Published in final edited form as:

Int J Geriatr Psychiatry. 2011 January ; 26(1): 21–26. doi:10.1002/gps.2497.

Depression and Barriers to Mental Health Care in Older Cancer Patients

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Abstract

Objective—To review the literature on depression in cancer patients with a particular focus on depression assessment and barriers to mental health treatment in older cancer patients.

Design—We conducted a review of the literature on depression and barriers to mental health treatment in older cancer patients.

Results—Depression is prevalent in cancer patients. However, little is known about prevalence rates of depression in older adults with cancer, assessing depression in older cancer patients and barriers that impede proper mental health treatment in this sample.

Conclusion—Improved diagnostic clarity and a better understanding of barriers to mental health treatment can help clarify and facilitate mental health referrals and ultimately improve access to care among older cancer patients in need. Continuing to consider the complexities associated with diagnosing depression in older cancer patients is necessary. Further work may be needed to develop new diagnostic measures for such detection, determine the prevalence of depression among older cancer and ways in which to overcome barriers to mental health care.

Keywords

depression; cancer; older; barriers to mental health treatment; assessment

Introduction

By the year 2030, 20% of the United States population will be over the age of 65. Sixty percent of new cancer diagnoses and 70% of cancer deaths occur in people over the age of 65. Moreover, recent estimates have shown that there is an expected 67% increase in cancer incidence among older adults compared with an 11% increase for younger adults from 2010–2030 (Smith et al. 2009). Based on the aging population statistics, geriatric oncology is becoming a new and burgeoning field, and some are even calling for it to become a formal sub-specialty (Lichtman et al. 2007). Given this expected rise in the number of older adults with cancer, the problem of depression in aging cancer patients has increasing public health importance.

Depression in Cancer Patients

Depression is particularly relevant to older cancer patients because of its high prevalence, cost, and deleterious impact on the individual and family. Rates of depression in cancer patients are wide-ranging. Rates of Major Depression are estimated as high as 38% whereas rates of depressive spectrum disorders have been found to be as high as 58% (Massie 2004). In a review of psychiatric issues in cancer patients, Breitbart (1995) reports the incidence of depression in cancer patients to be between 20–25% and increases with higher levels of disability, advanced illness and pain (Breitbart 1995). Grassi and Rosti (1999) found that out of 201 recently diagnosed cancer patients, 15% met criteria for Major Depression (Grassi and Rosti 1996). In another study, Sharpe (2004) found the prevalence of Major Depression to be nearly half that at 8% (Sharpe et al. 2004). In a review of the depression and cancer literature, Sellick and Crooks (1999) summarized the results from 15 published studies on the prevalence rates of depression and cancer from 1983–1994 (Sellick and Crooks 1999). Sellick and Crooks also found wide ranging prevalence rates of depression across studies (6 to 33%), in line with others, and have suggested that this variation has been attributed to the methodology of the study, the depression criteria and assessment tool used, and cancer site (Massie 2004) (Pasquini and Biondi 2007) (Sellick and Crooks 1999). In a recent evidence report on the occurrence, assessment and treatment of depression in cancer patients, Pirl states that the rate of Major Depressive Disorder and depressive symptoms in cancer patients ranges between 10–25%. (Pirl 2004). It has also been postulated that while many cancer patients do not meet criteria for Major Depression, subsyndromal symptoms are highly prevalent and likely require treatment (Sellick and Crooks 1999) (Pasquini and Biondi 2007). In sum, depression is a significant problem for people living with cancer (Sellick and Crooks 1999), and needs increased attention so proper assessment and recognition can improve.

As early as 1984, Massie and Holland postulated that depression in cancer patients is under-recognized, under-diagnosed and under-treated because many work under the assumption that cancer patients should be depressed (Massie and Holland 1984). This notion still pervades the field even today as this was first discussed over 25 years ago (Greenberg 2004). In a large study of over 1100 cancer patients in Indiana, for example, Passik (1998) found that oncologists had difficulty identifying patient's depression on the Zung Self-Rating Depression Scale (Passik et al. 1998). Physicians correctly identified nearly 80% of patients without depression, but only 33% of patients with mild to moderate depression and only 13% of those with severe depression.

