Extraordinary Means and Depression at the End of Life

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Abstract. Untreated depression at the end of life may affect treatment and raise ethical concerns. Patients with a major depressive disorder may desire a hastened death, may refuse reasonable and beneficial medical care, or may present with cognitive distortions that hinder their ability to make decisions about care. Treating depression can avert or minimize these problems in many cases. For a patient who does not respond to antidepressant medications and other interventions, however, the unrelieved depression could tip the balance and make additional medical treatments burdensome. In such cases, a proposed medical treatment might be considered extraordinary. *National Catholic Bioethics Quarterly* 14.4 (Winter 2014): 697–710.

When depression among terminally ill patients is treated, suicide rates drop, and more patients accept medical care that they previously rejected because of a desire for death. In one study, 25 percent of depressed and elderly patients near the end of life changed their minds about treatment refusal once their mood disorder was addressed.[1] Treating depression can also improve the success of compassionate care and enable patients to complete important tasks, engage with family members and health care staff, and just feel better than they otherwise would during the final days of their lives.[2]

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[1] Tara Friedman, Jane Loitman, and Tarris Rosell, "Primary Depression and the Voluntary Suspension of Eating and Drinking: Considerations," *American Academy of Hospice and Palliative Medicine Bulletin* 11.2 (Summer 2010): 1.

[2] Barry Rosenfeld, Jennifer Abbey, and Haylay Pessin, "Depression and Hopelessness near the End of Life: Assessment and Treatment," in *Psychosocial Issues Near the End*

There are not enough data to show how many patients are successfully treated for depression near the end of life.[3] However, it is known that individuals in despair at this stage remain largely underdiagnosed and undertreated.[4] This is also true of the elderly in general, including those who are not terminally ill.[5] Although mild or moderate depression deserves attention, it is less likely to raise significant treatment concerns.[6] This essay focuses on individuals who meet the criteria for a major depressive episode as defined by the *Diagnostic and Statistical Manual of Mental Disorders*.[7]

These patients may experience a loss of appetite and refuse food, they may discount the benefits of proposed treatment, or they may even seek a hastened death. When a major depressive episode is combined with other health issues, it could tip the balance and make further medical treatment distinctly burdensome or even repugnant and therefore extraordinary. Such an extreme case would arise only when treatment for depression in a particular patient cannot be remedied by any available means and has itself become a part of the patient's deteriorating condition.

Symptoms of Depression

Mild or moderate depression is common among patients at the end of life, who experience many losses. Major depression is less common, occurring in perhaps 20 to 50 percent of those who are both depressed and terminally ill.[8] Some studies have

of Life, ed. James L. Werth and Dean Blevins (Washington, DC: American Psychological Association, 2006), 163–164.

[3] Donald L. Rosenstein, "Depression and End-of-Life Care for Patients with Cancer," *Dialogues in Clinical Neuroscience* 13.1 (March 2011): 101–108, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181973/.

[4] Susan D. Block and J. Andrew Billings, "Evaluating Patient Requests for Euthanasia and Assisted Suicide in Terminal Illness: The Role of the Psychiatrist," in *End-of-Life Decisions: A Psychosocial Perspective*, ed. Maurice D. Steinberg and Stuart J. Youngner (Washington, DC: American Psychiatric Press, 2005), 213; and Hayley Pessin, Barry Rosenfeld, and William Breitbart, "Assessing Psychological Distress near the End of Life," *American Behavioral Scientist* 46.3 (November 2002): 359, http://www.fordham.edu/images/undergraduate/psychology/rosenfeld/distress.ambehsci.pdf.

[5] Eithne Bolger, "Depression in Later Life," *World of Irish Nursing* 13.11 (December 2005): 39, http://www.inmo.ie/Home/Index/6157/5377.

[6] Pessin et al., "Assessing Psychological Distress near the End of Life," 357–358.

[7] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (*DSM-IV*) (Washington, DC: APA, 2006), 237. Symptoms include a depressed mood, diminished interest in activities, weight loss, insomnia, psychomotor agitation or retardation, fatigue, inappropriate guilt, diminished ability to think or concentrate, and recurrent thoughts of death or suicide.

