Pirl and Roth synthesize well the rich literature that now exists on the prevalence, causes, and treatment of depression in patients with cancer. Their review focuses attention on: (1) those factors—patient- as well as disease- and treatment-related— that may place an individual at increased risk for depression when cancer is diagnosed; and (2) the need for regular screening of patients with respect to their emotional and social functioning throughout the disease course.[1]

**Barriers to Optimal Psychological Care**

Given how much we know already about depressive disorders in cancer patients, one might reasonably ask, why aren’t we doing a better job of recognizing and treating these disorders when they occur? The answer to this question may lie in a broader appreciation of the potential barriers, both provider- and patient-based, to optimal psychological care of cancer patients.

Chief among these barriers, both in the past and today, is the lack of a perceived need. As the authors observe, the common presumption that a certain degree of “suffering” is simply attendant to a cancer diagnosis often results in clinicians failing to recognize, and patients to report, symptoms that warrant further follow-up. How often, in the face of a patient’s distress, have we heard someone say (or even thought to ourselves): “Gee, I’d be depressed too if I had cancer”?

At times, the debate over which symptoms are likely attributable to a medical condition and which to a cognitive or emotional state itself can be a barrier to more aggressive intervention. The critical message to clinicians is that signs of depression, whatever their nature (neurovegetative or cognitive/emotional) or source (disease, treatment, situational, personal), warrant careful, prompt evaluation, particularly if they persist.

**Assessing Patients for Depression**

A number of other provider barriers further contribute to inadequate patient care. Although Pirl and Roth provide brief guidelines on assessing cancer patients for depression, techniques for evaluating a patient’s emotional status are not systematically covered in most oncology training programs. As a result, clinicians may feel ill-prepared to address this aspect of their patients’ health; they may also incorrectly conclude that it is not their responsibility.

Recent trends in managed care, in which providers are being asked to see more patients for a lower cost, tend to foster such a stance. In the busy practice where there is already limited time to deal with the demands of complex medical management, psychosocial concerns often have little place. Clinicians may assume that this component of treatment is being provided by others. Unfortunately, unless someone is specifically identified to address a patient’s social and emotional well-being, these aspects of care are often neglected.

As the authors and others note, there now exist a number of tools clinicians can use to conduct psychosocial assessments.[2,3] In a team care setting, it is possible to assign one team member to discuss these issues with each patient. Furthermore, training programs to enhance established physicians’ skills in patient interviewing are beginning to appear.[4]

**Gaining Familiarity With Referral Resources**

Reservations about acknowledging distress can arise from a concern about what to do if the patient “goes to pieces” or starts crying in the office. Before launching into a discussion with a patient about emotional functioning, clinicians must be knowledgeable about available mental health referral systems, from colleagues in psychiatry, to other psycho-oncology support providers (psychology, social work, pastoral care, nursing, peer counselors), to community resource programs. Diverse psychosocial services are routinely available in large clinical centers.[5,6] However, these types of interventions may be harder to access by those in private offices or the community, and require additional research by the treating staff to identify referral resources.
Alternatively, a mental health professional can serve as a regular member of the oncology team.[7,8] This model has the advantage of making the provision of mental health services an integral part of care, more accessible and acceptable to patients and staff alike. In addition, a number of brief interventions that can be delivered by oncology staff are available and can be useful in managing reactive distress in the clinical setting.[9,10]

Although many oncologists may feel comfortable about prescribing antidepressant medications, most cancer patients are reluctant to take mood-altering drugs. Furthermore, because the depression seen in cancer patients is often complicated by concurrent situational as well as medical factors, it is rarely sufficient to treat these conditions with medication alone. Counseling and other “talk” therapies are often necessary adjuncts to successful treatment of depression in cancer patients.

**Concern Over Cost and Consequences**

Finally, physicians may be reluctant to refer a patient for psychiatric evaluation out of concern for the cost and consequences of such care. Despite major advances in our understanding of mental disorders, they still carry a considerable stigma in our society. Fortunately, patients themselves are beginning to lobby to make such services more readily affordable and available to those with chronic medical conditions, without fear of jeopardizing future employment or insurance options. On the other hand, the clinician who correctly identifies signs of depression in a patient should be aware that resistance to referral or treatment can also come from the patient. Worden and Weisman, in their seminal work on recognizing and treating psychological distress in cancer patients, found that one-third of patients identified as needing more intensive psychological intervention refused help when it was offered.[10]

Although more research is needed to determine the reasons why cancer patients do not seek such help, several explanations can be offered. Most patients wish to be perceived as handling their illness well. Consequently, patients may resent or feel overwhelmed by any suggestion that they are not coping well with their cancer. They may feel guilty for burdening family, or for not being able to manifest the fighting spirit that they or their loved ones expect. By the same token, family members, fearful of the meaning of psychological care to them or others, can undermine the clinicians’ attempts to access such care for a patient.

Physicians need to be aware of the central role that they play in helping patients obtain psychological care. Expressing interest in a patient’s emotional health and, as appropriate, referring the patient for further evaluation and treatment are often the keys to enabling the patient to receive and benefit from optimal medical care.

**Benefits of Treating Depression**

As Pirl and Roth point out, the benefits of treating depression in the oncology setting are significant, not just for the patient but also for the provider. Although many clinicians fear that eliciting and listening to a patient’s distress will foster lengthy visits, the reverse appears to be the case. Timely recognition and treatment of a patient’s suffering can prevent more complex, costlier treatment of the same problem when, if left unattended, it reaches a crisis stage. Mental health interventions in other arenas have already proven to reduce medical costs, including additional doctor visits.[11,12] It is hoped that after reading this review, few oncologists will assume that depressive symptoms are normal in the patients in their care and, importantly, will feel better prepared to identify and address depression in those patients.

**References:**


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