The importance of recognizing and treating depression cannot be understated as depression is associated with decreased quality of life, significant deterioration in recreational and physical activities, relationship difficulties, and sleep problems (Alexopoulos 2005). Specific to cancer patients, depression is associated with more rapidly progressing cancer symptoms, and more metastasis and pain compared with non-depressed cancer patients (Hopko et al. 2008). Depression may not cause these issues, but the presence of depression typically worsens the distress experienced from these physical and psychosocial symptoms, and can interfere with effective coping. In a recent study of 87 advanced cancer patients assessed with the Edinburgh Depression Scale (EDS), depression was found to be an independent predictor of poor survival in patients with advanced cancer (Lloyd-Williams et al. 2009) during the 12 months following baseline. Results showed that a one-point increase on the EDS raised one's risk of death by 7%. In addition, mortality follow-up data from a randomized trial of depressed geriatric primary care patients found that among cancer patients, those in the intervention group had significantly longer survival than those receiving usual care (Gallo et al. 2007).

Another significant consequence of depression in cancer patients may be higher suicide rates. Older adults have the highest rate of suicide compared with any other age group. People with cancer and other severe medical illnesses are also at risk of suicide. Therefore, older, cancer patients are at increased risk for suicide based on their membership to two high-risk groups. Several recent studies have shown that suicide among older cancer patients is higher than in patients with other medical illnesses, after controlling for psychiatric illness and risk of dying within a year (Miller et al. 2008). Recent reports have documented the increase in suicidal thoughts (Walker et al. 2008) and specifically an increase in suicide in older patients with cancer (Misono et al. 2008). In one study, older age and severe depression were found to be significant risk factors for suicidal ideation among cancer patients (Akechi et al. 2000). Older men are particularly at high risk of suicide. In addition to proper assessment of depressive symptoms, a thorough and proper suicide assessment must be conducted. Given the negative consequences of depression, improvements need to be made in diagnosing, assessing and treating depression in cancer patients (Winell and Roth 2004).

Assessing Depression in Cancer Patients

Lack of recognition or treatment of depression in older cancer patients is explained, in part, by the challenge of assessment. Depression has been found to be one of the most difficult psychiatric problems to diagnose in cancer patients (Massie 2004) since many symptoms of cancer and the side effects of treatment overlap with the symptoms of depression. For example, significant weight loss, sleep problems, fatigue/anergia, difficulty concentrating, and thoughts of suicide may be either symptoms of depression *or* symptoms of cancer and/or its accompanying treatment side effects. Depressive symptoms may also be difficult to separate from other problems associated with cancer such as pain, anxiety, or adjustment to the cancer diagnosis.

In a recent meta-analysis, Mitchell examined data from seventeen studies to determine whether or not using the two gateway symptoms of depression (i.e. depressed mood and anhedonia) is valid in the detection of depression in cancer settings (Mitchell 2008). The findings showed that the use of *both* questions assessing, respectively, 'depressed mood' and 'anhedonia' had a sensitivity of 91% and a specificity of 86% with the PPV being 57% and the NPV being 98%. Screening patients for depression using these two symptoms may indicate the patients who require more in-depth and further psychiatric assessment. In a study of 33 cancer patients with and without Major Depression and 25 matched controls, Guo et al. employed a biostatistical approach to determine which of the Hamilton Rating Scale for depression (HAM-D) items can differentiate depression among cancer and non-cancer patients and found that six items were optimal in diagnosing depression in cancer patients (Guo et al. 2006). Specific symptoms that differentiated the groups were the presence of late insomnia, agitation, psychic anxiety, diurnal mood variation, depressed mood and sexual interest (Guo et al. 2006), setting the ground work for the potential development of a new depression measure for cancer patients. Proper assessment of depressive and suicidal symptoms in cancer patients is critical so appropriate interventions can be offered in a timely fashion.