[8] Laurie Rosenblatt and Susan D. Block, "Depression, Decision-Making, and the Cessation of Life-Sustaining Treatment," *Western Journal of Medicine* 175.5 (November 2001), 321, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1071609/; Rosenfeld et al., "Depression and Hopelessness," 163; Block and Billings, "Evaluating Patient Requests for Euthanasia," 209; and Rosenstein, "Depression and End-of-Life Care," 1.

found a higher incidence.[9] In a study conducted in 1995, two-thirds of patients who expressed a desire to die met the criteria for major depression.[10]

My interest stems from my work in pastoral care and my previous experience for over twenty-five years as a clinical social worker in outpatient mental health. One case was of particular interest to me, that of an eighty-nine-year-old gentleman with diabetes who had had surgery to amputate his leg above the knee after his toe became infected. He passed away three months after the surgery, and I offer his story here in scattered vignettes as a case study of depression at the end of life.

A couple weeks after surgery, my friend was transferred to a rehabilitation unit in a hospital in Peoria, Illinois. He had stopped eating and complained about the rigors of physical therapy. He had never been a fan of hospital food or therapy in the past, so this was nothing new, but the fact that he had eaten and drunk very little since the surgery was a source of increasing concern. I had expected some depression after the amputation, but it was not until he turned to me and said, "I can't even describe how I feel," that I suspected, almost at once, that he was seriously depressed. It wasn't just his words but the look in his eyes—a beseeching quality—that I had seen in my mental health clients. I spoke with the nurse, who arranged for a consultation with a psychologist on staff.

The Catholic Guide to Depression, by psychiatrist Aaron Kheriaty, MD, with Father John Cihak, offers a comprehensive guide to this illness and adds impressive coverage of its relationship to faith. The following symptoms of depression are condensed from Kheriaty's list: (1) inability to focus, with a sluggish flow of thoughts and mental fog that can make conversations hard to follow and books difficult to comprehend; (2) changes in sensory perception, including a sort of tunnel vision and an environment that appears negative or threatening; (3) disruption of sleep (or, with atypical depression, increased sleep); (4) loss of appetite (or, with atypical depression, increased appetite); (5) low energy; (6) changes in psychomotor movements (slowed or agitated); (7) inappropriate feelings of guilt; (8) anhedonia, or the inability to find joy or gratification in activities; (9) frequent thoughts of death; and (10) anxiety.[11]

Bodily (or "vegetative") symptoms—such as low energy, changes in appetite, sleep disruption, and slowed movements—that would help identify major depressive disorder in younger and healthy adults create a special challenge in the evaluation of patients who are seriously ill, since they may instead be symptoms of other illnesses. The psychiatrists and psychologists in my sources cope with this by relying more on

[9] Andrea Axtell, "Depression in Palliative Care," *Journal of Palliative Medicine* 11.3 (April 2008), 529, http://www.aahpm.org/pdf/depression.pdf; and Christopher Gibson et al., "Mental Health Issues near the End of Life," in Werth and Blevins, *Psychosocial Issues*, 144.

[10] Block and Billings, "Evaluating Patient Requests for Euthanasia," 208.

[11] Aaron Kheriaty, *The Catholic Guide to Depression* (Manchester, NH: Sophia Institute Press, 2012), 9–15.

the cognitive symptoms.[12] Asking about personal or family history of depression may also help in the diagnosis for some individuals.[13] In extreme cases, the only way to know if suspected depression is present is to treat and reevaluate.[14] As Kheriaty notes, the impaired concentration that might occur in mood disorders in aging patients can sometimes make their depression look like dementia, or (to make evaluation even more challenging) the two disorders may be present at the same time.[15]

While knowledge of clinical symptoms can help doctors, nurses, and family members recognize a serious mood disturbance, it is useful to know what the experience of depression is like and how it affects perception and choices. The experience of despair can be difficult to understand. Kheriaty writes about the "basic inability of healthy people to imagine a form of torment so alien to everyday experience."[16] He also assures us that "a mood disorder is not a character defect, moral fault, or spiritual failure," and points out that some of our saints have experienced depression.[17]

Severe depression can be like driving in fog so dense that you cannot see the road signs. Sylvia Plath, who died by her own hand in 1963 at the age of thirty, left us with volumes of poetry that describe her despair:

> Fumy, spirituous mists inhabit this place
> Separated from my house by a row of headstones.
> I simply cannot see where there is to get to.[18]

