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SCREENING FOR DEPRESSION IN CANCER PATIENTS

by

Annie Kitzman

Bachelor of Science in Nursing, North Dakota State University, 2005

An Independent Study

Submitted to the Graduate Faculty

Of the

University of North Dakota

In partial fulfillment of the requirements

For the degree of

Master of Science in Nursing

Grand Forks, North Dakota

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2012

PERMISSION

Title: Screening for Depression in Cancer Patients

Department: Nursing

Degree: Master of Science

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Date 4/27/2012

Abstract:

A diagnosis of cancer is not only stressful, but can be a traumatic experience. Research has documented many negative psychosocial effects from malignant disease. Many patients with cancer will experience a vast amount of distress due to the impact cancer has on multiple areas of their life. Advances in pharmaceuticals have allowed us to make significant advances in symptom control and treatment in cancer patients. However, emotional adjustment to a cancer diagnosis also requires initiating a variety of psychological resources. A systematic review of published literature was utilized. Databases such as PubMed, CINAHL, and Google Scholar were utilized for this project. The literature concludes that there is a consensus among need for improvement in the recognition and treatment of psychosocial effects such as and depression in patients with a cancer diagnosis. Most patients will face some degree of or depression with a diagnosis of cancer. It is integral as healthcare providers that we recognize and treat these symptoms as we would any other symptoms associated with cancer.

Introduction:

Depression is very common psychological stressors faced by the majority of cancer patients. As the number of cancer patient's increases so will the incidence of depression in these patients. Our nature as health care providers is often to become preoccupied with treating the multitude of physical symptoms patients experience related to their cancer. However, often times the emotional toll the disease is taking on patients is overlooked.

Are oncology patients being appropriately screened and treated for psychosocial problems such as anxiety and depression? Is their psychosocial well being treated like a 6th vital sign in these cases? Improving cancer treatment effectiveness for cancer patients has become a major area of interest over the last several years. However, research indicating the prevalence of anxiety and depression and effectiveness of treating these emotional aspects in cancer patients is lacking.

Increasing awareness and knowledge of screening and treating cancer patients for psychosocial aspects of their disease would further increase the quality of life in these patients. Depression is a frequent problem of cancer patients and is often under diagnosed and therefore undertreated.

Purpose:

Depression occurs among 15% of cancer patient's (Rhondali et al, 2012) The purpose of this study is to portray the significance depression and anxiety pose on cancer patients. There is a need to develop evidence-based guidelines to help introduce interventions in cancer patients as untreated depression and anxiety in this patients can lead to morbidity (Jadoon, Munir, Shahzad, Choudhry, 2010).

There are several consequences of a missed diagnosis of depression in oncology patients. Some of the consequences include: increase in morbidity and mortality, decrease in compliance with medical regimen, greater somatic experienced by the patient, relationships strains whether it be work, family, or friends, and a decrease in the overall well-being of these patients.

Health care providers must inquire about depression in cancer patients as they would other symptoms such as nausea, swelling, or weight loss or pain.

Anxiety and depression have been identified as a common psychological distress faced by many cancer patients. (Rajandram, Ho, Samman, Chan, McGrath, Zwahlen, 2011). However, there are multiple barriers as to why providers don't recognize these psychosocial needs in cancer patients. The reasons for this are complex. For instance, some health care providers are unfamiliar with the symptoms of clinical depression in these patients or some view sadness as part of the normal coping concept when dealing with cancer (Chochinov, 2011).

In order to accurately treat depression in oncology patients it must be recognized by health care providers, whom must have the ability to differentiate patients experiencing clinical depression and those showing a normal emotional response to their illness (Chochinov, 2011). There is an under recognition of depression in cancer patients that affects treatment outcomes and patients satisfaction with treatment. The purpose/deliverable of this study is to educate providers by creating a power point displaying simple screening tools given at each oncology patient's visit to monitor for depression. Also, to educate provider's with the PowerPoint on the importance of screening for depression.

