JOURNAL OF PALLIATIVE MEDICINE
Volume 27, Number 12, 2024
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DOI: 10.1089/jpm.2024.0135

Palliative Care Specialists Series

Feature Editors: William E. Rosa and Christopher A. Jones

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Top Ten Tips Palliative Care Clinicians Should Know About the Psychiatric Manifestations of Nonpsychiatric Serious Illness and Treatments

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Abstract

Mental health issues are widespread and significant among individuals with serious illness. Among patients receiving palliative care (PC), psychiatric comorbidities are common and impact patient quality of life. Despite their prevalence, PC clinicians face challenges in effectively addressing the intricate relationship between medical and psychiatric disorders due to their complex, intertwined and bidirectionally influential nature. This article, created collaboratively with a team of psychiatric–palliative care experts, is the second in a two-part series examining the bidirectional relationship between medical and psychiatric illness in PC. This article explores 10 prevalent psychiatric manifestations associated with severe illness and its treatment. Building upon the first article, which focused on 10 common physical manifestations of psychiatric illness among patients receiving PC, these two articles advocate for an integrated approach to PC that prioritizes mental and emotional wellbeing across the continuum of serious illness.

Keywords: anxiety; catatonia; end-of-life; major depressive disorder; mental health; hospice; palliative care; psychiatry; psychological distress; sleep disturbance; substance use disorders; total pain

Introduction

Psychiatric comorbidities are common and impactful among patients receiving specialty palliative care (PC). Depression and/or anxiety, for example, which have been shown to impact up to 50% of patients with serious illness, can lead to higher physical symptom burdens, higher health care utilization, and poor quality of life among patients with serious illness.[1–4] While other psychiatric comorbidities, such as psychotic disorders or substance use disorders, have been less studied, they may also be prevalent and impactful among patients receiving PC.[5,6]

The management of psychological and psychiatric aspects in serious illness is crucial within PC, exerting considerable

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Accepted April 10, 2024.

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influence on referrals and ranking among the primary concerns for both patients and PC specialists.[7,8] However, significant gaps persist in care and training. Despite the invaluable frontline mental health expertise provided by PC social workers, there is a lack of integration of formal mental health interventions or measurements, resulting in the underdiagnosis and undertreatment of common psychiatric comorbidities.[9,10] Around 80% of PC clinicians observe that unmet mental health needs negatively affect their PC services delivery.[11] Moreover, PC clinicians' comfort and utilization of psychiatric skills, including capacity assessment and managing psychiatric emergencies such as suicidality, are poorly understood, likely due to inadequate training opportunities.[11] Although most hospice and palliative medicine (HPM) fellowships provide some psychiatric training, didactic content varies widely, with essential topics, such as depression, anxiety, and dementia, not universally covered.[12] Additionally, only 15% of programs offer required experiential psychiatric training through clinical rotations.[12]

The bidirectional relationship between medical and psychiatric illnesses poses challenges for PC clinicians. This article is the second of a two-part series, and Table 1 provides a list of the 10 tips from both articles for convenience. Part one emphasized the need for caution in attributing physical symptoms solely to psychiatric factors, while also underscoring their potential contribution.[13] Conversely, psychiatric illness can originate or be exacerbated by medical conditions. While this article will not explore specific instances of direct causation, such as post-ICU depression or post-traumatic stress disorder (PTSD) resulting from cancer treatments, this second article will explore 10 prevalent psychiatric manifestations of serious medical illness and its treatment encountered by professionals working with patients facing serious illnesses. PC clinicians developing competence in recognizing the interplay between medical and psychiatric illness among those patients facing serious illness is vital for delivering comprehensive whole-person.[14] For a complete glossary of terms, refer to Table 1 included within the first of this two-part series.[13]

Tip 1: Both a Cancer Diagnosis and Cancer Treatments Can Precipitate Cognitive and Mood Symptoms

Cancer is strongly associated with new onset or recurrent psychiatric diagnoses.[15,16] Approximately half of cancer patients exhibit significant psychological distress during their illness and a third will meet criteria for a neuropsychiatric disorder.[17,18] Patients with advanced disease or approaching the end of life may have even higher rates of psychiatric comorbidity. The most common psychiatric comorbidities of cancer include anxiety, depression, and adjustment disorders; many other disorders such as PTSD, personality disorders, and substance use disorders are understudied but may also be prevalent.[19]

Psychiatric comorbidities among patients with cancer may be associated with differential health service utilization and decreased survival.[15,16] By assessing and treating psychiatric comorbidities in this population, PC clinicians can support patients' quality of life, reduce suffering, and improve outcomes.