Her inability to "see where there is to get to" shows the impaired concentration and tunnel vision that Kheriaty describes. When pervasive hopelessness enters the picture, that dark tunnel can make death seem like the *only* answer. Psychologist Thomas Joiner calls this "only" a four-letter word in his study of suicide.[19]

Those of us who have worked with depressed persons observe what we call "soft signs," or occasional symptoms not included in the diagnostic manual's select criteria. Not everyone who is depressed will experience these: (1) sensing heaviness in the muscles; (2) gravitating toward what is dark or muted (caves, black holes, winter nights); (3) thinking that happy, optimistic people do not see life as it really is; (4) believing that the despair will never end; (5) feeling shame, as if one is infected or tainted; (6) losing the meaning or point of life; (7) enduring intense crying spells; (8) neglecting personal grooming or housecleaning; and (9) imagining that one is imprisoned behind invisible walls or otherwise separated from society.

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[12] Mark Sullivan, "Depression and the Refusal of Life-Saving Treatment," in Steinberg and Youngner, *End-of-Life Decisions*, 65–67; and Rosenfeld et al., "Depression and Hopelessness," 168–170.

[13] Sullivan, "Depression and the Refusal of Life-Saving Treatment," 67.

[14] Ibid.

[15] Kheriaty, *Catholic Guide to Depression,* 17.

[16] Ibid., 7.

[17] Ibid., xxviii, 57.

[18] Sylvia Plath, "The Moon and the Yew Tree," in *The Collected Poems* (New York: Harper Perennial, 1992), 172.

[19] Thomas Joiner, *Why People Die by Suicide* (Cambridge, MA: Harvard University Press, 2005), 41.

Depressed individuals also seem to make less eye contact and may speak at a slowed rate, they may have pronounced dark circles under their eyes, and their posture may be slumped, as if road-weary.

Normal bereavement and other adverse life events will produce depressive reactions. An episode of major depression can grow out of these events if symptoms develop disproportionately.[20] The elderly in general experience more loss and physical illness. Social isolation and physical limitations are other factors that place them at risk.[21] Certain medical illnesses may also cause "organic" depression. Finally, depression can result from a medication side effect.

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Before talking with the nurse, I described in a few sentences what depression might feel like and waited for my friend to decide if this matched his inner experience. The psychologist was not able to spend more than ten or fifteen minutes with my friend, but it was long enough to make a quick assessment and arrange for a specific antidepressant medication that might also stimulate his appetite. Within a few days, my friend began to eat more small amounts of food and drink nutritional beverages.

In one study, 197 terminally ill patients were asked, "Are you depressed?" and their responses were compared to the results of a longer diagnostic assessment. The researchers found that this approach had "100% sensitivity and specificity in detecting depression."[22] The depressions ranged from mild to major in these patients, but the researchers propose that this simple and direct question may be very useful to "alert health care providers to ask about emotional as well as physical health."[23]

Psychological Evaluation

Who should evaluate the terminally ill when depression is suspected? Psychiatrists are the ideal first choice, because they acquire medical knowledge as part of their formation.[24] Physicians in hospitals and clinics are able to assess and prescribe medications but prefer to consult with a specialist for serious mood disorders, especially when managing complex issues like suicide or competence.

Mental health clinicians usually receive little training or education to prepare them for encounters with dying patients.[25] Psychologists have written about this topic and have recently ventured into this territory. Social workers have long worked in hospice, nursing homes, or hospitals and may be aware of emotional needs, but are not qualified to assess for psychiatric illness without specific training, clinical

[20] Kheriaty, *Catholic Guide to Depression*, 22.

[21] Bolger, "Depression in Later Life," 39.

[22] Rosenblatt and Block, "Depression, Decision-Making," 29.

[23] Pessin et al., "Assessing Psychological Distress near the End of Life," 361.

[24] Mary F. Morrison, "Obstacles to Doctor–Patient Communication at the End of Life," in Steinberg and Youngner, *End-of-Life Decisions,* 129.

[25] Rosenfeld et al., "Depression and Hopelessness," 167.

practice, and ongoing supervision by a psychiatrist. (Laws and standards vary by state.) Master's-level therapists with degrees in other fields generally must meet the same requirements as social workers.

