

Consensus Statement on Depression, Anxiety, and Oncology

James C. Ballenger, M.D.; Jonathan R. T. Davidson, M.D.;
Yves Lecrubier, M.D.; and David J. Nutt, M.D., Ph.D.
(International Consensus Group on Depression and Anxiety);
and Richard D. Jones, M.D.; and Ray M. F. Berard, M.D.

Cancer patients are vulnerable to depression and anxiety for many reasons: metabolic or endocrine alterations, treatment with debilitating chemotherapy regimens, immune response modifiers, and chronic pain associated with their physical illness. Quite apart from the normal emotional impact of the diagnosis of a life-threatening illness, an estimated 20% to 25% of cancer patients meet diagnostic criteria for major depression or anxiety, treatable psychiatric conditions that have serious detrimental effects on their quality of life.¹

At our consensus meeting on depressive and anxiety disorders in general medicine, the International Consensus Group on Depression and Anxiety reviewed depression, anxiety, and oncology from the perspectives of both the oncologist and the psychiatrist. This article sets forth our views on the detection and diagnosis of depression and anxiety in the oncology patient, examines management issues, and identifies further areas for research.

IMPACT OF DEPRESSION AND ANXIETY ON PROGNOSIS IN THE CANCER PATIENT

Depression and anxiety not only affect quality of life but also compromise compliance with anticancer treatment, are associated with prolonged hospitalization, and may have a negative effect on prognosis and even survival.^{2,3} Among patients with breast cancer, for example, depression is reported to be related to a significantly reduced chance of survival over 5 years.⁴ An attitude of helplessness or hopelessness in response to the stress of cancer also has a detrimental effect. When the predominant coping response is a fighting spirit, the cancer patient has better

emotional well-being, with less psychological morbidity, and is more likely to adhere to his or her chemotherapy regimen. There is, however, no conclusive evidence that a coping response characterized by a fighting spirit is associated with a prolonged duration of survival.

SCREENING FOR DEPRESSION AND ANXIETY IN THE CANCER PATIENT

Mood, coping skills, and social support all influence the functional status of patients suffering from cancer, but often oncologists devote little time to the assessment of the psychosocial needs of their patients. Oncologists often fail to ask patients about their psychological state, sometimes because of skepticism or lack of knowledge about appropriate intervention if they were to detect psychiatric symptoms. Patients often fail to volunteer any information about their distress, not recognizing its importance and wrongly accepting it as an inevitable reaction to their medical condition.

We feel strongly that greater screening for depression and anxiety is essential for appropriate and effective care of oncology patients. Some of the most important challenges in the management of oncology patients are the rapid identification of psychological distress, diagnosis of psychiatric symptoms, and administration of the appropriate level of mental health intervention.

As more oncology care transfers to outpatient settings and pressure on consultation time with patients continues, rapid screening for psychological distress is essential. We recommend the use of a self-report screening questionnaire such as the Hospital Anxiety and Depression Scale (HADS),⁵ an instrument that assesses anxiety and depression as 2 dimensions scored separately and has been validated in cancer patients.^{6,7} The HADS is useful because it excludes questions about physical symptoms, which may be confused with symptoms caused by depression or anxiety disorders.

The HADS questionnaire has been used successfully to screen for psychological distress in patients with breast cancer, prostate cancer, or head and neck cancer or lymphoma who are attending outpatient oncology clinics.⁸⁻¹⁰

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Reprint requests to: James C. Ballenger, M.D., Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, 171 Ashley Ave., Charleston, SC 29425-0742.

Compliance with completing the questionnaire is high.⁹ The form can be given out by the nurse for the patient to fill out in the waiting room, and it can then be reviewed by the oncologist, who can either initiate treatment in the patient with a high score (> 11) or refer that patient for psychiatric evaluation (see section on treatment of depression and anxiety). This simple screening approach, which takes little of the oncologist's time, can rapidly identify patients who need treatment for anxiety and depression as part of their overall management. We believe that this strategy is crucial in establishing an acceptable standard of care for oncology patients.