The association between cancer and neuropsychiatric disorders is multifactorial and includes the pathophysiology of cancer (e.g., inflammation and other neuroendocrine changes), the psychosocial stressors of having a serious illness, physical symptom burden, and the effects of many cancer treatments. Given this complexity, PC clinicians can best serve as stewards of mental health for patients receiving cancer treatment by both recognizing the general elevated risk of psychiatric comorbidities and understanding common risk factors for psychiatric symptoms. Such risk factors include cancer type and stage (e.g., head-and-neck cancers and more advanced cancers confer greater risk), psychosocial factors (e.g., patients lacking social support may have higher risk), and treatment-related factors (e.g., radiation treatment to the brain, cytotoxic chemotherapy, certain medications, including interferons and corticosteroids, are all examples of treatments that may increase the risk of neuropsychiatric complications).

Tip 2: Patients with End-Stage Organ Failure, Including Cirrhosis, Dialysis-Dependent Renal Disease, and Heart Failure, Experience High Rates of Depression, Anxiety, and Cognitive Impairment Associated with Their Condition

Organ dysfunction of any kind can cause, contribute to, and exacerbate mental health problems, including depression, anxiety, and cognitive impairment.[20–24] For example, among 1021 patients across a tertiary care center, a safety net hospital, and a Veterans Affairs hospital, 15.6% of patients with cirrhosis reported having moderate-to-severe depression when screened.[20] Moreover, the sicker the patient perceived themselves to be, the more likely they were to have depression.

Similarly, end-organ damage appears to significantly affect patients' cognitive function, leading to further difficulties in coping with their illness. These psychological and cognitive factors contribute to the experience of the physical illness (e.g., "total pain" as outlined in the first article of this two-part series), the capacity to adhere to care plans, and engagement in meaningful daily activities.[13] Patients with organ dysfunction should be screened for these problems. A common and easy-to-use screening instrument for depression is the Patient Health Questionnaire-9 (PHQ-9), for anxiety is the Generalized Anxiety Disorder-7 (GAD-7), and for cognitive impairment is the St. Louis University Mental Status (SLUMS) examination.[25–27] Positive screening results should prompt further evaluation by the PC clinician and possibly a mental health clinician.

Tip 3: Delirium is the Master Mimicker; It Presents with Other Psychiatric Symptoms and Is Difficult to Diagnose Without Intentional Screening

Delirium is very common across PC settings, with a point prevalence of 35% on admission to inpatient palliative care units.[28] The risk appears to increase significantly in the presence of modifiable factors such as opioid use, sleep disturbance, and dehydration; and by unmodifiable factors such as age, dementia, and brain cancer.[29] While the attentional deficits of severe delirium are readily noticed, clinicians often miss delirium when it presents with other psychiatric symptoms such as depression, anxiety, or psychosis. For example, in one study of PC admissions, 59% of patients who met criteria for delirium also met screening criteria for major

Table 1. Tips on the Bidirectional Nature of Medical and Psychiatric Illness in Palliative Care from the Two-Part Series