Difficulties can emerge in assessment of the terminally ill; some have already been mentioned, such as determining whether symptoms stem from medical illness or from a mood disorder. The mental health professional needs to sort out matters like informed consent, record keeping, and confidentiality. Not enough research has been done to establish best-practice guidelines for approaching these patients, but examples of suggested advice include engaging in a conversation, focusing on present concerns, and accepting the patient's story "as reflected in behaviors, relationships, memories, and beliefs."[26] A depressed patient may lack the energy or time to allow for a long assessment—there is a need to "get to the point more quickly."[27] Family members may be a useful part of the information-gathering process.[28] Patients may minimize their symptoms because of denial, fear of stigma, fear of being a "bad" patient, or a desire to shield family members from additional burden.[29] Patients and families may already have "a lot on their minds and have difficulty with open communications."[30]

For a number of reasons, it is useful to know whether a patient has been depressed in the past. Each subsequent episode of major depression increases the likelihood of recurrence.[31] The good news is that patients who have educated themselves or sought treatment have acquired skills that help them adapt to the illness. They know what strategies have worked for them in the past to ease their distress. They are more likely to recognize emerging symptoms as they develop and to reach out for help. This does not mean that they are protected from vulnerability associated with cognitive distortions or a desire for death.

My friend was transferred to a nursing home. His progress in physical therapy was slow because of his age and the weakness that followed his surgeries. He underwent four surgical procedures during the week his leg was removed. A section of his colon was removed, and he now had a colostomy bag. His wife moved into an assisted living apartment in a wing of the nursing home building, with the intention that he would soon join her there. At this time, he was optimistic about recovery and worked at moving from wheelchair to a bed or chair using a transfer board. He helped pick out furniture for the new apartment.

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[26] Kevin P. Kault, "End-of-Life Assessment within a Holistic Bio-Psycho-Social-Spiritual Framework," in Werth and Blevins, *Psychosocial Issues,* 117.

[27] James L. Werth and Phillip M. Kleespies, "Ethical Considerations in Providing Psychological Services in End-of-Life Care," in Werth and Blevins, *Psychosocial Issues,* 66.

[28] Kault, "End-of-Life Assessment," 121.

[29] Moira Cairns, Marney Thompson, and Wendy Wainwright, *Transitions in Dying and Bereavement* (Baltimore, MD: Health Professions Press, 2003), 136.

[30] Ibid.

[31] Kheriaty, *Catholic Guide to Depression*, 16.

The most troubling ethical issue is suicidal intentions or actions. Only 2 to 4 percent of terminally ill patients commit suicide, and those who do are usually depressed.[32] Two critical periods when suicide rates increase occur after patients have received the terminal diagnosis and after they have learned that there is no further hope for a cure.[33]

Suicidal Ideation

In the general population, there have been estimates that 50 percent of suicides are attributed to depression.[34] Ninety-five percent of those who end their life in this way have some type of psychiatric disorder at the time of death.[35] In countries that keep statistics, the greatest number of successfully completed suicides occur in white men over the age of sixty-five, and the most common method in this age group is firearms.[36] Among older adults, one out of four suicide attempts results in death compared with one out of one-to-two hundred among younger adults.[37] Older adults plan attempts carefully, use more lethal methods, and are less likely to be rescued or recover if they are rescued.[38] Several studies have shown that suicidal ideations and depression are more common among nursing home residents than those who live elsewhere, especially during the first year of residency.[39]

Occasional thoughts of suicide occur "with some frequency" among the terminally ill, but "persistent thoughts, plans, or intent are far less common" and considered exceptional.[40] "Recurrent thoughts of death" or "recurrent suicidal ideations without a specific plan" are given as symptoms of depression in the *Diagnostic and Statistical Manual of Mental Disorders*.[41] Thoughts about suicide can enter the mind not by willful choice, but in the same way that unwanted thoughts about chocolate cake enter the mind of a dieter. After assessment for risk, those concerned about suicidal ideations may need to learn that occasional benign thoughts are not the same thing as intentional choice. Suicidal ideations can even be useful if nothing else has alerted them to the possibility of depression, just as a fever may be useful in pointing

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[32] E. Joanne Angelo, "Depression and Assisted Suicide in the Terminally Ill," *National Catholic Bioethics Quarterly* 1.3 (Autumn 2001): 307.