Difficulty in diagnosing depression in cancer patients has led to the development of several diagnostic approaches used for the assessment of depression in this group including inclusive, etiologic, exclusive, and substitutive approaches (Trask 2004). These categories differ on the symptoms used for the diagnosis of depression and whether or not it encompasses the origin or etiology of the depression. The inclusive approach uses all of the symptoms of depression, regardless of whether they may or may not be secondary to a physical illness. The etiologic approach determines whether a somatic symptom is either illness or treatment related *or* due to depression as used in the DSM. The exclusive approach

excludes the somatic symptoms such as fatigue and appetite or weight change that can be seen in many cancer patients (Trask 2004). Finally, the substitutive approach replaces symptoms that may be related to the physical illness such as fatigue with additional cognitive symptoms such as hopelessness or pessimism (Trask 2004).

Diagnosing Depression in Older, Cancer Patients

Diagnostic challenges in detecting depression in cancer patients are compounded when trying to diagnose depression in older cancer patients because symptom presentation often manifests differently in both later adulthood and, as discussed, in patients with cancer (Winell and Roth 2005). Therefore, age and disease represent barriers to properly diagnosing depression. At this time, there is little epidemiologic data on the prevalence of depression in older cancer patients, and an area of further inquiry. Although not depression, distress has recently been highlighted in the empirical literature. In a large recent study of distress in 245 older cancer patients, Hurria et al. (2009) found that more than 40% of older patients with cancer had a distress thermometer score of 4 or greater (Hurria et al. 2009), a cutoff found to indicate clinically significant distress among cancer patients (Jacobsen et al. 2005). In a recent survey of 448 practicing oncologists, Muriel et al. (2009) found that the oncologists estimated that over one-third of their patients experience psychological distress needing intervention (Muriel et al. 2009). Only half of these oncologists however indicated having mental health services affiliated with their practice, and only about half (214 of 447) reported both making a referral and starting psychiatric medications.

In addition to the complexities noted above in diagnosing depression in cancer patients, older adults often present with more somatic complaints (such as body aches and malaise) as opposed to affective complaints (i.e. sadness, guilt and self-criticism) when compared with younger adults (Brodaty et al. 2005; Husain et al. 2005; Kim et al. 2002). Diagnosing depression in older cancer patients is therefore complex and requires careful assessment of depressive symptoms (e.g. (Roth and Modi 2003; Spoletini et al. 2008; Weinberger et al. 2009). The two “gateway” symptoms of depression, depressed mood and loss of pleasure or interest, are essential for assessing depression in cancer patients, yet older depressed patients are less likely to endorse these symptoms. Moreover since the somatic symptoms of depression tend to be more relevant for older patients, a cancer diagnosis can further blur the lines about the presence of depression.

In response to these complexities, it has been suggested that an assessment of depression in older cancer patients begin with a proper and thorough assessment of the two gateway symptoms of depression (i.e. depressed mood and anhedonia) (see Table 1) (Weinberger et al. 2009). Since older depressed patients are less likely to endorse these gateway questions, it is important to continue the assessment with questions that elicit information about other potential symptoms of depression in cancer patients including “general malaise” as opposed to being depressed or having loss of interest, or “general” aches and pains or stomach aches as opposed to specific tumor site pain or specific side effect of cancer treatment.

Hopelessness should also be assessed as many patients with cancer express some hope for a meaningful future regardless of life expectancy or a cure of their cancer. Thus, reporting little or no hope for either may be a sign of depression. Sleep may be problematic for both patients with cancer and older adults ; however, it is important to ask if the patient wakes-up in the middle of the night (middle insomnia) and has difficulty getting back to sleep because they worry or feel anxious, or wakes up too early in the morning (late insomnia) (Guo et al. 2006). Though nuanced, it is important to look for reason or cause for the insomnia. An older depressed patient may also report mood variation during the day. For example, the patient may report that during part of the day their mood is euthymic, however, an older cancer patient may spend most of the day with a general malaise signaling depression.

Barriers to Mental Health Treatment Among Cancer Patients

In addition to the difficulties of diagnosing depression in older cancer patients, once depression is properly diagnosed and referrals are made, many older cancer patients face barriers to accessing mental health treatment services. Even though effective treatments exist for depression, these treatments appear to be underutilized among cancer patients (Kadan-Lottick et al. 2005). Among advanced cancer patients, 12% were found to have a major psychiatric condition assessed via psychiatric interviewing, yet only approximately one-fourth of these patients accessed a mental health intervention (Kadan-Lottick et al. 2005). The reasons for this lack of mental health service use are largely unknown.

