Invited Commentary

LESS IS MORE

The Antidepressant Effect of Hospice
Need for a More Potent Prescription

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Although caring for a terminally ill spouse can be gratifying, it can also be depressing. Research[1,2] has shown that caregiving poses risks to a spouse's mental health both before and after the ill spouse dies. Depending on the circumstances of the death, psychological distress may increase or decrease as the surviving spouse transitions from caregiver to widow or widower. Important environmental factors external to the caregiver may contribute to a widowed person's bereavement adjustment. One such environmental factor is the end-of-life care that the patient receives. For example, research[3] has shown that the rate of major depressive disorder increases significantly among bereaved caregivers following deaths that involve aggressive life-prolonging care compared with deaths that do not involve such care. Given caregivers' heightened vulnerability to psychological distress and their expanding role in the provision of care for terminally ill patients, there is a human, clinical, and public health interest in determining ways in which end-of-life care might improve the mental health of spousal caregivers.

Is hospice the right prescription for reducing depressive symptom severity among widowed caregivers? Results from the study by Ornstein et al[4] in this issue of *JAMA Internal Medicine* suggest that hospice care has a modest antidepressant effect among surviving spouses. Why would hospice services reduce the severity of depressive symptoms that were shown to increase, on average, as spouses transitioned from caregiver to widowed survivor? The answer may lie in the ability of hospice services to protect spouses from the depressing aspects of caregiving.

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Hospice care may offset the emotional costs of caregiving by creating an environment that is less depressing. Hospice may ease a caregiver's burden by tending to the patients' physical and emotional needs, offering caregivers respite, and providing opportunities to take time for themselves. In addition, hospice care focuses on comfort and is associated with higher rates of completion of advanced directives that would limit the caregiver's exposure to potentially harrowing inpatient life-prolonging procedures.[3,4] Hospices may also promote the spouse's preparation for the patient's impending death and may combat feelings of isolation and helplessness by providing social interaction and professional support. Because hospices recognize the family as the unit of care, they may offer counseling services for caregivers and are required to provide a bereavement follow-up service. Although there is variability in the content and frequency of these bereavement services, even minimal contact may lessen the widowed individual's feelings of abandonment by the health care team.[5] In these ways, hospice services may counteract the demoralizing and dispiriting aspects of caring for a dying spouse.

Nevertheless, it is not surprising that hospice use was associated with only moderate improvement in bereavement-related depression in the study by Ornstein et al.[4] As with prolonged grief disorder, major depressive disorder following the death of a spouse is likely to be rooted, perhaps deeply, in the surviving spouse's relationship to the decedent and in the intricacies and configuration of their life together. Hospice services may touch on the meaning of the death to surviving family members, but the resolution of depressive symptoms may require a more profound and targeted approach. Interventions that focus on core attachment issues have been shown[6] to reduce symptoms of major depressive disorder and prolonged grief disorder in acutely distressed, bereaved survivors. Well-established and validated psychotherapeutic approaches are likely to prove more effective for the treatment of bereavement-related depression than is hospice care.

Hospice care may significantly improve the quality of life of patients and their surviving family members. Hospice care has been linked[3] to better patient quality of life; in turn, better patient quality of life in the last week of life has been shown to predict better bereaved caregiver quality of life 6 months later.[3] In these ways, hospice may have an indirect, if somewhat diluted, positive effect on surviving spouses' bereavement adjustment. Given the observed increase in depressive symptoms in the spouses, regardless of hospice enrollment, the results of the Ornstein et al report[4] point to a need for hospices to increase the potency of their treatment of bereavement-related depression.

There are many ways in which hospice could further ease the transition from caregiver to surviving spouse. Before the patient's death, hospice services might routinely screen family members for clinically significant psychological distress and make referrals to mental health professionals for those whose results of the screening are positive. Hospice staff might also help family members explore how the patient's impending death is likely to affect them emotionally and materially. This could include the practice of "affective forecasting," whereby family members would be asked to anticipate how they expect to feel after the death, as well as hearing from recently widowed people about how the loss affected them.[7] Planning for the filling of practical and emotional roles vacated by the deceased (eg, mechanic, financial and social planner, "taxi driver," and cook) might go a long way in countering feelings of helplessness and symptoms of depression.

After the patient's death, hospice services could also do more to promote bereavement adjustment. The required bereavement follow-up visit should be standardized and aug-

mented, if necessary, to conform to current best practices in the delivery of bereavement care. Improvements could include increasing the duration and frequency of the bereavement follow-up visits, access to reliable resources to ease the transition to widowhood, mandated screening for bereavement-related mental disorders (eg, major depressive disorder, posttraumatic stress disorder, and prolonged grief disorder) and suicidal thoughts and gestures, and referral of highly distressed widowed survivors to mental health professionals.[6] Hospices could also combat feelings of loneliness and social isolation experienced by widowed persons with monthly telephone calls and enhanced outreach through the use of social media (eg, emails and online chats).

Should we conclude that hospice is the first-line treatment for depressions associated with widowhood? Probably not, but it may well lighten the heavy load of caring for a terminally ill spouse and may ease the trauma of watching and worrying while a loved one dies as well as the transition to widowhood. The potency of hospices' antidepressant effect could be strengthened with greater attention to the psychological needs of spouse caregivers and widowed survivors. Given the growing number of hospice deaths, the mood of future generations of widows and widowers may depend on it.

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