[33] Ibid., 308–309.

[34] Gibson et al., "Mental Health Issues Near the End of Life," 144.

[35] Kheriaty, *Catholic Guide to Depression*, 91.

[36] Joiner, *Why People Die by Suicide*, 162.

[37] Substance Abuse and Mental Health Services Administration, *A Guide to Promoting Emotional Health and Preventing Suicide in Senior Living Communities*, HHS publication SMA 4515, CMHS-NSPL-0197 (Rockville, MD: Center for Mental Health Services, SAMHSA, 2011), 13, http://store.samhsa.gov/shin/content/SMA10–4515/Guide.GettingStarted.pdf.

[38] Ibid., 13.

[39] Ibid., 14.

[40] Sullivan, "Depression and the Refusal of Life-Saving Treatment," 58; and Pessin et al., "Assessing Psychological Distress near the End of Life," 368.

[41] American Psychiatric Association, *DSM-IV*, 327.

to infection. Persistent thoughts of suicide that could lead to plans or intent are a different matter. Because persistent thoughts can grow from benign ones, suicidal thinking should never be ignored.

Philosopher and medical ethicist Daniel Callahan believes that depression or a history of psychiatric disorders is a "far better predictor of a serious desire for suicide than illness, pain, or old age."[42] Requests to hasten death "require special attention and are outside the usual response to dying."[43] For all individuals and age groups, hopelessness is a significant and well-established risk factor, even for those without severe depression.[44] Some additional factors that increase suicidal risk for the terminally ill include personal or family history of suicide attempts, substance use, confusion, uncontrolled pain, feeling like a burden, lack of social support, a desire for control, and a diagnosis of AIDS or cancer.[45]

Despite our knowledge of risk factors, Kheriaty reminds us that "suicide is a very difficult event to predict. … Many who think about suicide act upon these thoughts only in a state of acute distress, anxiety, or substance intoxication. Such states tend to be transient. … A person suffering [depression] is liable to do things which, when not depressed, he would never consider."[46]

Kheriaty reiterates the Church's teaching on this topic: "Objectively, the act remains wrong and immoral, but the person's subjective guilt or culpability may be diminished, or even eliminated, in such mental states."[47] Finally, he offers this observation: "A significant body of research demonstrates that suicide is an area within psychiatry where Christian faith has proven beneficial and even life-saving. Research findings have consistently shown that religious faith and spiritual practices lower the risk of suicide."[48] There are three reasons for this. One is the support network found in religious communities or groups, the second is moral teachings that deter those who might otherwise consider this option, and the third is the theological virtue of hope."[49]

Although faith does not prevent depression, it can help to prevent suicide.[50] An interesting comparison exists between suicidal psychiatric patients, who can be treated involuntarily, and medical patients who express desire for death but are considered competent until proved otherwise.[51]

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[42] Daniel Callahan, "Physician-Assisted Suicide: Moral Questions," in Steinberg and Youngner, *End-of-Life Decisions*, 292.

[43] Block and Billings, "Evaluating Patient Requests for Euthanasia," 211.

[44] Gibson et al., "Mental Health Issues Near the End of Life," 145; Rosenfeld et al., "Depression and Hopelessness," 165; and Joiner, *Why People Die by Suicide,* 39.

[45] Rosenblatt and Block, "Depression, Decision-Making," 24–25; and Gibson et al., "Mental Health Issues Near the End of Life," 144.

[46] Kheriaty, *Catholic Guide to Depression*, 94, 108.

[47] Ibid., 103.

[48] Ibid., 96.

[49] Ibid., 97–98.

[50] Ibid., xxviii.

[51] Sullivan, "Depression and the Refusal of Life-Saving Treatment," 58.