MANAGEMENT ISSUES FOR DEPRESSION AND ANXIETY IN THE CANCER PATIENT

The diagnosis and treatment of cancer include distinct phases. The first phase of investigations leading to confirmation of the diagnosis is a time of acute emotional distress for the patient, who must accept having a life-threatening illness. This is the phase when patients and their families most need information about the disease, information about alternative treatment strategies, and psychosocial support from their physicians. The second phase is acute treatment, when patients undergo radiotherapy, chemotherapy, or possibly surgical intervention for their cancer. The third phase is long-term treatment and follow-up.

Documented anxiety levels are highest in the phase leading to confirmation of the diagnosis, and the short-term use of benzodiazepine anxiolytics can be successful at this time. The risk of the patient developing clinical anxiety or depression is reduced considerably by the level of psychosocial support provided by the physician and by the existence of a supportive family network.

The quality of information the patient receives from the health care team also helps to reduce anxiety. In this context, patients perceive their oncologist as the most important person involved in their care and the one person who can supply the information they most need to know about their cancer. Starting the anticancer treatment prescribed by the oncologist can be seen as a positive step.

As anticancer treatment continues, the patient can become despondent. Whether clinical depression and anxiety develop is influenced by factors related to the patient and the malignancy of the cancer. How patients tend to cope with the stress of cancer—whether they have an optimistic or a helpless/hopeless mindset—will affect their psychological morbidity. Other risk factors associated with depression and anxiety in cancer patients include a history of mood disorder, poor communication with the health care team, and lack of a supportive network of family and friends. Factors associated with the cancer are poor control of pain or other symptoms, whether anticancer treatment is prolonged or involves surgical intervention, and chemotherapy- or radiotherapy-induced side effects.

Management of the patient's psychological state is important at every phase of the disease, irrespective of the type of malignancy and its treatment. Psychiatric management is one aspect of cancer care that is central to every oncology patient. The psychological distress experienced by the patient ranges from the normal reaction to the stress of coping with cancer and its treatment to symptoms so intense that they fulfill clinical criteria for depression and/or anxiety disorders. Oncologists should assess the severity of psychological distress experienced by their patients to ensure that they are managed appropriately.

TREATMENT OF DEPRESSION AND ANXIETY IN THE CANCER PATIENT

We reached consensus agreement that ample clinical evidence justifies the detection, diagnosis, and treatment of depression and anxiety in the cancer patient. Effective treatment lessens suffering and improves quality of life, makes a difference in terms of the patient's resolve, and may improve prognosis. Despite the fact that feelings of sadness or worry are logical in the context of cancer and its treatment, there is no reason not to treat depression and anxiety in the cancer patient. However, when a patient is receiving a complex regimen of cancer chemotherapy, antibiotics, and other agents, the clinician should consider the potential for drug interactions with antidepressant therapy. Most newer antidepressants inhibit 1 or more of the cytochrome P450 isoenzymes, and, in theory, a drug interaction may be expected when they are coadministered with an agent metabolized by the same isozyme, although in practice there may be no clinically important interaction. For an overview of newer antidepressants and the cytochrome P450 system, the reader is referred to Nemeroff et al.¹¹

The status of research on depression and anxiety in oncology is, perhaps, comparable with that in cardiology a decade ago. On the basis of current clinical evidence, we are unable to recommend specific antidepressant therapy for the cancer patient. Initial studies with selective serotonin reuptake inhibitors (SSRIs), the accepted first-line treatment for depression, are encouraging, but more data are needed on, for example, how long to continue treatment to prevent relapse of depressive symptoms. There is also evidence that SSRIs, like tricyclic antidepressants, have analgesic properties in patients with neuropathic pain and can be helpful as adjuvant therapy in the control of chronic pain in oncology.¹²

PSYCHIATRIC LIAISONS

When should an oncologist refer a cancer patient for psychiatric evaluation or treatment? We advocate involving a specialist in the treatment of complicated cases of depression, for example, in which the cancer patient fails

to respond to antidepressant therapy after 4 to 6 weeks or experiences recurrent episodes of depression.

We favor a system of liaison psychiatry in which a psychiatrist is available at the oncology clinic for half a day each week. This affiliation provides an opportunity for the psychiatrist to establish an ongoing relationship with oncologists and their patients. The success of the system will depend largely on the interpersonal skills of the psychiatrist in forging effective working relationships with medical colleagues; without it, the system will involve sporadic consultative services rather than an ongoing liaison.

