

## The Use of Hospice Care in End-Stage Psychiatric Patients

Gillian Bassirpour, M.D.,<sup>1</sup> Gregory Mahr, M.D.,<sup>2</sup> Bobby Lee, M.D.,<sup>3</sup> and Maria Torres, M.D.<sup>4</sup>

### Abstract

Hospice care is rarely used in end-stage psychiatric patients, yet situations exist where psychiatric intervention is futile and comfort care is the best option. Delusional disorder is rare, typically begins later in life, and has a chronic course that responds poorly to treatment. The prognosis is affected by factors such as chronicity and insight. A case of a chronic and intractable delusional disorder that affected eating behavior and subsequently caused serious medical complications. Due to the severity of the case and the unique ethical issues it presented, the prognosis was determined to be poor and the patient was discharged home with hospice care. The case presented a rare opportunity to assess hospice care provided to an end-stage psychiatric patient.

### Introduction

**D**ELUSIONAL DISORDER is rare, affecting about 0.03% of the population (DSM4).<sup>1</sup> Delusional disorder typically begins later in life than other forms of psychosis, has a chronic course, and responds poorly to treatment. Prognosis is affected by factors such as chronicity and insight, with the jealous subtype having the best prognosis.

The authors describe an unusual case of a chronic and intractable delusional disorder that affected eating behavior and subsequently caused serious medical complications. Such cases of psychotic individuals who do not eat can resemble anorexia nervosa, but there is a lack of the body image alterations seen in true anorexia.<sup>2</sup> The case demonstrates the complexity of dealing with issues about late-life management of intractable psychiatric disorders and the use of hospice care in such cases.

### Case Report

Ms. X is a 64-year-old Caucasian female who was admitted directly for mental status changes that began while she was bedridden secondary to severe deconditioning.

Ms. X was married for many years and had one adult son. Neither the adult son nor the husband were supportive of any treatment or intervention that would go against the wishes of the patient, including psychiatric treatment.

Ms. X's psychiatric disorder originated approximately four decades ago, when she was living in Japan, where she worked

as an artist. During her time abroad, Ms. X believed she was repeatedly exposed to chromic acid in glass pieces. She became more selective of her diet and noticed an increased sensitivity to the smell of soaps and perfumes. She stated that all food, with the exception of fish, resulted in an inflammatory bowel reaction. Her selective diet continued over the next several decades. Ms. X stated that, starting five years ago, her diet consisted only of organic fruits and vegetables such as avocados, sesame seeds, bananas, and apples. She would supplement her food with desiccated aloe and only drank bottled water from a specific producer. Over the years, Ms. X had had several courses of psychiatric treatment and trials of antidepressants and antipsychotics with no benefit.

Over the past year, Ms. X progressively lost weight and became physically weaker. She recently developed dysphagia for solids and then for liquids, with persistent vomiting. Symptoms worsened, peaking at two weeks before admission, when she became confused, refused to eat, and rejected pleas to see a physician. At the time of admission, Ms. X had a BMI of 13.7. She was noted to be dependent with respect to the majority of her activities of daily living (ADLs). Her palliative performance score was 40.

On being interviewed, Ms. X was oriented to person, but very slow to respond. She had irrelevant speech and prominent thought blocking, and repeatedly used sophisticated words out of context. Physical exam revealed severe muscle wasting with significant fat loss. A Stage II decubitus ulcer was

<sup>1</sup>Department of Internal Medicine, University of Michigan, Ann Arbor Michigan.

<sup>2</sup>Oakwood Hospital-Psychiatry, Wayne State University School of Medicine, Dearborn, Michigan.

<sup>3</sup>Oakwood Hospital-Internal Medicine, Dearborn, Michigan.

<sup>4</sup>Crittenton Hospital-Internal Medicine, Dearborn, Michigan.

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present on her coccyx and pedal edema was noted. The rest of the physical exam was unremarkable.

Bloodwork done on Ms. X revealed significant metabolic derangements and nutritional deficiencies, including macrocytic anemia, mild neutropenia, electrolyte imbalance, hypoglycemia, hypothyroidism, and low albumin, Vitamin B12, and Vitamin D levels. Ms. X did a modified barium swallow test, but refused the solid phase of the test. EGD showed a normal esophagus, gastric bezoar, and atony, with chronic gastroduodenitis. An enhanced CT without contrast of the head, thorax, abdomen, and pelvis was unremarkable.