Almost no research has been done to understand passive suicide, which may involve taking unnecessary risks or refusing to eat or drink, accept medications, or follow treatment plans.[52] When such a refusal leads to death, suicide is usually not stated as the reason for death, which hinders the gathering of statistics.[53] Researchers have suggested that nursing homes might be the best place to study this problem.[54] Little is known about the effects of self-chosen terminal dehydration on patients and family members, how often it is sustained to the point of death, or what its emotional costs are.[55] Passive suicide takes longer than other means to cause serious harm or death, which allows more time for discovery and intervention.[56]

Major depression inclines people to do the very things that will make their depression worse. One tendency is to withdraw into an unlit room with the curtains closed and remain in bed while dark thoughts parade through the mind. Food may have no appeal. Even for those without health concerns, recalling when they last ate something can require concentrated effort. Weight loss can become a matter of indifference for those who are seriously depressed. Working with outpatients, I would talk about food ("What about toast or strawberries? Do you like strawberries?") in an effort to get them to eat more. They would try to eat once they understood the relationship between food and mood.

My friend's depression returned, and his mood plummeted. After weeks of physical therapy, he could do no more than scoot along the transfer board and did that only with assistance. He had grown weak from hours in bed and developed redness that erupted into bedsores that the nurses treated. He stopped watching television, kept the lights off in his room, napped as much as he could during the day, and complained about being repositioned in bed. He pushed aside his food tray. He expressed a desire to die, although he was not terminally ill at this point. The physician at the nursing home increased the dose of his antidepressant medication. His sister met with the director of nurses and was able to get the rules relaxed so that he could spend afternoons in the apartment with his wife. She also brought in food that he liked. He developed a close relationship with a dedicated nurse's aide who was able to get through to him at times when no one else succeeded. All of this helped somewhat.

Mary Morrison has observed that end-of-life decision making in inpatient settings is often stressful and rushed.[57] She encourages physicians to explore reasons

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[52] SAMHSA, *Guide to Promoting Emotional Health*, 12.

[53] Stephen M. Marson and Rasby Marlene Powell, "Suicide among Elders: A Durkheimian Proposal," *International Journal of Aging and Later Life* 6.1 (June 2011), 71, http://www.ep.liu.se/ej/ijal/2011/v6/i1/a03/ijal11v6i1a03.pdf.

[54] Ibid., 67.

[55] Werth and Kleespies, "Ethical Considerations in Providing Psychological Services," 72.

[56] SAMHSA, *Guide to Promoting Emotional Health*, 34.

[57] Morrison, "Obstacles to Doctor–Patient Communication," 132.

for treatment refusal, because a patient may not even be aware of all of them. Elderly patients may defer to family or doctors, and some may avoid disclosing their thoughts for fear of being a "bad" patient.[58] Both physicians and families influence decision making by their approaches to communicating with the patient.[59]

Depression and Extraordinary Means

In his book *Ordinary and Extraordinary Means of Conserving Life*, Archbishop Daniel Cronin mentions excessive fear and repugnance as reasons why medical care may be considered extraordinary.[60] In this excerpt, he quotes Francisco de Vitoria, a sixteenth-century moral theologian:

> If a means involves great difficulty for a particular individual, even though men in general do not find any great difficulty in its use, it ceases to be ordinary for this individual. In other words, even if the great difficulty is only relative, not absolute, it is still sufficient to render a means extraordinary for a particular individual. … Vitoria writes, "If the depression of spirit is so low and there is present such consternation of spirit in the appetitive power that only with the greatest of effort and as though by means of a certain torture can the sick man take food, right away that is reckoned a certain impossibility and therefore he is excused."[61]

In the twentieth century, a procedure like dialysis may become disproportionate (extraordinary) because of a patient's fatigue and emotional distress, and the patient may forgo it "so long as the issue is one of burden of treatment and not an underlying death wish. Death must not be the intended object of the decision to withdraw."[62] Deacon Peter Gummere writes, "When patients on dialysis are contemplating withdrawal, it is likely they are depressed. That reactive depression itself is often a consequence of the now excessive burden that ongoing treatment imposes on the patient. But such patients may express themselves in terms that make them sound more like a depressed person who is suicidal than a person who is suffering under excessive burden of treatment. Few of our parishioners or patients have the theological sophistication or the language to express their underlying concerns about an excessive or disproportionate burden."[63]

It is hard to think of a situation in which accepting treatment for depression would be burdensome for someone who is terminally ill, except perhaps when help is not readily available, when fee adjustments are not possible for a poor family, or when the patient has too few remaining days for help to be effective. However, it is

[58] Ibid., 69–72.

[59] Rosenblatt and Block, "Depression, Decision-Making," 324.