	Top Ten Tips Palliative Care Clinicians Should Know about the Physical Manifestations of Psychiatric Illness and Treatment[13]	*Top Ten Tips Palliative Care Clinicians Should Know about the Psychiatric Manifestations of NonPsychiatric Serious Illness and Treatments*
Tip 1	Neurovegetative symptoms are common in a major depressive episode (MDE) and can contribute to diagnostic uncertainty	Both a cancer diagnosis and cancer treatments can precipitate cognitive and mood symptoms
Tip 2	Patients with anxiety disorders can present with physical symptoms, such as shortness of breath or nausea	Patients with end-stage organ failure including cirrhosis, dialysis-dependent renal disease, and heart failure experience high rates of depression, anxiety, and cognitive impairment associated with their condition
Tip 3	Sleep disturbances may be the initial warning sign of psychiatric illness	Delirium is the master mimicker; it presents with other psychiatric symptoms and is difficult to diagnose without intentional screening
Tip 4	There is a bidirectional relationship between psychological symptoms and pain, underscoring the need to assess "total pain"	Anxiety and sleep disturbance are the brain's "fevers of unknown origin" (symptoms related to diagnoses of exclusion)—keep the differential diagnosis broad
Tip 5	Patients with substance use disorders (SUDs) often have intoxication and withdrawal symptoms that create a "total symptom" presentation with the advanced illness symptoms	Seizures and their treatments, especially levetiracetam, can present with neuropsychiatric symptoms and/or precipitate or worsen irritability, agitation, and depression
Tip 6	Catatonia is a neuropsychiatric syndrome, which can stem from serious medical or psychiatric illness	Psychosis, anxiety, and/or depression commonly present before cognitive impairment in early-stage dementia
Tip 7	Extrapyramidal symptoms, such as akathisia, dystonia, parkinsonism, and tardive dyskinesia, are common side effects of antipsychotic medications and can masquerade as other neurological or psychiatric conditions	Although neurocognitive disorders may not be categorized as psychiatric disorders, they are included in the DSM and are strongly associated with a range of psychiatric symptoms
Tip 8	Serotonin syndrome, which presents with autonomic dysfunction, neuromuscular excitation, and encephalopathy, is a possible side effect of combining serotonergic agents	Substance use and substance-induced mood disorders present therapeutic challenges at the end of life
Tip 9	Somatic Symptom Disorder (SSD) is often comorbid with other symptoms, requiring holistic approaches to care	Pathological and iatrogenic disturbances of the endocrine system have varied neuropsychiatric presentations
Tip 10	Psychotropic medications may need to be adjusted at the end of life to prevent significant delirium and/or cognitive impairment	Passive suicidal ideation, different from active suicidal ideation that is accompanied by a plan of action and intent to proceed, is common at the end of life or in serious illness

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depression.[30] Similarly, up to 50% of patients with delirium have psychotic symptoms.[31,32]

In the hospital setting, screening tools, such as the Confusion Assessment Method for the ICU (CAM-ICU), are more likely to detect delirium than clinicians performing a standard clinical interview.[33] To effectively treat psychiatric symptoms, clinicians must incorporate a bedside screening test of delirium before diagnosing medically ill patients with a primary psychiatric condition. For example, inadvertently starting a benzodiazepine for anxiety masquerading as delirium could severely exacerbate delirium further. Validated bedside tests of attention that are easy to incorporate include the CAM-ICU, the Ultra-Brief (UB-2) Delirium Screen, and 4A's Test for Delirium Screening (4-AT).[33–35] The hallmark exam finding is to assess for an impairment in attention, such as squeezing one's hands whenever the letter A is recited for the word "CASABLANCA" or reciting the months backward. When symptoms of anxiety, depression, and psychosis are present with delirium, clinicians should try to treat reversible causes of delirium and provide nonpharmacological interventions, before considering psychotropic pharmacological interventions.[36]

Tip 4: Anxiety and Sleep Disturbance Are the Brain's "Fevers of Unknown Origin" (Symptoms Related to Diagnoses of Exclusion)—Keep the Differential Diagnosis Broad

Clinicians often reify the symptoms of anxiety and sleep disturbance into primary psychiatric diagnosis that require pharmacological treatment. This is particularly true for anxiety, which even in physically healthy people is commonly due to another condition such as depression, mania, psycho sis, PTSD, or the personality trait of neuroticism.[13,37] In patients who are seriously medically ill, symptoms of anxiety are often due to a medical condition such as delirium,

uncontrolled pain, air hunger, medications such as steroids, or due to psychological factors such as existential distress and grief.[38] For these conditions, treating the underlying cause will be more effective than providing a medication targeting the symptoms.

Similarly, sleep disturbance is commonly due to another medical or psychiatric condition that requires treatment before medications for insomnia. For example, outpatient pharmacology trials for insomnia disorder routinely exclude 50%–60% of patients due to medical conditions such as sleep apnea and restless leg syndrome, or psychiatric conditions such as major depressive disorder or PTSD.[39,40] Medications for insomnia typically do not work well, averaging about 20–30 additional minutes of nonrestorative sleep per night.[41] For this reason, even when insomnia disorder is suspected, all major sleep guidelines recommend cognitive behavioral therapy for insomnia (CBT-I) first before pharmacological interventions.[42,43]

Tip 5: Seizures and Their Treatments, Especially Levetiracetam, Can Present with Neuropsychiatric Symptoms and/or Precipitate or Worsen Irritability, Agitation, and Depression

Neuropsychiatric symptoms are more prevalent in patients with epilepsy or those undergoing seizure disorder treatments compared with the general population.[44] The lifetime prevalence of psychiatric disorders among individuals with epilepsy is 33%.[45] In adults, meta-analyses reveal a 23.1% prevalence of active depression among those with epilepsy a 2.7 times higher likelihood compared with the general population.[46]

