

Managing Psychological Conditions in Palliative Care

Dying need not mean enduring uncontrollable anxiety, depression, or delirium.

By Judith A. Paice, PhD, RN, FAAN

Life-threatening illness presents extraordinary psychological challenges to those afflicted. Anxiety, depression, and delirium, three of the most common psychological conditions seen in the terminally ill, can each occur as a result of the primary disease, concomitant physical conditions, inadequate pain management, medication side effects, or a combination of these.

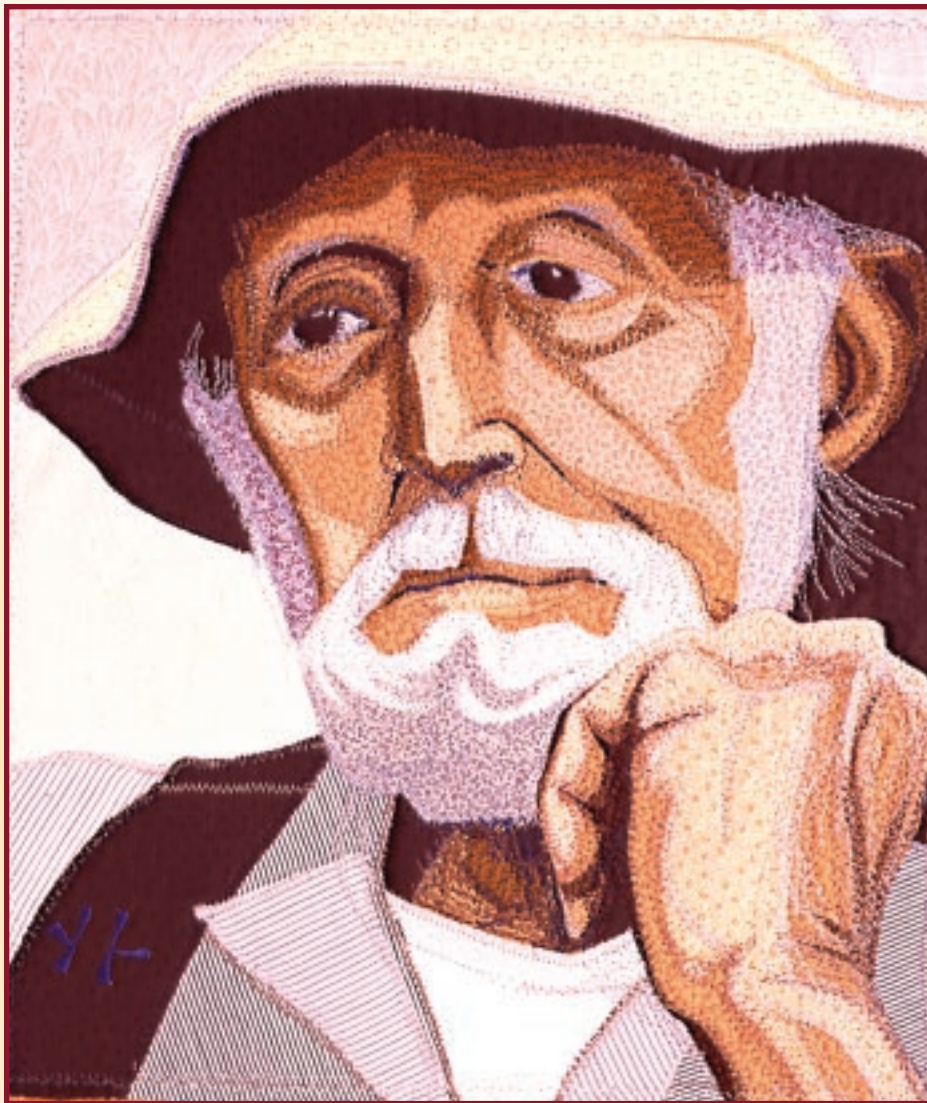
Consider the case of Beatriz Hernández, who is crying and moaning and keeps trying to get out of bed. A 55-year-old divorced woman with stage IV breast cancer, she has been admitted to the ED; she is confused and agitated and in obvious pain. Her sister reports that Ms. Hernández has been noticeably more anxious than usual. Assessment reveals mild dehydration, as demonstrated by poor skin turgor and a heart rate of 110. An IV is started and hydromorphone 1 mg IV push given to control pain and lorazepam 0.5 mg IV to reduce agitation. Laboratory values are normal, as is oxygenation

level (partial pressure of oxygen is 93% on room air). Less agitated but still confused after 90 minutes, Ms. Hernández is transferred to the oncology unit.