Significance:

The published information on the prevalence of depression has not been easy to interpret. There are several different percentages and numbers representing the estimated percent of oncology patients suffering from depression. However, despite the variation the consistency remains that reported rates of depression occurs among an estimated 15% of cancer patients (range, 1-77.5%) (Rhondali et al, 2011).

However, studies have proven that the vast majority of patients with depression are not receiving accurate treatment of their symptoms. Undertreating depression in cancer patients can have a substantial negative impact on many areas. It can reduce the patient's quality of life, compromise family member function, interfere with treatment decisions, and may even shorten survival (Block, 2010).

Patients diagnosed with cancer can experience distress because of the multiple physical and cognitive dysfunctions resulting from a cancer diagnosis and treatment. In relation to the multiple difficulties these patients face, the need for psychosocial interventions to improve these patient's quality of life has been well documented. (Tamagawa, Garland, Vaska, Carlson, 2012.).

Many patients my not seek advice for their symptoms or express the need for intervention when it comes to depression. This may be for several reasons. Sometimes the anxiety and sadness that come naturally with cancer may be considered appropriate in context by patients. The vegetative symptoms with depression may overlap the vegetative symptoms with medical illness (Greenberg, 2004). Often time, physicians may not ask therefore a patient does not tell. Many times the uncertainty of a diagnosis of cancer leaves limited time and therefore questions about emotions are avoided. Therefore a simple and time favorable screening tool would better help assess the patient's symptoms prior to their visit. The creation of a simple tool such as this could help identify and treat an increased number of cancer patients and vastly improve their quality of life.

Theoretical Framework:

The framework chosen for this study was the Theory of Unpleasant Symptoms. The TUS provides an excellent model for the experience of, and relationships between, concurrent symptoms. The theory initially evolved from the work of three investigators that began work on two concepts that represent unpleasant symptoms, dsypnea and fatigue simultaneously.

The initial model was constructed to acknowledge influence from three factor categories physiologic, psychological, and situational. Each symptom can vary in duration, intensity, quality, and distress. After initial publication, the authors acknowledged that further development of the model and theory was needed. It was also acknowledged that further work was needed to provide for the potential for the experience of multiple symptoms to have a multiplicative effect.

Lenz et al. determined that because many of the same factors may be involved in the experience of multiple symptoms, similar interventions might be effective for more than one symptom simultaneously. Lenz et al. (1995) acknowledged this as a middle range theory, which is less, abstract than a grand theory, more appropriate for empirical testing, and more applicable to practice for explanation and implementation.

A revision of the TUS was published in 1997. This revision sought to re-emphasize the three major components of the theory: they symptoms, influencing factors that give rise to or affect the nature of the symptom experience, and the consequences of the symptom experience. This revised model allows for multiple symptoms at the same time. It also allows for one or several symptoms to exacerbate effects on performance as well as provide reciprocal influence on physical, psychological, and situation factors. The dimensions of the symptom experience are as follows

- Intensity (strength or severity of the symptom)
- Timing (duration and frequency of occurrence)
- Distress (level of distress perceived, degree of discomfort or bothersomeness)
- Quality (the patients description of what the symptom feels like). (Liehr, 2005, p155).

Lenz stated that the dimensions are separable but related. Each symptom can be measured separately or in combination with other symptoms. The revised theory can describe the presence of physiologic pathology that may trigger a psychological response such as anxiety. In the same token, psychological factors as symptom experience may be exacerbated or mediated by situational factors such as a strong or weak support system.

This framework supports the suggestion for a screening tool for depression in cancer patients. It displays that patients with a diagnosis of cancer and undergoing chemotherapy display a multitude of symptoms and that it is important to control each individual symptom on its own to prevent them from becoming interrelated or one affecting the other.