Other conditions, such as anxiety, psychogenic nonepileptic seizures, and schizophrenia, are also more common with prevalence ranging from 5–20%.[47–49] Similar comorbidities are observed in children with epilepsy, including attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder (ASD), depression, and anxiety.[50] This relationship is bidirectional, with psychiatric disorders, such as depression, psychosis, ADHD, and ASD having an increased risk of developing epilepsy.[51] Furthermore, psychiatric comorbidities in epilepsy negatively impact patient quality of life, and their presence is considered a potential prognostic indicator.[52] Psychiatric disorder severity, especially depression, correlates with lower odds of achieving seizure remission, increased risk of antiseizure medication side effects, and a fourfold higher risk of drug resistance in focal and generalized epilepsies.[53]

The connection between epilepsy and psychiatric disorders arises from both psychosocial and biological factors. Epilepsy brings about social limitations, unpredictable seizures, and associated challenges such as social embarrassment, diminished self-esteem, social withdrawal, and isolation.[52] Psychiatric symptoms may also be influenced by the neurobiology of the seizures themselves, occurring before or after seizures or stemming from epilepsy treatments, including antiepileptic medications or surgery. The neuropsychiatric symptoms associated with antiepileptic medications are outlined in Table 2.[52] Levetiracetam is commonly associated with irritability, aggression, anxiety, depression, and psychosis, making it one of the most frequently implicated agents. In epilepsy patients with psychiatric symptoms, consideration of transitioning from levetiracetam to an alternative antiepileptic agent is advisable if tolerated.

Addressing comorbid psychiatric syndromes with epilepsy can be complex, as psychiatric treatments may affect seizure threshold or interfere with epilepsy treatment. A recommended approach involves a broad interdisciplinary team including PC, psychiatry, epileptology, social work, pharmacy, and others to effectively manage these overlapping conditions.

Tip 6: Psychosis, Anxiety, and/or Depression Commonly Present Before Cognitive Impairment in Early-Stage Dementia

Neuropsychiatric symptoms are almost ubiquitous in people with dementia or major neurocognitive disorder (MNCD), with prevalence estimates as high as 97%.[54] There is growing evidence that neuropsychiatric symptoms may precede the prodromal stages of dementia; this phenomenon has received less attention than dementia's traditional clinical hallmarks, such as cognitive and functional decline. Depression, anxiety, apathy, irritability, agitation, psychosis, and other symptoms can present before cognitive impairment in early-stage dementia.[55] For example, one study of new-onset dementia patients captured the point prevalence for delusions (18%) and hallucinations (10%) at baseline.[56]

Table 2. Psychiatric Side Effects of Common Antiseizure Medications[a]

Medication	*Psychiatric side effect*
Barbiturates	Depression, sedation
Benzodiazepines	Delirium, depression; may present with hyperactivity, aggression or irritability in some patient subsets (ie., those with intellectual disability)
Carbamazepine, oxcarbazepine, eslicarbazepine	None reported
Gabapentin, pregabalin	Depression
Lacosamide, rufinamide	None reported
Lamotrigine	Hyperactivity, irritability, aggression in some patient subsets
Levetiracetam, brivaracetam	Irritability, aggression, anxiety, depression, psychosis
Phenytoin	Psychosis
Zonisamide	Depression, irritability, psychosis
Topiramate	Depression, irritability, psychosis
Valproate	Sedation

[a]Modified from Mula et al., Continuum 2002[53].

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Anxiety can manifest as an early sign of Alzheimer's disease (AD), even heralding the initial stages of cognitive decline. In these instances, anxiety can stem from the individual's awareness of cognitive decline, fear of losing independence, or difficulty coping with initial deficits in memory and cognition. Anxiety is a risk factor for an increased conversion rate from mild cognitive impairment to dementia, as elevated anxiety levels are associated with more rapid decline in memory. Prodromal anxiety has been shown to possibly be most prominent among patients with early-onset forms of AD that begin at <65 years of age.[57] Early identification and treatment can mitigate detrimental effects, since anxiety symptoms can exacerbate cognitive impairment, disrupt daily activities, and impair quality of life when untreated.

Depression is also common in the early stages of dementia and can present with symptoms, such as persistent sadness, anhedonia, changes in appetite or sleep patterns, and feelings of hopelessness or worthlessness. People who become depressed late in life have a 70% increased risk of dementia.[58] Patients with late-life depression symptoms have a two-fold increase in AD, and those with midlife and late-life depressive symptoms have a threefold increase in vascular dementia.[58] Evidence underscores the bidirectional relationship between depression and cognitive decline, emphasizing the urgency for early intervention to break this cycle.