Her nurse there is surprised to hear that Ms. Hernández had been so agitated. During prior admissions for treatment of bone pain (primarily in several ribs and the right femur), Ms. Hernández appeared sad and somewhat withdrawn, yet she consistently denied being depressed. During her last stay three weeks ago, Ms. Hernández described right-upper-quadrant pain and was found to have liver metastases. She was placed on an analgesic regimen of long-acting morphine 60 mg every 12 hours, with immediate-release morphine 20 mg for breakthrough pain as needed. She required only two or three doses of breakthrough pain medication daily until a week ago, when her pain intensified, requiring as many as eight doses of immediate-release morphine daily. In response, her oncologist had ordered dexamethasone 16 mg PO daily two days ago. Her sister and two teenage daughters are at the bedside, as they have been during previous hospitalizations, witnessing Ms. Hernández's confusion tearfully.

In such scenarios, the aforementioned psychological conditions—especially anxiety and depression—are underdiagnosed and undertreated,^{1, 2}

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Unsaid, by Deidre Scherer, fabric and thread, 11" × 10", 1997; photo by Jeff Baird.

"I try to give clear attention, to listen for our relationship, and to hear what is unsaid," Scherer says of her father, who is depicted in this artwork. For more about the artist and her work, go to www.dscherer.com.

Frank
discussion of
patients' fears
may alleviate
anxiety.

perhaps because anxiety and depression can be normal after a devastating diagnosis and because distress can vary from mild to severe. But anxiety and depression can be intractable, crippling conditions requiring treatment. Delirium, too, often goes undetected and untreated in this population.³ Good palliative care requires that nurses understand all three of these conditions, including risk factors, assessment techniques, and pharmacologic and nonpharmacologic approaches to their management. As in all aspects of palliative care, an interdisciplinary approach is best, and interventions should be directed toward both the patient and the family. This article discusses how to distinguish these conditions and considers appropriate treatments.

ANXIETY: PREVALENT BUT MANAGEABLE

Reactions to a life-threatening diagnosis vary from lightheadedness to palpitations, diaphoresis, an inability to concentrate, dyspnea, and apprehension and fear—even terror. One patient might describe feeling "nervous"; another might say "I can't stop worrying." Either patient might cope with the initial diagnosis by gathering information about the primary illness or by joining a support group. But anxiety often increases as the disease progresses, treatments become less effective, pain worsens, and feelings of isolation and dependency develop. Intervention may be warranted, depending on the severity and duration of the anxiety and its effects on both patient and family.

A recent literature review reported prevalence rates of anxiety among people with cancer or AIDS from 0% to 39%⁴; another study found that roughly 25% of people with cancer report significant anxiety at some point during the course of their disease.⁵ Anxiety rates in patients with other life-threatening illnesses aren't known but are probably similar.⁴

Causes. In palliative care, anxiety is highly correlated with unrelieved pain.⁶ Thus, treating pain may decrease anxiety. Simply acknowledging that pain is almost always treatable will comfort and reassure many patients and families. Nonsteroidal anti-inflammatory drugs such as ibuprofen, opioids (including morphine), and adjuvant agents such as corticosteroids, anticonvulsants, local anesthetics, and others may be considered. (See "Difficulties in Managing Pain at the End of Life," July.)

Many medications—corticosteroids, neuroleptics (including metoclopramide), bronchodilators, antihistamines, digitalis, and occasionally benzodiazepines (which can cause a paradoxical reaction in elderly patients)—can result in motor restlessness and agitation. Abrupt withdrawal from alcohol, opioids, benzodiazepines, or nicotine can produce these effects, as can alcohol abuse, which often goes unrecognized in palliative care.⁷ To ease nicotine withdrawal in hospitalized patients, nicotine patches may be used.

