Palliative Care Review

Anxiety Disorders in the Seriously Ill

In general terms, anxiety can be described as a mood state characterized by fearful anticipation of future negative events or danger. While anxiety is closely related to fear, there is an important difference. While fear generally has an identifiable cause (e.g., fear of upcoming surgery, fear of side effects from treatment, fear of dying), anxiety may or may not be related to identifiable causes, and the patient may simply report general worry and mental suffering without a specific source.

While symptoms of anxiety are common and expected in serious and advanced illness, it is important to differentiate between symptoms of anxiety and anxiety disorders. Transient anxiety can be adaptive and even help the patient and the family mobilize necessary energies while navigating the medical system and pursuing treatment options. Thus, when anxiety is not clinically significant, the level of arousal returns to baseline after the perceived threat or danger is controlled or neutralized, and the patient can continue functioning. However, when anxiety becomes persistent and significantly interferes with the patient's psychosocial functioning, the presence of an anxiety disorder should be considered and assessed. Depending on the assessment method used, the prevalence of anxiety disorders in palliative care patients has been described between 10% and 30%.

Burden of Undertreated Anxiety

The burden of undertreated anxiety is significant, causing great suffering for the patient and the family. Undertreated anxiety has been associated with increased interest in a hastened death, decreased ability to understand clinical information and participate in the treatment plan, decreased trust in the treating physicians, and decreased expectations that adequate symptom control will be provided at the end of life.

Clinical Manifestations of Anxiety

The clinical manifestations of anxiety include physical, psychological, and cognitive symptoms. Physical symptoms include diaphoresis, diarrhea, nausea, dizziness, tachycardia or tachypnea, palpitations, chest discomfort, and gastrointestinal distress. Psychological symptoms include feeling edgy or irritable. Cognitive symptoms include worrying, hypervigilance, catastrophizing, and rumination.

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Medical Causes of Anxiety

Medical conditions and medications can mimic, precipitate, or worsen anxiety. Anxiety is associated with specific diseases, such as hyperthyroidism and pheochromocytoma, or tachyarrhythmias of any cause. Undertreated pain and poorly controlled dyspnea are well-recognized causes of anxiety. Corticosteroid treatment or stimulant drug intoxication can cause anxiety, as can any disorder associated with a confusional state.

Psychosocial and Spiritual Factors Associated with Anxiety

Existential distress and uncertainty about the future in the face of advanced illness; spiritual crises, doubt and loss of faith; difficult relationships with the treating team; and practical concerns related to finances or insurance coverage are all factors that can contribute to creating or worsening anxiety for the patient and the family. Additionally, fear of dying and of uncontrolled symptoms at the end of life can also increase anxiety and suffering.

Assessment and Diagnosis

Clinicians should routinely screen patients for the presence of anxiety symptoms. This can ensure that the patient will receive adequate support and that pathological forms of anxiety will be identified in a timely manner and addressed in the treatment plan. It is important to note that patients may not recognize, acknowledge, or verbalize anxiety. Clinicians should pay attention to the patient's behaviors, affect, or speech that may be indicative of anxiety, such as statements about feeling nervous, concerned, or worried. A brief screening tool such as the Patient Health Questionnaire for Anxiety and Depression (PHQ) can help clinicians identify patients with anxiety during routine clinical encounters.

Additionally, simple questions can be routinely integrated into the clinical interview:

- Do you feel nervous?
- What do you think about most of the time?
- Have you felt fearful, worried, or tense?
- Do you ever feel like you cannot stop worrying?
- Do you ever wake up in the middle of the night and worry?

Anxiety Disorders

Anxiety disorders common in patients with advanced illness are: adjustment disorders with anxious features, generalized anxiety disorders, panic disorders, and post-traumatic stress disorder. Diagnosis of anxiety disorders is based on DSM-5 criteria.

Adjustment disorder with anxiety is characterized by severe symptoms that develop within 3 months of an identifiable stressor (e.g., receiving a diagnosis of serious or advanced illness).

