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Routine Depression Screenings for Advanced Cancer Patients

Reducing Disparities, Identifying Depression, and Improving Quality of Life

Danielle R. Larkin, BSN, RN

Advanced cancer patients are at an increased risk of developing depressive symptoms, which can lead to major depressive disorder and a poor quality of life. It is important that symptoms of depression to be addressed early and frequently throughout the trajectory of the disease process. Depression is underdiagnosed and therefore undertreated in advanced cancer patients. Clinicians often fail to perform regular depression screenings as recommended by the National Comprehensive Cancer Network. Depressive symptoms are overlooked as they tend to overlap with the effects of disease progression and cancer treatments. Patients' complaints of anorexia, chronic pain, and sleep disturbances do not necessarily trigger practitioners to perform depression screenings. African Americans with advanced cancer are at a higher risk of developing depression, but may not identify as depressed due to the stigma of mental health in the black community. Screening tools such as the 2- and 9-item Patient Health Questionnaire, Beck Depression Inventory II, Hospital Anxiety and Depression Scale, and the Distress Thermometer and Problem List are common brief instruments that can screen for depression. Providing early symptom relief of depressive symptoms through psychotherapy and pharmacologic interventions will benefit the patient, family, and caregivers while improving the quality of life throughout the trajectory of the illness.

KEY WORDS
advanced cancer, African American, cancer disparity, depression, quality of life

The prevalence of depression is high in patients with advanced cancer.[1] An advanced cancer diagnosis can have a profound adverse impact on the trajectory and quality of one's life. Overwhelming feelings of sadness, distress, and anhedonia are not uncommon for advanced cancer patients due to this life-changing event. Depression is often undiagnosed and therefore undertreated.[2,3] The symptoms of depression can be difficult to detect as they often overlap with somatic complaints from the disease or treatments, such as anorexia, disturbed sleep, and functional decline.[2-5] In addition, patients present these depressive symptoms with irritability, chronic pain, and fatigue, which can lead to an increasingly poor quality of life (QOL) for the patient and family caregivers.

Culture can have a direct impact on the expression of depression as well. In many cultures, such as the African American culture, there is a stigma attached to mental illness. Words describing mental illness such as "depression" are not typically verbalized. African Americans utilize vernacular such as "feeling down" or "blue"; therefore, it does not often trigger a depression screening for many health care professionals.

African Americans often face increased incidence, prevalence, and morbidity related to their advanced cancer diagnosis.[6] The American Cancer Society states that African Americans have the highest death rate and the shortest survival of any racial and ethnic group in the United States.[7] Although mortality cannot be avoided, health care providers should address symptoms of depression to ensure high-quality care while promoting comfort and well-being.[5] Timely and thorough screenings, assessments, diagnosis, treatment(s), and follow-up are necessary to provide cancer patients and their caregivers with the best outcomes throughout the trajectory of the disease.

Psychosocial care is becoming an integral part of the clinical management and supportive care for cancer patients.[8] Unfortunately, racial disparities in health outcomes exist across the continuum of care. Clinicians that have not been trained in mental health can miss depressive symptoms in advanced cancer patients.[4] Early detection and treatment of depression can reduce pain and suffering as well as the likelihood of developing a major mood disorder.[9] Frontline health care providers can gain additional cultural congruency to improve the QOL for African Americans and others who suffer from symptoms for optimal outcomes. Registered nurses (RNs) and advance practice RNs (APRNs)

Danielle R. Larkin, BSN, RN, is graduate student, University of Alabama at Birmingham, School of Nursing.

The author has no conflicts of interest to disclose.

Address correspondence to Danielle R. Larkin, BSN, RN, School of Nursing, University of Alabama at Birmingham, NB 1002, 1720 2nd Avenue South, Birmingham, AL 35294-1210 (dlarkin1@uab.edu).

DOI: 10.1097/NJH.0000000000000618

are in a position to provide frequent depression screenings throughout the disease process and promote interventions for symptoms of depression to improve their QOL.

SUPPORTIVE CARE FRAMEWORK FOR CANCER PATIENTS

Margaret Fitch[10] developed the Supportive Care Framework for Cancer Patients. The model was developed for clinicians who work with cancer to conceptualize the care patients and their family may need.[10] Seven needs were identified by Fitch in regard to the needs of cancer patients, which include psychological, physical, emotional, practical, informational, spiritual, and social. Utilizing Fitch's[10] framework, some examples of supportive care needs in relation to advanced cancer patients with depression are listed in the Figure.