Hypoxia, pulmonary embolus, sepsis, hypoglycemia, thyroid abnormalities, and heart failure are associated with anxiety, as are certain tumors, including pheochromocytomas, and some pancreatic cancers. Primary or metastatic lung cancers and chronic cardiopulmonary conditions can lead to dyspnea, which can produce anxiety, too.

Assessment. Patients should be asked in the clinical interview about nervousness, fear, tension, apprehension, and other symptoms. A nurse might begin with simple yes-or-no questions such as, "Do you feel nervous or anxious?" and "Have you felt that you might be going crazy or losing control?" A patient with a history of panic disorder, phobia, obsessive-compulsive disorder, generalized anxiety disorder, or other anxiety disorders will have an increased risk of anxiety if diagnosed with a life-threatening illness. A thorough assessment of alcohol, tobacco, and drug use should rule out withdrawal as a possible cause. (It bears repeating that questions framed in a nonjudgmental way and asked in a neutral tone are more likely to elicit the truth.) Consider also whether any of these physical conditions is a contributing factor, and review the patient's current medications. It's also important to know whether the patient is now or was recently on an anxiolytic regimen.

The patient's history can help distinguish preexisting and untreated or poorly managed anxiety from new-onset anxiety—which occurs in reaction to a diagnosis, symptoms of the illness, treatment,

or other related factors. Pharmacologic management may be more complicated in patients who have a history of severe anxiety or other psychological conditions. Furthermore, most drugs take time to produce their full effects, limiting usefulness in patients near death. And many nonpharmacologic therapies, such as guided imagery and relaxation, require energy, concentration, and social interaction that may be beyond a dying patient's abilities.

Family members' fears can intensify a patient's anxiety. For example, a child who is terrified that her father will die may repeatedly wake him; other family members may urge him to eat or walk. Unfortunately, in seeking to reassure themselves by comforting him, family members might be adding to his anxiety. Consult social workers, clergy, and others to find alternative ways, such as prayer or massage, for family members to maintain closeness with the patient.

Clinical management. Although many providers avoid bringing up painful topics with patients, frank discussion of patients' fears may alleviate anxiety. Strive to create a supportive environment that encourages communication.⁸ Sit with the patient; if he is comfortable with being touched, do so. Acknowledge the patient's feelings by nodding and using reflective statements when appropriate. For example, if a patient says, "I'm scared of dying," you might respond by saying gently, "I know you're scared." Ask open-ended questions, listen actively, and take time to clarify uncertainties. For instance, you might ask this patient, "Can you say more about what frightens you?" Even silence can be therapeutic, allowing the patient time to find words for feelings.

Promote relaxation through the use of audiotapes, breathing exercises, and guided imagery.

Consult psychiatric liaison nurses, social workers, psychologists, or psychiatrists as appropriate. If the patient had a previously good relationship with a therapist, you might suggest reestablishing contact by telephone. Support groups and family therapy can be helpful.

Pharmacologic treatment of anxiety usually consists of benzodiazepines, but they can alter mental status in some patients, especially the elderly and those with decreased hepatic function (see "Paradoxical Reactions to Benzodiazepines," July 2001). Lorazepam is often selected because it's short acting and produces fewer adverse effects; it also has antiemetic properties, an added benefit. A typical initial dosage is 0.5 to 2 mg PO TID or QID. Lorazepam can be placed sublingually, which is useful when patients have difficulty swallowing, or given parenterally as a bolus or infusion. Haloperidol is often used for short-term management of severe anxiety and as an antipsychotic, with an initial dosage of 0.5 to 1 mg BID.⁶

DEPRESSION: A COMPLEX DIAGNOSIS

Like anxiety, depression encompasses a continuum of moods. Of course, sadness and grief are to be expected in someone who has received a diagnosis of a life-threatening illness, but clinical depression should be treated. Distinguishing between normal sorrow and depression—and knowing when a patient requires treatment—can be complicated. The capacity to feel pleasure is one important indicator: a patient who is depressed will feel sad “most of the time” and almost all activities will fail to bring pleasure. The prevalence of major depression in people with cancer is thought to be approximately 25%, although rates vary among studies.² The prevalence in those with other terminal illnesses is not well known but is believed to be similar.²

Causes of depression in people with terminal illness include uncontrolled pain, as well as constipation, anorexia, and fatigue. Abnormal metabolic conditions and illnesses such as hypercalcemia, anemia, hypothyroidism, and sepsis can contribute to depression. Tumors of the central nervous system or radiation therapy directed at the brain may be associated with the condition. Medications such as corticosteroids and certain chemotherapeutic agents (vincristine, vinblastine, asparaginase, intrathecal methotrexate, interferon, and interleukins) may precipitate depression, as can financial concerns. Risk factors include age under 45, a previous history of depression, limited social support, and diminished function.