Generalized anxiety disorder is characterized by ongoing, excessive, and uncontrollable anxiety and worry that lasts for at least 6 months and significantly impacts the patient's psychosocial functioning.

Panic disorder is characterized by recurrent panic attacks and worry, and apprehension about future attacks that significantly impairs psychosocial functioning. A panic attack is a sudden onset of intense anxiety and fear, often accompanied by shortness of breath and palpitations, lasting usually 15-20 minutes.

Post-Traumatic Stress Disorder (PTSD) is characterized by re-experiencing a traumatic event with nightmares, intrusive memories, and hypervigilance. Patients with PTSD also

experience avoidance and numbness. As with adjustment disorders, patients may develop PTSD after receiving news of a diagnosis of advanced illness, a limited prognosis, or after complications of treatment.

Treatment

Nonpharmacological Approaches

Nonpharmacological approaches may be effective and should always be considered as a first line of treatment, if possible, or in conjunction with pharmacological treatment. Cognitive-behavioral therapy can improve the patient's sense of control, self-confidence, and coping by addressing cognitive distortions and automatic negative thoughts that can precipitate and worsen anxiety. Complementary and integrative medicine approaches such as clinical hypnosis, guided imagery, and music therapy can similarly increase the patient's empowerment by decreasing arousal and promoting relaxation and positive imagery.

Pharmacological Approaches

Pharmacological agents are chosen based on goals, life-expectancy, and side-effect profile. If the patient's life expectancy is greater than 2-3 months, preferred treatments include antidepressants (e.g., SSRIs such as escitalopram, citalopram, and sertraline, or SNRIs such as venlafaxine and duloxetine) or gabapentinoids (e.g., gabapentin). Antidepressants are preferred if the patient has comorbid depression. Benzodiazepines (e.g., lorazepam or alprazolam) are usually considered the drugs of choice for the management of acute anxiety. If anxiety is associated with an emerging confusional state, a neuroleptic (e.g., haloperidol) should be considered). Anxiety associated with terminal delirium can be managed with either a benzodiazepine or a neuroleptic.

Bibliography

Bradt et al., Music intervention for improving psychological and physical outcomes in cancer patients. Cochrane Syst Rev. 2011.

Brugnoli MP. Clinical hypnosis for palliative care in severe chronic diseases: a review and the procedures for relieving physical, psychological and spiritual symptoms. *Ann Palliat Med.* 2016; 5(4):280-297.

Buoli M, Caldiroli A, Caletti E, Paoli RA, Altamura AC. New approaches to the pharmacological management of generalized anxiety disorder. Expert Opin. Pharmacother. 2013;14(2):175-184.

Caruso et al., Psychopharmacology in psycho-oncology. Curr Psychiatry Rep. 2013;15:393.

Fairman N, Hirst JM, Irwin S. Clinical manual of palliative care psychiatry. 2016. American Psychiatric Association Publishing.

Greer et al., Tailoring cognitive-behavioral therapy to treat anxietycomorbid with advanced cancer. J Cogn Psychother. 2010;24:294-313.

Hinshaw D, Carnahan J, Johnson D. Depression, anxiety and asthenia in advanced illness. J Am Coll Surg 2002;195(2):271-278.

Kolva et al. Anxiety in terminally ill cancer patients. J Pain Symptom Manage. 2011;42(5):691-701.

Kroenke et al. An ultra-brief screening scale for anxiety and depression: the PHQ-4. Psychosomatics. 2009; 50(6):613-621.

Montgomery et al., Hypnosis for cancer care: over 200 years young. Cancer J Clin. 2013;63:31-44.

Protus et al. Palliative Care Consultant. 2015 HospiceScript.

Spencer et al. Anxiety disorders in advanced cancer patients: correlates and predictors of end-of-life outcomes. Cancer.2010:116:1810-1819.

Strada A. Palliative Psychology: Clinical Perspectives on this Emerging Subspecialty. Oxford University Press. In Press.

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