Ms. X was subsequently given intravenous fluid hydration, which resulted in significant improvement in her mentation. All slowness of response resolved and there was no longer evidence of delirium or dementia. However, she refused all nutritional replacements, medications, and parenteral or enteral supplemental feeding. Psychiatric evaluation indicated somatic delusional disorder. The diagnosis of delusional disorder was made because of the persistent, chronic, non-bizarre delusions starting late in life, in the absence of any other symptoms of schizophrenia. She did not suffer from anorexia nervosa because her concerns about diet were related to delusional issues, not to concerns about obesity, and she did not have altered body image and she was not cognitively impaired. Involuntary commitment was considered, but family was not supportive of inpatient treatment and, after her medical recovery, it was not clear that Ms. X was, in fact, committable.

A competency evaluation was performed and Ms. X was judged to be competent. The decision about capacity to make informed decisions was, of course, quite complex, and involved extensive interactions between the treatment team and family. The patient clearly fully grasped the treatment options and understood the recommendations, but felt that treatment was not helpful on previous occasions and did not want further treatment. Her decision was highly consistent with her previously expressed intentions regarding treatment. One might argue that her delusions clouded her judgment, but her next of kin, who did not share her delusions, concurred with her decision because of her prior frustration with treatment and lack of response.

Finding the patient not able to make decisions would have no practical impact, unless both family members were deemed unfit to serve as her guardians, which seemed inappropriate. Because of her diagnosis, the chronicity of her condition, her lack of insight, and the collusion of her family, her prognosis was determined to be poor. Ms. X was discharged home with hospice care under the provision of general debility and failure to thrive.

## Discussion

This case illustrates the complex ethical issues involved in managing late-life issues in chronic psychiatric patients. We are uncomfortable thinking of psychiatric illnesses as "terminal." Because psychiatric illness involves disordered attitudes and beliefs, and beliefs and attitudes are ordinarily volitional, psychiatric illnesses can sometimes appear more treatable than they are. For a psychiatric illness to be considered terminal, the diagnosis must be well-established, the prognosis must be known to be poor, and reasonable attempts at treatment must have failed.

The first two elements were clearly met in this case; the third is more complex. Modern psychiatric complex polypharmacy in-

volves almost infinite permutations and combinations of agents, so it can be difficult to say definitively that reasonable attempts at treatment have failed, but, in Ms. X's case, standard treatment trials had failed. It should also be noted that, subsequent to the circumstances described in this admission, for complex reasons beyond the scope of this paper, Ms. X was hospitalized psychiatrically and treated involuntarily with no benefit.

Little is known about the use of palliative care in patients with severe and persistent mental illness. Management is also complicated by the fact that these patients are more vulnerable, present with more comorbidities, and suffer from higher mortality rates<sup>3</sup> than other patients with similar medical issues. Special issues affecting Mrs. X's case included: 1) the poor prognosis for delusional disorder, coupled with the poor prognosis associated with her advanced failure to thrive; 2) her severe chronicity and lack of insight; 3) lack of family support for more-aggressive psychiatric interventions, such as involuntary treatment; 4) her poor functional status and inability to meet her chronic needs at home with the traditional medical model; and 5) the inability to provide forced feeding (parenterally and enterally). Because of these special issues, the decision was made to concur with the autonomy and wishes of patient and family, and refer the patient to hospice care.

Hospice care is rarely used in end-stage psychiatric patients. Although many hospices and palliative care teams are available, none of them specifically address management of the serious and persistently mentally ill population.<sup>4</sup> Psychiatric illnesses are not usually viewed as terminal or untreatable, and hospice programs are not often comfortable with managing psychiatric issues. We must be extremely careful about viewing a psychiatric illness as untreatable. We must resist countertransference frustration and anger. We must thoughtfully address the philosophically complex issues such as the degree of volitional control psychiatric patients that have over their symptoms, and avoid colluding with them and/or their families. Yet, situations exist where psychiatric intervention is futile and comfort care is the best option.

## Author Disclosure Statement

No competing financial interests exist.

## References

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 4th ed., text revision. Washington, DC: American Psychiatric Association, 2000.
2. Wenokur B, Luby ED: Anorexia nervosa presenting as a somatic delusional disorder responsive to pharmacotherapy. *J Amer Osteopathic Assn* 1997; 97:231.
3. Woods A, Willison K, Kington C, Gavin A: Palliative care for people with severe persistent mental illness: A review of literature. *Canadian J Psychiatry* 2008; 53(11):725.
4. Baker A: Palliative and end-of-life care in the serious and persistently mentally ill population. *J Amer Psychiatric Nurses Assn* 2005; 11:298.

Address correspondence to:  
 Gregory Mahr, M.D.  
 1801 Oakwood Boulevard  
 Dearborn, MI 48124

E-mail: mahrg@oakwood.org