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# Depression: A Challenge during Palliative Care

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and Sonika Charak*

## Abstract

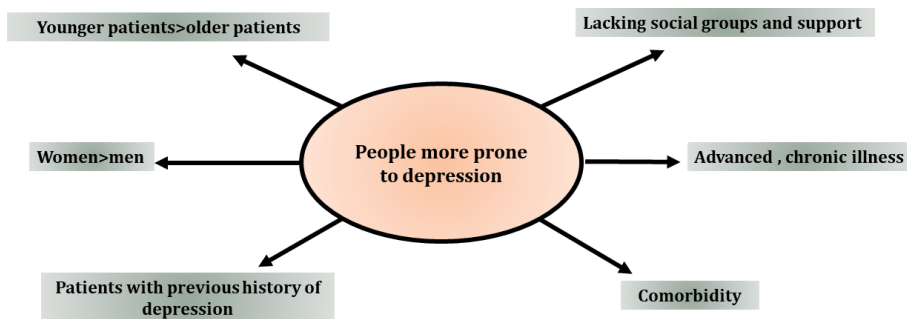
Depression is a serious concern among patients and their family members undergoing treatment for acute and chronic illnesses. The quality of palliative care has great significance in improving the mental health of patients. The patient usually undergoes various stages of treatment before reaching the palliative care stage. Therefore, the tendency of denying treatment at later stages of illness increases. Depression could arise either early or at later stages of treatment. Most doctors feel restrained to prescribe antidepressants to the patient, as antidepressants could have a serious side effect on the physiology of the patient. Antidepressants only work for a smaller group of patients. A proper diagnostics and structured interview with extensive checks of reliability and viability could be used for assessment. Various factors like sociodemographic, gender, age, support health groups have a drastic effect on the mental health of the patient. Palliative care to the patients with social health support groups psychotherapy, relaxation meditation yoga, along with the appropriate pharmacological approach, works wonders for some patients. Continued efforts should be made to treat and deal with depression in palliative care.

**Keywords:** depression, palliative care, acute, chronic illness, assessment, antidepressants

## 1. Introduction

Depression is thought to be one of the most serious and common mental disorders that could arise in palliative care settings. The term depressed is widely misunderstood among a large section of people. Often depressed is misused by the word “feeling sad”. Many physical symptoms like fatigue, weight loss, sleep cycle, weakness, lack of interest are common in advanced illness. There should be proper monitoring of symptoms in depression. A survey was done by Lauren Rayner and team [1] that determined the pervasiveness of depression in patients receiving palliative care, after the initial assessment by clinicians, nurses 300 patients were interviewed. According to the survey, 58 patients met the criteria for MDD (major depressive disorder) while 109 met the criteria for any depressive disorder. Males were more prone to MDD. Depression could not be only identified by somatic symptoms, but a proper psychological assessment and support are also needed. A study done by Franca Warmenhoven and team suggested that [2] many physicians failed to distinguish between the normal and abnormal sadness, patients receiving palliative care, the therapeutic and diagnostic processes for depression is a continuous