Assessment. Many symptoms associated with depression—weight loss or gain, fatigue, insomnia or excessive sleep, and diminished ability to concentrate—aren’t good indicators of depression in people who are terminally ill because the symptoms may be caused by the primary illness or its treatments. Chochinov and colleagues found that simply asking a patient in this population, “Are you depressed?” was a reliable way to diagnose depression.⁹ Other indicators include excessive feelings of guilt or worthlessness,¹ continual feelings of hopelessness, and persistent thoughts of suicide.¹⁰ Several screening tools have been found to be valid and reliable, including the Beck Depression Inventory and the Hospital Anxiety and Depression Scale, although not with patients who are gravely ill, exhausted, or cognitively impaired. If you suspect that a patient may be considering suicide, you might ask, “Have you thought about ending your life?” If the response is affirmative, ask whether the patient has a plan for doing so. A patient who has a plan is at higher risk for suicide and will need close monitoring.

Cultural factors must also be taken into account. For example, stoicism (in which depression is considered a sign of weakness) and “somaticizing” emotional distress (in which depression is described in physical terms such as “nerves” or headache)

Clouded Skies

‘Cultural diversity’ and depression.

In writing *The Noonday Demon: An Atlas of Depression*, Andrew Solomon investigated depression in cultures worldwide. He found that cultural and economic factors (such as ethnicity, education, and class) are often intertwined with depression in ways that are hard to unravel. This makes it harder for some people to acknowledge feeling depressed, either to themselves or to others—and for providers of dissimilar backgrounds to diagnose their condition. Some people may “somaticize” their feelings. For example, Solomon describes a Dominican building superintendent in New York City who broke down when his marriage ended. He became unable to eat, sleep, or function at his job. He told Solomon, “I didn’t think of it as depression. . . . I thought I was probably dying and that maybe I had a physical disease.”

And some might know that they’re depressed yet feel very reluctant to admit this. In Greenland, Solomon met a fisherman’s wife who had lost her mother, her grandfather, her older sister, and three nieces and nephews (her brother’s children) in rapid succession. Then her brother committed suicide. She told Solomon, “We Greenlanders are too close to be intimate. And we all have so many burdens here, and none of us wants to add our burdens to the burdens of others. . . . Until my brother died, I was proud not to be a cloud in the sky for other people.”

Increasingly, the mind and the body are seen as “parts of a single system” rather than as two distinct entities. As Anna Fels, MD, noted in a recent *New York Times* article, “When something goes awry with [the] production [of certain substances] in the brain, it is likely to have gone wrong in other places as well. Our old, vaporous notions of depression are giving way to more concrete and physical ones.” The implications for health care of that often-repeated phrase “cultural diversity” need to be understood more concretely as well. —*Sylvia Foley, senior editor*

Sources: Solomon A. *The noonday demon: an atlas of depression*. New York: Scribner; 2001; Fels A, Mending of hearts and minds. *New York Times*, May 21, 2002.

may be ways in which a patient’s ethnicity can affect assessment of depression. (See *Clouded Skies*, above.) A future article in this series will address cultural issues more thoroughly.

As a patient nears death, he may undergo a “transitional withdrawal.” Whereas social withdrawal is associated with depression, transitional withdrawal usually is not.¹¹ The patient becomes profoundly weak, increasingly drowsy, and less interested in food; he may also become disoriented or have an extremely short attention span. Transitional with-

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drawal results primarily from the body failing rather than from psychological changes.

Clinical management. “Life review and reminiscence” is a relatively new practice, in which the patient remembers and recounts to at least one other person the story of his life. For example, a patient might write letters to loved ones in a journal or videotape himself relating significant past events; this can help him to identify ways he has coped and strengths he has used in the past. It may also help patients and families to resolve long-standing differences.