Definitions:

The DSM-IV defines a major depressive episode as experiencing either dysphoria or anhedonia in addition to at least five somatic symptoms for at least 2 weeks. The somatic symptoms may overlap with those experienced by patients as a direct result of their cancer or treatment. Among these symptoms are changes in weight, appetite, sleep, fatigue, loss of energy, and diminished ability to think or concentrate. (Journal of Supportive Oncology)

The term screening, as defined by the UK National Screening Committee in an article I reviewed is as follows "a public health service in which members of a defined population, who do not necessarily perceive they are at risk of, or are already affected by, a disease or its complications, are asked a question or offered a test to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of a disease or its complications." (Meijer, Roseman, Milette, Coyne, 2011). Thus, screening for depression may involve questionnaires to identify patients who may have depression, but are not seeking treatment for symptoms and whose depression is not otherwise recognized.

The population to benefit in this project includes all patients of age 18 years and older, male or female with a cancer diagnosis. The population directed to help facilitate the deliverable includes all healthcare providers working with cancer patients in their profession in a Midwest urban setting.

Process

A number of databases were utilized to obtain professional articles that pertained to my deliverable. There were a surprising amount of research articles pertaining to this topic while using the different databases available. The following search terms were utilized and the results they provided:

1. "Depression Cancer"—Pubmed revealed 13,167 results and Google Scholar provided 1,050,00 results. This was obviously too vast of a number so the search needed to be narrowed.

2. "Screening Tools Depression Cancer"—Pubmed gave 112 results while Google Scholar provided 19,000. There were many excellent articles to support my research, however still quite a tedious amount to review.
3. "Recognizing Depression in Cancer Patients"—Pubmed gave 5 results and Google Scholar gave 36,100. I was able to find most of the most applicable articles utilizing this search.

Utilizing multiple databases was necessary in the research to provide different articles and searches pertaining to the topic chosen. A variety of the articles came from PubMed as they offer free full-text articles and in the case of the full text article being unavailable there was usually a link providing access to the article.

Cancer and EBP is a robust area of research in this age so one of the limitations in this review of literature was narrowing down a search to an acceptable number of appropriate articles related to my specific search. However, it was found that the more specific I became with search terms created a smaller number of articles, however many articles suitable for this research.

The intended target audience for this research project was very generalized. It was not only to be directed toward oncology providers, but to all providers in as a whole that work with patients with a cancer diagnosis. This includes Physicians, Nurse Practitioners, Physician's Assistant, and any other provider that would be monitoring or caring for a patient with cancer.

Although there are many screening tools available in different clinic settings across the nation to assess depression in cancer patients. There is one currently available in the CancerCare Center in this community. However I do not feel it is being used

consistently. I sought to create a screening tool for depression that could be used at the CancerCare Center in a urban Midwest setting and also a PowerPoint to educate the staff at the CancerCare Center on the importance of screening their patients for depression.

Screening tools being currently used for depression include: Brief Edinburgh Depression Scale (BEDS), Edmonton Symptom Assessment System (ESAS), Hospital Anxiety and Depression Scale, Beck Depression Inventory, and Edinburch Depression scale to name a few (Rhondalini et al, 2011).

After reviewing previous scales utilized to monitor depression in cancer patients there were a few points I found necessary to keep in mind while creating a tool to monitor depression in oncology patients. According to Rhondali et al, while creating a screening tool it is important to remember that screening tools are more likely to be used and administered if they are easy to perform and don't require specialized training. Patients also must find them acceptable in terms of being easy to complete, time to complete, and the ability to not cause discomfort or embarrassment while completing them (Rhondali et al, 2011).

These factors were taken into consideration while developing a screening tool for the CancerCare Center in an urban midwestern area. Also, cost was a factor when developing the tool, as this is always something that must be kept in the back of one's mind when developing a tool for health care. The Director of the CancerCare Center in the chosen urban Midwest area. She has 7 years experience in cancer research and she was who was contacted to review my project and provide recommendations.