and overlapping process. There is high non-specificity in diagnostic methods for depression in palliative care settings. The occurrence of depression also depends upon the past life of the patients and their relationship with their family members. A study conducted by Moira o Connor, Kate white RN and team upon patients with cancer in Western Australia and new south wales [3], has shown that depression is more prevalent in patients with a family history of anxiety. Many patients battling life-threatening illnesses have gone through a lot of pain, trauma, diagnostic measures by the time they approach palliative care. Each of the phases they have gone through has a psychological impact on the patient. Depending upon the diagnostic criteria used the rates of depression could range from 3–69% [4]. Gender, age, demographics widely influence the personality and mental status of patients. Participants diagnosed with mental disorders were significantly younger than the other participants and have a smaller social network. Women are significantly likely to be more depressed than men ( $P = 0.082$ ) [5]. Patients receiving palliative care with moderate to severe depression could be benefited from an intense narrative intervention as the score reduced on PHQ-9 [patient health questionnaire, it is a multiple-choice questionnaire that is used for screening for depression]. Healthcare workers who understand the background of patients thoroughly with practitioners could deliver the intervention. Intervention is a partially structured narrative that is performed by experienced scientists with research trainers who had background knowledge of patients with advanced illness [6]. Patients are more prone to depression in advanced stages of illness (**Figure 1**). Helping patients with support groups in the initial stages of disease could prove effective. Taking care of patients suffering from idiopathic pulmonary fibrosis is very challenging because at that time no medication could prove its efficacy that could improve the quality of patient's life, but many therapies could reduce symptoms in patients. However, a placebo effect could have improved the outcome, when introduced to the support groups and palliative care have increased the quality of life [7]. A comorbid condition for the patient in palliative care could be very challenging to treat. A study suggested that psychotherapy when given to patients with advanced and serious illness in palliative care can reduce symptoms of depression and tends to improve the quality of life [8]. Cognitive-behavioral therapy helps the patients to accept the condition and treat emotional distress, intervention narrated by health professionals also has significant effects [8]. Detection of depression in palliative care screening could be an effective way as it excludes the non-depressed patients from the depressed ones, but one disadvantage is that it could not detect the degree to which a diagnostic criterion is applied to the patient. Comprehensive clinical evaluation should not be substituted by screening but supplement it. Mostly the detected cases rarely take into account the duration of symptoms. The ability to detect and treat depressive symptoms should be an initial priority to treat depression in palliative care [9, 10]. To achieve quality palliative care, an acceptable or good amount of psychological care is a must.



**Figure 1.**  
*Factors responsible for depression in patients.*

Most patients face a stigma from seeking help from medical professionals, thus it should be dealt with and solved. Members of the medical and research team should arm themselves with interactive communication skills. Unconsciously or unknowingly the healthcare workers should be very vigilant not to portray hopelessness or any negative thought in respect to the disease diagnosis or treatment to the patient. They should be compassionate and empathetic towards the patient. In the advanced stages of the disease, the intensity and frequency of physical symptoms can vary. Screening for mood disorders and depression should be done in patients expressing the significantly high intensity of physical symptoms to provide treatment to the condition [11]. Lack of support system from friends and family at the time of palliative care is certainly a risk factor for non-remission. A strong correlation was found between remission of depression and improvement of physical symptoms [12]. An additional amount of psychological care could benefit depressed patients in palliative care with low support groups for their treatment [12]. Psychological therapies including cognitive behavior therapy showed some positive results in the treatment procedure. Some interventions like antidepressants and psychostimulants remain challenging, requiring a wide level of clinical trials. Pharmacological approach when combined with psychotherapy, support group therapy, an aromatherapy massage could be proven very effective in treating depression [13]. A study performed in cancer patients to detect depression states that no method has been completely accurate for definitive screening. Detailed tests combined with simple questions could be considered as a method. Work carried out in future generation should be beyond screening for psychopathy alone, there is a wide variety of psychological distress that also require medical help [14].

## **2. Assessment and diagnosis**

The first step is the assessment and is one of the most important and crucial steps in the diagnosis of depression. This step could itself be very challenging in the environment. In a study, a structured interview was constructed for assessing the symptoms of patients in the advanced cancer stage receiving palliative care. Visual analogue scales (VAS) were also completed by the participants along with the interview. Impressive interrater reliability was shown by interview items (interclass correlations were  $> 0.9$ ). Structured interview for symptoms and concerns was found to be sensitive between each participant of the subgroup. Thus, a structured interview method of assessment could be proven reliable and valid way in determining depression during palliative care [15]. To treat a disease, the first step is to identify it. Undetected depression in patients receiving palliative care could lead to severe consequences. Often physicians find it difficult to distinguish between sadness and depression in patients with advanced illness at the end of their life so there should be a different diagnostic mechanism for determining depression in terminally ill patients. Correlation between subscale of depression and HADS (hospital anxiety and depression scale) of the 25 patients that were admitted to a hospice correlated with 100 mm linear Visual analogue scale (VAS). VAS thus was thought to be an effective screening tool for patients who were suffering from depression in advanced disease [16]. Hospital anxiety and depression scale (HADS) could be used in yielding numerical scores and is quite acceptable to the patients. The person who deals with this scale should have proper knowledge and time to deal with psychological and emotional stress generated by its use. There comes a time when patients tend to have consistent high HADS scores, a proper review should be maintained in that situation. Earlier detection could be made possible by regular screening from the referral time and thus could be followed by treatment protocols [17].

