Difficulty Accepting a Terminal Prognosis Linked with Depression, Anxiety, and Suffering

A new study finds that in terminally ill patients, nonacceptance of the prognosis appears to be associated with an increased sense of suffering, anxiety and depression, and an overall feeling of hopelessness.

Genevieve N. Thompson, RN, PhD, and colleagues from across Canada conducted a survey study of 381 cancer patients who were expected to survive for fewer than 6 months (J Clin Oncol. 2009;27:5469-5475).

Nearly three-quarters (74%) of study participants reported that they had fully accepted their situation. A remaining 17.1% had minimal or mild difficulty with acceptance, and 6.8% reported moderate or strong difficulty. On the other end of the spectrum were the 1.8% of patients who reported severe or extreme difficulty in accepting a terminal prognosis. It was this portion of the group who demonstrated the highest self-reported suffering, depression, anxiety, and hopelessness.

“This really is a small minority of people we are talking about who have difficulty accepting. For most people, acceptance of their prognostic terminality is not an issue,” says Dr. Thompson, an assistant professor in the Faculty of Nursing at the University of Manitoba in Canada.

“Clinically, we need to be attuned and vigilant about looking for these individuals,” Dr. Thompson says. “We did find that individuals who have a smaller social network or are younger may have trouble coming to some sort of resolution and acceptance at the end of life, and we need to be attuned to that. We need to approach these people with the utmost sensitivity and allow them a safe place to talk about things.”

The researchers are careful to note that the study was not designed to determine the direction of causality. Dr. Thompson suggests that acceptance occurs along a wide clinical gradient and that only patients with a marked or rigid lack of acceptance might require clinical intervention.

“Given uncertainties regarding the direction of causal linkages between acceptance and distress, therapeutic considerations should be based on individual needs, bearing in mind that symptom management and insight-enhancing approaches are not mutually exclusive,” she says.
Although exchanging hope for acceptance may not be clinically valuable, nonacceptance is clearly linked with suffering, which clinicians are charged with relieving. Acceptance may be associated with a higher quality of life in patients with a terminal illness.

“We’ve begun to accumulate a body of literature that suggests that patients who have more cognitive awareness of their terminal prognosis are less depressed,” says William S. Breitbart, MD, vice chair of the Department of Psychiatry and Behavioral Sciences, and chief of the Psychiatry Service at Memorial Sloan-Kettering Cancer Center.

“This last study [by Thompson, et al] is another piece of evidence showing that if [clinicians] are able get someone gently to be more aware of their prognosis, to accept it with some sense of peace and equanimity, that there can be better outcomes in terms of patient quality of life, timely completion of advance directives, and the course of bereavement in family members,” he adds.

Another option that has been shown in previous studies to be an effective therapy for terminally ill patients is something called dignity therapy. Dignity therapy is a concept that has been developed and promulgated by one of Dr. Thompson’s coauthors, Harvey M. Chochinov, MD, PhD, of the Department of Psychiatry at the University of Manitoba.

“Loss of dignity for people with advanced cancer is associated with high levels of psychological and spiritual distress and the loss of the will to live. Dignity therapy is a brief psychotherapy, which has been developed to help promote dignity and reduce distress,” Dr. Chochinov and his colleagues write. Dignity therapy was touted by Dr. Breitbart and others as a potential treatment option in depressed or anxious patients with a terminal prognosis.

Another option is to treat the symptoms of nonacceptance, anxiety, and depression pharmacologically. “We do prescribe antidepressants for people who are terminally ill and depressed,” Dr. Breitbart explains. “We tend to prescribe drugs that work a little more quickly than conventional antidepressants, drugs like Ritalin or amphetamines that work in days rather than weeks. It’s very common.”

**Dissenting Opinion**

Not all clinicians agree with the foregoing interpretations of these findings. “I’ve certainly seen people who denied dying up to their last breath and somehow never accepted it,” Dr. Holland tells CA. “Were they more upset? I’m not sure.”

She cautioned against allowing the findings by Dr. Thompson and colleagues to set a tone in which nonaccepting patients are viewed as dysfunctional. Death is as individualized as is life, she argues, invoking Sir William Osler, who said “Basically, people die as they have lived.”

She suggested that Dr. Thompson and her colleagues had identified “a subgroup that had been maladaptive all along,” meaning that patients who were anxious or depressed after a terminal prognosis were likely anxious or depressed before the prognosis. [doi:10.3322/caac.20064](https://doi.org/10.3322/caac.20064)

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### New Joint Outpatient Chemotherapy Administration Standards

The Oncology Nursing Society (ONS) and the American Society of Clinical Oncology (ASCO) have released a set of joint standards for the safe administration of chemotherapy in the adult outpatient setting. The standards, published in the journals of both societies ([Oncol Nurs Forum. 2009;36:651-658 and J Clin Oncol. 2009;27:5469-5475](https://doi.org/10.3322/caac.20064)), are intended to improve patient safety, reduce the risk of medication errors, increase clinical efficiency, and provide a framework for best practices.

The guidelines were created largely in response to recent studies that have examined reports of chemotherapy administration errors among outpatients, and to reports of an increased risk of errors with the administration of new oral chemotherapeutics.

The ASCO/ONS recommendations call for “standardized approaches, development of policies and procedures for system improvement, and review of errors by interdisciplinary professional staff,” the authors write. The steering group also recommends the increased use of electronic medical record systems, such as E-prescribing. Research has shown that automated systems can reduce errors and increase patient safety.

**The Standards**

[The standards] “were developed to help reduce the risk of errors in chemotherapy administration, thereby assuring patient safety.” says Terri Ades, DrNP, a member of the steering committee that developed the standards and director of Cancer Information and Health Promotions at the American Cancer Society.