[60] Daniel A. Cronin, *Ordinary and Extraordinary Means of Conserving Life* (Philadelphia: National Catholic Bioethics Center, 2011), 156–158.

[61] Ibid., 136.

[62] Peter J. Gummere, "Discontinuing Renal Dialysis," *Ethics & Medics* 34.10 (October 2009), 3.

[63] Ibid., 4.

another matter when every reasonably possible treatment for depression has been tried, and the patient approaching the end of life has not responded and remains depressed.

In Cronin's opinion, as noted above, treatment is no longer ordinary when it involves great difficulty for a *particular* individual, even though it may continue to be considered ordinary for someone else. When treatment for depression has been unsuccessful, it is possible that the depression itself, combined with other health issues, may make further medical treatments distinctly burdensome or even repugnant. In other words, the depression may add an extra layer of burden and tip the balance, as it does for a patient undergoing dialysis. In such a case, a proposed medical treatment might be considered extraordinary.

A couple of weeks after my friend's depression grew worse, he faced a new medical complication: two toes on the remaining leg developed dark spots. Were these bruises, or evidence of a new infection? The foot doctor recommended setting up an appointment with a vascular specialist, but my friend decided that he did not want additional surgery. However, we heard from different sources that allowing a possible infection to run its course could lead to unbearable pain. So the appointment with the vascular specialist was made, and we waited for it with trepidation, hoping that perhaps this time blood flow could be restored to the foot and it would heal.

A psychiatrist might be called to determine whether a patient is competent to make decisions about medical treatment. To declare a patient incompetent is what Stuart Youngner has called an "all-or-nothing" determination that places psychiatrists "in an unnatural position, sacrificing subtle analysis in favor of a reductionistic legal perspective that sees only the dichotomous choice of competent or incompetent." Patients with dementia, for example, might retain "some ability to make choices." Other patients with no psychiatric diagnosis might show some impairment in their ability to make decisions because of their overall health status or what he calls "morbidity."[64]

Impaired Judgment in the Depressed

At present, "there is no formal agreement on the criteria to determine competence to make medical decisions."[65] Psychiatrists and psychologists rely on their own tools and the legal requirements for the jurisdiction in which they live.[66] They differentiate between competence and decision-making ability, and competence is less likely to be an issue in patients with depression.[67] In addition, a depression itself

[64] Stuart J. Youngner, "Competence to Refuse Life-Sustaining Treatment," in Steinberg and Youngner, *End-of-Life Decisions,* 24.

[65] Werth and Kleespies, "Ethical Considerations in Providing Psychological Services," 68.

[66] Ibid., 69.

[67] Rosenstein, "Depression and End-of-Life Care," 103.

may be transient or "self-limited."[68] Central aspects of decision-making include the capacity to reason and deliberate, a "stable set of values," and the ability to understand medical information and communicate choice.[69] Some factors that affect decision making in mood disorders are cognitive distortions, guilt that makes suffering seem deserved, helplessness, anhedonia that decreases the perceived value of medical intervention, and a belief that things will never change.[70]

Depressed patients may understand risks of proposed treatment but "may not always appreciate benefits."[71] As stated earlier, mild to moderate depression is less likely to influence treatment decisions. Mark Sullivan notes that we cannot just assume that depression is distorting judgment, and we cannot assume it is not.[72] When depression affects choices, the recommendation is to treat the mood disorder.[73]

Some have suggested that a living will should not be honored following a suicide attempt.[74] Others recommend that the execution of an advance directive be postponed until after depression is treated.[75] Still others point out the need for further assessment when a psychiatric inpatient refuses reasonable care or requests a do-not-resuscitate order when circumstances do not indicate a need for that document.[76]

During the week before my friend's appointment with the vascular specialist, he passed blood into his colostomy bag from an unknown source, and his condition declined rapidly. After a day with almost no response, he rallied and was alert for another day; his condition declined again, and he passed away two days later. I believe that various efforts to lift his mood made the final weeks easier and better for him than they would have been otherwise. His wife knew that he died from a medical illness and not from a refusal to eat, which has helped her grief to remain uncomplicated. Although he was ready to die, he was with us as long as he could be—sad but not in great despair—and he passed away quietly in his sleep. His last words were to tell his wife, once again, that he loved her.

