are described only briefly.

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