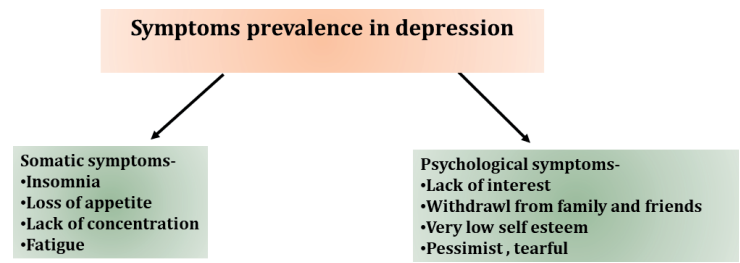


Psychological distress comes in many ways and forms. Its proper assessment makes it a big task. Psychiatric questionnaires when routinely assessed by the clinical staff could produce proper results. Awareness could be raised in non-psychiatric staff by educational programs, screening for the disease could be most effective when it coupled with informative and educational seminars in the presence of responsible psychiatric input. The attention of psychologists and researchers is often attracted by unidimensional scales like distress thermometers because they are easy to use, but there is always a question on their validity in complex psychological constructs. The scale with a length of 6–30 items is multidimensional scales that focuses on a wide variety of distress like somatic, behavioral. The large size of the questionnaire poses one disadvantage. Identifying the causes of depression, distressing symptoms, mood swings that co-exist with other illnesses in the patient could be detected through the HADS anxiety subscale. To improve the clinical issue, screening for psychological issues should be the priority. To gain as many benefits as possible from screening it should be accompanied by validation of treatment. There is a minute difference between assessment and screening for a disorder that is assessment is a more complex process that involves various steps like identification of the problem, a good therapeutic relationship followed by management strategies, whereas screening involves only identification of the psychological distress that eventually leads to assessment in the identified patients [18]. Patients suffering from advanced stages of cancer often face mood disorders and various psychiatric problems which are often underdiagnosed or overlapped with the symptoms of the disease. This may be led to severe difficulties and the patient could lead to poor quality of life. A comparison was bought in the screening procedure between Edmonton Symptom Assessment System (ESAS) for depression with Hospital Anxiety and Depression Scale (HADS). The study suggested that a sample of 216 patients were analyzed using ESAS and the score for depression was found to be 2(0–10) and 6(0–16) using HADS. The sensitivity using ESAS was found out to be 77% and 83% and specificity was found out to be 55% and 47% for moderate to severe depression. The cut-off point that was analyzed using ESAS for the screening of depression in palliative care was 2 out of 10 [19]. Interviewing for psychiatric illness in the palliative care setting is very important. There was a comparison between formal psychiatric interview compared with two-item screening interview which determined the specificity and sensitivity of two item screening interview was the main objective in the study to identify the depressed patients in palliative care study. The sensitivity and specificity of the two-item questionnaire were found out to be 90.7% and 67.7%. The false-positive and false-negative results were 32.3% and 9.3%. The study concluded that the two-question screening tool has high sensitivity and low false-negative results. There was also an easy detection and the patients tend to respond positively to the two-item questionnaire who previously had some experience of depression in the earlier stage than the patients with no prior history of depression [20]. One in four palliative care patients tends to show symptoms of depression, so the screening tool therefore must be very accurate. A comparison was drawn out between three screening tools. The initial was the verbally rating mood on the scale of 0–10, responding to the question that was asked to the patients “Are you Depressed?” in either yes or no format, and last was the completion of the Edinburg depression scale. Using DSM IV criteria, a semi-structured interview was also performed. When determined the sensitivity and specificity of the “yes” answer it was found to be 55% and 74%. The sensitivity and specificity of verbally rating mood on the scale were found to be 80% and 43% and at last, the Edinburg depression scale was found to be highly accurate with the sensitivity of 70% and specificity of 80%. In comparison to these three scales, the Edinburg depression scale was found to be highly reliable in detecting depression in