PC clinicians' ability to recognize and address the neuropsychiatric symptoms early in the course of dementia is crucial for prognostication, optimizing quality of life, enhancing patient and caregiver wellbeing, and improving treatment outcomes. PC teams' interdisciplinary approach can offer medical, psychological, spiritual–existential, and social interventions necessary to manage these complex symptoms effectively in PC settings.

Tip 7: Although Neurocognitive Disorders May Not Be Categorized as Psychiatric Disorders, They Are Included in the DSM and Are Strongly Associated with a Range of Psychiatric Symptoms

Behavioral and psychological symptoms of dementia (BPSD) frequently occur in patients diagnosed with MNCD.[59] Depressive disorders are also prevalent in neurodegenerative conditions such as multiple sclerosis (30.5%) and Huntington's disease (38%).[60,61]

Due to the interdisciplinary nature of PC and in the absence of alternative resources, PC clinicians are frequently tasked with addressing these symptoms and should be familiar with the latest evidence pertaining to both pharmacological and nonpharmacological interventions.[11]

BPSD, including aggression and agitation, are frequently encountered and pose challenges for PC clinicians. The first-line treatment options for the management of these symptoms in MNCD include behavioral interventions, Selective Serotonin Reuptake Inhibitors (SSRIs) (mainly Sertraline and Escitalopram), and acetylcholinesterase inhibitors with a noted differential response to each. For breakthrough behavioral disturbances, Trazodone can serve as a first-line option due to its low risk of adverse events; benzodiazepines and antipsychotics are not recommended as a first-line intervention.[62]

The management of depression in neurodegenerative disorders follows the same principles as in the general population. First and foremost, it is crucial to establish a diagnosis among the depressive disorders to tailor the treatment plan and set expectations. The choice of treatment depends on the prominent presenting symptoms and when possible, use monotherapy to target as many symptoms as possible. Owing to high fatigue comorbidity in neurodegenerative disorders, agents, such as amantadine, psychostimulants, modafinil, and bupropion, have been studied and could be considered as therapeutic agents in this population.

Tip 8: Substance Use and Substance-Induced Mood Disorders Present Therapeutic Challenges at the End of Life

Patients with comorbid substance use disorders (SUDs) are increasingly seen in PC practice, including the ambulatory setting. Mood and anxiety disorders can be increasingly challenging to diagnose and manage with active substance use, intoxication, or withdrawal.

Depression is common for patients with comorbid substance use disorders, opioid use disorder (OUD), and alcohol use.[63,64] Few studies have evaluated a specific diagnostic process for patients with serious illness and SUDs in screening and diagnosing depression, and fewer have tested specific interventions for depression treatment. Evidence has shown that treating the underlying SUDs can improve depression symptoms, including the use of buprenorphine for patients with OUD.[65] When possible, we recommend engaging with addiction specialists and psychiatric support services for patients and developing comanagement plans tailored to specific patient needs.

Pharmacological therapies for patients with substance-induced mood disorders, should focus on guideline-directed therapies for patients' underlying serious illness. For example, patients with advanced heart failure and comorbid depression, should be treated with an SSRI, such as sertraline based on prior studies of safety and outcomes.[66] In general, pharmacotherapy should be reserved for patients with moderate-to-severe major depressive symptoms as measured by standardized tools such as the PHQ-9.[25] In line with other studies, we recommend escitalopram or sertraline among SSRIs, or the serotonin and norepinephrine reuptake inhibitors (SNRIs) duloxetine, venlafaxine, or desvenlafaxine if patients have a significant component of neuropathic pain or fibromyalgia.[67]

Tip 9: Pathological and Iatrogenic Disturbances of the Endocrine System Have Varied Neuropsychiatric Presentations

The endocrine system and central nervous system function interrelatedly to coordinate metabolism, maintain circadian regulation, and manage stress, among other roles. Endocrinopathies often have neuropsychiatric manifestations. Almost all endocrine perturbations may include neuropsychiatric symptoms, which can vary widely.[68] Such symptoms may manifest before—or in the absence of—other symptoms. Psychiatric manifestations may be due to hormone dysregulation (e.g., excess thyroid hormone), secondary metabolic issues (e.g., calcium dysregulation in parathyroid pathology), or shared common etiologic factors (e.g., auto-antibodies).