Review of the Literature

There were a total of 20 articles reviewed for this project and 15 of them chosen for critical analysis described in the matrices on the last pages after this project. This particular project was chosen based on the author's own experience with the lack of screening for depression/anxiety in oncology patients. However, the literature had a lot of insight into this topic as well.

This project contains multiple study designs including journal articles, qualitative studies, quantitative studies, meta-analyses, systematic reviews, and clinical guidelines. A variety of settings and patient populations were used in the studies chosen from inpatient settings, outpatient settings, and patient's own environment.

The consensus of many of the studies displayed that there was in a majority of cases an unmet psychosocial need of oncology patients. This need varied from depression, anxiety, or other psychological needs of patients. It seems that despite increasing awareness of depression that the studies reveal an under-diagnosis of depression in oncology patients.

The research shows that perhaps several barriers exist in treating depression. Some of these barriers include: cost, uncertainty of diagnosis, or even uncertainty of screening tools available to providers.

The amount of literature on this particular topic was astonishing. It wasn't known that depression and anxiety had been researched so much in previous articles. The author's belief is one of the main emphasis of the research found is that depression exists in its cancer victims. The percent of patients that experienced anxiety or depression in each article reviewed varied. However, one would tend to believe that because the

Discussion

Interpretation

Perhaps, one of the most devastating phrases an individual can hear is "I'm sorry, but it is cancer." The author has first hand experience diagnosed with Stage 3 Colon cancer 2 years ago, at the age of 27. After chemotherapy for 6 months, and sitting in the waiting room of a Cancer Care Center in Midwestern North Dakota more times than a countless number of times the author learned a lot. Some of the most amazing individuals were also undergoing treatment during this time. Individuals who have had cancer are similar to veterans of war, they have a bond knowing that what we are experiencing you cannot truly imagine until you have experienced it yourself.

These patients shared things with one another that they didn't share with their physician because of this bond. They all wanted to know what symptoms one another were experiencing and what was working and what wasn't. The author never did her own official research on this topic at the time, not knowing she would make it this far in her graduate program. However, it can be said with confidence that nearly all of the patients met during this time were suffering from depression or anxiety of some form. There were a handful of patients whom had been receiving treatment for some time that were being treated, however many of us were not.

The author did not respond well to chemotherapy and became very ill both physically and mentally. The focus of the majority of the oncology appointments was on controlling her nausea, weight loss, neuropathy, and so on. There was never a time remembered that feelings on this diagnosis were approached. Perhaps, it's a rhetorical question as how would anyone with cancer feel? I secluded myself in a room for the

majority of my treatment and months afterwards. Relationships with family suffered, compliance with treatment suffered, and overall well being suffered.

The author was fortunate enough to have encouragement from peers, classmates, and faculty to keep going with my graduate studies and she is pleased to be able to share her story and emphasize the importance of screening oncology patients for cancer. It is truly an area of passion for the author and the belief is this an area in health care that needs more focus.

There was a vast amount of literature supporting this view while doing this review. It seems likely that the author was not the only patient with unmet needs during a cancer diagnosis. The review of literature of articles and extensive research showed strong evidence that cancer patients are under diagnosed and undertreated for depression as a whole. Although there may be a subgroup of individuals that proceed without problems in this psychosocial area, many will not.

The review suggests that several screening tools are widely available to providers to identify depression in oncology patients and that when used effectively is accurate in doing so. However, these tools are not used often enough in settings with cancer patients because of multiple reasons.

The review of literature summarizes that an effective tool in screening for depression must be many things: easy to administer, be able to be done in a timely matter, accurate in identifying cases of depression, and cost effective. Currently the Cancer Care facility researched uses the NCCN Guidelines Version 1.2011 Distress Management (available in appendix).

Outcome/Dissemination

The deliverable was to review previous tools utilized and create one of my own with points I found beneficial from previous tools to develop a tool to present to the Director of Cancer Care in an urban Midwest area and the Cancer Care Primary Nurse Navigator for review and feedback.