One way to help a patient begin a life review is simply to say, “Tell me your story.” Patients themselves may also initiate such conversations during routine care. An astute nurse will recognize the patient’s desire and willingness to talk and take the opportunity to listen. The patient’s tears may be cathartic and aren’t necessarily an indication to change the topic. Nurses must also consider their own responses carefully. For example, responses such as “You’re healthy as a horse” or “Don’t talk like that” aren’t helpful. Comments that steer the conversation away from the patient, such as “I know what you mean, my friend had the same thing,” are likely to be discouraging as well. (For more on these informal processes, see the Web site of the International Institute for Reminiscence and Life Review at <http://reminiscenceandlifereview.org>.)

An interdisciplinary team should be involved in managing a patient’s depression. In order to address emotional and spiritual needs, referrals to social workers, psychologists, psychiatrists, clergy, and art therapists may be warranted. The effectiveness of therapy will depend on the patient’s ability to participate—that is, physically, cognitively, and emotionally.¹² Care of the family is vital as well. Bereavement counselors can assist patients and families by identifying those at high risk for complicated (unresolved) grief or depression and providing early interventions.

Antidepressants and psychostimulants are the primary pharmacologic treatments for depression among the terminally ill. A variety of factors will determine the choice of drug; prognosis is an important consideration. Because antidepressants can take two to four weeks to take effect, patients near the end of life might receive greater benefit from a psychostimulant.

Tricyclic antidepressants such as amitriptyline, nortriptyline, and desipramine have anticholinergic effects (constipation, dry mouth, urinary retention, and tachycardia) and can also cause sedation, dizziness, and orthostatic hypotension. Thus, second-generation antidepressants such as the selective serotonin reuptake inhibitors (SSRIs), a class that includes paroxetine and sertraline, are generally preferred for treatment of patients who are medically fragile (those with cardiac, renal, or hepatic disorders).¹³ As with most drugs, these agents should be started at the lowest effective dose and gradually increased. Side effects can include anxiety, insomnia, nausea, diarrhea, and tremor. An even newer class of antidepressants, the serotonin–norepinephrine reuptake inhibitors, includes venlafaxine, which is generally better tolerated with fewer side effects. Venlafaxine also carries a lower risk of drug–drug interactions than do the SSRIs.

For a patient who is very near death, psychostimulants such as methylphenidate or dextroamphetamine are warranted. A low dose of 2.5 or 5 mg of either drug is given in the morning and at lunchtime to prevent sleeplessness at night. Patients report improved mood and reduction in fatigue within a few days. The dose is increased until the mood and energy levels improve or until side effects such as insomnia, anxiety, or hyperarousal occur, in which case the dose is decreased. Adverse effects generally abate within 24 hours. Whether treatment should continue despite these side effects depends on their severity and the patient’s distress.

DELIRIUM: DIFFICULT TO ASSESS

Most people with a terminal illness develop delirium at some point, particularly during the final weeks of life.¹⁴ Altered perception, impaired memory, emotional lability, hallucinations, incoherent speech, and disorientation to time, place, and person are common features of delirium. Early symptoms are often misdiagnosed as anxiety or depression. In many cases, delirium is reversible.

Causes. Medications are a common cause of delirium, including many drugs—opioids, corticosteroids, benzodiazepines, adjuvant analgesics, and some chemotherapeutic agents—commonly given to the terminally ill. Other contributors include metabolic changes resulting from hypercalcemia and hyperglycemia, sepsis, central nervous system involvement by tumor, encephalopathy, and other organ system failure.

Assessment of delirium may involve a review of the onset of symptoms with family members and caregivers. Tests of cognition such as the Mini-Mental Status Exam can help to determine degree of impairment. Recently, two subtypes of delirium have been identified, hyperactive and hypoactive, based on level of psychomotor activity. Signs and

symptoms of hyperactive delirium include agitation, hyperarousal, hallucinations, and delusions. This type is commonly seen in patients in withdrawal from benzodiazepines or alcohol. Conversely, patients with hypoactive delirium appear lethargic and withdrawn³ but will not weep or express hopelessness (distinguishing this delirium from depression). Hypoactive delirium is more commonly associated with encephalopathies and organ system failure.