Kheriaty reprints an address of Pope John Paul II on the theme of depression that reminds us to "stretch out a hand to the sick, to make them perceive the tenderness of God, to integrate them into a community of faith and life in which they can

[68] Angelo, "Depression and Assisted Suicide," 307.
[69] Rosenblatt and Block, "Depression, Decision-Making," 324.
[70] Sullivan, "Depression and the Refusal of Life-Saving Treatment," 68.
[71] Ibid., 63–64.
[72] Ibid., 62.
[73] Angelo, "Depression and Assisted Suicide," 307.
[74] Sullivan, "Depression and the Refusal of Life-Saving Treatment," 58.
[75] Gibson et al., "Mental Health Issues Near the End of Life," 144.
[76] Sullivan, "Depression and the Refusal of Life-Saving Treatment," 61.

feel accepted, understood, supported, respected; in a word, in which they can love and be loved."[77]

Depressed persons certainly benefit from the presence of warm and loving caregivers. In fact, they need to be around someone who is not depressed—someone who can solve problems and gently correct distorted perceptions. Pep talks, platitudes, and guilt-inducing exhortations are not helpful and cause despondent patients to feel even more isolated and misunderstood.

Although antidepressant medications are the treatment of choice for a major depressive disorder, the commonly prescribed selective serotonin reuptake inhibitors take a few weeks to reach full effect and longer still for those who require a lower starting dosage.[78] Psychostimulants may be a better option for patients nearing the end of life, as these drugs produce faster results, though with more side effects than SSRIs.[79] A group of fast-acting antidepressants that are now in the testing phase might also be helpful eventually.[80] Medications do not always work for everyone. According to one study, 30 percent of elderly patients did not respond to first-line antidepressants.[81]

Electroconvulsive therapy has been used successfully with some terminally ill patients, and Eithne Bolger notes that it is effective in 70 to 80 percent of depressed patients.[82] She also notes that electroconvulsive therapy is generally recommended for those who do not respond to medications and are acutely suicidal, and for those who have severe psychomotor retardation or psychotic symptoms.

Other treatments include modified cognitive therapy, supportive therapies, guided imagery or relaxation exercises, and suggestions for improved sleep, physical exercise, and social interactions.[83] Instilling hope presents more of a challenge, but avenues to explore include conversations about family, values, memories, spirituality, and faith.[84] Patients with cancer who are in palliative care experience fewer symptoms of depression, live an average of almost three months longer, and have a better overall quality of life than those in usual care.[85] Palliative care is "clearly

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[77] Kheriaty, *Catholic Guide to Depression*, 244, quoting John Paul II, Address to the Participants in the Eighteenth International Conference promoted by the Pontifical Council for Health and Pastoral Care on the Theme of Depression (November 14, 2003).

[78] Rosenfeld et al., "Depression and Hopelessness," 174–175.

[79] Ibid.

[80] Federation of American Societies for Experimental Biology, "Fast-Acting Antidepressant Appears within Reach," news release, *Science Daily*, April 30, 2014, http://www.sciencedaily.com/releases/2014/04/140430161301.htm; and University of Chicago Medicine, "A Potential New Class of Fast-Acting Antidepressants," news release, October 29, 2013, http://www.uchospitals.edu/news/2013/20131029-antidepressants.html.

[81] Bolger, "Depression in Later Life," 40.

[82] Ibid.

[83] Kheriaty, *Catholic Guide to Depression*, 126–129; and Gibson et al., "Mental Health Issues Near the End of Life," 143.

[84] Gibson et al., "Mental Health Issues Near the End of Life," 143.

[85] Rosenstein, "Depression and End-of-Life Care," 106.

supported by the Catholic Church" and produces positive effects for the spiritual and emotional needs of family members as well.[86]

The first approach to major depression is treatment. Addressing the emotional needs of patients with depression at the end of life can prevent ethical problems, such as a desire for a hastened death, the refusal of reasonable and beneficial medical care, or an impaired ability to make treatment decisions. For some patients at the end of life who do not respond to antidepressant medication or other treatment, it is reasonable to consider that major depression itself, combined with other health issues, may make treatment itself excessively burdensome and extraordinary.

[86] Rachelle Barina, "The Good of Palliative Care," *Ethics & Medics* 39.1 (January 2014): 1.