patients in palliative care [21]. In medical oncology and palliative care settings patients are prone to depression. The rapid screening for depression could be validated by BCD (Brief Case find for Depression). A comparison was drawn out to carry the validation of BCD in a palliative care setting with Primary Care Evaluation of Medical Disorders (PRIME -MD), HADS and beck depression inventory (BDI). Validity was constructed by comparing depressed patients and non-depressed patients relating to symptoms, pain, performance status by using these methods the prevalence of depression was found to be 34%, 12%, 19% and 14% respectively of BCD, PRIME MD, BDI and HADS. BCD was found to be much sensitive than other instruments as it detected a higher rate of depression as compared to other methods. BCD when compared to PRIME MD could recognize both major and minor depression whereas PRIME MD could be used for detection for major depression among patients. The validity of BCD could also be proved by patients having a high BDI score, HADS depression score with probable depression on BCD compared to those without probable depression. A comparison was also drawn between depressed patients according to BCD and non-depressed patients significantly showed scores on the higher side on PRIME MD. The administration of BCD is not very complicated, could be a part of a routine clinical interview. The results could be obtained immediately. Depression and anxiety are often thought to be the same, distinction was obtained between these two by using BCD that supports its discriminatory validity. Thus, BCD could be introduced in standard clinical practices [22].

### 3. Diagnostic challenges

Patients with severely ill conditions receiving palliative care are prone to depression and other psychiatric illnesses but assessing these psychiatric conditions could be very challenging by the medical staff. Multiple somatic symptoms are expressed in the patients with advanced cancer which could overlap with symptoms of depression, thus depression assessment could be very challenging. The study found out the occurrence of depression was significantly related to poor performance status and more pain. One could not exclude somatic symptoms in the assessment of depression which could have a direct or indirect relation with it. Comorbid depression characterization was increasing pain, poorer physical condition than expected normally [23]. There should be no omission of somatic symptoms when as they remain influential in the diagnosis of depression. All somatic symptoms were present in any depressive disorder (ADD) like insomnia or sleeping too much, poor appetite, lack of concentration, etc., whereas major depressive disorder includes both somatic and non-somatic symptoms. Defining depression with HADS score the symptoms were psychologically followed up by somatic symptoms. Thus, in a palliative care setting symptoms like poor appetite, feeling tired overpowered symptoms like feeling bad or speaking slowly. There should be proper symptom diagnosis to determine the broad or narrow concept of depression [24]. Many clinical find these steps challenging as to differentiate between the symptoms (**Figure 2**). Mood disorders symptoms can be the effect of physiological impairment in the body. Pancreatic cancer is highly malignant, and it is very hard to treat. Patients are often feared for it because of its deadly reputation. Patients that develop psychological conditions like mood disorders, depression is likely the outcome of disruptive physiological conditions of the pancreas like impaired secretion of hormones, digestive enzymes or neurotransmitters. Thus, here the reason for psychological symptoms was impaired physiological processes of the patients [25]. Depression prevalent among cancer patients could range from 3.8–58%. 25% patients suffer from depression who have