CASE PRESENTATION

Mr D. is a 63-year-old African American building inspector who was diagnosed with advanced lung cancer. Shortly after diagnosis, Mr D. was told that his tumor was inoperable, and his oncologist began aggressively treating him with chemotherapy with plans for radiation in the near future. Mr D. had recurrent complaints of generalized chronic pain, fatigue, and insomnia for the past several months. At his outpatient chemotherapy infusion appointments, his wife, who is also his primary caregiver, often apologized for his curt behavior and grumpiness to the staff and practitioners. Mr D. was known as a fun and outgoing "jokester" around his friends and family. His mood had drastically declined since his diagnosis and initiation of cancer treatment.

At his previous infusion appointment, he reported feeling "down" to his infusion nurse when she asked him how he was feeling. When the infusion nurse asked Mr D. if he was depressed, he became angry. Mrs D. interjected that it was the annual fish fry that weekend at their church, but Mr D. was not planning on going. This was the first year in 15 years he had not been involved in the planning and execution of it. Mr D. replied bitterly, "I do not care about the fish fry anymore, I do not feel like going anyway." Mr D. had always involved himself in social activities in his local church and neighborhood organizations. He has become socially withdrawn since his diagnosis. Because of his illness, Mr D. no longer spent time volunteering in his community and attending church services. His inability to work caused financial strain on his family.

After his fourth round of chemotherapy, Mr D. underwent a computed tomography scan due to his increased complaints of pain and dyspnea. At the follow-up appointment, Mr D. and his wife met with his oncologist to discuss the results of the computed tomography scan; a palliative care physician and a social worker were present as well. His oncologist told Mr D. that his disease was progressing and recommended stopping curative treatment. His doctor then introduced palliative care services with the intent to transition to hospice care.

DEFINITION AND CRITERIA FOR MAJOR DEPRESSIVE DISORDER

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* is the criterion standard in defining and diagnosing mental health disorders. Depressive symptoms can lead to major depressive disorder (MDD) if not

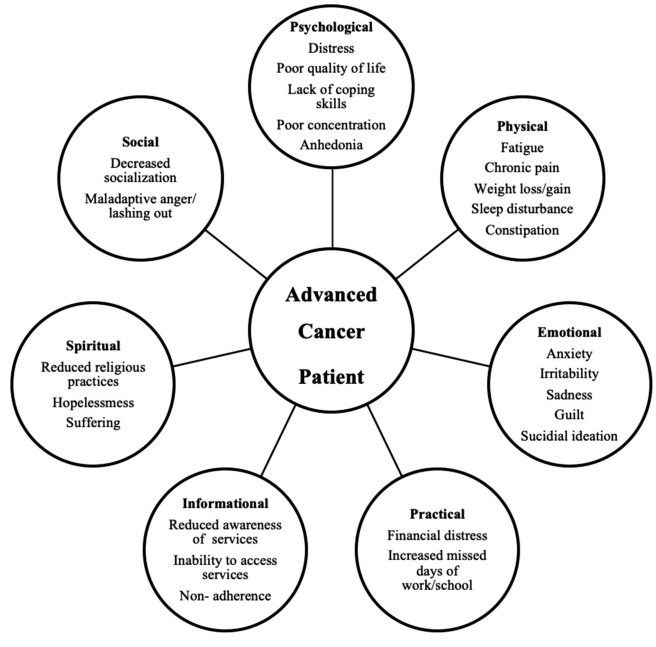

FIGURE. Examples of supportive care needs in relation to advanced cancer patients with depression. Adapted from Fitch's supportive care framework.[10]

treated. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* describes MDD as a depressed mood and a loss of interest or pleasure in daily activities for more than 2 weeks. The diagnostic criteria for MDD state that 5 or more of the symptoms listed below must be present during the same 2-week period and represent a change from previous function such as

1. depressed mood most of the day, nearly every day, as indicated by either subjective report or an observation made by others
2. either subjective or observational diminished interest or pleasure in all, or almost all activities of the day, nearly every day
3. significant weight loss (when not dieting) or weight gain (±5% of body weight); decrease or increase of appetite
4. insomnia or excessive sleeping
5. subjective or observational psychomotor agitation
6. fatigue or loss of energy nearly every day
7. feeling of worthlessness or inappropriate guilt
8. diminished ability to think or concentrate
9. recurrent thoughts of death (not just a fear or dying), recurrent suicidal ideation with or without a plan to commit suicide[11]