Research in the United States suggests empirical support for a "stepped" approach to specialist involvement, meaning that the involvement increases from a psychiatric consultation by telephone, to seeing the patient briefly and giving an opinion, to taking over the patient's psychiatric management. Graded use of specialists, with appropriate use of nurses and physician extenders as facilitators, strikes a balance between need and limited availability.

PSYCHOTHERAPY

Cognitive-behavioral therapy that focuses on the patient's coping strategies and promotes a fighting spirit is reported to reduce psychological distress in cancer patients.¹³ Weekly sessions of psychotherapy over an 8-week period (1 hour per session) produced a more positive attitude toward cancer and lessened anxiety significantly. This form of psychological therapy, directed at problem-solving in individual patients, is also reported to be more effective than supportive counseling in modifying the coping response and reducing clinical anxiety.¹⁴ Since the way a patient responds to the stress of cancer can influence survival, it is clearly important to try to modify this response when it is dominated by a pessimistic attitude of hopelessness or helplessness. How a patient reacts to having cancer can be assessed with the Mental Adjustment to Cancer (MAC) Scale.¹⁵ (This 40-item questionnaire is designed to measure fighting spirit, helplessness/hopelessness, anxious preoccupation, and fatalism.) The response on the MAC scale correlates with measures of depression and anxiety on the HADS.

Cognitive-behavioral therapy is a sophisticated psychological technique that requires trained personnel to apply it. We recognize that oncologists may not have easy access to the resources needed to apply this treatment properly.

PHARMACOTHERAPY

There is placebo-controlled evidence for the antidepressant effect of mianserin, derived from small studies in patients with breast cancer.^{16,17} Although the drug has been used in Europe and South Africa, it has never been approved for use in the United States because of concerns

about its safety profile. In the only reported placebo-controlled study of an SSRI,¹⁸ cancer patients treated with fluoxetine had significantly improved quality-of-life scores but a decrease in depressive symptoms that was not significantly different from placebo. Later comparative studies with tricyclic antidepressants did demonstrate positive antidepressant effects for fluoxetine and paroxetine in cancer patients.¹⁹

Since nausea is a recognized side effect of SSRI therapy, there is a theoretical concern about the use of SSRIs in cancer patients receiving chemotherapy regimens. However, there is no clinical evidence for a negative interaction between SSRIs and chemotherapy-induced nausea: depressed patients with advanced cancer are no more likely to discontinue SSRI therapy than tricyclic antidepressant therapy owing to side effects.

Research Needs: As a group, we are concerned about the relative paucity of clinical studies of antidepressant therapy in oncology. There has also been a reluctance to look at basic psychotherapeutic techniques in well-controlled comparative studies. Clinical practice cannot be endorsed on the basis of clinical experience alone. We need more clinical studies to show that antidepressants such as the SSRIs are effective and well tolerated in oncology patients and that effective treatment has a significant impact not only on quality of life but also on pain control and mortality. We also need to know how long antidepressant therapy should be continued in a seriously depressed cancer patient and what the place of psychotherapy in the overall management strategy is. Until we have quality studies of pharmacotherapy and psychotherapy alone, it is not appropriate even to consider combination studies.

CAREGIVERS

The families of cancer patients are recognized as caregivers who are at increased risk for psychological problems.²⁰ Another group that is adversely affected by depression and anxiety is the health care providers. Providing the best possible quality of life for patients and their families is a major goal in cancer care, but exposure to stressful situations is especially prevalent in oncology and can affect the health care provider. Burnout and psychiatric morbidity are common phenomena in staff caring for cancer patients; these phenomena are provoked by the prolonged stress of dealing with patients' suffering and problems and of feeling overloaded and underresourced.²¹ Burnout is particularly apparent in younger physicians and in physicians who feel they have inadequate communication skills.²² We advise that attention be paid to the level of stress experienced by physicians caring for oncology patients and that professional training widen its focus be-

yond technical care to include psychosocial training and communication skills. We also accept the importance of continued occupational support for staff working in highly stressful situations that includes a forum for discussion of psychosocial issues relating to patient interaction, interpersonal problems, and management. This support could be provided through a system of liaison psychiatry. Physicians and other health care professionals should be able to provide care for cancer patients and patients' families without damaging their own mental health.

Drug names: fluoxetine (Prozac), paroxetine (Paxil).

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