**Figure 2.**  
*Differentiating between symptoms of depressions.*

been hospitalized with a significant level of physical impairment [26]. Barriers in assessment could form if there arises confusion about depression with some different sources of sadness among cancer patients. The consequence of depression could lead to suicidal or self-harm tendencies if not assessed properly. It is unclear that patients having a comorbid condition like having cancer with depression could be worse than patients only having depression without underlying disease. There is an uncertainty in identifying symptoms of depression in patients with severe diseases because the symptoms tend to overlap with the disease. The cases of depression are often missed. Physicians and nurses were capable of identifying only half of the cases and half of the cases were left undetected [27, 28]. A study was conducted that determined the accuracy of physicians to detect depressive symptoms among patients. A survey was performed on 1,109 subjects who were treated by 12 oncologists by 25 ambulatory oncology clinics that were affiliated with community cancer care Indiana [29]. Subjects had to complete ZSDS (Zung Self-Rating Depression Scale) and physicians rated their patients based on depressive symptoms, pain, anxiety. To detect depression physicians, tend to rate their patients based on how the patient endorses on the ZSDS scale (**Figure 3**). The rating of the physician was also influenced by the medical correlation of the patient. The patient’s mood symptoms like sadness, hopelessness also affected the rating. Physicians tend to be affected by symptoms like crying mood, depressive mood, but this could not be labeled as the reliable indicator of depression [29]. In the UK, a study was done to assess the ability of 143 doctors in 34 cancer centers and hospitals [31]. It was found out that the misclassification of psychiatric morbidity in 34.7% of 797 patients and wrong assessment was made. There was a lack of proper communication skills between doctors and the patients. There should be a need in the improvement of skills during the consultation [31]. Many patients from rural background who are not economically capable of affording a psychiatrist are often left undetected. In physically ill patients, the diagnosis of depression is often complicated because of pervasive somatic symptoms that could be or could not be due to primary disease. In confounding somatic symptoms many options have been proposed. Symptoms that are directly caused by medical conditions are excluded according to DSM IV. The distinction between the symptoms practically could be very challenging.

Zung self rating depression scale	
Score range	Interpretation
25-49	Normal
50-59	Mild depression
60-69	Moderate depression
70 and above	Severe depression

**Figure 3.**  
*Zung self rating depression scale (ZSDS standard scale) [30].*



For the diagnosis of major depressive disorder, 5 out of 9 symptoms should be present when all the symptoms were excluded. This is highly standardized that could only identify severely depressed patients [32, 33]. When the false-negative results are greater, there is a failure to treat depression, or false-positive results the risk of initiating unnecessary therapy. Cassem suggests that clinicals should include on the side of caution the somatic symptoms in diagnosing medically ill patients [34]. However, when the approach suggested by Cassem is used there could be a possibility of prevalence of an exaggerated number of patients with the depressive disorder [15, 34].

#### **4. Treatment and therapies**

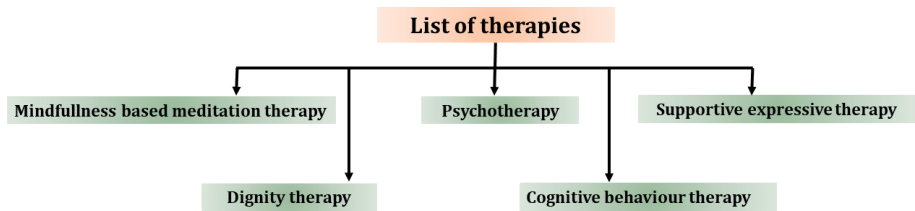
When depression is identified in patients with terminal illness requires various measures to treat it. Treatment procedures could include pharmacological treatment, psychological treatment or the combination of both of these. A study was conducted to prove the efficacy of antidepressants in patients with depression in palliative care. It was found out the administration of antidepressants in these patients was found to be more effective than the placebo effect, and it was more apparent within 4–5 weeks and increased with its continuous use [35]. Patients showing depressive symptoms or depressed anxiety mixed symptoms were daily given oral doses of ketamine hydrochloride. In this 28-day trial, there was found to be a significant improvement in both depressive and anxiety symptoms in patients, the improvement was significant and gradual for 28 days with some rare side effects like diarrhea, insomnia, trouble sitting [36]. There is a slight misconception that the psychotherapeutic approach is not beneficial in severely depressed patients but in a study done by Driessen, et al., it was found that psycho-therapeutic approaches could be beneficial in both mild and severe depression [37].

#### **5. Psychotherapy**

Depressive symptoms that diminish with psychological interventions can also be provided by medical caregivers apart from the specialist in psychological oncology. When the relation of health care workers with the patients is perceived as supportive then the patients with cancer tend to show less traumatic stress. Patients with leukemia significantly show stress symptoms which are associated with physical symptoms, psychological intervention could prevent traumatic stress in the patients. A study of breast cancer patients identified that women who don't have emotional support from family and friends have difficulty in interacting with nurses and physicians [38, 39]. For both undergraduate and postgraduate medical training, there is deterioration in clinical empathy [40].