CLINICAL GUIDELINES

As uncontrolled and distressing symptoms continue to occur, the perception of QOL decreases and mental symptoms such as depression worsen.[5] There are very few clinical pathways for the identification and management of depression in cancer patients.[9] Distress Guidelines were established to help clinicians identify patients who may benefit from additional emotional support. The Distress Management Guideline provided by the National Comprehensive Cancer Network (NCCN) identifies standards of clinical care and provides guidance and recommendations to support cancer patients who suffer from distress such as depression, anxiety, and other emotional disorders. The NCCN asserts that all cancer patients, regardless of their stage, should be screened for depression at every medical visit, or at a minimum at the initial visit and with any change in disease status such as treatment-related changes, progression, and reoccurrence.[8] Frequent depression screening addresses patient concerns over their depressive symptoms while providing an opportunity to explore patient fears of uncertainty of the future and prognosis.

SCREENING INSTRUMENTS

There are several easy-to-administer instruments to screen for depression in both ambulatory and inpatient areas. Outpatient clinics can utilize the brief 2-question screening instrument called the Patient Health Questionnaire (PHQ-2) to identify patients who are at high risk of depression. The PHQ-2 highlights 2 core symptoms of depression, which are anhedonia and decreased mood; it is scaled from 0 through 3. If the patient screens positive by answering "more than half the day" or "nearly every day" to those questions, the 9-item Patient Health Questionnaire (PHQ-9) can then be administered for further evaluation and severity of MDD.[12] Like the PHQ-2, the PHQ-9 questionnaire is scaled from 0 through 3. On the PHQ-9, a total score of 1 through 4 indicates minimal depression, 5 through 9 indicates mild depression, 10 through 14 indicates moderate depression, 15 through 19 indicates moderately severe depression, and a score of 20 through 27 indicates severe depression.

Ambulatory settings can also employ the self-administered Beck Depression Inventory II (BDI-II) instrument. The BDI-II is a 21-item self-reported multiple-choice questionnaire to measure the severity of depressive symptoms. The BDI-II addresses both somatic symptoms such as anorexia and fatigue as well as cognitive symptoms such as guilt and hopelessness. The scores can range from 0 through 63. The severity scoring is as follows: 1 through 10 suggest normal affect, 11 through 16 indicate mild mood disturbance, 17 through 20 indicate borderline clinical depression, 21 through 30 indicate moderate depression, 31 through 40 indicate severe depression, and any scores greater than 40 indicate extreme depression.

The Hospital Anxiety and Depression Scale can be utilized in the inpatient setting to identify advanced cancer patients with anxiety and depression. It is a brief 14-item self-assessment scale developed to capture clinically significant states of anxiety and depression.[13] Each subscale (anxiety and depression) has 7 items and can be scored individually (from 0 through 3). For each subscale, total scores 0 through 7 are normal, 8 through 10 indicate borderline depression and anxiety, and higher scores, 11 through 21, indicate a definitive case of anxiety and depression.

The Distress Thermometer and Problem List are common rapid instruments devised by the NCCN that have been adopted in both the inpatient and outpatient setting. The Distress Thermometer and Problem List are commonly used in care to identify patients with distress and depressive symptoms. The Distress Thermometer helps identify distress in patients, whereas the Problem List identifies the causative factors for the distress. Recognizing patients who are distressed and depressed while concurrently discovering the factors that are causing the symptoms can facilitate further discussion and elicit greater information through follow-up questions. The test is a simple illustration of a thermometer, which ranges from 0 (no distress) through 10 (extreme distress). The patient will circle the number correlating with his/her perception of distress in the past week. Following the Distress Thermometer, the Problem List should be administered next. The Problem List is a simple yes/no questionnaire that addresses issues such as physical problems, practical problems (eg, housing,

child care, transportation), family problems, emotional problems, and spiritual/religious concerns.

MANAGEMENT

The purpose of treating depressive symptoms upon early recognition or initial patient report is to prevent the patient from developing MDD and improve their perception of their QOL. The NCCN recommends psychotherapy, psychotropic medication, mental health appointments with follow-up, and consideration of additional services if they are at risk of harming themselves or others.[8] An important intended outcome of psychotherapy is to provide an outlet for patients to discuss and understand their emotions and behaviors with a licensed mental health practitioner. Uncovering factors that contribute to their depressive symptoms, as well regaining a sense of control while learning coping techniques, is an important outcome of psychotherapy to improve mood and QOL.[14] However, if a patient verbalizes intent to harm themselves or others (with or without a plan), immediate psychiatric attention must be given.