There is a paucity of research in examining barriers to depression care among cancer patients. Uncertainty and cost have been found to be major barriers to depression care among cancer patients (Greenberg 2004). That is, cancer patients are often confused about the occurrence of depression compared with other sources of sadness related to their cancer diagnosis or comorbid symptoms of cancer, and other psychiatric syndromes such as adjustment disorder or dysthymia. Both patients and clinicians therefore require diagnostic clarity. This uncertainty often leaves the patient unsure about their psychiatric diagnosis and related treatment options. Cost has also been identified as a major barrier to care. Since mental health coverage is often limited, cost can reduce the access to and the positive impact of psychosocial interventions (Greenberg 2004). New psychosocial interventions that can be covered under Medicare should be explored for older cancer patients with depression to alleviate or offset their cost barrier. However, one financial barrier for older cancer patients accessing care is finding a mental health professional who accepts Medicare insurance.

Similar to patients without cancer, cancer patients worry about medication side effects, confidentiality issues, and stigma of treatment (Von Korff et al. 2001). Many cancer patients also assume that depression is a 'normal' reaction rather than a comorbid and serious condition that can benefit from treatment (Passik et al. 1998). Recent research has found that advancing age was associated with a lower likelihood of being referred for specialized psychosocial oncology care regardless of level of distress (Ellis et al. 2009). In the most depressed in this study, only 22% of patients over age 70 were referred compared to 100% of patients under 40 years old (Ellis et al. 2009). More generally, less than half of the older patients who scored above the specific cutoff on measures of depression and hopelessness at baseline were referred. Therefore, older adults with cancer and significant psychological distress are typically not being referred for psychiatric treatment. In one of the few studies to clarify the types and occurrence of patient perceived barriers to psychological care in a medical context among cancer patients, Endo and colleagues factor analyzed data from a self-administered measure of 100 lung cancer patients in Japan (M age=65 years of age) (Endo et al. 2008). Results illustrated that patients reported that a lack of correct information or misunderstanding about treatments, negativity toward psychotropic medications, and more severe psychological distress were barriers to mental health care.

Summary and Conclusion

Improved diagnostic clarity and a better understanding of barriers to mental health treatment can help clarify and facilitate mental health referrals and ultimately improve access to care among older cancer patients in need. Continuing to consider the complexities associated with diagnosing depression in older cancer patients is necessary. Further work is needed to develop new diagnostic measures for such detection, determine the prevalence of depression among older cancer and ways in which to overcome barriers to mental health care.

Acknowledgments

This review was supported by NIMH grant to support the lead author (MIW) (T32 MH073553; S. Bartels/M. Bruce)

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Table 1**Diagnosing Depression in Older Cancer Patients****Step 1: Gateway Symptoms of Depression**

Assess two gateway symptoms of depression (depressed mood and anhedonia)

Step 2: Additional Symptoms of Depression

Assess other symptoms of depression that may help differentiate depressive from cancer symptoms

- Weight loss or gain
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue
- Feelings of worthlessness or inappropriate guilt
- Reduced ability to concentrate
- Recurrent thoughts of death or suicide

Step 3: Differentiating Depression

Assess symptoms to focus on differentiating cancer and depressive symptoms in older patients with cancer.

- General malaise: Older patients may be less likely to report 'loss of interest' and 'sad mood,' and more commonly report a general malaise or dissatisfaction.
- General aches and pains/stomach aches: As opposed to cancer or tumor specific pain
- Diffuse somatic complaints: As opposed to specific complaints associated with treatment side effects.
- Hopelessness: Most patients with cancer are somewhat hopeful about the upcoming treatment and potential outcome; however older depressed adults may see little purpose or hope to treatments.
- Late insomnia: Waking up in the middle of the night with difficulty getting back to sleep because of worry or concern.
- Mood variation: The reporting mood changes throughout the day.
- Change/Loss of sexual interest

Table adapted from Weinberger, Roth and Nelson (2009), *The Oncologist* (Weinberger et al. 2009)