Depression in the Elderly with Emphasis on Terminal Illness

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In a Japanese study from the Journal of Clinical Oncology, it was reported that 25% of terminal cancer patients experienced significant depression during their illness, due to multiple factors. Such findings prompt us to consider the ethical obligations of Christians to terminally ill patients, especially those experiencing depression.

Depression in the elderly as a group is common, and often goes undiagnosed and untreated. The stress of terminal illness can trigger a new onset of depression or exacerbate chronic underlying depression in patients. One result is that patients often experience a sense of hopelessness, which may be accompanied by a desire that death be hastened through physician-assisted suicide. Studies have shown that terminally ill patients with major depression do respond to therapy, resulting in an improved quality of life and a loss of the desire to hasten death. The recognition and treatment of depression is an important and often overlooked aspect of holistic palliative care.

While Christians do not have a monopoly on addressing depression in terminally ill individuals, we are able to address aspects of hopelessness in unique ways. All physicians can help improve palliative care significantly by recognizing depression, prescribing antidepressant medications, and arranging for counseling. Christians, in addition, are able to address spiritual issues that may have a direct causative effect on emotional distress. We need to determine if the depression is related to spiritual issues such as a lack of a concept of transcendence. Is the depression secondary to a fear of death because death indicates a total cessation of being? Is the patient unsure of his or her relationship to God? Professing Christians may be confused by lack of understanding or inaccurate teaching. Is there a faulty understanding of the Gospel of Grace such that the patient thinks he or she needs to earn a relationship with God? Are there
unresolved conflicts with family members that the patient feels can never be reconciled? Any of these issues can be the cause of depression and Christians are uniquely able to find and address them.

Though time constraints limit the role any physician can play, the role remains critical. Physicians who treat elderly patients, particularly those with terminal illnesses, should develop a team approach to dealing with depressed patients. Multiple studies have shown the effectiveness of a team approach that uses telephone care managers, systematic office-based education, and a collaborating psychiatrist in addition to the primary physician. Pastors and Christian counselors can be an invaluable resource for Christian physicians as well. Christian-based outreach programs can also be helpful.

There are limits to what can be achieved in an institutional setting. If the patient has family members available to assist in providing care, those care-giving family members need to understand institutional constraints and appreciate the role they will need to play in meeting the emotional and spiritual needs of dying relatives. In spite of all we as physicians try to do, patients often prefer that care be provided by loving family members. Often, though, family members feel they are simply too busy to meet such needs. What they often fail to understand is that they are modeling to their children how to care for the elderly. The standard they set will someday be applied to them.

Christians must remember that the Holy Spirit continues to work in the life of dying patients until the moment of death. The current secular trend is to devalue persons who can no longer function effectively, particularly those who are terminally ill. From the perspective of eternity, some of the most critical growth in a person’s spiritual life may occur as they face death. At the same time, it should not be surprising that depression can be a problem, even for Christians. We must keep in mind that death is not part of God’s original design for creation; it is a result of the Fall. Having been created in the very image of God, we sense this “unnatural” aspect of death, and may experience anger, frustration, and sadness as death approaches. Recall that Jesus experienced strong emotions as he stood before the tomb of his friend Lazarus.

We must help each other face death. Shortly before her death, a dearly loved relative of ours told us, “Dying is the hardest thing I have ever done.” This remark prompted us to reflect on another aspect of death; the dying to self that Jesus told us is so essential. We all face physical death, and we all must die to self-centered living. “For whoever wants to save his life will lose it, but whoever loses his life for me will save it.” 

Surrounded with and overwhelmed by everyday busyness and activities that are often inconsequential, what opportunities for spiritual growth are we missing by failing to minister to those who are dying? Caring for the dying seems so unimportant compared to many of our other activities, but that is what makes it so important. Working with terminally ill patients can be humble and invisible, but in so doing, we die a little more to ourselves and, in the process, further the work of God’s kingdom.
Death is the point where heaven and earth collapse into one. For those with no hope of heaven the collapse seems an end to existence. Who would not be depressed by such a prospect? The authors of the Japanese study rightly point to the need to discover and treat depression in terminally ill patients. Christians are called to provide spiritual comfort and hope as well as physical care. Such are the ethics of the Kingdom.


6 John 11:33-43.


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