The power point was presented to both the Nurse Navigator and the new director at Minot's Cancer Care Center. The feedback from them was positive. They believed that the powerpoint brought about and emphasized several good reasons that a screening tool for cancer patients is of importance they both also agreed that the examples given in the powerpoint were great examples of possible screening tools.

The nurse navigator did email the author the screening tool that they utilize as of now in Cancer Care Center. The tool they currently are using is a version developed by the National Comprehensive Cancer Network. It is titled the NCCN Guidelines Version 1.2011 Distress Management. It has two different portions to it. The first is utilizing the distress thermometer as suggested in the PowerPoint. The next portion has the patient circle yes or no indicating if any of the listed problems have been an issue for the patient in the past week. The problems include practical problems, family problems, emotional problems, spiritual concerns, and physical problems.

This sparked the realization that perhaps many of the Cancer Care Centers do have screening tool that they use as resource to screen for depression in cancer. However, the thought is that perhaps these tools are utilized as frequently as they should. The research and review of literature displayed that it wasn't necessarily the fact that a lack of screening tools for depression were present, more so they were not being implemented to all cancer patients. It seems that we do an excellent job documenting the

interventions, referrals, and community resources available to meet each individual patient's needs for depression. It is also important to educate providers on triaging patients with high distress with suicidal ideation or plan to psychiatry or the Cancer Counseling Center if available.

Policy

A contribution that has been made to assist in the barriers to treatment of depressive disorders among cancer patients has been made by the National Comprehensive Cancer Network Guidelines for Management and Distress. The NCCN has developed guidelines for treatment of specific tumors that serve as a reference guideline for oncologists. The Guidelines of the Management of Distress offer an algorithm for care of depressive disorder and other psychiatric disorders in the oncology setting. This guideline also encourages interactions between psychiatrists, psychologists, social workers, and pastoral counselors who will consult each other and give feedback to the oncology physician and team (Greenberg, 2004, p134).

Research

Further research is needed in the area of depression and oncology. There is a need for studies displaying the many benefits of early diagnosis and treatment of depression are needed. Also, further research is needed on the effectiveness of different screening tools in cancer patients in relation to depression. It would be of benefit to know what tool is the most cost effective and efficient. An area of interest and more needed research would be following psychological screening in cancer patients after they achieve remission. There are some studies that display many cancer survivors continue to struggle with depression for years for multiple reasons such as financial concerns or

worry of re-occurrence. Research depicting depression occurrence post remission would be interesting and of great value to cancer patients.

Summary/Conclusions

The most common definition one may think of for a cancer survivor is "an individual who has had cancer current or past who is still living". The author of this article is a cancer survivor. A cancer survivor who struggled not only with physically debilitating effects from the disease, but more debilitating were the psychological/psychosocial effects.

Upon diagnosis of any illness such as cancer, we look for a reason. "Why me, why now, why not the single lady next door without a career or children." It was very difficult to digest the physical changes from chemotherapy along with the emotional changes impacting the life of the author. It still is very difficult to digest as a 29-year-old mother of two waiting for a PET scan and oncology appointment every 3 months to see if the cancer has returned. However, there have been several found reasons why this happened to the author. She has become very passionate about cancer research and screening for depression in cancer patients.

Cancer is difficult. There isn't a better way to describe it. It affects every area of a cancer victim's life physically, emotionally, spiritually, and psychologically. Over time, there have been multiple leaps in medicine to treat each of these areas. However, the research is apparent that we, as health care providers could be doing a better job screening patients for depression. There are multiple tools that have been proven effective in which to do this, we just need to be more conscious of using them. As cancer survivors we can attest first hand the importance and impact you will be making on your

patients, their families, their co-workers, and even their social network by screening and treating symptoms of depression. We can make a world of difference in these patient's lives and they deserve it.

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