Several types of psychological therapies are being performed depending upon the severity of depressive symptoms (**Figure 4**) stage of the disease, the interest of the patient and motivation to participate in psychological therapy. Cancer patients who were diagnosed with mild to moderate depression could be benefitted from cognitive behavioral therapy, methods of relaxation, approaches to problem-solving [40–42]. Supportive expressive therapy could be beneficial for the patients who have more advanced disease that targets the fear related with death and existential concerns. Many psychotherapies have been developed like meaning-centred group therapy which is beneficial spiritual and emotional wellbeing [43], dignity therapy which empowers meaning to life [44], mindfulness-based meditation therapy, effective in cancer patients [45], and managing cancer and living peacefully [46].





**Figure 4.**  
*Therapies performed to treat depression.*

## 6. Pharmacological approaches

Administration of antidepressants in physically healthy patients has shown improvement in treating depression, but when it comes to treating physically ill patients there has been a serious doubt in using it. Tricyclic antidepressants (TCA) and selective serotonin reuptake inhibitors (SSRI) are two classes of antidepressants that showed effective results than the placebo effect. But patients stopped taking them after 6–8 weeks of treatment because they experienced serious side effects like sexual dysfunction and dry mouth [47]. There is an inhibition of cytochrome P450 by SSRI drug–drug interaction. Citalopram is well tolerated as it has the fewest drug interaction compared to fluvoxamine which is a potent inhibitor of CYP1A2 and CYP2C19. The assessment of SSRI drug combination should be administered on an individual basis [48]. Drugs such as quetiapine and olanzapine are some antipsychotic medications that have been proposed for symptom palliation because they are thought to improve insomnia, appetite changes, nausea related to chemotherapy with some additional effects on depression, but rather than cancer population its efficacy is derived from general psychiatric [49]. Fatigue and symptoms of depression are very common in terminally ill older patients with advanced illnesses. Administration of methylphenidate showed possible effectiveness towards depressive symptoms and fatigue because of its rapid onset of action [50]. Patients that develop depression in palliative care were restricted and not allowed to use psychostimulants according to European guidelines [51]. Physicians prescribing drugs should be well aware of their toxicity and interactions with other drugs. When antidepressants were administered to the patient’s suicidal tendencies increased mostly between young adults and adolescents [52]. It is important to study drug interaction because patients with cancer when administered antidepressants can alter the pharmacokinetics of the other drugs that were prescribed to the patient for its illness. For example, women who received tamoxifen for the treatment of breast cancer when administered with antidepressants can significantly decrease the survival chances. Paroxetine which is a potent irreversible inhibitor of CYP2D6 which is an antidepressant when administered with tamoxifen increases the risk of death in breast cancer patients [53]. Antidepressants to the patient should be provided following its symptoms of depression and physical illness. In a study done by Mehmet et al., it was found that when low doses of mirtazapine were administered for the treatment of depression in cancer patients, it was significantly safe until 24 weeks period of time, which reduced depressive symptoms [54].

## 7. Age, demographics gender

Depression is common in patients with serious illness in palliative care. Age factor could also contribute to its prevalence. A study was conducted in determining the prevalence of depression in heart failure patients [55]. In the total of patients, it

Age scale	
Age range	Depression severity in percentage
19-29	5%
30-44	7.5%
65 and above	1.4%

**Figure 5.**  
*Prevalence of depression in different age groups [55].*

was found out 48% of the patients were depressed [55]. Younger patients tend to be more depressed when compared to non-depressed patients. The age group between 19 and 29 had a 5% depression rate, 30–44 years had a 7.5% prevalence of depression and those over 65 years had the least depression rate that is 1.4% (**Figure 5**). When compared between men and women (64%) of women are likely to be more depressed than men (44%) [55].