Clinical management. Initial treatment of delirium involves correcting underlying metabolic alterations (such as hypercalcemia) and discontinuing offending medications. Nonpharmacologic management includes fostering a safe, quiet environment. During the day, ensure that the patient's room is well lit and that clocks are visible; at night, dim the lights and minimize interruptions. (A normal pattern of waking and sleeping is believed to help prevent disorientation.) But reality orientation, once taught widely in nursing and medical schools, is no longer considered effective with actively hallucinating patients; in fact, correcting the patient's perceptions may only increase anxiety and agitation. Instead, it's suggested that caregivers speak in a calm, relaxed tone, ask questions gently, and offer support. For example, one patient in my facility recently believed that he was swimming. Rather than insist that he understand he was in bed in a hospital, I asked where he was swimming. He replied, "Home." I commented, "It must feel good to be going home." He smiled and relaxed visibly. It's common for patients near the end of life to speak of "going home" and to "see" or talk to loved ones who have died.

Pharmacologic therapy for delirium includes haloperidol, which blocks dopamine. (An excess of dopamine, a neurotransmitter, has been implicated as one of many factors in delirium.)¹⁵ Low doses (0.5 to 1 mg) can be given orally, intravenously, rectally, or subcutaneously. Newer agents such as risperidone and olanzapine are also used, but are not yet available parenterally.³ Benzodiazepines such as lorazepam have been found to worsen delirium and cognitive impairment,¹⁶ and are not recommended.

CASE REVISITED: ANXIETY, DEPRESSION, DELIRIUM?

Possible causes of Ms. Hernández's anxiety include her unrelieved pain, fear of dying, and concerns about what will happen to her daughters after she dies. She also recently began a course of dexamethasone, a corticosteroid (a class of drugs that can cause motor restlessness and agitation).

After careful evaluation, including obtaining laboratory values to rule out metabolic changes and chart review of medication changes, the palliative care team determined that because of the absence of other chemical abnormalities and the timing of the

Resources

Callanan M, Kelley P. *Final gifts: understanding the special awareness, needs, and communications of the dying*. New York: Bantam Books; 1997.

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Lipson JG, et al. *Culture & nursing care: a pocket guide*. San Francisco: UCSF Nursing Press; 1996.

onset of her symptoms, Ms. Hernández's delirium resulted from the dexamethasone. Her primary care provider stopped the dexamethasone and ordered two doses of haloperidol, and within 24 hours she was no longer confused and disoriented. But the nurse felt that Ms. Hernández might also be suffering from anxiety, depression, or both. During a quiet moment the nurse asked, "Are you feeling nervous or depressed?" Ms. Hernández remained silent for a few moments and then began to cry, saying that she was afraid to die and was afraid to die in pain. She said her fears were so strong that sometimes her heart raced wildly and she could barely sleep at night. The nurse listened, maintaining eye contact, as the patient, who was deeply religious, described the emotional pain of her recent divorce and her fear that the divorce meant she would not "go to Heaven." Ms. Hernández hesitated, saying, "Maybe you can't understand." The nurse encouraged her to continue, saying "I understand how upsetting this is for you." Ms. Hernández then said she no longer enjoyed spending time with her daughters or her sister; instead, she felt "crazy with worry" about who would care for her daughters and whether they would remember her after she died.

The nurse consulted hospital clergy to address Ms. Hernández's spiritual concerns and met with her social worker to discuss financial matters and arrange custody for her daughters after her death. Another consultation with Ms. Hernández's physicians resulted in changes to her pharmacologic treatment: lorazepam was added to treat anxiety and venlafaxine was added to manage depression. The team decided to continue lorazepam as long as the anxiety persisted and to gradually decrease the dosage if her symptoms resolved.

The nurse arranged for the family to meet with the entire team the next day, in order to discuss pain

relief strategies. The team assured Ms. Hernández and her family that pain relief is possible for most patients. They also discussed ways to help Ms. Hernández talk about her life with her daughters, including videotaping her account of her life story and writing letters to her daughters to be opened on landmark events in their lives. Through these efforts, Ms. Hernández lived her final weeks in comfort and with dignity. ▼

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