Pharmacotherapy can be a very effective adjunct to psychotherapy. Drug classes such as selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, tricyclic antidepressants, and atypical antidepressants (such as mirtazapine) can be employed to increase mood. No particular class of medication has been proven to be superior to another class; however, selective serotonin reuptake inhibitors are the preferred first line therapy for treating depression because they are typically better tolerated.[1] As with any antidepressant, it is important to start at the lowest dose and to increase titration slowly to the maximum effective dose.

Antidepressants can provide depressive symptom relief if patients adhere to the prescribed regimen. Providing pharmacological interventions for African Americans can be challenging, because of their mistrust of the medical system and challenges with affording care.[15] Nurses can help African Americans overcome barriers to medication adherence by providing referrals to prescription assistance programs, such as Partnership for Prescription Assistance and Rx Hope. Nurses also need to educate patients on their medications and potential adverse effects. Other valuable tools to assess depression, such as suicide risk assessments and the Geriatric Depression Scale, may be beneficial, depending on the patients' subjective feeling of self-harm and advanced age. A referral to spiritual care services can also be warranted in advanced cancer patients with depression. For many advanced cancer patients, especially African Americans, spiritual healing can offer solace.

CASE STUDY CONCLUSION

Depression can be difficult to detect in African Americans because of vagueness in reported symptoms, cultural presentation of these symptoms, and lack of cultural understanding.[16] Detecting depression in African American cancer patients can be more challenging because this population typically reports more physical symptoms when they are feeling depressed.[17] In addition, the somatic symptoms reported by advanced cancer patients appear to overlap with depression symptoms, making depression difficult to identify. The case study presented a patient with several overlapping somatic and depressive symptoms. Many African Americans may not identify with the term "depressed," which alone poses a barrier to providing mental health care.[18] There were several opportunities for depression screening, such as at the initial diagnosis, at the outpatient appointments, and with the change in diagnosis; however, practitioners failed to perform depression screenings. When a conversation about depression was initiated and challenged by the patient, no further inquiries were made. Mr D. would have benefited from routine depression screening and mental health interventions.

NURSING IMPLICATIONS

Registered nurses and APRNs work very closely with patients. If nurses do not inquire about depression, a pathway cannot be created for patients to access mental health care services if needed. The inability to distinguish mental health concerns from natural disease progression and treatment(s) prevents RNs and APRNs from achieving better patient outcomes such as avoidance of MDD and improved QOL. Hospice and palliative care nurses should have a comprehensive understanding of depression, feel confident in supporting patients with depression, exhibit comfort with addressing potential self-harming behaviors in advanced cancer patients, and have knowledge of services to assist with depression. Awareness of depression screening tools and interventions are also imperative in supporting patient's high risk of developing depression. Respecting autonomy and providing antidepressant medication education are important when working with advanced cancer patients who suffer from depressive symptoms.[19] Advance practice registered nurses can provide the initial depression screening for baseline data and assess the patient at subsequent visits for any changes to baseline.[20] Registered nurses and APRNs can further support the patient and the family members by educating them on the importance of taking their antidepressant as prescribed and not abruptly stopping medication.

CONCLUSION

Depression is common among advanced cancer patients. The presence of persistent depressive symptoms can lead to MDD and is a strong indicator of a poor QOL in advanced cancer patients.[21] Decreased recognition of depression by clinicians is multifactorial due to the lack of

knowledge and self- efficacy of working with mentally ill patients as well as the somatic symptoms that mimic the disease and treatments. Early identification and treatment are key in treating depression in advanced cancer patients. Utilizing both pharmacological therapy in conjunction with psychotherapy has proven to be efficacious.

Per recommendations from the NCCN, screening should occur at every encounter. Screening tools such as the PHQ-2 and PHQ-9, BDI-II, the Hospital Anxiety and Depression Scale, and Distress Thermometer and Problem List can help identify patients at risk of an MDD. Ethnic groups such as African Americans require culturally sensitive care and additional monitoring of depression due to the stigma of mental illness and barriers to adherence. With a better understanding of depressive symptoms in advanced cancer patients and available screening tools, early recognition and treatment of depression can improve their QOL throughout the trajectory of their illness. Nurses can more promptly recognize and treat their depression and help improve their QOL.

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