### 8. Social support and support groups

Support groups for the patients suffering from depression in palliative care could be beneficial as it is associated with the gradual improvement of depressive symptoms and helps in improving the patient’s emotional stress and quality of life of the patient. Cancer patients when participated in these support groups had a positive impact [56]. Patients with ostomy when participated in ostomy support group functioned at much more advanced levels than they were in any other previous support group. They experience a willingness to live and tried making new friends [57]. The efficiency of support groups increases when there is additional social support provided by friends and family members. A study done on breast cancer patients analyzed that how women cope with stress and anxiety [58]. It was found out that women who received social support from family showed an effective way of coping with stress. For effective stress management, it was determined that social support was very necessary [58]. Apart from family and friends nurses also play a crucial role in providing social support to the patients. In the medical staff nurses are the ones that are closest to the patient when they need anything. The connection between patients and healthcare is built by nurses themselves, so they need to understand the whole social support system and the nurses should be trained in providing counseling to the patients who are unable to get social support. In a study done on breast cancer patients, there was found to be a direct relationship between psychiatric morbidity and social [59]. For patients suffering from different types of cancer, one year after diagnosis for psychological disorder it was found out that 31.8% of the patients were diagnosed with depression who had low social support scores [59, 60]. A study conducted on different types of cancer, breast cancer, other cancer and mixed cancer by Bina Nausheen and team, results collectively suggested that there is a relationship between cancer progression and social support is strong for breast cancer [61].

Depression is treatable in palliative care patients if one identifies it at the right time. Delayed diagnosis will always lead to delayed treatment which in order will worsen the situation. In the assessment procedure VAS (Visual analogue scale) is very effective for screening depression that correlated well with HADS [16]. Another sensitive diagnostic method is BCD (Brief Case find for Depression) which is very simple to administer which could detect both major and minor depression. PRIME MD (Primary Care Evaluation of Medical Disorders) has a

certain limitation that it could identify only major depressive disorders [22]. For the assessment to be smooth and functioning, there should be well-equipped hospitals with improvised mechanisms and techniques and well-trained staff. When patients were openly asked about feeling depressed the responses recorded from most of the patients were less sensitive and showed false results because the patients tend to hide their illness because of them being stigmatized. The stigma of depression should be eradicated as it hampers the testing problem. To eradicate this stigmatization one must preach to everyone in the family and hospital staff, should organize some seminars and conduct workshops. Many of the medical staff and even doctors treating patients are not well aware of depression as a psychological illness. For the patients to be comfortable with the doctors and staff, there should be good interpersonal communication skills between both doctors and the patients, which could be established by a non-judgemental and emphatic behavior of doctors towards patients [31]. The mental and emotional support from friends and family to the patient at the time of illness could also help the patient to recover more likely than those who do not have it. In the hospital where nurses play a vital role and act as a bridge between doctors and patients, they need to be well trained and highly professional. Untrained staff and nurses in the hospital could be a major reason for prolonged and untreated depression in the patients. Once the depression is assessed, treatment methods could be both psychological and pharmacological. The major limitation of pharmacological drugs is it has certain side effects in some patients apart from treating depression [35, 47, 49, 51]. Patients who experience side effects from antidepressants or psychostimulants should be treated in combination with psychotherapy, yoga and meditation are also effective in the treatment process which helps the patient to achieve peace of mind.

## **9. Conclusion**

Depression is very common in patients with terminal or life-threatening illnesses in a palliative care setting. It is therefore important to diagnose it at a right time. Diagnosing it at a right time will result in effective treatment and could improve the symptoms. There could be many hurdles for the physician to diagnose it because of the overlapping with physical symptoms of the illness. The medical staff should be trained to give counseling to the patients. Many patients tend to resist their treatment because of a lack of social support from family and friends. Psychotherapy which includes various therapies like cognitive behavior therapy was found to be effective in the treatment procedure. Antidepressants when given to patients with depression but with no illness could be very effective but when given to patients with some advanced illness had severe side effects. Doctors must resist the use of drugs that tend to interact with other drugs because it could hamper the treatment of the patients. Social support from family and friends plays a crucial role in combatting depression as it increases the quality of life and gives meaning to live a life, lack of a support system could also be a reason for depression. When it comes to gender, women are the ones who tend to be more depressed than men. Young adolescents and adults when compared to people on the older side are more depressed. There is a lack of hope, suicidal tendencies in the patient with depression. Thus, depression could be a serious challenge in the palliative care settings due to various reasons and we need to deal with it in a more precise way.

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