Many serious illnesses are associated with endocrine dysfunction due to inflammation, the effects of treatment,

malnutrition, and other pathophysiological changes associated with serious illness. As a result, rates of endocrinopathies among patients with serious illness are high. The epidemiology of endocrine disorders in patients with serious illness has predominantly been studied in people with cancer. Patients receiving immunotherapy (e.g., among non-small cell lung cancer patients receiving pembrolizumab, 20% experienced thyroid dysfunction) and long-term cancer survivors (half of long-term cancer survivors experience at least one endocrinopathy) are at particularly high risk.[69–73] In evaluating the potential role of endocrine dysfunction in psychiatric symptoms among individuals with serious illness, PC clinicians should aim to balance clinical vigilance with the risk of over-testing/treatment. In general, psychiatric symptoms are secondary to endocrinopathies when:

- Patients develop new psychiatric symptoms that are inconsistent with their prior history—or even their prior coping with their serious illness.
- There are prominent cognitive symptoms that are atypical of the presenting psychiatric symptoms.
- Psychiatric symptoms are accompanied by physical symptoms (e.g., changes in temperature tolerance, excessive sweating, excessive thirst, neurological symptoms) or laboratory findings (e.g., perturbations in glucose or calcium) that raise concern for endocrinopathies.
- Patients have diseases or treatments (e.g., immunotherapies, interferon-alpha, corticosteroids) that are known to cause endocrinopathies.

In such cases, PC clinicians should collaborate with an endocrinologist for diagnostic workup/management. In some cases, the underlying cause of endocrine disruption cannot be directly addressed (e.g., androgen deprivation therapy necessary for cancer management). As it is often difficult to definitively ascertain the etiology of psychiatric symptoms, appropriate psychiatric treatment should be simultaneously initiated. Such treatment is rarely contraindicated and may help alleviate symptoms, even if patients are found to have an endocrinological disorder that may be causing their psychiatric distress.

Tip 10: Passive Suicidal Ideation, Different from Active Suicidal Ideation That Is Accompanied by a Plan of Action and Intent to Proceed, Is Common at the End of Life or in Serious Illness

Active suicidal ideation, with both a plan of action and an intent to proceed, is considered a true psychiatric emergency warranting involvement of a psychiatrist and consideration of legal hold for safety. In contrast, passive suicidal ideation is much more common. Passive suicidal ideation is the desire for death in the absence of any plan or intent to achieve that outcome. Patients may make comments such as, "I'm not sure why I do it anymore," "I wish it would all end," "I don't see the point anymore," "Sometimes I wish I could go to sleep and not wake up," or "You'd be better off without me."

One study assessing the prevalence of desires for death in patients with terminal illness found that such feelings correlated with pain ratings, low family support, and most significantly depression.[74] When faced with passive suicidal ideation, the primary tasks of any clinician are to recognize that multiple factors may be contributing to these feelings and to create a safe, open space in which to explore and better understand these feelings with patients. Along with screening for depression, this may more broadly include symptomatic screening, including existential or psychosocial screenings. Demoralization, for example, is an entity distinct from depression (although at times comorbid with depression) that can be associated with feelings of hopelessness and passive suicidal ideation.[75] In cases of existential distress contributing to desires for a hastened death, holistic approaches targeted at existential suffering (such as meaning-making, spiritual care, dignity therapy, and others) may have an important role. At other times, passive suicidal ideation may be an indication that one's stressors feel as though they are overwhelming one's available coping resources; in these cases, alleviating modifiable stressors and/or bolstering coping and support can help to palliate.

Conclusion

In the provision of high-quality PC, understanding and navigating the complex interplay between medical and psychiatric conditions is essential. As demonstrated in our two-part 'top ten' series, the bidirectional relationship between medical and psychiatric illness not only presents challenges but also offers opportunities for PC specialists to comprehensively evaluate and manage both medical and psychiatric presentations. Emphasizing the need for caution in attributing symptoms solely to one domain or the other is paramount. PC clinicians must prioritize thorough assessments, rule out potential medical contributors to patients' symptoms and ensure comprehensive and tailored support for individuals facing serious illnesses. Ultimately, integrating mental health considerations into the broader spectrum of PC contributes to meeting patients' medical, psychological, and spiritual needs, embodying the essence of high-quality PC.

Author Disclosure Statement

No competing financial interests exist.

Funding Information

J.A.W.—Patient-Centered Outcomes Research Institute (grant funding), American Academy of Hospice and Palliative Medicine (honoraria). W.E.R.—partially funded by National Institutes of Health/National Cancer Institute Comprehensive Cancer Center (Grant P30 CA008748).

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